Article - Health - General

§1–101.

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

(a–1) "Active service member" has the meaning stated in § 9–901 of the State Government Article.

(b) "County" means a county of this State and, unless expressly provided otherwise, Baltimore City.

(c) "Department" means the Maryland Department of Health.

(d) "Domestic partner" means an individual who meets the requirements of § 6–101 of this article.

(e) "Health officer" means, unless expressly provided otherwise, the Baltimore City Commissioner of Health or the health officer of a county.

(f) "Includes" or "including" means includes or including by way of illustration and not by way of limitation.

(g) "Local health planning agency" means the health department of a jurisdiction or a body designated by the local health department to perform health planning functions.

(h) "Medical examiner" means:

(1) The Chief Medical Examiner;

(2) The Deputy Chief Medical Examiner;

(3) Any assistant medical examiner; or

(4) Any deputy medical examiner.

(i) "Person" means an individual, receiver, trustee, guardian, personal representative, fiduciary, or representative of any kind and any partnership, firm, association, corporation, or other entity.

(j) "Physician" means an individual who is authorized under the Maryland Medical Practice Act to practice medicine in this State.

(k) "Secretary" means the Secretary of Health.

(k–1) "Service member" has the meaning stated in § 9–901 of the State Government Article.

(l) "State" means:

(1) A state, possession, or territory of the United States;

(2) The District of Columbia; or

(3) The Commonwealth of Puerto Rico.

(m) "Uniformed services" has the meaning stated in § 9–901 of the State Government Article.

(n) "Veteran" has the meaning stated in § 9–901 of the State Government Article.

§1–201.

(a) A requirement in this article that a document be verified means that the document shall be verified by a declaration made under the penalties of perjury that the matters and facts contained in the document are true to the best of the knowledge, information, and belief of the individual making the declaration.

(b) The verification shall be made:

(1) Before an individual authorized to administer oaths; or

(2) By a signed statement of verification that:

(i) Is in the document or attached to and made part of the document; and

(ii) States that the statement is made under the penalties for perjury.

(c) If the procedures provided in subsection (b)(2) of this section are used, the statement of verification subjects the individual making the statement to the penalties for perjury to the same extent as if the statement had been verified under oath before an individual authorized to administer oaths.

§1–202.

Before any license or permit may be issued under this article to an employer to engage in an activity in which the employer may employ a covered employee, as defined in § 9-101 of the Labor and Employment Article, the employer shall file with the issuing authority:

(1) A certificate of compliance with the Maryland Workers' Compensation Act; or

(2) The number of a workers' compensation insurance policy or binder.

§2–101.

There is a Maryland Department of Health, established as a principal department of the State government.

§2–102.

(a) The head of the Department is the Secretary of Health, who shall be appointed by the Governor with the advice and consent of the Senate.

(b) (1) The Secretary serves at the pleasure of the Governor and is responsible directly to the Governor. The Secretary shall advise the Governor on all matters assigned to the Department and is responsible for carrying out the Governor's policies on these matters.

(2) The Secretary is responsible for the operation of the Department and shall establish guidelines and procedures to promote the orderly and efficient administration of the Department. The Secretary may establish, reorganize, or abolish areas of responsibility in the Department as necessary to fulfill the duties assigned to the Secretary.

(c) The Secretary is entitled to the salary provided in the State budget.

§2–103.

(a) (1) With the approval of the Governor, the Secretary shall appoint the following five deputy secretaries:

(i) The Deputy Secretary for Behavioral Health;

(ii) The Deputy Secretary for Health Care Financing;

(iii) The Deputy Secretary for Operations;

(iv) The Deputy Secretary for Public Health Services; and

(v) The Deputy Secretary for Developmental Disabilities.

(2) The deputy secretaries serve at the pleasure of the Secretary.

(3) The deputy secretaries are entitled to the salary provided in the State budget.

(4) The deputy secretaries have the duties provided by law or delegated by the Secretary.

(b) (1) The Secretary may employ a staff in accordance with the State budget.

(2) Each deputy secretary and professional consultant is appointed by and serves at the pleasure of the Secretary.

(3) Except as provided in paragraph (5) of this subsection or otherwise by law, the Secretary shall appoint and remove all other staff in accordance with the provisions of the State Personnel and Pensions Article.

(4) The appointment or removal of staff of any unit in the Department is subject to the approval of the Secretary. As to any unit in the Department, the Secretary may delegate this authority to the head of that unit.

(5) All personnel in the Department, Grade 18 and above, who administer or direct a program, shall:

(i) Be in the executive service, management service, or special appointments in the State Personnel Management System; and

(ii) Be appointed by, and serve at the pleasure of, the Secretary.

(6) All personnel in the Department, Grade 18 and above, who administer or direct a program, shall disclose all other employment and compensation outside the Department to the Secretary. An individual under this paragraph may not be employed or receive compensation outside the Department that would create a conflict of interest, an appearance of a conflict of interest, or impair the impartiality and independence of judgment of the individual.

(c) In determining the staff-to-resident ratio in any residential facility that the Department operates, the number of residents shall be the total of the residents who are physically present and who are on leave of 18 days or less.

§2–104.

(a) The Secretary is responsible for the budget of the office of the Secretary and for the budget of each unit in the Department.

(b) (1) The Secretary may adopt rules and regulations to carry out the provisions of law that are within the jurisdiction of the Secretary.

(2) (i) The Secretary shall adopt regulations, in consultation and cooperation with local governing bodies, to govern the siting of community residences for special populations funded by the Department, the Department of Housing and Community Development, the Department of Human Services, and the Department of Juvenile Services.

(ii) Any regulations adopted shall comply with the federal Fair Housing Amendment Act of 1988.

(iii) Prior to the adoption of any regulations proposed under this paragraph, the Secretary shall conduct a public hearing for the sole purpose of allowing all the governing bodies of each county and municipality the opportunity to review and comment on the proposed regulations.

(3) The Secretary shall review and may revise the rules and regulations of:

(i) Each unit in the Department that is authorized by law to adopt rules and regulations; and

(ii) The Department.

(c) The Secretary may create an advisory board for the Department. The Secretary shall determine the size of the advisory board. The members shall be representative of the different professional areas or fields of endeavor with which the Department is concerned.

(d) The Secretary may create any advisory council that the Secretary considers necessary and assign appropriate functions to it.

(e) The Secretary shall have a seal.

(f) (1) The Secretary is responsible for the coordination and direction of all planning that the office of the Secretary initiates.

(2) The Secretary shall keep fully apprised of plans, proposals, and projects of each unit in the Department and, except as expressly provided otherwise, may approve, disapprove, or modify any of them.

(g) Each unit in the Department shall report to the Secretary as provided in the rules, regulations, or written directives that the Secretary adopts.

(h) Except as expressly provided otherwise, the Secretary may transfer, by rule, regulation, or written directive, any function, staff, or funds from any unit in the Department to the office of the Secretary or another unit in the Department. Any staff transferred to the office of the Secretary shall be provided space, equipment, and services by the unit from which it was transferred, unless the Secretary orders removal to another location for the proper and efficient functioning of that office.

(i) The Secretary may apply for, receive, and spend grants–in–aid by the federal government or any of its agencies or any other federal funds made available to the Department for use in carrying out the powers and duties of the Secretary or the Department.

(j) The Secretary shall pay all money collected by the Department under this article into the General Fund of this State.

(k) (1) The Secretary or a designee of the Secretary may subpoena any person or evidence, administer oaths, and take depositions and other testimony.

(2) If a person fails to comply with a lawful order or subpoena issued under this subsection, on petition of the Secretary or designee, a court of competent jurisdiction may compel obedience to the order or subpoena or compel testimony or the production of evidence.

(3) A witness who is subpoenaed at the request of the Secretary or designee is entitled to receive the same fees and mileage provided for by law in civil cases. However, a witness who is subpoenaed at the request of any other party is not entitled to fees or mileage, unless the Secretary or designee certifies that the testimony was material to the matter investigated. The fee and mileage paid under this subsection shall be audited and paid by this State in the same way other expenses are audited and paid and shall be charged to the general appropriation for the Department.

(l) (1) The Secretary or an agent or employee of the Secretary may enter, at any reasonable hour, a place of business or public premises if the entry is necessary to carry out a duty under this article or the Health Occupations Article.

(2) A person may not deny or interfere with an entry under this subsection.

(3) A person who violates any provision of this subsection is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100.

(m) The Secretary shall carry out and enforce the provisions of this article, the rules and regulations of the Department, and any other provisions of law that relate to the Secretary or the Department.

(n) (1) The Secretary may adopt regulations establishing fees not to exceed an amount sufficient to cover the administrative costs associated with:

(i) Inspections or investigations carried out under this article; and

(ii) Permits, licenses, certifications, or registrations issued under this article.

(2) The Secretary may waive all or part of any fee established under this subsection.

(o) (1) The Secretary shall designate an agricultural ombudsman.

(2) The agricultural ombudsman shall:

(i) Serve as the primary point of contact for individuals involved in agriculture who interact with the Department; and

(ii) Provide information regarding departmental regulations relating to on–farm food processing, on–farm food preparation, and other on–farm activities.

(p) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Alternative workweek" means a work schedule for an employee of a State facility under which the employee may work less than 40 hours in a week.

(iii) "State facility" means a health care facility that is:

1. Owned or operated by the Department; and

2. Open 24 hours a day and 7 days a week.

(2) Beginning May 1, 2021, the Secretary may authorize an employee of a State facility to work according to an alternative workweek if the alternative workweek is consistent with:

(i) Any applicable collective bargaining memorandum of understanding; or

(ii) If the employee is not covered by an applicable collective bargaining memorandum of understanding, any other written agreement.

(3) An employee of a State facility who works an alternative workweek as authorized under paragraph (2) of this subsection shall be considered a full–time employee of the State, notwithstanding any other provision of law.

§2–104.1.

(a) Before procuring a system for collecting and storing electronic health records, as defined in § 19–142 of this article, the Department shall consult with local health departments to assess the necessary qualities of an electronic health records system.

(b) If the Department procures a system for collecting and storing electronic health records, the Department shall notify each health officer for a county and offer the county health department the opportunity to join the procurement.

§2–105.

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

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

(c) The Secretary shall adopt and revise as necessary a State health improvement plan that includes the following:

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

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

(3) Identification of unmet needs and excess services for facilities and services not regulated by the certificate of need program; and

(4) An assessment of the financial resources required and available for the health care system.

§2–106.

(a) The following units are in the Department:

(1) Anatomy Board.

(2) Behavioral Health Administration.

(3) Developmental Disabilities Administration.

(4) Health Services Cost Review Commission.

(5) Maryland Psychiatric Research Center.

(6) Office of the Chief Medical Examiner.

(7) Board of Examiners for Audiologists, Hearing Aid Dispensers, Speech–Language Pathologists, and Music Therapists.

(8) Board of Chiropractic Examiners.

(9) Board of Dental Examiners.

(10) Board of Dietetic Practice.

(11) Board of Electrologists.

(12) Board of Morticians and Funeral Directors.

(13) Board of Nursing.

(14) Board of Long–Term Care Administrators.

(15) Board of Occupational Therapy Practice.

(16) Board of Examiners in Optometry.

(17) Board of Pharmacy.

(18) Board of Physical Therapy Examiners.

(19) Board of Physicians.

(20) Board of Podiatric Medical Examiners.

(21) Board of Professional Counselors and Therapists.

(22) Board of Examiners of Psychologists.

(23) Board of Social Work Examiners.

(24) Acupuncture Board.

(25) Board of Massage Therapy Examiners.

(26) Board for Certification of Residential Child Care Program Professionals.

(27) Board of Environmental Health Specialists.

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

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

§2–107.

(a) The Attorney General is legal adviser to the Department.

(b) The Attorney General shall assign to the Department the number of assistant attorneys general authorized by law to be assigned to the Department and any additional ones necessary to give effective legal advice and counsel. The Attorney General also shall designate an assistant attorney general as counsel to the Department.

(c) The counsel to the Department may have no duty other than to give the legal aid, advice, and counsel required by the Secretary and any other official of the Department, to supervise the other assistant attorneys general assigned to the Department, and to perform for the Department the duties that the Attorney General assigns. The counsel shall perform these duties subject to the control and supervision of the Attorney General. After the Attorney General designates the counsel to the Department, the Attorney General may not reassign the counsel without consulting the Secretary.

§2–108.

(a) On the Secretary's initiative or on request of a community or voluntary, nonprofit organization, the Secretary may conduct a survey to identify any area in this State that has a substantial deficiency in general or specific medical or health care facilities, staff, or services.

(b) In cooperation with appropriate county and State groups, the Secretary may provide the community or organization with counsel and other help to establish medical or health care facilities or services and to recruit medical or health care staff in an underserved area identified as a result of the survey conducted in accordance with subsection (a) of this section.

(c) If the counsel and other help provided under subsection (b) of this section do not result in feasible or successful proposals, or if other action is necessary to assure the public health of the underserved area, the Secretary may:

(1) Provide the needed health care facilities, staff, or services by contract with one or more physicians, hospitals, or other medical groups or personnel; or

(2) To facilitate the provision of State health care services to the underserved area, approve a contract or other written arrangement with a public or private health care entity, including:

(i) A federally qualified health center;

(ii) A health care facility, as defined in § 19–114 of this article;

(iii) A health benefit plan or insurance carrier;

(iv) A health maintenance organization;

(v) A managed care organization; and

(vi) Any other entity that finances the provision of or delivers health care services to the area.

§2–301.

The Governor shall include in the State budget, beginning with fiscal year 1997, at a minimum, sufficient funds for local health services as required by this subtitle.

§2–302.

(a) The funding required in the State budget for local health services, exclusive of special fund and federal appropriations, shall be at least the amount set forth in subsection (b) of this section.

(b) The funding shall be:

(1) For fiscal years 2019, 2020, 2021, 2022, 2023, and 2024, the amount of funding provided through the formula for the preceding fiscal year adjusted for:

(i) Inflation, as measured by the Consumer Price Index (All Urban Consumers), on June 30 of the second preceding fiscal year, calculated by the Bureau of Labor Statistics of the U.S. Department of Labor; and

(ii) Population growth, as measured by the growth in the total population of the State on June 30 of the second preceding fiscal year, according to the most recent statistics available through the U.S. Department of Commerce;

(2) For fiscal year 2025, $70,000,000, to be distributed to each municipality or subdivision in the same proportion as the fiscal year 2024 funding distributed to each municipality or subdivision;

(3) For fiscal year 2026, $80,000,000, to be distributed to each municipality or subdivision in the same proportion as the fiscal year 2025 funding distributed to each municipality or subdivision; and

(4) For fiscal year 2027 and each subsequent fiscal year, the greater of:

(i) The funding provided by the formula for the immediately preceding fiscal year; or

(ii) The actual funds appropriated for the immediately preceding fiscal year, adjusted for:

1. Inflation, as measured by the Consumer Price Index (All Urban Consumers), on June 30 of the second immediately preceding fiscal year, calculated by the Bureau of Labor Statistics of the U.S. Department of Labor; and

2. Population growth, as measured by the growth in the total population of the State on June 30 of the second immediately preceding fiscal year, according to the most recent statistics available through the U.S. Department of Commerce.

(c) For fiscal year 2027 and each subsequent fiscal year, no subdivision may receive less State funding for local health services under this section than that subdivision received in fiscal year 2026.

(d) The Secretary shall, in consultation with local health department directors, adopt regulations to guide the distribution of the funding required under this section. The regulations shall give consideration to appropriate measures of community health need, local funding effort, and other relevant factors.

§2–303.

As to appropriations required by this subtitle, a local match shall be required as a condition of any distribution to a subdivision; however, the local match percentage required by the Secretary of Health may not exceed the local match percentage required for the subdivision for fiscal year 1996.

§2–304.

The appropriations described in this subtitle shall be used for programs, including related administrative expenses, directed at the following:

(1) Communicable disease control services;

(2) Environmental health services;

(3) Family planning services;

(4) Maternal and child health services;

(5) Wellness promotion services;

(6) Adult health and geriatric services;

(7) Data management and exchange services regarding communicable diseases and other health matters, as allowed under federal and State law;

(8) Providing protective equipment for nurses, physician assistants, physicians, and other health care personnel in contact with patients;

(9) Providing equipment, medication, and other materials determined to be appropriate to prepare for potential communicable disease emergencies, or other public health emergencies; and

(10) Administration and communication services associated with the provision of the services described in items (1) through (9) of this section.

§2–305.

The funds designated for the provision of local health services under this subtitle may not be transferred to any other program for any other purpose.

§2–401.

(a) A local health planning agency shall:

(1) Develop a local health plan by assessing local health needs and resources; and

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

(b) The Department may require that in developing local health plans, each local health planning agency:

(1) Use data compatible with State data and data used by other local health planning agencies;

(2) Meet applicable planning specifications; and

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

(c) Subject to the annual State budget, the Department shall provide funding to local health planning agencies for implementation of the functions under

this section and any other functions required by the Department or the Maryland Health Care Commission.

§2–501.

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

(b) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to a program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized health care standards.

(c) "Claim" means a request or demand for money, property, or services made under contract or otherwise, by a contractor, grantee, provider, or other person seeking money for the provision of health services if:

(1) The State or Department provides any portion of the money or property that is requested or demanded; or

(2) The State or Department reimburses the contractor, grantee, provider, or other person for any portion of the money or property that is requested or demanded.

(d) "Employee" means any individual who performs services for, or under the control or direction of, a provider for wages or other remuneration.

(e) (1) "Fraud" means an intentional material deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit or payment.

(2) "Fraud" includes any act that constitutes fraud under applicable State or federal law.

(e–1) "Office" means the Maryland Office of the Inspector General for Health established under § 2–502 of this subtitle.

(f) "Program" means the Medical Assistance Program, the Cigarette Restitution Fund Program, the Developmental Disabilities Administration, the Behavioral Health Administration, the Prevention and Health Promotion Administration, or any other unit of the Department that pays a provider for a service rendered or claimed to have been rendered to a recipient.

(g) (1) "Provider" means:

(i) An individual licensed or certified under the Health Occupations Article to provide health care;

(ii) A licensed facility that provides health care to individuals;

(iii) Any other person who or entity that provides health care, products, or services to a program recipient; or

(iv) A contractor, subcontractor, or vendor who directly or indirectly provides the Department or its recipients supplies, drugs, equipment, or services.

(2) "Provider" does not include a State agency that receives grant funding from or through the Department if that agency has in place a corporate compliance program that meets departmental requirements.

(h) "Recipient" means an individual who receives benefits under a program.

(i) "Recovery" means the repayment of money to the Department by a provider through return, reimbursement, recoupment, withholding of future payments, offsets, or any other method.

§2–502.

(a) There is a Maryland Office of the Inspector General for Health.

(b) The Office is an independent unit of the State.

(c) (1) Subject to paragraph (2) of this subsection, the Office shall have access to the following services of the Department:

(i) Information technology;

(ii) Budget and finance;

(iii) Human resources;

(iv) Police;

(v) Procurement; and

(vi) Support services.

(2) The Office shall, in consultation with the Department, develop policies and adopt regulations regarding the use and confidentiality of the services listed in paragraph (1) of this subsection.

(d) The Office shall:

(1) Maintain a physical location within the Department; and

(2) Develop policies and adopt regulations regarding the use and confidentiality of the location of the Office.

§2–502.1.

(a) There is an Inspector General in the Maryland Office of the Inspector General for Health.

(b) (1) An individual is eligible to be the Inspector General only if the individual executes an affidavit stating that the individual will not accept appointment to, or be a candidate for, a State or local office:

(i) During the period of service as the Inspector General; and

(ii) For at least 3 years immediately after the individual last serves as the Inspector General.

(2) The Inspector General shall renew the affidavit every 2 years during the period of service.

(3) A failure to renew the affidavit under this subsection shall subject the Inspector General to removal from office under this section.

(c) (1) The Inspector General shall be appointed unanimously by the Governor, the Attorney General, and the State Treasurer, subject to the advice and consent of the Senate.

(2) The term of the Inspector General is 5 years, beginning July 1 after the appointment of the Inspector General.

(3) At the end of a term, the Inspector General shall continue to serve until a successor is appointed.

(4) If a vacancy occurs in the Office, an interim Inspector General shall be appointed as successor to serve for the remainder of the unexpired term.

(d) The Inspector General may be removed unanimously by the Governor, the Attorney General, and the State Treasurer for:

(1) Misconduct in office;

(2) Persistent failure to perform the duties of the Office; or

(3) Conduct prejudicial to the proper administration of justice.

(e) (1) Subject to paragraph (2) of this subsection, the Inspector General must be professionally qualified through experience or education in at least one of the following areas:

(i) Law;

(ii) Auditing;

(iii) Government operations;

(iv) Financial management; or

(v) Health policy.

(2) If the Inspector General is professionally qualified in the area of health policy, the Inspector General also must be professionally qualified through experience or education in at least one of the other areas listed in paragraph (1) of this subsection.

(f) (1) The Inspector General is entitled to the salary provided in the State budget.

(2) Funding for the Office shall be as provided in the State budget.

§2–502.2.

(a) There is a Compliance Officer within the Maryland Office of the Inspector General for Health.

(b) (1) The Compliance Officer shall be designated by the Inspector General.

(2) The Compliance Officer shall be professionally qualified through experience or education in at least one of the following areas:

(i) Administrative management;

(ii) Health care compliance standards; or

(iii) Public health.

(c) The Compliance Officer shall ensure that units and employees of the Department comply with:

(1) Best practices in health care, public health, and government administration; and

(2) Laws, regulations, and Department policies.

§2–503.

(a) The Inspector General:

(1) May investigate fraud, waste, abuse of departmental funds, and behavior in the Department that threatens public safety or demonstrates negligence, incompetence, or malfeasance;

(2) Shall cooperate with and coordinate investigative efforts with the Medicaid Fraud Control Unit and where a preliminary investigation establishes a sufficient basis to warrant referral, shall refer such matters to the Medicaid Fraud Control Unit; and

(3) Shall cooperate with and coordinate investigative efforts with departmental programs and other State and federal agencies to ensure a provider is not subject to duplicative audits.

(b) (1) The Inspector General or a designated Assistant Inspector General may subpoena any person or evidence, administer oaths, and take depositions and other testimony for the purpose of investigating fraud, waste, abuse of departmental funds, or behavior in the Department that threatens public safety or demonstrates negligence, incompetence, or malfeasance.

(2) If a person fails to comply with a lawful order or subpoena issued under this subsection, on petition of the Inspector General or a designated Assistant Inspector General, a court of competent jurisdiction may compel:

(i) Compliance with the order or subpoena; or

(ii) Testimony or the production of evidence.

(c) Within 30 business days after receiving a complaint or allegation, the Inspector General, the Compliance Officer, or a designated Assistant Inspector General shall respond to the individual who filed the complaint or allegation with:

(1) A preliminary indication of whether the Office of the Inspector General is able to investigate the complaint or allegation; and

(2) If the Office of the Inspector General is unable to investigate the complaint or allegation:

(i) The reason for not being able to investigate, unless providing the reason would have a negative impact on or jeopardize an investigation being conducted by the Office of the Inspector General, a managed care organization, another unit of government, or law enforcement; and

(ii) The contact information for the Office of Legislative Audits Fraud Hotline.

§2–504.

The Inspector General, in collaboration with the appropriate departmental program, may:

(1) Take necessary steps to recover any mistaken claims paid or payments obtained in error or fraudulent claims paid to or obtained by a provider; and

(2) Take necessary steps to recover the cost of benefits mistakenly paid or obtained in error, or fraudulently paid to or obtained by a recipient.

§2–504.1.

(a) Except as otherwise prohibited by State or federal law, in the sole discretion of the Inspector General, the Inspector General may impose a civil money remedy against a provider for a violation of State or federal law governing the conditions of payment for any service or item for which the provider submitted a claim for payment and received payment.

(b) A civil money remedy imposed under this section:

(1) Is in lieu of full payment or full adjustment of the paid claim and not in addition to repayment of the claim;

(2) May not be less than the federal financial participation share of the identified improper claim amount;

(3) May not be imposed if the claim was included in the universe of claims under an extrapolation calculation; and

(4) Is only available if the provider has not been subjected to a repayment penalty or fine, a criminal action, or a civil false claims action under either federal or State law for the same claim.

(c) (1) A civil money remedy may not exceed the amount of reimbursement that the provider received for the paid claim.

(2) In determining whether to impose a civil money remedy under this section and in setting the amount of the civil money remedy, the Inspector General shall consider:

(i) The number, nature, and seriousness of the violations;

(ii) The provider's history of compliance;

(iii) The efforts made by the provider to correct the violations and any continuation of conduct after notification of possible violations;

(iv) The provider's level of cooperation with the Department or Inspector General as it relates to the review of the claim;

(v) The degree of risk to the health, life, or safety of consumers as a result of the violations; and

(vi) Any other reasonable factors as fairness may require.

(3) In weighing the factors set forth in paragraph (2) of this subsection, the Inspector General shall, if appropriate, give special consideration to the extent to which the provider's size, operations, or financial condition:

(i) May have contributed to the violations; and

(ii) May affect the provider's ability to provide care and continue operations after payment of a civil money remedy.

(d) If a civil money remedy is imposed under this section, the Inspector General shall issue a written notice and order to the provider that:

(1) States the total amount of the civil money remedy; and

(2) Includes the following information:

(i) The basis on which the order is made;

(ii) Each regulation or statute violated;

(iii) The amount of each civil money remedy imposed for each violation;

(iv) The number of claims and total value of the claims identified with errors; and

(v) The manner in which the amount of the civil money remedy was calculated.

(e) The notice and order shall be served on the provider by certified mail and shall include a statement that explains the provider's right to appeal the order in accordance with Title 10, Subtitle 2 of the State Government Article.

(f) (1) An order that imposes a civil money remedy is final when the provider has exhausted all opportunities to contest the civil money remedy in accordance with Title 10, Subtitle 2 of the State Government Article.

(2) After exhaustion of all appeals, a provider shall pay a civil money remedy to the Department within 10 days after the provider receives a final order that affirms the imposition of the civil money remedy unless the Inspector General negotiates and approves a repayment schedule.

(g) The Inspector General, in consultation with stakeholders, shall adopt regulations to implement this section.

§2–505.

(a) A person is not civilly liable for:

(1) Making a report in good faith of fraud, waste, or abuse; or

(2) Participating in any investigation related to fraud, waste, or abuse.

(b) (1) This subsection does not apply to an employee as defined in § 1–501(c) of the Health Occupations Article or a State employee.

(2) A provider may not take a retaliatory action against an employee because the employee:

(i) Discloses or threatens to disclose to a supervisor or to a public body an activity, policy, or practice of the provider that the employee reasonably believes is in violation of this subtitle or a regulation adopted under this subtitle;

(ii) Provides information to, or testifies before, a public body conducting an investigation, hearing, or inquiry into a suspected violation by the provider under this subtitle or a regulation adopted under this subtitle; or

(iii) Objects to or refuses to participate in any activity, policy, or practice that the employee reasonably believes is in violation of this subtitle or regulations adopted under this subtitle.

(3) Any employee who is subject to an action in violation of paragraph (2) of this subsection may institute a civil action in the county where:

(i) The alleged violation occurred;

(ii) The employee resides; or

(iii) The provider maintains its principal office in the State.

(4) The action shall be brought within 1 year after the alleged violation of paragraph (2) of this subsection or within 1 year after the employee first became aware of the alleged violation of paragraph (2) of this subsection.

(5) In any action brought under this subsection, a court may:

(i) Issue an injunction to restrain continued violation of this subsection;

(ii) Reinstate the employee to the same or an equivalent position held before the violation of paragraph (2) of this subsection;

(iii) Remove any adverse personnel record entries based on or related to the violation of paragraph (2) of this subsection;

(iv) Reinstate full fringe benefits and seniority rights;

(v) Require compensation for lost wages, benefits, and other remuneration; and

(vi) Assess reasonable attorney's fees and other litigation expenses against:

1. The provider, if the employee prevails; or

2. The employee, if the court determines that the action was brought by the employee in bad faith and without basis in law or fact.

(6) A provider shall:

(i) Conspicuously display notices of its employee protections under this subsection; and

(ii) Use appropriate means to inform its employees of the protections and obligations provided under this subsection.

§2–506.

On or before December 1 each year, the Office shall submit a report to the Secretary, the Governor, and, in accordance with § 2–1257 of the State Government Article, the Senate Budget and Taxation Committee, the Senate Finance Committee, the House Appropriations Committee, the House Health and Government Operations Committee, and the Joint Audit and Evaluation Committee on:

(1) The Office's activities during the immediately preceding fiscal year, including:

(i) Investigations of fraud, waste, and abuse of departmental funds undertaken by the Office, including specific findings and recommendations related to the investigations;

(ii) A summary of matters referred to the Medicaid Fraud Control Unit by the Office;

(iii) Recoveries by the Office of mistaken claims paid or payments obtained in error or fraudulent claims paid to or obtained by a provider;

(iv) Recoveries by the Office of the cost of benefits mistakenly paid or obtained in error, or fraudulently paid to or obtained by a recipient; and

(v) A summary of matters referred to prosecutive authorities and the resulting prosecutions and convictions; and

(2) Any regulatory or statutory changes necessary to ensure compliance with applicable federal and State laws.

§2–601.

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

(b) (1) "Claim" means a request or demand, under a contract or otherwise, for money or other property, whether or not the State has title to the money or property, that is:

(i) Presented through a State health plan or a State health program to an officer, employee, or agent of the State; or

(ii) Made to a contractor, grantee, or other recipient, if the money or other property is to be spent or used on the State's behalf or to advance a State interest through a State health plan or State health program, and the State:

1. Provides or has provided any portion of the money or other property requested or demanded; or

2. Will reimburse the contractor, grantee, or other recipient for any portion of the money or other property that is requested or demanded.

(2) "Claim" does not include requests or demands for money or other property that the State through a State health plan or State health program has paid to an individual as compensation for State employment or as an income subsidy with no restrictions on that individual's use of the money or other property.

(c) "Documentary material" includes:

(1) The original or a copy of:

(i) A book;

(ii) A record;

(iii) A report;

(iv) A memorandum;

(v) A paper;

(vi) A communication;

(vii) A tabulation;

(viii) A chart;

(ix) A document; or

(x) Data compilation stored in or accessible through a computer or other information retrieval system, including instructions and all other materials necessary to use or interpret the data compilation; and

(2) Any product of discovery, including:

(i) The original or duplicate of any deposition, interrogatory, document, thing, result of an inspection of land or other property, examination, or admission that is obtained by any method of discovery in any judicial or administrative proceeding of an adversarial nature;

(ii) Any digest, analysis, selection, compilation, or derivation of any item listed in item (i) of this item; and

(iii) Any index or other manner of access to any item listed in item (i) of this item.

(d) "Employee" means an individual who performs services:

(1) For and under the control and direction of an employer; and

(2) Under an employer's promise or implied promise of payment of wages or other remuneration.

(e) "Employer" means a person or group of persons who, acting directly or indirectly on behalf of another person or group of persons:

(1) Allows an employee to perform services under the employer's control and direction; and

(2) Promises or implies that the employee will receive wages or other remuneration in payment for the performance of those services.

(f) (1) "Knowing" or "knowingly" means, with respect to information and without requiring proof of specific intent to defraud, that a person:

(i) Has actual knowledge of the information;

(ii) Acts in deliberate ignorance of the truth or falsity of the information; or

(iii) Acts in reckless disregard of the truth or falsity of the information.

(2) "Knowing" or "knowingly" does not mean, with respect to information, that a person acts in a manner that constitutes mistake or negligence.

(g) "Material" means having a natural tendency to influence or be capable of influencing the payment or receipt of money or other property.

(h) "Obligation" means an established duty, whether or not fixed, arising from:

(1) An express or implied:

(i) Contractual relationship;

(ii) Grantor–grantee relationship; or

(iii) Licensor–licensee relationship;

(2) A fee–based or similar relationship;

(3) Statute or regulation; or

(4) The retention of an overpayment.

(i) "Provider" has the meaning stated in § 2–501 of this title.

(j) "Public body" means:

(1) The General Assembly or any other elected body;

(2) A member or an employee of the General Assembly or other elected body;

(3) A State court;

(4) A member or an employee of a State court;

(5) A State or local regulatory, administrative, or public agency or authority;

(6) An instrumentality of a State or local regulatory, administrative, or public agency or authority;

(7) A State or local law enforcement agency, prosecutorial office, or police or peace officer;

(8) A State or local department of an executive branch of government; or

(9) A division, board, bureau, office, committee, or commission of any of the public bodies listed in this subsection.

(k) "Retaliatory action" means:

(1) Discharging, suspending, demoting, threatening, harassing, or discriminating against an employee, contractor, or agent; or

(2) Any other adverse action taken against an employee, contractor, or agent relating to the conditions of employment, contract, or agency.

(l) (1) "State health plan" means:

(i) The State Medical Assistance Plan established in accordance with the federal Social Security Act of 1939, as amended;

(ii) A medical assistance plan established by the State; or

(iii) A private health insurance carrier, health maintenance organization, managed care organization as defined in § 15–101 of this article, health care cooperative or alliance, or another person that provides or contracts to provide health care services that are wholly or partially reimbursed by, or are a required benefit of, a health plan established in accordance with the federal Social Security Act of 1939, as amended, or by the State.

(2) "State health plan" includes a person who provides or contracts or subcontracts to provide health care services for an entity described in paragraph (1) of this subsection.

(m) "State health program" means the Medical Assistance Program, the Cigarette Restitution Fund Program, the Developmental Disabilities Administration, the Behavioral Health Administration, the Prevention and Health Promotion Administration, or any other unit of the Department that pays a provider for a service rendered or claimed to have been rendered to a recipient.

(n) "Supervisor" means an individual within an employer's organization who has the authority to:

(1) Direct and control the work performance of an employee; or

(2) Take corrective action regarding the violation of a law or regulation that is the subject of a complaint or charge under this subtitle.

§2–602.

(a) A person may not:

(1) Knowingly present or cause to be presented a false or fraudulent claim for payment or approval;

(2) Knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim;

(3) Conspire to commit a violation under this subtitle;

(4) Have possession, custody, or control of money or other property used by or on behalf of the State under a State health plan or a State health program and knowingly deliver or cause to be delivered to the State less than all of that money or other property;

(5) (i) Be authorized to make or deliver a receipt or other document certifying receipt of money or other property used or to be used by the State under a State health plan or a State health program; and

(ii) Intending to defraud the State or the Department, make or deliver a receipt or document knowing that the information contained in the receipt or document is not true;

(6) Knowingly buy or receive as a pledge of an obligation or debt publicly owned property from an officer, employee, or agent of a State health plan or a State health program who lawfully may not sell or pledge the property;

(7) Knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or other property to the State;

(8) Knowingly conceal, or knowingly and improperly avoid or decrease, an obligation to pay or transmit money or other property to the State; or

(9) Knowingly make any other false or fraudulent claim against a State health plan or a State health program.

(b) (1) A person who is found to have violated subsection (a) of this section is liable to the State for:

(i) A civil penalty of not more than $10,000 for each violation of subsection (a) of this section; and

(ii) An additional amount of not more than three times the amount of damages that the State sustains as a result of the acts of that person in violation of subsection (a) of this section.

(2) The total amount owed by a person under paragraph (1) of this subsection may not be less than the amount of the actual damages the State health plan or State health program incurs as a result of the person's violation of subsection (a) of this section.

(c) (1) In determining the appropriate amount of fines and damages under subsection (b) of this section, the court shall consider:

(i) The number, nature, and severity of the violations of this subtitle for which the person has been found liable;

(ii) The number, nature, and severity of any previous violations of this subtitle;

(iii) The degree of loss suffered by the State health plan or State health program;

(iv) The person's history of billing compliance;

(v) Whether the person has a compliance program in place;

(vi) The extent to which the person has taken steps to address and correct the violation since the person became aware of the violation;

(vii) The extent to which the violation caused harm or detriment to patients or consumers of the State health plan or State health program;

(viii) Any funds previously returned to the State health plan or State health program in compliance with federal requirements regarding overpayments, to the extent the funds represented losses to the State health plan or State health program caused by the violation;

(ix) Whether the person self–reported the violation, the timeliness of the self–reporting, the extent to which the person otherwise cooperated in the investigation of the violation, and the extent to which the person had prior knowledge of an investigation or other action relating to the violation; and

(x) Any other factor as justice requires.

(2) In weighing the factors set forth in paragraph (1) of this subsection, the court shall, where appropriate, give special consideration to:

(i) The extent to which the person's size, operations, or financial condition may have affected each of the factors set forth in paragraph (1) of this subsection; and

(ii) The extent to which the person's size, operations, or financial condition may affect the person's ability to provide care and continue operations after payment of damages and fines.

(d) The penalties provided in subsection (b) of this section are in addition to any criminal, civil, or administrative penalties provided under any other State or federal statute or regulation.

§2–603.

(a) If the State finds that a person has violated or is violating § 2–602(a) of this subtitle, the State may file a civil action in a court of competent jurisdiction within the State against the person.

(b) In filing a civil action under this section, the State may seek:

(1) The penalties provided under § 2–602(b) of this subtitle; and

(2) Subject to the guidelines set forth in § 2–605(a)(4) of this subtitle, court costs and attorney's fees.

§2–604.

(a) (1) (i) A person may file a civil action on behalf of the person and the State in a court of competent jurisdiction within the State against a person who has acted or is acting in violation of § 2–602(a) of this subtitle.

(ii) A civil action filed under subparagraph (i) of this paragraph shall be brought in the name of the State.

(2) A person filing an action under this section may seek:

(i) The penalties provided under § 2–602(b) of this subtitle; and

(ii) Subject to the guidelines set forth in § 2–605(a)(4) of this subtitle, court costs and attorney's fees.

(3) (i) The person shall serve on the State a copy of the complaint and a written disclosure of substantially all material evidence and information that the person possesses, in accordance with the provisions of Title 2 of the Maryland Rules for serving process on the State.

(ii) 1. The complaint shall be filed in camera and shall remain under seal for at least 60 days.

2. The complaint may not be served on the defendant until the complaint is unsealed and the court orders the complaint served.

3. Within 60 days after the State receives the complaint and the material evidence and information, the State may elect to intervene and proceed with the action.

(4) (i) For good cause shown, the State may move the court for extensions of the time during which the complaint remains under seal under paragraph (3)(ii)1 of this subsection.

(ii) Any motions made under subparagraph (i) of this paragraph may be supported by affidavits or other submissions in camera.

(5) (i) The defendant may not be required to answer a complaint filed under this section until after the complaint is:

1. Unsealed and ordered by the court to be served; and

2. Served on the defendant in accordance with Title 2 of the Maryland Rules.

(ii) When answering a complaint filed under this section, a defendant shall follow the time frames and other provisions for filing answers to a complaint as required under Title 2, Chapter 300 of the Maryland Rules.

(iii) During the period in which the complaint is under seal, if the State's investigation reveals that the act, transaction, or occurrence that gave rise to the alleged violation of this subtitle is reasonably likely to be continuing, the State shall notify the defendant as soon as practicable without jeopardizing the course and conduct of the State's or the federal government's investigation of the violation, compromising the development of evidence, or violating any State or federal law.

(6) Before the later of the expiration of the 60–day period during which the complaint remains under seal under paragraph (3)(ii)1 of this subsection or any extension of the 60–day period obtained under paragraph (4) of this subsection, the State shall:

(i) Intervene and proceed with the action in a court of competent jurisdiction within the State; or

(ii) Notify the court that it will not intervene and proceed with the action.

(7) If the State does not elect to intervene and proceed with the action under paragraph (6) of this subsection, before unsealing the complaint, the court shall dismiss the action.

(8) If a person initiates an action under this section, no person other than the State may intervene in the action or initiate a related action based on the facts underlying the pending action.

(b) (1) If the State intervenes and proceeds with the action under subsection (a)(6)(i) of this section:

(i) The State shall have the primary responsibility for proceeding with the action and may not be bound by any act of the person who initiated the action; and

(ii) Subject to paragraphs (3) through (6) of this subsection, the person who initiated the action may continue as a party to the action.

(2) (i) During an investigation by the State conducted either independently or in conjunction with a civil action filed under this subtitle, the Attorney General shall have the same rights of discovery as a civil litigant in the circuit court under Title 2, Chapter 400 of the Maryland Rules.

(ii) A person from whom the Attorney General seeks discovery shall be considered a party under Title 2, Chapter 400 of the Maryland Rules.

(3) (i) Notwithstanding the objections of the person initiating the action, the State may elect at any point to withdraw its intervention as a party to the action.

(ii) If the State elects to withdraw as a party to the action:

1. The State shall notify the court and the party initiating the action; and

2. The court shall dismiss the action.

(4) Notwithstanding the objections of the person initiating the action, if the court determines after a hearing that a proposed settlement is fair, adequate, and reasonable under the circumstances, the State may settle a civil action filed under this section.

(5) On motion of the State or the defendant or on the court's own motion, the court may impose limitations on the participation of the person initiating an action under this section if:

(i) The State shows that the person's unrestricted participation in the action would:

1. Interfere with or unduly delay the State in its pursuit of the civil action; or

2. Be repetitious, irrelevant, or harassing to the defendant; or

(ii) The defendant shows that unrestricted participation by the person initiating the action would harass the defendant or cause the defendant undue burden or unnecessary expense.

(6) Limitations imposed by the court under paragraph (5) of this subsection may include:

(i) A limitation on the number of witnesses the person may call to testify;

(ii) A limitation on the length of the testimony of witnesses called by the person;

(iii) A limitation on the person's cross–examination of witnesses; or

(iv) A limitation on the participation of the person in the litigation.

(c) (1) Instead of proceeding with a civil action filed under this subtitle, the State may pursue any alternative remedy available to the State, including any appropriate administrative proceeding to determine a civil money penalty.

(2) If the State seeks an alternative remedy in another proceeding after intervening in a civil action filed under this section, the person initiating the action shall have the same rights in the alternative proceeding as the person would have had if the civil action had continued under this section.

(3) (i) A finding of fact or conclusion of law made in any alternative proceeding that has become final shall be conclusive on all parties to an action filed under this subtitle.

(ii) For purposes of subparagraph (i) of this paragraph, a finding or conclusion is final if:

1. It has been finally determined on appeal to the appropriate court of the State;

2. All time for filing the appeal with respect to the finding or conclusion has expired; or

3. The finding or conclusion is not subject to judicial review.

(d) (1) On a showing in camera by the State that certain actions of discovery by the person initiating the action would interfere with the State's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay the discovery for a period of not more than 60 days.

(2) The court may extend the 60–day period on a further showing in camera that:

(i) The State has pursued the criminal or civil investigation or proceeding with reasonable diligence; and

(ii) Any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceeding.

§2–605.

(a) (1) If the State intervenes and proceeds with an action filed under § 2–604 of this subtitle and the State prevails, the court shall award the person initiating the action an amount that is:

(i) Not less than 15% and not more than 25% of the proceeds of the action or settlement of the claim; and

(ii) Proportional to the amount of time and effort that the person substantially contributed to the final resolution of the civil action.

(2) (i) If the court finds that the action is based primarily on disclosures of specific information relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative or administrative report, hearing, audit, or investigation, or from the news media, the court may make an award to the person initiating the action that:

1. The court considers appropriate, taking into account the significance of the information and the role of the person initiating the action in advancing the case to litigation; and

2. Does not exceed 10% of the proceeds of the action.

(ii) The information described in subparagraph (i) of this paragraph does not include information disclosed and provided by the person initiating the action.

(3) Any payment to a person under paragraph (1) or (2) of this subsection shall be made from the proceeds of the action.

(4) (i) In addition to the amount provided under paragraphs (1) and (2) of this subsection, a court may award the person initiating the action:

1. An amount for reasonable expenses that the court finds to have been necessarily incurred; and

2. Reasonable attorney's fees and costs.

(ii) In determining the amount of any award under subparagraph (i) of this paragraph, the court shall consider the amount of any penalties and damages recovered in the action and any other factor as justice may require.

(iii) Any expenses, fees, and costs awarded under this paragraph shall be awarded against the defendant.

(b) (1) If a court finds that the action is initiated by a person who planned and initiated or otherwise deliberately participated in the violation on which the action was based, the court may, to the extent it considers appropriate, reduce the share of the proceeds of the action that the person otherwise would have received under this section.

(2) In reducing the share of the proceeds of the person initiating the action under this subsection, the court shall consider:

(i) The role of the person in advancing the case to litigation; and

(ii) Any relevant circumstances relating to the underlying violation.

(3) (i) If the person initiating a civil action under § 2–604 of this subtitle is convicted of criminal conduct arising from the person's participation in the violation on which the action was based prior to a final determination of the action, the person:

1. Shall be dismissed from the action; and

2. May not receive any share of the proceeds of the action.

(ii) The dismissal of the person initiating the action in accordance with this paragraph does not prejudice the right of the State to continue the action.

(4) If the person initiating a civil action under § 2–604 of this subtitle is convicted of criminal conduct arising from the person's participation in the violation on which the action was based after the proceeds from the action are awarded to that person, the court shall order the person to repay the proceeds previously awarded.

(c) A court may award reasonable attorney's fees and expenses to a defendant and against the person initiating the action if:

(1) The defendant prevails in the action; and

(2) The court finds that the claim of the person initiating the action was brought primarily for purposes of harassment or otherwise brought in bad faith.

§2–606.

(a) No court in this State shall have jurisdiction over an action filed under § 2–604 of this subtitle against any member of the Legislative Branch or the Judiciary of the State, any member of the Governor's Executive Council, the Attorney General, the Comptroller, or the State Treasurer if the action is based on evidence or information known to the State when the action was filed.

(b) A civil action may not be brought under this subtitle by a person who is or was a public employee or public official if the allegations of the action are based substantially on:

(1) Allegations of wrongdoing or misconduct that the person had a duty or obligation to report or investigate within the scope of the person's public employment or office; or

(2) Information or records to which the person had access as a result of the person's public employment or office.

(c) A person may not bring an action under § 2–604 of this subtitle that is based on allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the State is already a party.

(d) (1) Except as provided in paragraphs (2) and (3) of this subsection, no court in this State shall have jurisdiction over an action filed under § 2–604 of this subtitle that is based on the public disclosure of allegations or transactions:

(i) In a criminal, civil, or an administrative hearing;

(ii) In a legislative or an administrative report, a hearing, an audit, or an investigation; or

(iii) From the news media.

(2) Paragraph (1) of this subsection does not apply if the action is initiated by a person who:

(i) Has direct and independent knowledge of the information on which the allegations are based; and

(ii) Has voluntarily provided the information to the State before filing an action under § 2–604 of this subtitle that is based on the information.

(3) The State, through the Attorney General, may file a civil action under § 2–603 of this subtitle based on the public disclosure described in paragraph (1) of this subsection.

(e) The State is not liable for expenses that a person incurs in bringing an action under § 2–604 of this subtitle.

(f) A person who is or was employed by the State, a local government, or any other political subdivision of the State as an auditor, investigator, attorney, financial officer, or contracting officer may not bring an action under § 2–604 of this subtitle that is based on allegations or transactions that the person discovered or learned of while acting in the person's capacity as an auditor, investigator, attorney, financial officer, or contracting officer for the State, local government, or other political subdivision of the State.

§2–607.

(a) A person may not take a retaliatory action against an employee, contractor, or grantee because the employee, contractor, or grantee:

(1) Acts lawfully in furtherance of an action filed under this subtitle, including an investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this subtitle;

(2) Discloses or threatens to disclose to a supervisor or to a public body an activity, policy, or practice of the person that the employee, contractor, or grantee reasonably believes is in violation of § 2–602(a) of this subtitle or a regulation adopted under this subtitle;

(3) Provides information to, or testifies before, a public body conducting an investigation, hearing, or inquiry into a violation of § 2–602(a) of this subtitle or a regulation adopted under this subtitle that is allegedly or actually committed by the person; or

(4) Objects to or refuses to participate in any activity, policy, or practice that the employee, contractor, or grantee reasonably believes is in violation of § 2–602(a) of this subtitle or a regulation adopted under this subtitle.

(b) (1) An employee, contractor, or grantee may file a civil action against a person other than a supervisor in State government, an appointing authority in State government, or the head of a principal unit in State government if the person takes a retaliatory action against the employee, contractor, or grantee in violation of subsection (a) of this section.

(2) The employee, contractor, or grantee may seek in the civil action:

(i) An injunction to restrain a continuing violation of subsection (a) of this section;

(ii) Reinstatement to the same seniority status held before the retaliatory action;

(iii) Reinstatement of full fringe benefits and seniority rights;

(iv) Two times the amount of lost wages, benefits, and other remuneration, including any interest accumulated;

(v) Payment by the person of reasonable costs and attorney's fees;

(vi) Punitive damages;

(vii) An assessment of a civil penalty:

1. Not exceeding $1,000 for the first violation; and

2. Not exceeding $5,000 for each subsequent violation; and

(viii) Any other relief necessary to make the employee, contractor, or grantee whole.

(3) The remedies provided under this section do not diminish or affect the rights, privileges, or remedies available to the employee, contractor, or grantee under:

(i) Any other federal or State statute or regulation; or

(ii) Any collective bargaining agreement or employee contract.

(c) This section does not apply to an employee as defined in § 1–501 of the Health Occupations Article or a State employee.

(d) (1) An employee as defined in § 1–501 of the Health Occupations Article who is subject to retaliatory action in violation of subsection (a) of this section may file a civil action under Title 1, Subtitle 5 of the Health Occupations Article.

(2) A State employee who is subject to retaliatory action in violation of subsection (a) of this section may file a complaint under Title 5, Subtitle 3 of the State Personnel and Pensions Article.

§2–608.

An employer shall:

(1) Conspicuously display notices of the protections provided to and obligations required of its employees under this subtitle; and

(2) Use any appropriate means to inform its employees of the protections and obligations provided under this subtitle.

§2–609.

(a) A civil action filed under this subtitle may not be filed after the later of:

(1) 6 years after the date on which the underlying violation of § 2–602(a) of this subtitle occurred; or

(2) 3 years after the date when facts material to the right of action are known by the relator, the State's Inspector General, or the Director of the State's Medicaid Fraud Control Unit or reasonably should have been known, but in no event more than 10 years after the date on which the underlying violation of § 2–602(a) of this subtitle is committed.

(b) A civil action may be filed under this subtitle for activity that occurred prior to October 1, 2010, if the limitations period under subsection (a) of this section has not lapsed.

(c) If the State elects to intervene and proceed with an action brought under this subtitle, the State, through the Office of the Attorney General, may:

(1) File its own complaint; or

(2) Amend the complaint of the person who brought the action to clarify, add detail to the complaint, or add additional claims to the complaint.

(d) To the extent that the claim of the State arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth by a person, a State pleading relates back to the filing date of the complaint of the person who originally brought the action.

(e) In an action filed under this subtitle, all essential elements of the cause of action, including damages, shall be proven by a preponderance of the evidence.

(f) Notwithstanding any other provision of law or rule of procedure or evidence in the Maryland Rules, a final judgment rendered in favor of the State in any criminal proceeding charging fraud or false statements, whether on a verdict after trial or on a plea of guilty or nolo contendere, shall stop the defendant from denying the essential elements of the offense in any action filed under this subtitle that involves the same act, transaction, or occurrence as in the criminal proceeding.

§2–610.

(a) Any remedy provided under this subtitle is in addition to any other appropriate legal or equitable relief provided under any other applicable State or federal statute or regulation.

(b) (1) The State shall make all reasonable efforts to coordinate any investigation of an alleged violation under this subtitle with any investigation conducted by the federal government involving the same violation.

(2) The State's objective shall be to avoid unnecessary duplication of effort on the part of the person alleged to have committed the violation and to minimize the burden of the investigation on the person.

(c) (1) Except as provided under paragraph (2) of this subsection, the Comptroller shall deposit any civil penalty or damages collected under this subtitle in the General Fund of the State.

(2) (i) If a violation of this subtitle affects any of the following funds, the Comptroller shall deposit any civil penalty or damages collected by the State under this title into the affected fund:

1. A fund that is not subject to § 7–302 of the State Finance and Procurement Article;

2. A special fund requiring the reversion of appropriated funds to the special fund under § 7–304 of the State Finance and Procurement Article;

3. A fund under the jurisdiction of the Board of Trustees for the State Retirement and Pension System; or

4. A fund under the jurisdiction of the State Employee and Retiree Health and Welfare Benefits Program.

(ii) If more than one fund is affected by a violation of this subtitle, the Comptroller shall deposit any civil penalty or damages collected by the State into the appropriate fund or the General Fund of the State on a pro rata basis.

(d) The Department or the Inspector General of the Department may adopt regulations to carry out the provisions of this subtitle.

§2–611.

(a) Beginning October 1, 2010, the Inspector General of the Department and the Director of the Medicaid Fraud Control Unit in the Office of the Attorney General shall report annually to the General Assembly, in accordance with § 2–1257 of the State Government Article, the following information for the previous fiscal year:

(1) The number of civil actions filed under this subtitle;

(2) The number of civil actions under this subtitle in which a judgment was entered, whether by settlement or adjudication; and

(3) The number of claims made by the State based on alleged violations of § 2–602(a) of this subtitle that are settled without the filing of a civil action under this subtitle.

(b) Unless the action is under seal in accordance with § 2–604 of this subtitle, for each civil action reported under subsection (a)(1) or (2) of this section, the report shall state:

(1) Whether the action was filed by the State or by a person on behalf of the State and, if filed by a person, whether the State intervened and proceeded with the action;

(2) The name of the defendant and the following information about the defendant:

(i) The number of employees and any other data relevant to the size of the defendant;

(ii) The amount of payments made to the defendant in the year prior to the filing of the action from State health plans and, to the extent known by the Inspector General and the Medicaid Fraud Control Unit, from other sources; and

(iii) Whether the defendant is a minority–owned business enterprise as defined by § 14–301 of the State Finance and Procurement Article;

(3) A description of the violation or alleged violation of § 2–602 of this subtitle; and

(4) The amount sought in the action and, if applicable, the amount for which the defendant is liable under a settlement agreement or court order.

(c) For each claim reported under subsection (a)(3) of this section, the report shall state:

(1) A description of the violation or alleged violation of § 2–602 of this subtitle;

(2) The resolution of the claim;

(3) The amount, if any, the person against whom the claim was made agreed to pay in settlement of the claim; and

(4) The amount, if any, collected by the State.

§2–701.

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

(b) "Claim" has the meaning stated in § 2–501 of this title.

(c) "Extrapolation" means the process of estimating an unknown value by projecting, with a calculated precision or margin of error, the results of the review of a sample to the universe from which the sample was drawn using a statistically valid sampling methodology.

(d) "Federal government" means an agency of the United States government or a contractor retained by the agency of the United States government.

(e) "Overpayment" means a payment that:

(1) Is made by the Department to a provider for services or goods for which the provider submitted a claim to the Department;

(2) Is found to be incorrect; and

(3) Results in a payment greater than that to which the provider is entitled.

(f) "Program" has the meaning stated in § 2–501 of this title.

(g) "Provider" has the meaning stated in § 2–501 of this title.

(h) "Statistically valid sampling methodology" means a methodology used for extrapolation that has a confidence level of 90% or greater and is validated by a statistician who possesses at least a master's degree in statistics.

(i) "Universe" means a defined population of claims submitted by a provider to the Department and paid to the provider by the Department during a specified time period.

§2–702.

(a) Subject to the requirements of this subtitle, the Inspector General, or a contractor or an agent acting on behalf of the Inspector General, may use extrapolation during an audit to recover an overpayment from a provider if:

(1) The federal government has also conducted an audit of the program for overpayment; and

(2) The monetary recovery amount determined to be due by the program to the federal government is based on the federal government's use of extrapolation.

(b) An audit conducted by the Inspector General or a contractor or agent acting on behalf of the Inspector General under subsection (a) of this section shall be limited to the scope of the federal audit, including claims for the same audit time period and the same type of claims.

§2–703.

(a) On a finding of an overpayment to a provider, the Inspector General may not use extrapolation unless there is a determination of a sustained or high level of payment error, as defined by regulation.

(b) When using extrapolation to determine an overpayment, the sample to be used may not include claims:

(1) In which the alleged overpayment would have no fiscal impact on the entire sample;

(2) That were submitted in accordance with the Department's, Inspector General's, or program's directives, policies, guidelines, or regulations; or

(3) That are the result of an unintentional overlap in services among unrelated providers caused by circumstances beyond the control of the provider that is subject to the audit, in which case the Inspector General may recover the original overpayment.

§2–704.

(a) The Inspector General or a contractor or an agent of the Inspector General that conducts an audit under this subtitle in which extrapolation may be used shall:

(1) Perform the audit in accordance with a methodology used by the federal government or conducted in accordance with Generally Accepted Auditing Standards (GAAS) and the Statement on Accounting Standards (SAS);

(2) Use a statistically valid sampling methodology; and

(3) Meet the following qualifications:

(i) Have at least 3 years of auditing experience;

(ii) Have experience in the procedural coding program used for the claim;

(iii) Be familiar, either independently or through training by the provider, with the format and content of paper and electronic medical records and claim forms used by the provider; and

(iv) Have general knowledge of the particular health care item or service that is the subject of the audit and the program rules that govern the health care item or service at the time the item or service was provided.

(b) (1) If the medical necessity of the claim is the subject of the audit, the entity that conducts the audit shall include as part of the audit team an individual licensed in the same health occupation as the provider.

(2) The individual included in the audit team under paragraph (1) of this subsection shall have significant knowledge of the audited procedure but is not required to be in the same specialty or practice area as the audited provider.

§2–705.

(a) Not less than 15 calendar days before commencement of an audit by the Inspector General under this subtitle, the Inspector General shall give to the provider written notice of the audit, including:

(1) The statistically valid sampling methodology to be used;

(2) The name, contact information, and credentials of each individual conducting the audit, including the individual validating the methodology;

(3) The audit location, including whether the audit will be conducted on–site at the location of the provider or through record submission; and

(4) The manner in which the information requested must be submitted.

(b) (1) Except in cases where the Inspector General refers the audit findings and conclusions to the Office of the Attorney General Medicaid Fraud Control Unit or other applicable law enforcement agency, the Inspector General shall, on completion of the audit, conduct an exit conference with the provider that is the subject of the audit.

(2) During the exit conference, the Inspector General shall:

(i) Present the provider with the audit draft written findings and conclusions and the estimated amount of recovery due as a result of overpayment to the provider; and

(ii) Give the provider the following information in writing:

1. A clear description of the universe from which the sample was drawn;

2. The sample size and the method used to select the sample;

3. The formulas and calculation procedures used to determine the amount to be recovered;

4. The list of claims that were reviewed;

5. A description of each claim, noting the errors that resulted in an overpayment; and

6. A specific list of the regulations, statutes, and transmittals on which the Inspector General relied in determining that the claim was improper.

(3) (i) A provider may challenge the draft findings and conclusions within 30 days after the exit conference unless, because of the size and scope of the audit, the provider:

1. Has negotiated a longer period with the Inspector General through a mutual good faith process; and

2. Has submitted additional information regarding the claims to the Inspector General.

(ii) The additional information submitted under subparagraph (i) of this paragraph may include evidence showing that:

1. The claims used in the sample were either paid properly or paid in accordance with § 2–703 of this subtitle; or

2. The audit does not meet applicable requirements or reach valid findings and conclusions.

(4) Failure to challenge the draft findings and conclusions contained in the preliminary report does not preclude a provider from appealing the final report and recovery letter under subsection (d) of this section.

(c) (1) The Inspector General shall review any additional documentation submitted by the provider under subsection (b) of this section or presented at any time during the audit.

(2) After review of any additional documentation submitted by the provider, the Inspector General shall, when appropriate, recalculate the error rate used in extrapolation and issue its final report and recovery letter.

(3) The final report and recovery letter shall state that the provider has 30 days after the date of the recovery letter to appeal the findings in the report in accordance with § 2–207 of this title, Title 10, Subtitle 2 of the State Government Article, and COMAR 10.01.03 and 28.02.01.

(d) (1) On appeal, the provider may present evidence of a second audit using the same sampling methodology but based on a different sample of claims identified and produced by the Inspector General.

(2) On request of the provider, the Inspector General shall provide a new sample of claims to the provider within 30 days after receipt of the request.

(3) The provider shall have 60 days after receipt of the new sample to conduct the audit and provide the results to the Inspector General, unless the provider has negotiated a longer period with the Inspector General.

(4) The Inspector General may review the provider's audit for compliance with the requirements of this subtitle.

(e) The recovery shall be stayed until completion of the administrative appeal process.

(f) This subtitle does not limit a provider from challenging the accuracy of the Inspector General's audit, including:

(1) The statistical and extrapolation methodology used in the audit;

(2) The credentials of any individual who performed or reviewed the audit; or

(3) Any other reasonable basis.

(g) (1) The Department may adopt the findings of the federal government, including the error rate, if the federal government conducts an audit that:

(i) Concludes that a provider received an overpayment;

(ii) Uses an error rate that is specific to a single provider;

(iii) Derives the overpayment from a statistically valid sample; and

(iv) Provides all supporting documentation of the audit.

(2) If the Department adopts the findings of the federal government, the Department shall provide to the provider a copy of the federal government's audit report and supporting documentation with the preliminary recovery letter stating the amount due to the State and the provider's appeal rights.

(3) (i) Within 30 days after receipt of the preliminary recovery letter, the provider may challenge the draft findings and conclusions unless, due to the size and scope of the audit, the provider:

1. Has negotiated a longer period with the Inspector General through a mutual good faith process; and

2. Has submitted additional information to the Inspector General.

(ii) The additional information submitted under subparagraph (i) of this paragraph may include evidence showing that:

1. The claims used in the sample were either paid properly or paid in accordance with § 2–703 of this subtitle; or

2. The audit did not meet applicable requirements or reach valid findings and conclusions.

(4) Failure to challenge the draft findings and conclusions contained in the preliminary recovery letter does not preclude a provider from appealing the final report and recovery letter under subsection (d) of this section.

(h) This subtitle does not apply to audits conducted in response to federal audits initiated before October 1, 2016.

§2–801.

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

(b) (1) "Essential off–patent or generic drug" means any prescription drug:

(i) For which all exclusive marketing rights, if any, granted under the Federal Food, Drug, and Cosmetic Act, § 351 of the federal Public Health Service Act, and federal patent law have expired;

(ii) 1. That appears on the Model List of Essential Medicines most recently adopted by the World Health Organization; or

2. That has been designated by the Secretary as an essential medicine due to its efficacy in treating a life–threatening health condition or a chronic health condition that substantially impairs an individual's ability to engage in activities of daily living;

(iii) That is actively manufactured and marketed for sale in the United States by three or fewer manufacturers; and

(iv) That is made available for sale in the State.

(2) "Essential off–patent or generic drug" includes any drug–device combination product used for the delivery of a drug for which all exclusive marketing rights, if any, granted under the Federal Food, Drug, and Cosmetic Act, § 351 of the federal Public Health Service Act, and federal patent law have expired.

(c) "Price gouging" means an unconscionable increase in the price of a prescription drug.

(d) "State health plan" has the meaning stated in § 2–601 of this title.

(e) "State health program" has the meaning stated in § 2–601 of this title.

(f) "Unconscionable increase" means an increase in the price of a prescription drug that:

(1) Is excessive and not justified by the cost of producing the drug or the cost of appropriate expansion of access to the drug to promote public health; and

(2) Results in consumers for whom the drug has been prescribed having no meaningful choice about whether to purchase the drug at an excessive price because of:

(i) The importance of the drug to their health; and

(ii) Insufficient competition in the market for the drug.

(g) "Wholesale acquisition cost" has the meaning stated in 42 U.S.C. § 1395w–3a.

§2–802.

(a) A manufacturer or wholesale distributor may not engage in price gouging in the sale of an essential off–patent or generic drug.

(b) It is not a violation of subsection (a) of this section for a wholesale distributor to increase the price of an essential off–patent or generic drug if the price increase is directly attributable to additional costs for the drug imposed on the wholesale distributor by the manufacturer of the drug.

§2–803.

(a) The Maryland Medical Assistance Program may notify the Attorney General of any increase in the price of an essential off–patent or generic drug when:

(1) The price increase, by itself or in combination with other price increases:

(i) Would result in an increase of 50% or more in the wholesale acquisition cost of the drug within the preceding 1–year period; or

(ii) Would result in an increase of 50% or more in the price paid by the Maryland Medical Assistance Program for the drug within the preceding 1–year period; and

(2) (i) A 30–day supply of the maximum recommended dosage of the drug for any indication, according to the label for the drug approved under the Federal Food, Drug, and Cosmetic Act, would cost more than $80 at the drug's wholesale acquisition cost;

(ii) A full course of treatment with the drug, according to the label for the drug approved under the Federal Food, Drug, and Cosmetic Act, would cost more than $80 at the drug's wholesale acquisition cost; or

(iii) If the drug is made available to consumers only in quantities that do not correspond to a 30–day supply, a full course of treatment, or a single dose, it would cost more than $80 at the drug's wholesale acquisition cost to obtain a 30–day supply or a full course of treatment.

(b) On request of the Attorney General, the manufacturer of an essential off–patent or generic drug identified in a notice under subsection (a) of this section, within 45 days after the request, shall submit a statement to the Attorney General:

(1) (i) Itemizing the components of the cost of producing the drug; and

(ii) Identifying the circumstances and timing of any increase in materials or manufacturing costs that caused any increase in the price of the drug within the 1–year period preceding the date of the price increase;

(2) (i) Identifying the circumstances and timing of any expenditures made by the manufacturer to expand access to the drug; and

(ii) Explaining any improvement in public health associated with those expenditures; and

(3) Providing any other information that the manufacturer believes to be relevant to a determination of whether a violation of this subtitle has occurred.

(c) The Attorney General may require a manufacturer or a wholesale distributor to produce any records or other documents that may be relevant to a determination of whether a violation of this subtitle has occurred.

(d) On petition of the Attorney General and subject to subsection (e) of this section, a circuit court may issue an order:

(1) Compelling a manufacturer or a wholesale distributor:

(i) To provide the statement required under subsection (b) of this section; and

(ii) To produce specific records or other documents requested by the Attorney General under subsection (c) of this section that may be relevant to a determination of whether a violation of this subtitle has occurred;

(2) Restraining or enjoining a violation of this subtitle;

(3) Restoring to any consumer, including a third party payor, any money acquired as a result of a price increase that violates this subtitle;

(4) Requiring a manufacturer that has engaged in price gouging in the sale of an essential off–patent or generic drug to make the drug available to participants in any State health plan or State health program for a period of up to 1

year at the price at which the drug was made available to participants in the State health plan or State health program immediately prior to the manufacturer's violation of this subtitle; and

(5) Imposing a civil penalty of up to $10,000 for each violation of this subtitle.

(e) The Attorney General may not bring an action for a remedy under subsection (d)(2) through (5) of this section unless the Attorney General has provided the manufacturer or wholesale distributor an opportunity to meet with the Attorney General to offer a justification for the increase in the price of the essential off–patent or generic drug.

(f) Any information provided by a manufacturer or a wholesale distributor to the Attorney General under subsections (b) and (c) of this section shall be considered confidential commercial information for purposes of § 4–335 of the General Provisions Article unless the confidentiality of the information is waived by the manufacturer or wholesale distributor.

(g) In any action brought by the Attorney General under subsection (d) of this section, a person who is alleged to have violated a requirement of this subtitle may not assert as a defense that the person did not deal directly with a consumer residing in the State.

§2–1001.

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

(b) "Commission" means the Commission on Civil Rights.

(c) "Gender identity" has the meaning stated in § 20–101 of the State Government Article.

(d) "Sexual orientation" has the meaning stated in § 20–101 of the State Government Article.

(e) "Unit of the Department" means a unit described under § 2–106 of this title.

§2–1002.

It is the policy of the State to:

(1) Provide affordable health care throughout the State to all regardless of race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability; and

(2) Prohibit discrimination with respect to the provision of health care by any person, in order to protect and ensure the peace, health, safety, prosperity, and general welfare of all.

§2–1003.

(a) (1) Notwithstanding any other law and except as provided in paragraph (2) of this subsection, the Secretary or a unit of the Department has exclusive jurisdiction to enforce by administrative action the laws of the State as provided for under this article and the Health Occupations Article.

(2) The Commission on Civil Rights has concurrent jurisdiction with the Secretary or a unit of the Department over alleged discrimination on the basis of race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability.

(b) When the Secretary or a unit of the Department has exclusive jurisdiction under subsection (a) of this section, the Commission may:

(1) Refer complaints about discriminatory practices to the Secretary or the unit of the Department;

(2) Appear before the Secretary or the unit of the Department as a party at a hearing about discriminatory practices;

(3) Make recommendations about discriminatory practices to the Secretary or the unit of the Department;

(4) Represent a complainant in a proceeding authorized under this article or the Health Occupations Article that is related to discriminatory practices; or

(5) Appeal as a party aggrieved by an order or decision of the Secretary or the unit of the Department in a proceeding authorized under this article or the Health Occupations Article that is related to discriminatory practices.

(c) The Secretary or a unit of the Department shall notify the Commission of any hearing scheduled on a complaint about alleged discriminatory practices.

(d) On request of the Commission and unless the complainant objects, the Secretary or a unit of the Department shall give the Commission all information regarding any complaint alleging discriminatory practices received by the Secretary or unit of the Department.

(e) The Secretary or a unit of the Department and the Commission shall set guidelines for determining when allegations of discriminatory practices in a complaint are sufficient to warrant a hearing.

§2–1004.

(a) This section does not prohibit a person that is licensed or otherwise regulated by the Department or a unit of the Department from refusing, withholding from, or denying any person services for failure to conform to the usual and regular requirements, standards, and regulations imposed by the licensed or regulated person, unless the refusal, withholding, or denial is based on discrimination on the grounds of race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability.

(b) A person that is licensed or otherwise regulated by the Department or a unit in the Department may not discriminate against any person because of the person's race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability.

§2–1101.

In this subtitle, "Corps" means the Maryland Medical Reserve Corps.

§2–1102.

(a) The Department shall organize the Maryland Medical Reserve Corps.

(b) The purpose of the Corps is to provide a statewide volunteer network integrated into community emergency systems to facilitate a coordinated approach to volunteer management.

(c) The Corps shall include clinical and nonclinical personnel capable of assisting during crises that strain the health care system or public health system, including public health emergencies, disease outbreaks, and natural disasters.

§2–1103.

The Department shall:

(1) Maintain an efficient and modern electronic registration system to register and track volunteers for the Corps; and

(2) Designate a Public Health Emergency Surge Coordinator among its staff to coordinate and plan improvements to the Corps.

§3–101.

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

(b) "County" does not include Baltimore City.

(c) "Health officer" does not include the Baltimore City Commissioner of Health.

§3–201.

(a) Except as provided in subsection (b) of this section, the governing body of a county is ex officio the board of health for the county.

(b) In a code county or charter county, the governing body is ex officio the board of health for the county, unless the governing body establishes a board of health.

§3–202.

(a) (1) Except as provided in paragraph (2) of this subsection, each county board of health shall exercise the duties imposed by law on a board of health.

(2) The county board of health shall exercise those duties in each municipality or special taxing district in the county unless the municipality or district has a charter provision or ordinance that:

(i) Covers the same subject matter;

(ii) Is at least as restrictive as the provision that the county board is required to enforce; and

(iii) Includes provisions for enforcement.

(b) In addition to the other duties provided by law, each county board of health shall:

(1) Meet in May and October of each year and at any other time the board considers necessary;

(2) Coordinate its activities with the Department; and

(3) Report to the Department on the sanitary conditions of the county whenever the board considers it important and necessary to do so.

(c) (1) Except as provided in paragraph (2) of this subsection, each county board of health may set any fee or charge in connection with its rules and regulations.

(2) A fee or charge for a service that is provided wholly or partly with State or federal funds that the Department administers is subject to approval and modification by the Secretary.

(d) In addition to the other powers provided by law and subject to the provisions of this article, each county board of health may adopt and enforce rules and regulations on any nuisance or cause of disease in the county.

§3–301.

(a) There is a health officer for each county.

(b) Subsection (a) of this section does not prevent an individual from serving as a health officer for more than 1 county.

§3–302.

(a) The health officer for a county shall be nominated by the county and appointed by the Secretary.

(b) (1) The governing body of each county shall establish, by ordinance or resolution, the process by which the county nominates an individual for health officer.

(2) If a vacancy occurs in the position of health officer for a county, the governing body shall establish a process, in consultation with the Department, for making a recommendation to the Secretary for the appointment of a health officer.

(3) The process established under paragraph (2) of this subsection shall include the requirements for recruiting, interviewing, and recommending applicants for the position of health officer.

(c) (1) If the Secretary finds that a nominee meets the qualifications of this section, the Secretary shall appoint the nominee as health officer.

(2) If the Secretary finds that the nominee does not meet the qualifications of this section, the Secretary shall reject the nomination, and the county shall provide the Secretary with another nomination.

(d) Each health officer:

(1) Shall have:

(i) A master's degree in public health and at least 2 years' work in the field of public health; or

(ii) At least 5 years' work in the field of public health;

(2) Shall have any other qualifications and training in the field of public health that the Secretary requires by rule or regulation; and

(3) Need not be a physician, if the health officer has a deputy who:

(i) Is a physician; and

(ii) Meets the qualifications of this subsection.

(e) Before taking office, each appointee to the office of health officer shall take the oath required by Article I, § 9 of the Maryland Constitution.

(f) (1) The health officer for a county may be removed from office with the concurrence of the governing body of that county and the Secretary.

(2) (i) Any information concerning the removal of a health officer from office is confidential in accordance with Title 4 of the General Provisions Article.

(ii) Any meeting of the governing body of a county or any meeting that includes the Secretary related to the removal of a health officer from office shall be closed.

(3) (i) If the Secretary and the governing body concur on the removal of a health officer, the Secretary shall provide written notification to the health officer that includes:

1. The basis for the removal;

2. Documentation supporting the removal; and

3. Notice of the opportunity to request a hearing with the Secretary within 10 days after receipt of the written notification and information on how to request the hearing.

(ii) If the health officer requests a hearing with the Secretary:

1. The Secretary promptly shall hold a hearing, provided that the hearing may not be held sooner than 10 days or later than 30 days after the Secretary sends the health officer a notice of the removal;

2. The health officer shall have an opportunity to be heard before the Secretary in the health officer's defense; and

3. The Secretary shall make a final decision not later than 10 days after the date of the hearing.

(4) Not later than 30 days after the Secretary makes a decision under paragraph (3) of this subsection, a health officer may request a hearing before the appropriate circuit court to ensure that the proceedings for the removal of the health officer were conducted in accordance with paragraph (3) of this subsection.

§3–303.

(a) If a health officer or deputy of a health officer is a physician, the health officer or deputy may practice medicine with the approval of the local governing body.

(b) The local governing body shall notify the Secretary of its approval.

§3–304.

(a) The health officer for a county is entitled to:

(1) The salary provided in the State budget;

(2) Reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget; and

(3) Any additional salary that the county provides.

(b) Except as otherwise provided by law, each health officer is a special appointment in the State Personnel Management System.

§3–305.

(a) (1) The governing body of each county shall establish, by ordinance or resolution, the process by which the county evaluates its health officer.

(2) The Secretary shall establish, by rule or regulation, the process by which the Secretary evaluates health officers.

(b) (1) At least annually, the health officer for a county shall be evaluated, in writing, by the Secretary and by the county.

(2) The Secretary and the county each shall review their respective evaluations of a health officer with the health officer.

§3–306.

(a) Except as provided by agreement between the Secretary and the local governing body, and in addition to the powers and duties set forth elsewhere, each health officer has the powers and duties set forth in this section.

(b) A health officer may obtain samples of food and drugs for analysis.

(c) (1) The health officer for a county is the executive officer and secretary of the county board of health.

(2) Except in Montgomery County, the health officer for a county shall appoint the staff of the county health department.

(3) The health officer for a county shall have an office at an accessible place in the county.

(4) (i) The health officer for a county shall enforce throughout the county:

1. Under the direction of the Secretary, the State health laws and the policies, rules, and regulations that the Secretary adopts; and

2. Except as provided in subparagraph (ii) of this paragraph, under the direction of the county board of health, the rules and regulations that the county board of health adopts.

(ii) The health officer for a county shall enforce in each municipality or special taxing district in the county the rules or regulations that the

county board of health adopts unless the municipality or district has a charter provision or ordinance that:

1. Covers the same subject matter as the county rule or regulation;

2. Is at least as restrictive as the county rule or regulation; and

3. Includes provisions for enforcement.

(5) A health officer shall perform any investigation or other duty or function directed by the Secretary or the county board of health and submit appropriate reports to them.

(d) (1) Subject to the consent of the governing body of the county and the written approval of the Secretary, a health officer for a county may enter into a contract or any other written agreement to assist or participate in the delivery of health care services with a person that is authorized to provide, finance, coordinate, facilitate, or otherwise deliver health care services in the State.

(2) If the Secretary does not respond to a request for written approval within 7 days after receiving the request, the health officer for the county may enter the contract or written agreement.

(e) (1) Except as provided in paragraph (2) of this subsection, a health officer for a county and the Baltimore City Commissioner of Health may authorize the county health department to retain all collections, including any unspent balance at the end of a fiscal year, received from:

(i) Fees authorized under this article;

(ii) Fees authorized under the Environment Article; and

(iii) Fees derived from charges authorized under Title 16, Subtitle 2 of this article.

(2) The authority to retain collections under paragraph (1) of this subsection does not apply:

(i) To license fees set by a county governing body or Baltimore City and paid to the chief financial officer of the county or Baltimore City as authorized under State law;

(ii) To fees that must be transferred to the General Fund under § 4–217(c) of this article from the fees collected for each birth certificate issued or report issued that a search was made but the requested record is not on file; or

(iii) If the retention of collections would be inconsistent with established local practice.

(3) Each health officer for a county and the Baltimore City Commissioner of Health shall report annually to the Secretary on the use of collections retained under paragraph (1) of this subsection.

(f) A health officer for a county may serve on the board of a hospital in the State as a representative of a local health department only if the health officer does not accept payment for the health officer's service on the board.

(g) The Secretary may delegate duties, powers, and functions as provided in this article to a health officer for a county or other county official authorized to administer and enforce health and environmental laws.

§3–306.1.

(a) This section applies only in Howard County.

(b) The Secretary shall notify the county health officer when the Department receives an application for licensure or certification for a health facility or program that will serve 16 or more individuals.

(c) If the county health officer receives notice under subsection (b) of this section, then the county health officer shall notify the county council.

§3–307.

(a) In the performance of official duties, a health officer may enter and inspect any private house if the health officer:

(1) Has obtained consent to enter and inspect;

(2) Has obtained a warrant; or

(3) Does not have time or opportunity to obtain a warrant and an exceptional or emergency situation exists.

(b) In the performance of official duties, a health officer may enter any place of business or employment.

§3–308.

If a health emergency exists, the Secretary may assign temporarily a health officer to another county or Baltimore City.

§3–309.

Whenever necessary, the Secretary may:

(1) Call a public conference of health officers; or

(2) Send a delegate to any conference of health officers.

§3–310.

Unless otherwise provided by State law or regulation, as each reference to a county health department or local health department in the Code applies to Montgomery County, the term means the Montgomery County government.

§3–401.

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

(b) "Authorized prescriber" means a licensed registered nurse, licensed dentist, licensed physician, licensed physician's assistant, licensed podiatrist, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

(c) "Committee" means the Committee on Registered Nurses Personally Preparing and Dispensing Drugs and Devices in Local Health Departments.

(d) (1) "Device" means an item used in the diagnosis, treatment, or prevention of disease.

(2) "Device" does not include:

(i) Surgical or dental instruments;

(ii) Physical therapy equipment;

(iii) X–ray apparatuses; or

(iv) Component parts of or accessories for any of the items described in items (i) through (iii) of this paragraph.

(e) (1) "Dispense" means a procedure that results in the receipt of a drug or device by a patient or a patient's agent.

(2) "Dispense" includes:

(i) Interpreting an authorized prescriber's prescription for a drug or device;

(ii) Selecting and labeling the drug or device prescribed;

(iii) Measuring and packaging the drug or device in accordance with State and federal law; and

(iv) Documenting the transaction in the patient's medical record.

(f) "Drug" means, unless the context requires otherwise, a prescription or nonprescription drug.

(g) "Formulary" means a list of drugs and devices.

(h) "Nonprescription drug" means a drug that:

(1) May be sold without a prescription; and

(2) Is labeled for use by a consumer in accordance with State and federal law.

(i) "Personally prepare and dispense" means to:

(1) Physically prepare a prescription;

(2) Perform a final check of the prescription before dispensing it to a patient; and

(3) Not delegate any step of the dispensing process.

(j) "Prescription drug" means a drug that, under § 21–220 of this article, may be dispensed only on the prescription of an authorized prescriber.

(k) "Registered nurse" means an individual who:

(1) Is licensed by the State Board of Nursing to practice registered nursing under Title 8 of the Health Occupations Article; and

(2) Personally prepares and dispenses drugs and devices in a local health department:

(i) In accordance with the Overdose Response Program under Title 13, Subtitle 31 of this article or the Expedited Partner Therapy Pilot Program under § 18–214.1 of this article; or

(ii) To patients in need of communicable disease, alcohol and drug abuse, family planning, or reproductive health services.

§3–402.

A registered nurse shall comply with:

(1) The formulary developed and approved under § 3–403(b) of this subtitle; and

(2) The requirements of § 8–512 of the Health Occupations Article.

§3–403.

(a) (1) There is a Committee on Registered Nurses Personally Preparing and Dispensing Drugs and Devices in Local Health Departments.

(2) The Committee consists of the following members:

(i) A representative of the Department, appointed by the Department;

(ii) A representative of the State Board of Nursing, appointed by the State Board of Nursing;

(iii) A representative of the State Board of Pharmacy, appointed by the State Board of Pharmacy;

(iv) A representative of the State Board of Physicians, appointed by the State Board of Physicians;

(v) A pharmacist who practices in the State, appointed by the State Board of Pharmacy;

(vi) A registered nurse who practices in the State, appointed by the State Board of Nursing;

(vii) A representative of the Office of Controlled Substances Administration, appointed by the Office; and

(viii) A representative of a local health department, appointed by the Department.

(3) (i) The term of a member is 4 years.

(ii) At the end of a term, a member continues to serve until a successor is appointed.

(4) A member of the Committee:

(i) May not receive compensation as a member of the Committee; but

(ii) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(5) The Secretary shall designate the chair of the Committee.

(6) The Department shall provide staff for the Committee.

(b) The Committee shall:

(1) Develop and approve a formulary for use by registered nurses that includes all nonprescription contraceptive drugs and devices approved by the U.S. Food and Drug Administration for over–the–counter use; and

(2) Annually review the formulary to ensure compliance with current prescribing standards.

§3–404.

A local health department that employs a registered nurse shall be subject to inspection by the Department.

§3–405.

(a) The Department shall establish and administer a training program for registered nurses.

(b) The training program shall be jointly developed and annually reviewed to ensure compliance with current prescribing standards by:

(1) The Department;

(2) The State Board of Nursing; and

(3) The State Board of Pharmacy.

§4–101.

In this subtitle, "confidential record" means any record, report, statement, note, or other information that:

(1) Is assembled or obtained for research or study by:

(i) The Drug Abuse Administration;

(ii) The Prevention and Health Promotion Administration; or

(iii) The Secretary; and

(2) Names or otherwise identifies any person.

§4–102.

(a) (1) Each confidential record shall remain in the custody and control of:

(i) The Drug Abuse Administration, if that Administration assembled or obtained the confidential record;

(ii) The Prevention and Health Promotion Administration, if that Administration assembled or obtained the confidential record; or

(iii) The Secretary or an agent or employee of the Secretary, if the Secretary assembled or obtained the confidential record.

(2) The confidential record may be used only for the research and study for which it was assembled or obtained.

(3) A person may not disclose any confidential record to any person who is not engaged in the research or study project.

(b) This section does not apply to or restrict the use or publication of any statistics, information, or other material that summarizes or refers to confidential records in the aggregate, without disclosing the identity of any person who is the subject of the confidential record.

§4–103.

A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

§4–201.

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

(b) "Attending clinician" means the physician, nurse midwife, or direct–entry midwife in charge of a birth outside an institution.

(c) "Attending physician" means the physician in charge of the patient's care for the illness or condition which resulted in death.

(d) "County registrar" means the registrar of vital records for a county.

(e) (1) "Dead body" means:

(i) A dead human body; or

(ii) Parts or bones of a human body if, from their condition, an individual reasonably may conclude that death has occurred.

(2) "Dead body" does not include an amputated part.

(f) "Direct–entry midwife" means an individual licensed to practice direct–entry midwifery under Title 8, Subtitle 6C of the Health Occupations Article.

(g) "Father" has the meaning stated in § 5–1001 of the Family Law Article.

(h) "Fetal death" means death of a product of human conception, before its complete expulsion or extraction from the mother, regardless of the duration of the pregnancy, as indicated by the fact that, after the expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as heart beat, pulsation of the umbilical cord, or definite movement of voluntary muscle.

(i) "File" means to present for registration any certificate, report, or other record including records transmitted by approved electronic media, including facsimile, of birth, death, fetal death, adoption, marriage, or divorce for which this subtitle provides and to have the Secretary accept the record.

(j) "Filing date" means the date a vital record is accepted for registration by the Secretary.

(k) "Final disposition" means the burial, cremation, or other final disposition of a body or fetus.

(l) "Institution" means any public or private establishment:

(1) To which individuals are committed by law; or

(2) That provides to 2 or more unrelated individuals:

(i) Any inpatient or outpatient medical, surgical, or diagnostic care or treatment; or

(ii) Any nursing, custodial, or domiciliary care.

(m) "Licensed health care practitioner" means:

(1) An individual who is:

(i) A physician licensed under Title 14 of the Health Occupations Article;

(ii) A psychologist licensed under Title 18 of the Health Occupations Article;

(iii) A registered nurse licensed and certified to practice as a nurse practitioner, nurse psychotherapist, or clinical nurse specialist under Title 8 of the Health Occupations Article; or

(iv) A licensed certified social worker–clinical licensed under Title 19 of the Health Occupations Article; or

(2) An individual who:

(i) Is licensed to practice a profession listed in item (1) of this subsection in another state; and

(ii) Meets the requirements under the Health Occupations Article to qualify for a license to practice the profession in this State.

(n) "Live birth" means the complete expulsion or extraction of a product of human conception from the mother, regardless of the period of gestation, if, after the expulsion or extraction, it breathes or shows any other evidence of life, such as heart beat, pulsation of the umbilical cord, or definite movement of voluntary muscle, whether or not the umbilical cord is cut or the placenta is attached.

(o) "Mortician" means a funeral director, mortician, or other person who is authorized to make final disposition of a body.

(p) "Mother" has the meaning stated in § 5–1001 of the Family Law Article.

(q) "Nurse midwife" means an individual certified to practice as a nurse midwife under Title 8 of the Health Occupations Article.

(r) "Physician" means a person authorized or licensed to practice medicine or osteopathy pursuant to the laws of this State.

(s) "Physician assistant" means an individual who is licensed under Title 15 of the Health Occupations Article to practice as a physician assistant.

(t) "Registration" means acceptance by the Secretary and incorporation in the records of the Department of any certificate, report, or other record of birth, death, fetal death, adoption, marriage, divorce, or dissolution or annulment of marriage for which this subtitle provides.

(u) "Vital record" means a certificate or report of birth, death, fetal death, marriage, divorce, dissolution or annulment of marriage, adoption, or adjudication of paternity that is required by law to be filed with the Secretary.

(v) "Vital statistics" means the data derived from certificates and reports of birth, death, fetal death, marriage, divorce, dissolution or annulment of marriage, and reports related to any of these certificates and reports.

§4–202.

(a) The Secretary shall appoint a State registrar of vital records, who shall be in the skilled service of the State Personnel Management System.

(b) The health officer for a county is the registrar of vital records for the county.

§4–203.

(a) The Secretary is charged with administering efficiently and uniformly this subtitle throughout this State.

(b) (1) The Secretary shall:

(i) Establish appropriate methods and the necessary forms for accurate registration of vital records;

(ii) On or before January 1, 2015, establish a process by which death certificates can be filed electronically; and

(iii) Educate physicians, physician assistants, and nurse practitioners regarding the process by which death certificates can be filed electronically.

(2) The forms shall provide for the information that the Secretary needs for proper registration and use of these vital records.

§4–204.

(a) The Secretary shall collect, index, and safeguard from fire, loss, or damage each certificate of birth, death, and fetal death.

(b) After registration of a completed birth, death, or fetal death certificate, the Secretary shall provide a copy of the original certificate to the county registrar for the county where the event occurred and the county registrar where the subject of the certificate resides or resided if the county of residence is different from the county where the event occurred.

(c) A copy of a certificate provided to a county registrar under this section may be used by the county health department to carry out public health functions.

(d) A copy of a certificate provided under this section may be photographic or electronic or produced by other means as prescribed by the Secretary.

§4–205.

(a) A county registrar shall preserve for 3 years each copy of a death or fetal death record that the Secretary sends to the county registrar.

(b) The county death and fetal death records shall be open to inspection by the Secretary, a designee of the Secretary, or an official of a municipal corporation or county, if the inspection is made for a proper purpose and in a manner that does not subject the contents of these records to risk of damage or alteration.

(c) If any omission or discrepancy in the personal or medical facts in a county death or fetal death record is called to the attention of a county registrar, the county registrar promptly shall:

(1) Investigate to determine the facts of record; and

(2) Send a certified statement of the facts to the Secretary.

(d) A county registrar shall investigate and inform the Secretary in full of any violation or suspected violation of this subtitle.

(e) (1) If the Secretary corrects a death or fetal death record, the Secretary shall send a notice of the correction to the county registrar for the county where the event occurred. The county registrar shall enter the correction on the county registrar's record by photographic, electronic, or other means prescribed by the Secretary.

(2) If a discrepancy exists between the record of the Secretary and the record of a county registrar, the record of the Secretary shall be considered correct.

§4–206.

(a) The Secretary shall collect, index, and safeguard the marriage, divorce, and annulment records that clerks of court file as provided by law.

(b) (1) The Secretary may change a marriage, divorce, or annulment record in the file of the Department only if a clerk of court sends, as provided by law, a certified report of the change.

(2) If a discrepancy exists between the record of a clerk of court and the record of the Secretary as to a marriage, divorce, or annulment, the record of the clerk of court shall be considered correct.

(c) (1) A clerk of court may provide a certified copy of a record of any marriage, divorce, or annulment in accordance with usual custom and as provided by law.

(2) The Secretary may not provide a certified copy of any record of divorce or annulment.

§4–207.

(a) (1) Each certificate of birth, death, or fetal death shall be typed or printed legibly in unfading black ink, or stored on electronic media approved by the Secretary.

(2) The person who is required to complete the record shall attest to its accuracy either by signature or by approved electronic process.

(b) A certificate is not complete or correct if it does not give each item of required information to the extent the information is obtainable.

§4–208.

(a) In this section, "gestational carrier" means a woman other than an intended parent or gamete donor who agrees to become pregnant for an intended parent with the intention of gestating and delivering the child of the intended parent.

(b) (1) Except as provided in subsection (g) of this section, within 5 calendar days after a birth occurs in an institution, or en route to the institution, or outside an institution with an attending clinician, the administrative head of the institution or a designee of the administrative head, or the attending clinician or a designee of the attending clinician, shall:

(i) Prepare, on the form that the Secretary provides, a certificate of birth;

(ii) Secure each signature that is required on the certificate;

(iii) File the certificate; and

(iv) If applicable, attach a copy of the order of the court establishing parentage.

(2) Except as provided in subsection (g) of this section, the attending physician, physician assistant, nurse practitioner, nurse midwife, or attending clinician shall provide the date of birth and medical information that are required on the certificate within 5 calendar days after the birth.

(3) The results of the universal hearing screening of newborns shall be incorporated into the supplemental information required by the Department to be submitted as a part of the birth event.

(4) When an individual who is not married gives birth to a child in an institution or outside an institution with an attending clinician, the administrative head of the institution or the designee of the administrative head, or the attending clinician or the designee of the attending clinician, shall:

(i) Provide an opportunity for the child's parents to complete a standardized affidavit of parentage recognizing parentage of the child on the standardized form provided by the Department of Human Services under § 5–1028 of the Family Law Article;

(ii) Furnish to the mother written information prepared by the Child Support Administration concerning the benefits of having the parentage of the child established, including the availability of child support enforcement services; and

(iii) Forward the completed affidavit to the Maryland Department of Health, Division of Vital Records. The Maryland Department of Health, Division of Vital Records shall make the affidavits available to the parents, guardian of the child, or a child support enforcement agency upon request.

(5) An institution, the administrative head of the institution, the designee of the administrative head of an institution, an employee of an institution, the attending clinician, and the designee of the attending clinician may not be held liable in any cause of action arising out of the establishment of parentage.

(6) If the child's mother was not married at the time of either conception or birth or between conception and birth, the name of the child's other parent may not be entered on the certificate without an affidavit of parentage as authorized by § 5–1028 of the Family Law Article signed by the mother and the person to be named on the certificate as the other parent.

(7) If the child's mother was married at the time of either the conception or birth or between conception and birth, the name of the mother's spouse shall be entered on the certificate as the child's other parent.

(8) (i) In any case that does not involve a gestational carrier in which parentage of a child is determined by a court of competent jurisdiction, the name of the parent who did not give birth to the child and surname of the child shall be entered on the certificate of birth in accordance with the finding and order of the court.

(ii) In any case that involves a gestational carrier in which parentage is determined by a court of competent jurisdiction:

1. The following shall be recorded on the forms provided by the Secretary:

A. An indication that the delivery of birth was by a gestational carrier;

B. The identity of the gestational carrier;

C. All relevant medical information regarding the gestational carrier and the delivery; and

D. Information regarding the intended parents;

2. An order of the court establishing parentage shall be attached to the forms provided by the Secretary; and

3. On receipt of the forms provided by the Secretary and the order of the court establishing parentage, the Division of Vital Records shall immediately:

A. Seal the forms provided by the court; and

B. Register the certificate of birth in accordance with the order of the court.

(9) If the parent who did not give birth to the child is not named on the certificate of birth, no other information about that parent shall be entered on the certificate.

(c) (1) Except as provided in subsection (g) of this section, within 5 calendar days after a birth occurs outside an institution without an attending clinician, the birth shall be verified by the Secretary and a certificate of birth shall be prepared, on the form that the Secretary provides, and filed by one of the following, in the indicated order of priority:

(i) The attending individual.

(ii) In the absence of an attending individual, either parent of the child.

(iii) In the absence or inability of either parent, the individual in charge of the premises where the birth occurred.

(2) In any case that involves a gestational carrier in which parentage is determined by a court of competent jurisdiction:

(i) The person specified in regulations adopted by the Department shall record the following on the forms provided by the Secretary:

1. An indication that the delivery of birth was by a gestational carrier;

2. The identity of the gestational carrier;

3. All relevant medical information regarding the gestational carrier and the delivery; and

4. Information regarding the intended parents;

(ii) The person specified in regulations adopted by the Department shall attach an order of the court establishing parentage to the forms provided by the Secretary; and

(iii) On receipt of the forms provided by the Secretary and order of the court establishing parentage, the Division of Vital Records shall immediately:

1. Seal the forms provided by the Secretary; and

2. Register the certificate of birth in accordance with the order of the court.

(d) (1) When a birth occurs on a common carrier within the United States and the child is first removed from the carrier in this State, the birth shall be registered in this State, and the place where the child is first removed shall be considered the place of birth.

(2) When a birth occurs on a common carrier while in international waters, air space, or in a foreign country and the child is first removed from the carrier in this State, the birth shall be registered in this State but the certificate shall show the actual place of birth insofar as can be determined.

(3) Except as provided in subsection (g) of this section, the certificate shall be filed within 5 calendar days after the child is removed from the carrier.

(e) (1) Each parent shall provide his or her own Social Security number on the form provided by the Secretary under this section.

(2) (i) If the parent who did not give birth to the child is not available to provide the parent's Social Security number on the form provided under paragraph (1) of this subsection, the parent shall provide the parent's Social Security number on a form provided by the Secretary for this purpose.

(ii) The form provided under this paragraph shall:

1. State that the form is for the purpose of providing the Social Security numbers of parents, to be included on the portion of the form that remains in the official birth record;

2. Contain a specific reference to this subtitle; and

3. State that the parent's Social Security number shall be provided under penalty of perjury.

(3) The Social Security number as provided by each parent shall be recorded on the portion of the form provided by the Secretary which remains in the official birth record.

(4) The Social Security numbers of the parents may not appear on the portion of the birth certificate issued as proof of birth.

(5) (i) The Secretary shall permit disclosure of the Social Security numbers of the parents only to the Child Support Administration of the Department of Human Services.

(ii) The Child Support Administration may use the Social Security numbers of the parents to:

1. Locate a parent;

2. Establish parentage; and

3. Establish and enforce a child support order under Title 10, Subtitle 1 of the Family Law Article.

(f) If, under subsection (e)(1) of this section, the Social Security number of the parent who did not give birth to the child is not entered on the form provided by the Secretary:

(1) Upon adjudication of parentage, the court shall order the parent to provide the parent's Social Security number to the clerk of court; and

(2) The clerk of court shall send the parent's Social Security number to the Secretary, as provided under § 4–211(f) of this subtitle.

(g) A certificate of birth may be filed within 10 days after the birth occurred if a parent of the child notifies the person required to file the certificate of birth on a form provided by the Secretary as soon as practicable after birth, but not later than 5 days after the birth occurs.

§4–209.

(a) (1) Within 72 hours after a person takes custody of a child of unknown parentage, the person shall prepare and file a report, on the form that the Secretary provides.

(2) The report shall state:

(i) The date and place of finding of the child;

(ii) The sex, color or race, and approximate date of birth of the child, as determined by a physician;

(iii) The name and address of the person with whom the child is placed for care;

(iv) The name that the custodian gives the child; and

(v) Any other information that the Secretary requires.

(b) The person shall enter the place where the child was found as the place of birth.

(c) A report under this section is the certificate of birth for the child.

(d) If the child is identified and a certificate of birth is found or obtained, the report under this section:

(1) Shall be sealed; and

(2) May be reopened only:

(i) On order of a court of competent jurisdiction;

(ii) On written order of a designee of the Secretary; or

(iii) As the rules and regulations of the Secretary provide.

§4–210.

(a) The Secretary may adopt rules and regulations to govern the filing of a record of birth if a certificate of birth is not filed within the time required by § 4-208 or § 4-209 of this subtitle.

(b) (1) If the Secretary rejects a delayed certificate of birth under this section, a person may petition a court of competent jurisdiction to order the establishment of a record of birth.

(2) If the court finds, from the evidence, that the individual for whom a delayed certificate of birth is sought was born in this State, the court shall make findings as to parentage and place and date of birth and any other findings that the case requires and shall order the Secretary to establish a record of birth. The order shall include the findings to be entered in the record of birth and the date of the court action.

(3) On or before the tenth day of each month, each clerk of court shall send to the Secretary each court order for a delayed certificate of birth that was entered during the preceding month.

§4–211.

(a) Except as provided in subsection (d) of this section, the Secretary shall make a new certificate of birth for an individual if the Department receives satisfactory proof that:

(1) The individual was born in this State; and

(2) Regardless of the location, one of the following has occurred:

(i) The previously unwed parents of the individual have married each other after the birth of the individual;

(ii) A court of competent jurisdiction has entered an order as to the parentage, legitimation, or adoption of the individual; or

(iii) If a parent who did not give birth to the individual is not named on an earlier certificate of birth:

1. The parent who did not give birth to the individual has acknowledged himself or herself by affidavit to be a parent of the individual; and

2. The mother of the individual has consented by affidavit to the acknowledgment.

(b) Except as provided in subsection (d) of this section, the Secretary shall make a new certificate of birth for an individual if the Department receives satisfactory proof that:

(1) The individual was born in this State; and

(2) Regardless of the location, one of the following has occurred:

(i) 1. A licensed health care practitioner who has treated or evaluated the individual has determined that the individual's sex designation should be changed because the individual has undergone treatment appropriate for the purpose of sex transition or has been diagnosed with an intersex condition;

2. The individual, or if the individual is a minor or disabled person under guardianship, the individual's parent, guardian, or legal representative, has made a written request for a new certificate of birth with a sex designation that differs from the sex designated on the original certificate of birth; and

3. The licensed health care practitioner has signed a statement, under penalty of perjury, that:

A. The individual has undergone surgical, hormonal, or other treatment appropriate for the individual, based on generally accepted medical standards; or

B. The individual has an intersex condition and, in the professional opinion of the licensed health care practitioner, based on generally accepted medical standards, the individual's sex designation should be changed accordingly;

(ii) A court of competent jurisdiction has issued an order indicating that the sex of an individual born in this State has been changed; or

(iii) Before October 1, 2015, the Secretary, as provided under regulations adopted by the Department, amended an original certificate of birth on

receipt of a certified copy of an order of a court of competent jurisdiction indicating the sex of the individual had been changed.

(c) Except as provided in subsection (d) of this section, the Secretary may make a new certificate of birth for an individual who was born outside the United States if one of the following occurred in this State:

(1) The previously unwed parents of the individual have married each other after the birth of the individual;

(2) A court of competent jurisdiction in this State has entered an order as to parentage or legitimation; or

(3) The parent who did not give birth to the individual acknowledged himself or herself by affidavit to be a parent of the individual and the mother of the individual has consented by affidavit to the acknowledgment.

(d) The Secretary may not make a new certificate of birth in connection with an order of a court of competent jurisdiction relating to the adoption of an individual, if one of the following so directs the Secretary:

(1) The court that decrees the adoption;

(2) The adoptive parents; or

(3) The adopted individual, if an adult.

(e) A new certificate of birth shall be prepared on the following basis:

(1) The individual shall be treated as having at birth the status that later is acquired or established and of which proof is submitted.

(2) (i) If the parents of the individual were not married and parentage is established by legal proceedings, the name of the parent who did not give birth to the individual shall be inserted.

(ii) The legal proceeding should request and report to the Secretary that the surname of the subject of the record be changed from that shown on the original certificate, if a change is desired.

(3) If the individual is adopted, the name of the individual shall be that set by the decree of adoption, and the adoptive parents shall be recorded as the parents of the individual.

(4) The new certificate of birth shall contain wording that requires each parent shown on the new certificate to indicate his or her own Social Security number.

(f) (1) When a new certificate of birth is made under subsection (b) of this section:

(i) The sex designation of the individual on the new certificate of birth shall be the sex designation for which satisfactory proof has been submitted in accordance with subsection (b) of this section; and

(ii) If the name of the individual has been changed at any time, the name of the individual on the new certificate of birth shall be the name that was last established and for which appropriate documentation has been submitted to the Department.

(2) A new certificate of birth made under subsection (b) of this section may not:

(i) Be marked "amended"; or

(ii) Show on its face that a change has been made to:

1. A sex designation; or

2. If applicable, a change of name.

(g) (1) If a new certificate of birth is made, the Secretary shall:

(i) Substitute the new certificate of birth for any certificate then on file; and

(ii) Place the original certificate of birth and all records that relate to the new certificate of birth under seal.

(2) The seal may be broken only:

(i) On order of a court of competent jurisdiction;

(ii) If it does not violate the confidentiality of the record, on written order of a designee of the Secretary; or

(iii) In accordance with Title 5, Subtitle 3A or Subtitle 4B of the Family Law Article.

(3) A certified copy of the certificate of birth that later is issued shall be a copy of the new certificate of birth, unless:

(i) A court of competent jurisdiction orders the issuance of a copy of the original certificate of birth; or

(ii) Title 5, Subtitle 3A or Subtitle 4B of the Family Law Article provides for the issuance of a copy of the original certificate of birth.

(h) Each clerk of court shall send to the Secretary, on the form that the Secretary provides, a report of:

(1) Each decree of adoption;

(2) Each adjudication of parentage, including the parent's Social Security number; and

(3) Each revocation or amendment of any decree of adoption or adjudication of paternity that the court enters.

(i) Upon receipt of a report or decree of annulment of adoption, the original certificate of birth shall be restored to its place in the files, and the adoption certificate and any accompanying documents are not subject to inspection except upon order of a court of competent jurisdiction or as provided by regulation.

(j) If no certificate of birth is on file for the person for whom a new birth certificate is to be established under this section, and the date and place of birth have not been determined in the adoption or paternity proceedings:

(1) A delayed certificate of birth shall be filed with the Secretary as provided in § 4–210 of this subtitle before a new certificate of birth is established; and

(2) The new birth certificate shall be prepared on the delayed birth certificate form.

(k) (1) The Secretary shall, on request, prepare and register a certificate in this State for an individual born in a foreign country and who was adopted:

(i) Through a court of competent jurisdiction in this State; or

(ii) 1. Under the laws of a jurisdiction or country other than the United States and has been granted an IR–3 or IH–3 visa by the U.S.

Citizenship and Immigration Services under the Immigration and Nationality Act; and

2. By an adopting parent who is a resident of this State.

(2) Except as provided in paragraph (3) of this subsection, the certificate shall be established on receipt of:

(i) A certificate of adoption from the court decreeing the adoption;

(ii) Proof of the date and place of the child's birth; and

(iii) A request from the court, the adopting parents, or the adopted person if 18 years of age or over that the certificate be prepared.

(3) If the child was adopted under the laws of a jurisdiction or country other than the United States and has been granted an IR–3 or IH–3 visa by the U.S. Citizenship and Immigration Services under the Immigration and Nationality Act, the certificate shall be established on receipt of:

(i) An official copy of the decree from the jurisdiction or country in which the child was adopted;

(ii) A certified translation of the foreign adoption decree;

(iii) Proof of the date and place of the child's birth;

(iv) Proof of IR–3 or IH–3 visa status;

(v) A request from the court, the adopting parents, or the adopted person if 18 years of age or over that the certificate be prepared; and

(vi) Proof that the adopting parent is a resident of this State.

(4) The certificate shall be labeled "Certificate of Foreign Birth" and shall show the actual country of birth.

(5) A statement shall also be included on the certificate indicating that it is not evidence of United States citizenship for the child for whom it is issued.

§4–212.

(a) This section does not apply to a fetal death.

(b) (1) A certificate of death regardless of age of decedent shall be filled out and signed by:

(i) The medical examiner, if the medical examiner takes charge of the body; or

(ii) If the medical examiner does not take charge of the body, the physician, physician assistant, or nurse practitioner who last attended the deceased.

(2) The medical examiner, physician, physician assistant, or nurse practitioner shall fill in only the following information on the certificate of death:

(i) The name of the deceased;

(ii) The cause of death and medical certification;

(iii) The date and hour of death; and

(iv) The place where death occurred.

(3) Any other information that is required on the certificate of death regardless of age of decedent shall be filled in:

(i) By the person who has charge of the body; or

(ii) If the State Anatomy Board has charge of the body, by the person who last had charge of the body before it was sent to the State Anatomy Board.

(4) The medical certification shall be completed within 24 hours after receipt of the death certificate by the physician, physician assistant, or nurse practitioner in charge of the patient's care for the illness or condition which resulted in death, except when inquiry is required by the medical examiner.

(5) In the absence or inability of the attending physician, physician assistant, or nurse practitioner or with the attending physician's, physician assistant's, or nurse practitioner's approval, the certificate may be completed by:

(i) The attending physician's associate;

(ii) The chief medical officer or designee of the institution in which death occurred;

(iii) The physician who performed an autopsy upon the decedent, provided the individual has access to the medical history of the case and death is due to natural causes; or

(iv) A physician designated by the State Anatomy Board, only if within 72 hours after the State Anatomy Board takes charge of the body, the State Anatomy Board has failed after a good faith effort to make contact with any of the individuals described in items (i), (ii), or (iii) of this paragraph or paragraph (4) of this subsection.

(6) The person completing the cause of death and medical certification shall attest to the accuracy by signature or by an approved electronic process.

(7) The funeral director or person acting as the funeral director shall in all cases obtain the medical certification from the person responsible for its completion or obtain assurance that the medical certification has been provided to the Secretary by an approved electronic process.

(c) Each individual concerned with carrying out this subtitle promptly shall notify the medical examiner if:

(1) The deceased was not under treatment by a physician, physician assistant, or nurse practitioner during the terminal illness;

(2) The cause of death is unknown; or

(3) The individual considers any of the following conditions to be the cause of death or to have contributed to the death:

(i) An accident, including a fall with a fracture or other injury;

(ii) Homicide;

(iii) Suicide;

(iv) Other external manner of death;

(v) Alcoholism; or

(vi) Criminal or suspected criminal abortion.

(d) (1) (i) If, within 24 hours after taking charge of a body, the medical examiner has not determined the cause of death, the medical examiner shall enter "investigation pending" in the cause of death section of the death certificate.

(ii) As soon as the medical examiner determines the cause of death, the medical examiner shall send to the Secretary a report of the cause of death, for entry on the certificate.

(2) (i) A physician who completes a death certificate under subsection (b)(5)(iv) of this section shall enter "unspecified natural causes" in the cause of death section of the death certificate.

(ii) The State Anatomy Board shall send to the Secretary a report of the cause of death for entry on a death certificate completed under subsection (b)(5)(iv) of this section if the State Anatomy Board receives information about the cause of death from an individual described in subsection (b)(4) or (5)(i), (ii), or (iii) of this section.

(e) (1) A physician, physician assistant, or nurse practitioner who fills out a certificate of death shall give it or transmit it by approved electronic media, including facsimile, to the mortician within 24 hours after the death occurred.

(2) A medical examiner who fills out a certificate of death shall give it or transmit it by approved electronic media, including facsimile, to the mortician within 24 hours after the medical examiner took charge of the body.

(f) (1) If a death occurs on a common carrier in the United States and the body is removed from the carrier in this State, the death shall be registered in this State, and the place where it is first removed shall be considered the place of death. When a death occurs on a common carrier while in international waters or air space or in a foreign country or its air space and the body is first removed from the carrier in this State, the death shall be registered in this State, but the certificate shall show the actual place of death insofar as can be determined.

(2) The individual in charge or the owner of the common carrier or a designee shall file a certificate of death within 24 hours after the body is removed from the carrier.

(3) If the death occurred under any of the conditions or circumstances set forth in subsection (c) of this section, the medical examiner shall be notified.

(g) A mortician who obtains a certificate of death under this section shall file the certificate within 72 hours after the death.

(h) (1) Except as authorized under this subtitle, an individual who has a duty to fill out and sign a certificate of death may not execute more than one certificate for a death.

(2) The attending physician, the physician assistant, the nurse practitioner, or a medical examiner who takes charge of a body may file a replacement death certificate if a correction that the physician, the physician assistant, the nurse practitioner, or medical examiner authorizes cannot be entered legibly on the original certificate.

§4–213.

(a) If a fetal death occurs after a gestation period of 20 weeks or more, then within 72 hours after delivery, a certificate of fetal death shall be filed by:

(1) The mortician who first takes custody of a fetus;

(2) The person in charge of the institution or the person's designated representative when a fetus is delivered in an institution;

(3) The physician in attendance at or immediately after delivery when a fetus is delivered outside an institution; or

(4) The medical examiner when a fetal death occurs without medical attendance at or immediately after the delivery when a medical examiner's inquiry is required.

(b) The person who files the fetal death certificate shall obtain:

(1) The personal information from the next of kin or the best qualified individual or source available; and

(2) The medical certification of cause of death:

(i) From the medical examiner, within 24 hours after the medical examiner takes charge of the fetus; or

(ii) If the medical examiner does not take charge of the fetus, from the attending physician within 24 hours after delivery.

(c) When a fetal death occurs on a common carrier and the fetus is first removed from the carrier in this State or when a fetus is found in this State and the place of fetal death is unknown, the fetal death shall be reported in this State.

(d) The place where the fetus was first removed from the carrier or the fetus was found shall be considered the place of fetal death.

§4–213.1.

(a) The Secretary shall establish procedures for the issuance of a certificate of birth resulting in stillbirth.

(b) The Department shall make available a certificate of birth resulting in stillbirth to the parent or parents of a stillborn child for whom a fetal death was registered.

(c) The individual preparing the certificate of birth resulting in stillbirth shall not include any references to the stillborn child's first name if the stillborn child's parent or parents do not wish to provide a first name for the stillborn child.

§4–214.

(a) A certificate or record registered under this subtitle may be amended only in accordance with this subtitle and any rules and regulations that the Secretary adopts to protect the integrity and accuracy of vital records.

(b) (1) If any certificate of birth, death, or fetal death is amended, the facts shall be certified to the Secretary and entered on the original certificate with the date of the amendment, over the signature or initials of a designee of the Secretary and with a line drawn through the original data.

(2) All amendments may be stored on electronic media approved by the Secretary.

(3) All copies of certificates that are amended shall contain a notation that an amendment has been made.

(4) A record shall be maintained which identifies the evidence upon which the amendment was based, the date of the amendment, and the identity of the person making the amendment.

(5) When an informant does not submit the minimum documentation required in the regulations for amending a vital record or when the Secretary has cause to question the validity or adequacy of the applicant's sworn statements or the documentary evidence, and if the deficiencies are not corrected, the Secretary shall not amend the vital record and shall advise the applicant of the reason for this action and shall further advise the applicant of the right of appeal to the Office of Administrative Hearings.

(6) (i) Except as provided in subparagraph (ii) of this paragraph, any amendments to death certificates requested beyond 3 years or more after the death shall require a court order.

(ii) The Office of the Chief Medical Examiner may amend the cause of death on a certificate of death at any time after registration without a court order.

(c) (1) Except as provided in § 4–211(f) of this subtitle, on receipt of a court order that changes the name of an individual who was born in this State and on request of the individual or a parent, guardian, or legal representative of the individual, the Secretary shall amend the certificate of birth to reflect the new name.

(2) (i) The Department may change the name on a birth certificate once without a court order if, within 12 months after the birth, the Department receives from both parents named on the birth certificate of the child or, if only one parent is named, the parent named on the birth certificate of the child:

1. A written request for the change of name; and

2. An affidavit that has been sworn before a notary public of the State and states that the individual is the parent of the child and is making the request of the individual's own free will.

(ii) If the Department receives an affidavit in accordance with subparagraph (i)2 of this paragraph from both parents named on the birth certificate of the child, only one affidavit signed by both parents is required.

§4–215.

(a) In this section, "cemetery" includes a crematory or other place for final disposition.

(b) (1) Within 72 hours after death or after delivery in a fetal death and before final disposition or removal of the body or fetus from this State, the mortician who first takes custody of the body or fetus shall obtain a burial–transit permit.

(2) If the death or fetal death certificate is on a multicopy form, one copy of which is designated specifically as a "burial–transit permit" and is signed by the attending physician or medical examiner, that copy shall provide for the later entry of final disposition information and serves as a burial–transit permit.

(c) (1) A person in charge of a cemetery may not permit the final disposition of a body or fetus unless it is accompanied by a burial–transit permit.

(2) The person in charge of a cemetery shall:

(i) Write on the permit:

1. The date of final disposition;

2. The name and physical address of the cemetery; and

3. A. The burial, inurnment, or scattering section and the lot and space number; or

B. If the body or fetus was cremated and an authorizing agent, as defined in § 5–508 of this article, takes control of the cremains, the name and address of the authorizing agent and the authorizing agent's relationship to the deceased or fetus;

(ii) Sign the permit; and

(iii) Within 10 days after final disposition, return the permit to the Secretary.

(3) If there is no person in charge of the cemetery, the mortician shall fill out the burial–transit permit.

(d) A burial–transit permit issued by any state or a foreign country is sufficient authority for transit through this State or final disposition in any cemetery in this State.

(e) (1) A permit for disinterment and reinterment is required before the disinterment of human remains if reinterment is not to be made in the same cemetery. The Secretary or a health officer shall issue the permit after receipt of an application on the form that the Secretary requires.

(2) If all human remains in a cemetery are to be disinterred for purposes of relocation or abandonment of the cemetery, one application is sufficient for that purpose.

(3) The Department shall keep a record of each permit issued for the disinterment and reinterment of human remains.

(4) Except as provided in paragraph (5) of this subsection, the Department may not disclose or allow public inspection of information in a permit record about the location of the site of a disinterment or reinterment if a local burial sites advisory board or the Director of the Maryland Historical Trust determines that:

(i) The site is historic property, as defined in § 5A–301 of the State Finance and Procurement Article; and

(ii) Disclosure would create a substantial risk of harm, theft, or destruction to the site.

(5) The Department may not deny inspection of a permit record to:

(i) The owner of the site of the disinterment or reinterment;

(ii) A governmental entity that has the power of eminent domain; or

(iii) The spouse, domestic partner, next of kin, or appointed personal representative of the deceased whose human remains have been disinterred or reinterred.

§4–216.

The administrative head of an institution shall record and report each birth, death, and fetal death and all statistical information required by this subtitle, about the incarcerated individuals or patients of the institution. The information shall be obtained from the best possible source and presented to the individual responsible for execution of a certificate under this subtitle.

§4–217.

(a) (1) Except as provided in subsection (b) of this section, the Secretary shall provide, on request, any person authorized by regulations adopted under this subtitle with a certified or abridged copy of a birth, death, or fetal death certificate registered under this subtitle or of the certificate of a marriage performed after June 1, 1951.

(2) Except as provided in subsection (b) of this section and subject to subsection (h) of this section, a local health department or the Motor Vehicle Administration may:

(i) Access electronically from the Department a certified or abridged copy of a birth certificate or death certificate registered under this subtitle; and

(ii) On request, provide any person authorized by regulations adopted under this subtitle with a certified or abridged copy of a birth certificate or death certificate registered under this subtitle.

(3) (i) The Secretary shall provide on request, to any person authorized by regulation adopted under this subtitle, a commemorative birth certificate.

(ii) The Department shall set a fee for the commemorative birth certificate.

(iii) The commemorative birth certificate shall:

1. Be in a form consistent with the need to protect the integrity of vital records but suitable for display; and

2. Have the same status as evidence as the original birth certificate.

(iv) A portion of the funds collected under this paragraph shall go to the Department for the production costs of issuing the commemorative birth certificates. The remainder of the funds collected shall be paid into the Children's Trust Fund established under § 13–2207 of this article to provide funding for the Child Abuse Medical Providers (Maryland CHAMP) Initiative.

(v) The Secretary shall adopt regulations to implement the provisions of this paragraph.

(b) (1) A certified or abridged copy of a birth certificate may be issued only:

(i) On order of a court of competent jurisdiction;

(ii) On request of the individual to whom the record relates;

(iii) On request of a parent, guardian, surviving spouse, or other authorized representative of the individual; or

(iv) In accordance with Title 5, Subtitle 3A or Subtitle 4B of the Family Law Article.

(2) A certified or abridged copy of a birth certificate may contain only the personal information that appears on the birth certificate and may not include any confidential medical information that appears on the birth certificate.

(3) Birth certificate information may not be given if it is to be used for commercial solicitation or private gain.

(4) A noncertified copy of a birth certificate including confidential medical information may be provided to a unit of the Department to carry out its legal mandate or to conduct Institutional Review Board (IRB) approved research or study. Any report resulting from this research or study may not contain personal identifiers unless authorized by the subject of the record or the subject's parent or authorized representative.

(5) A copy of a birth certificate may be given to the Maryland Immunization Program to improve childhood immunization rates.

(c) (1) Except as otherwise provided by law:

(i) The Department shall collect a $12 fee:

1. For each certified or abridged copy of a fetal death, marriage, or divorce verification certificate;

2. For a report that a search of the fetal death, marriage, or divorce verification certificate files was made and the requested record is not on file;

3. For each change to a fetal death, marriage, or divorce verification certificate made later than 1 year after the certificate has been registered with the Department; or

4. To process an adoption, foreign adoption, or legitimation;

(ii) The Department shall collect a $10 fee:

1. Except as provided in paragraph (6)(ii) of this subsection, for each certified or abridged copy of a birth certificate;

2. For the first copy of a certified or abridged death certificate issued in a single transaction;

3. For a report that a search of the birth or death certificate files was made and the requested record is not on file; or

4. For each change to a birth or death certificate made later than 1 year after the certificate has been registered with the Department; and

(iii) The Department shall collect a $12 fee for each additional certified or abridged copy of a death certificate provided concurrently with an initial requested death certificate.

(2) From the fee the Department collects under paragraph (1) of this subsection, the Department shall transfer the entire fee to the General Fund.

(3) (i) Any local health department or the Motor Vehicle Administration may set and collect a fee for processing and issuing a birth certificate or death certificate, or for a report that a search of the files was made and the requested record is not on file, that covers:

1. The administrative costs of providing this service; and

2. The requirements of subparagraph (iii) of this paragraph.

(ii) The fee set by the local health department or the Motor Vehicle Administration for processing and issuing a birth certificate or for a report under subparagraph (i) of this paragraph may not exceed the actual costs to the local health department or the Motor Vehicle Administration for processing and issuing a birth certificate or death certificate or a report.

(iii) From the fee the local health department or the Motor Vehicle Administration collects under subparagraph (i) of this paragraph, $10 shall be transferred to the General Fund.

(iv) Prior to setting and collecting a fee for processing and issuing a birth certificate or death certificate or for a report under subparagraph (i) of this paragraph, the local health department or the Motor Vehicle Administration shall enter into a memorandum of understanding with the Maryland Department of Health that outlines the local health department's or the Motor Vehicle Administration's fee structure.

(4) The Department, a local health department, or the Motor Vehicle Administration may collect a fee for a certificate requested by an agency of the State or any of its political subdivisions.

(5) The Secretary may waive all or part of a fee if chargeable to an agency of the United States.

(6) (i) The Department may not collect a fee for a copy of a vital record issued to:

1. A current or former member of the uniformed services; or

2. The surviving spouse or child of the member, if the copy will be used in connection with a claim for a dependent or beneficiary of the member.

(ii) 1. In this subparagraph, "homeless individual" has the meaning stated in the federal McKinney–Vento Homeless Education Assistance Improvements Act of 2001.

2. Subject to subsubparagraph 4 of this subparagraph, the Department may not collect a fee for a certified or an abridged copy of a birth certificate issued to a homeless individual.

3. The Department shall accept as proof of homelessness a signed written statement from a homeless services provider located in the State that:

A. Affirms that the individual is homeless; and

B. Includes the address to which the copy of the birth certificate requested under this section may be sent.

4. A homeless individual may receive one copy of a birth certificate without a fee in a single transaction.

5. The Department shall adopt regulations to implement this subparagraph.

(iii) The Department may not collect a fee for a certified or abridged copy of a death certificate of a first responder, as defined in § 18–213.2 of this article, killed in the line of duty, if the copy is issued to a surviving spouse or child of the first responder and will be used in connection with a claim for a dependent or beneficiary of the first responder.

(d) (1) (i) Except as provided in subparagraph (ii) of this paragraph, any local health department or the Motor Vehicle Administration may set and collect a fee for processing and issuing a death certificate that covers the administrative costs of providing this service.

(ii) A local health department or the Motor Vehicle Administration may not collect a fee for processing and issuing a certified or abridged copy of a death certificate of a first responder, as defined in § 18–213.2 of this article, killed in the line of duty, if the copy is issued to a surviving spouse or child of the first responder and will be used in connection with a claim for a dependent or beneficiary of the first responder.

(2) The fee set by the local health department or the Motor Vehicle Administration for processing and issuing a death certificate under this subsection may not exceed the actual costs to the local health department or the Motor Vehicle Administration for processing and issuing a death certificate.

(e) The Secretary shall include with every copy of a death certificate, in a form prescribed and provided by the Insurance Commissioner, a notice which advises that certain individuals may be entitled to continuation of group health insurance benefits under § 15–407 of the Insurance Article.

(f) The Secretary shall include with every copy of a death certificate that is completed by the Chief Medical Examiner a notice that advises a person in interest, as defined in § 4–101(g) of the General Provisions Article, of the right to appeal a denial by the Chief Medical Examiner of a request to correct findings and conclusions as to the cause and manner of death recorded on a death certificate as provided under § 5–310(d) of this article.

(g) A person may use a photocopy of a birth, death, fetal death, or marriage certificate for any nonfraudulent and nondeceptive purpose.

(h) (1) The Department shall develop and implement security protocols and other protections to:

(i) Ensure a person without authorization is prohibited from accessing any vital records; and

(ii) Minimize the disclosure of and the access to medically sensitive information from the vital records database by employees not employed by the Department.

(2) The security protocols and other protections developed under paragraph (1) of this subsection shall include an auditable record of the following information:

(i) The date and time a certified or abridged copy of a birth certificate was printed; and

(ii) The identification of the employee who printed the certified or abridged copy of the birth certificate.

§4–218.

(a) In consultation with the State Health Planning and Development Agency, the Department shall prepare annually population estimates for this State and each county.

(b) The population estimates shall include categories of age, sex, and race.

§4–219.

(a) At least annually, the Secretary shall:

(1) Publish a report of vital statistics, including population estimates; and

(2) Print and distribute the report to any official, agency, library, or other person whom the Secretary considers entitled to the report.

(b) In addition to the requirements of subsection (a) of this section, by June 30 of each year the Secretary shall report to the Morbidity, Mortality, and Quality Review Committee established under § 18–107 of this article on the number and cause of death of Maryland children under the age of 1 year who died during the prior calendar year ending December 31st.

(c) In addition to the requirements of subsections (a) and (b) of this section, within 24 hours of notification of a death, the Secretary shall report to the Mortality and Quality Review Committee any death of an individual who at the time of death was:

(1) An individual with a developmental disability, as defined in § 7–101(g) of this article, who resided in or was receiving services from any program or facility licensed or operated by the Developmental Disabilities Administration; or

(2) An individual with a mental illness who resided in or was receiving services from any program or facility approved, licensed, or operated by the Behavioral Health Administration.

§4–220.

(a) The Secretary may provide the United States Department of Health and Human Services with copies of vital records or other information that is required for national statistics, on the condition that the information may not be used for other than statistical purposes unless authorized by the Secretary.

(b) On request, the Secretary may provide federal, State, local, and other public or private agencies with copies of vital records or other information for statistical purposes on terms or conditions that the Secretary sets.

(c) On request, the Secretary may provide the State designated health information exchange with select information from death certificates to allow linkage of the data to the State designated health information exchange master patient index in order that a date of death may be associated and stored with the records of those patients who have died for statistical and clinician notification purposes in accordance with regulations or a data sharing agreement.

§4–221.

The Secretary may approve specific projects for typewritten, photographic, or other reproductions of originals, carbon copies, and indexes of vital records. These projects shall state the method of reproduction, the disposition or location of the depository of any record reproduced, and the type of records and the period covered.

§4–222.

The Secretary shall provide to the Executive Director of the Social Services Administration in the Department of Human Services birth record information for a child born to an individual whose identifying information has been provided to the Secretary within the previous 10 years by the Executive Director or a court under § 5–715 of the Family Law Article.

§4–223.

(a) Except as otherwise provided in this section, if a certificate of birth, death, or fetal death is filed within 1 year after the event, the original or a certified copy of the certificate is prima facie evidence of the facts stated in it.

(b) (1) Except as provided in paragraph (2) of this subsection, any information in the certificate that relates to a parent who did not give birth to a child is prima facie evidence.

(2) If the parentage of the child is contested, and the parent who did not give birth to the child is a putative father as defined in § 5–1001 of the Family Law Article, the information that relates to the putative father is not evidence in any proceeding adverse to the interests of the putative father or the putative father's heirs, next of kin, devisees, legatees, or other successors in interest.

(c) If a certificate or record is filed more than 1 year after the event or is amended, the court or official before whom the certificate or record is offered as evidence shall determine its evidentiary value.

§4–224.

To protect the integrity of vital records, to ensure their proper use, and to ensure the efficient and proper administration of the vital records system, a person may not, except as authorized in § 4–217, § 4–220, § 4–221, or § 4–222 of this subtitle or § 9–1015 of the State Government Article or by the rules and regulations of the Department:

(1) Permit inspection of or disclose any information contained in a vital record; or

(2) Copy or issue a copy of all or part of any vital record.

§4–225.

(a) (1) The Secretary may investigate any irregularity or violation of this subtitle.

(2) On request of the Secretary, each registrar shall help the Secretary in the investigation.

(b) If the Secretary considers it necessary, the Secretary shall report a violation of this subtitle to the State's Attorney for the appropriate county, with a statement of the relevant facts and circumstances, for appropriate action.

§4–226.

(a) A person may not fail or refuse to execute and deliver a certificate of birth, death, or fetal death required by this subtitle.

(b) (1) A person may not willfully provide false information for entry or willfully enter false information on a certificate of birth, death, or fetal death.

(2) A person may not fail to provide a Social Security number or willfully provide a false Social Security number to the clerk of court under § 4–208(f) of this subtitle.

(c) Except as authorized by this subtitle, a person may not willfully alter any certificate, certified copy of a certificate, or other certified statement that relates to a birth, death, fetal death, or marriage registered under this subtitle.

(d) (1) A person may not willfully use or attempt to use, with the intention to deceive, any certificate of birth or certified copy of a record of birth knowing that the certificate or certified copy:

(i) Was issued on a record that is wholly or partly false; or

(ii) Relates to the birth of another individual.

(2) A person may not willfully and knowingly provide a certificate of birth or a certified copy of a record of birth to another person with the intention that it be used by that person to deceive.

(e) Without authorization, a person may not produce, reproduce, or distribute a blank certificate or other form that the Secretary uses to register or certify facts that relate to a birth, death, fetal death, or marriage.

(f) A person may not willfully use or attempt to use a photocopy of a birth, death, fetal death, or marriage certificate for any fraudulent or deceptive purpose.

(g) A person who has access to the birth, death, or fetal death records in the custody of the Secretary or an agent of the Secretary may not willfully communicate to anyone known to the person to be unauthorized any fact recorded on any birth, death, or fetal death certificate.

(h) A person may not willfully transport or accept for transportation, dissection, or other disposition a body without a burial–transit permit, as provided in this subtitle.

(i) A person may not willfully:

(1) Violate any provision of this subtitle;

(2) Neglect to perform any duty imposed by this subtitle; or

(3) Violate any rule or regulation adopted under this subtitle.

§4–227.

A person who violates § 4-226 of this subtitle is guilty of a misdemeanor and on conviction is subject to the following penalties:

(1) For violating § 4-226(a) or (b), a fine not exceeding $100.

(2) For violating § 4-226(g) or (h), a fine not exceeding $200.

(3) For violating § 4-226(d), a fine not exceeding $500.

(4) For violating § 4-226(c), a fine not exceeding $500 or imprisonment not exceeding 6 months or both.

(5) For violating § 4-226(e), a fine not exceeding $500 or imprisonment not exceeding 1 year or both.

(6) For violating § 4-226(i), except where a different penalty is provided in this section, a fine not exceeding $100.

(7) For violating § 4-226(f), a fine not exceeding $1,000 or imprisonment not exceeding 30 days or both.

§4–301.

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

(b) "Common ownership" means ownership of a health care entity:

(1) By two or more health care providers;

(2) By two or more health care providers employed by a mutual employer for a wage, salary, fee, or payment to perform work for the employer;

(3) By health care organizations operating as an organized health care arrangement, as defined in 45 C.F.R. § 160.103;

(4) By a health care entity or health care entities that possess an ownership or equity interest of 5% or more in another health care entity; or

(5) By affiliated providers operating under the same trade name.

(c) "Directory information" means information concerning the presence and general health condition of a patient who has been admitted to a health care facility or who is currently receiving emergency health care in a health care facility.

(d) "Disclose" or "disclosure" means the transmission or communication of information in a medical record, including an acknowledgment that a medical record on a particular patient or recipient exists.

(e) "Emergency" means a situation when, in the professional opinion of the health care provider, a clear and significant risk of death or imminent serious injury or harm to a patient or recipient exists.

(f) "General health condition" means the health status of a patient described in terms of "critical", "poor", "fair", "good", "excellent", or terms denoting similar conditions.

(g) "Health care" means any care, treatment, or procedure by a health care provider:

(1) To diagnose, evaluate, rehabilitate, manage, treat, or maintain the physical or mental condition of a patient or recipient; or

(2) That affects the structure or any function of the human body.

(h) (1) "Health care provider" means:

(i) A person who is licensed, certified, or otherwise authorized under the Health Occupations Article or § 13–516 of the Education Article to provide health care in the ordinary course of business or practice of a profession or in an approved education or training program; or

(ii) A facility where health care is provided to patients or recipients, including a facility as defined in § 10–101(g) of this article, a hospital as defined in § 19–301 of this article, a related institution as defined in § 19–301 of this article, a health maintenance organization as defined in § 19–701(g) of this article, an outpatient clinic, a medical laboratory, a comprehensive crisis response center, a crisis stabilization center, and a crisis treatment center established under § 7.5–207 of this article.

(2) "Health care provider" includes the agents, employees, officers, and directors of a facility and the agents and employees of a health care provider.

(i) (1) "Health information exchange" means:

(i) An individual or entity that determines, controls, or has the discretion to administer any requirement, policy, or agreement that allows, enables, or requires the use of any technology or services for access, exchange, or use of electronic protected health care information:

1. Among more than two unaffiliated individuals or entities that are enabled to exchange electronic protected health information with each other; and

2. That is for a treatment, payment, or health care operations purpose, as those terms are defined in 45 C.F.R. § 164.501, regardless of whether the individuals or entities are subject to the requirements of 45 C.F.R. parts 160 and 164; or

(ii) A health information technology developer of certified health information technology that develops or offers health information technology, as that term is defined in 42 U.S.C. 300jj(5), and has one or more Health Information Technology Modules certified under a program for the voluntary certification of health information technology that is kept or recognized by the National Coordinator in accordance with 42 U.S.C. 300jj–11(c)(5).

(2) "Health information exchange" does not include:

(i) An entity composed of health care providers under common ownership if the organizational and technical processes the entity provides or governs are for health care treatment, payment, or health care operations purposes, as those terms are defined in 45 C.F.R. § 164.501;

(ii) A carrier, as defined in § 15–1301 of the Insurance Article if the organizational and technical processes the carrier provides or governs are for health care treatment, payment, or health care operations purposes, as those terms are defined in 45 C.F.R. § 164.501;

(iii) An administrator, as defined in § 8–301 of the Insurance Article, if the organizational and technical processes the administrator provides or governs are for health care treatment, payment, or health care operations purposes, as those terms are defined in 45 C.F.R. § 164.501;

(iv) A health care provider, as defined in subsection (h) of this section, if the organizational and technical processes the health care provider provides or governs are for health care treatment, payment, or health care operations purposes, as those terms are defined in 45 C.F.R. § 164.501;

(v) A carrier's business associate, as defined in 45 C.F.R. § 160.103, if the organizational and technical processes provided or governed by the business associate are transactions, as defined in 45 C.F.R. § 160.103; or

(vi) A carrier exchanging information as required by 45 C.F.R. § 156.221.

(j) "Legally protected health care" means all sensitive health services, medications, and supplies related to:

(1) The provision of abortion care; and

(2) Reproductive health and other sensitive health services as determined by the Secretary based on the recommendations of the Protected Health Care Commission established under § 4–310 of this subtitle.

(k) (1) "Medical record" means any oral, written, or other transmission in any form or medium of information that:

(i) Is entered in the record of a patient or recipient;

(ii) Identifies or can readily be associated with the identity of a patient or recipient; and

(iii) Relates to the health care of the patient or recipient.

(2) "Medical record" includes any:

(i) Documentation of disclosures of a medical record to any person who is not an employee, agent, or consultant of the health care provider;

(ii) File or record maintained under § 12–403(c)(13) of the Health Occupations Article by a pharmacy of a prescription order for drugs, medicines, or devices that identifies or may be readily associated with the identity of a patient;

(iii) Documentation of an examination of a patient regardless of who:

1. Requested the examination; or

2. Is making payment for the examination; and

(iv) File or record received from another health care provider that:

1. Relates to the health care of a patient or recipient received from that health care provider; and

2. Identifies or can readily be associated with the identity of the patient or recipient.

(l) (1) "Mental health services" means health care rendered to a recipient primarily in connection with the diagnosis, evaluation, treatment, case management, or rehabilitation of any mental disorder.

(2) For acute general hospital services, mental health services are considered to be the primarily rendered service only if service is provided pursuant to Title 10, Subtitle 6 of this article or Title 3 of the Criminal Procedure Article.

(m) "Patient" means a person who receives health care and on whom a medical record is maintained.

(n) "Person in interest" means:

(1) An adult on whom a health care provider maintains a medical record;

(2) A person authorized to consent to health care for an adult consistent with the authority granted;

(3) A duly appointed personal representative of a deceased person;

(4) (i) A minor, if the medical record concerns treatment to which the minor has the right to consent and has consented under Title 20, Subtitle 1 of this article; or

(ii) A parent, guardian, custodian, or a representative of the minor designated by a court, in the discretion of the attending physician who provided the treatment to the minor, as provided in § 20–102 or § 20–104 of this article;

(5) If item (4) of this subsection does not apply to a minor:

(i) A parent of the minor, except if the parent's authority to consent to health care for the minor has been specifically limited by a court order or a valid separation agreement entered into by the parents of the minor; or

(ii) A person authorized to consent to health care for the minor consistent with the authority granted; or

(6) An attorney appointed in writing by a person listed in item (1), (2), (3), (4), or (5) of this subsection.

(o) "Primary provider of mental health services" means the designated mental health services provider who:

(1) Has primary responsibility for the development of the mental health treatment plan for the recipient; and

(2) Is actively involved in providing that treatment.

(p) "Protected health information" means all individually identifiable health information held or transmitted by a covered entity or its business associate protected under the U.S. Department of Health and Human Services Privacy Rule.

(q) "Recipient" means a person who has applied for, for whom an application has been submitted, or who has received mental health services.

(r) "Sensitive health services" includes:

(1) Reproductive health services other than abortion care; and

(2) Gender–affirming care.

(s) "State–designated health information exchange" means the health information exchange designated by the Maryland Health Care Commission and the Health Services Cost Review Commission under § 19–143 of this article.

§4–302.

(a) A health care provider shall:

(1) Keep the medical record of a patient or recipient confidential; and

(2) Disclose the medical record only:

(i) As provided by this subtitle; or

(ii) As otherwise provided by law.

(b) The provisions of this subtitle do not apply to information:

(1) Not kept in the medical record of a patient or recipient that is related to the administration of a health care facility, including:

(i) Risk management;

(ii) Quality assurance; and

(iii) Any activities of a medical or dental review committee that are confidential under the provisions of § 1–401 and Title 4, Subtitle 5 of the Health Occupations Article and any activities of a pharmacy review committee;

(2) Governed by the federal confidentiality of alcohol and drug abuse patient records regulations, 42 C.F.R. Part 2 and the provisions of § 8–601(c) of this article; or

(3) Governed by the developmental disability confidentiality provisions in §§ 7–1008 through 7–1011 of this article.

(c) (1) Unless the patient has restricted or prohibited the disclosure of directory information, a health care provider may disclose directory information about a patient to an individual who has asked for the patient by name.

(2) A health care provider shall:

(i) Inform a patient of the health care information that the health care provider may include in a directory and the persons to whom the health care provider may disclose the information; and

(ii) As soon as practicable, provide the patient with the opportunity to restrict or prohibit disclosure of directory information.

(3) If providing an opportunity under paragraph (2)(ii) of this subsection to restrict or prohibit the disclosure of directory information is not practicable because of the patient's incapacity or need for emergency care or treatment, a health care provider may disclose the patient's directory information if the disclosure is:

(i) Consistent with a prior expressed preference of the patient that is known to the health care provider; and

(ii) Determined to be, based on the health care provider's professional judgment, in the patient's best interest.

(d) A person to whom a medical record is disclosed may not redisclose the medical record to any other person unless:

(1) The redisclosure is:

(i) Authorized by the person in interest;

(ii) Otherwise permitted by this subtitle;

(iii) Permitted under § 1–202(b) or (c) of the Human Services Article; or

(iv) Directory information; or

(2) (i) The person to whom the medical record was disclosed is a guardian ad litem who received the medical record in accordance with § 4–306(b)(12) of this subtitle;

(ii) A reasonable effort to secure a qualified protective order has been made in accordance with 42 C.F.R. § 164.512(e)(1)(v); and

(iii) The guardian ad litem determines that it is necessary to redisclose the medical record to carry out the guardian ad litem's official function to protect the best interests of a minor or a disabled or elderly individual in a criminal or juvenile delinquency court proceeding.

(e) (1) Except as provided in paragraph (2) of this subsection, a person may not disclose by sale, rental, or barter any medical record.

(2) This subsection shall not prohibit the transfers of medical records relating to the transfer of ownership of a health care practice or facility if the transfer is in accord with the ethical guidelines of the applicable health care profession or professions.

(f) The provisions of this subtitle may not be construed to constitute an exception to the reporting requirements of Title 5, Subtitle 7 and Title 14, Subtitle 3 of the Family Law Article.

§4–302.1.

(a) Payors that accept claims originating in this State from medical care electronic claims clearinghouses shall accept claims only from medical care electronic claims clearinghouses that are:

(1) Accredited by the Electronic Healthcare Network Accreditation Commission; or

(2) Certified by the Maryland Health Care Commission.

(b) The Maryland Health Care Commission shall adopt regulations to carry out this section.

§4–302.2.

(a) The Maryland Health Care Commission shall adopt regulations for the privacy and security of protected health information obtained or released through a health information exchange.

(b) (1) The regulations adopted under subsection (a) of this section shall:

(i) Govern the access, use, maintenance, disclosure, and redisclosure of protected health information as required by State or federal law, including the federal Health Insurance Portability and Accountability Act, the federal Health Information Technology for Economic and Clinical Health Act, the federal 21st Century Cures Act, and Title 21, Subtitle 2A of this article;

(ii) Include protections for the secondary use of protected health information obtained or released through a health information exchange;

(iii) Require the State–designated health information exchange to develop and maintain a consent management application, subject to State and federal law, that:

1. Allows a person in interest to opt out of having electronic health information shared or disclosed by a health information exchange;

2. Informs the person in interest of the electronic health information that may be shared or disclosed notwithstanding the choice to opt out;

3. Requires that the State–designated health information exchange provide a health information exchange with the opt–out status of a person in interest, on receipt of an electronic request from the health information exchange for the opt–out status of the person in interest;

4. Requires a health information exchange to obtain the opt–out status of a person in interest from the State–designated health

information exchange before sharing or disclosing the electronic health information of the person in interest; and

5. Except as provided in paragraph (2) of this subsection, prohibits a health information exchange from sharing or disclosing the electronic health information of a person in interest if the person in interest has opted out of having electronic health information shared or disclosed by a health information exchange; and

(iv) Provide appropriate penalties for noncompliance with the regulations, including fines that do not exceed $10,000 per day and that are determined based on:

1. The extent of actual or potential public harm caused by the violation;

2. The cost of investigating the violation; and

3. Whether the person committed previous violations.

(2) The regulations adopted under subsection (a) of this section may not prohibit:

(i) The Department, the Maryland Health Care Commission, or the Health Services Cost Review Commission from using electronic health information, subject to federal and State law, for health regulatory and public health functions;

(ii) The sharing or disclosing of information that is required to be exchanged under Title 21, Subtitle 2A of this article; or

(iii) The sharing or disclosing of information that is required to be exchanged under federal law, including for the purposes of payment, as defined in 45 C.F.R. § 164.501.

(3) This section does not prohibit the Commission from adopting regulations that are more stringent than federal law in accordance with 45 C.F.R. § 160.203.

(c) Data obtained or released through a health information exchange:

(1) May not be sold for financial remuneration until the regulations required under subsections (a) and (b) of this section are adopted; and

(2) May be sold for financial remuneration only in accordance with the regulations adopted under subsections (a) and (b) of this section.

(d) The Maryland Health Care Commission shall consult with health care providers, payors, State health agencies, consumer advocates, and employers before adopting regulations under subsections (a) and (b) of this section.

§4–302.3. IN EFFECT

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

(2) "Electronic health care transactions" means health care transactions that have been approved by a nationally recognized health care standards development organization to support health care informatics, information exchange, systems integration, and other health care applications.

(3) "Electronic health network" means an entity:

(i) Involved in the exchange of electronic health care transactions between a payor, health care provider, vendor, and any other entity; and

(ii) Certified by the Maryland Health Care Commission.

(4) "Nursing home" has the meaning stated in § 19–1401 of this article.

(5) "Standard request" means a request for clinical information from a health information exchange that conforms to the major standards version specified by the Office of the National Coordinator for Health Information Technology.

(b) This section applies to:

(1) Except for the State–designated health information exchange, a health information exchange operating in the State; and

(2) A payor that:

(i) Holds a valid certificate of authority issued by the Maryland Insurance Commissioner; and

(ii) Acts as, operates, or owns a health information exchange.

(c) An entity to which this section applies shall connect to the State–designated health information exchange in a manner consistent with applicable federal and State privacy laws.

(d) When a standard request for clinical information is received through the State–designated health information exchange, an entity to which this section applies shall:

(1) Respond to the request to the extent authorized under federal and State privacy laws; and

(2) Transmit the response to the State–designated health information exchange in the manner specified in the regulations adopted under subsection (g) of this section.

(e) A consent from a patient to release clinical information to a provider obtained by an entity to which this section applies shall apply to information transmitted through the State–designated health information exchange or by other means.

(f) (1) On request of the Department, a nursing home shall submit electronically clinical information to the State–designated health information exchange to facilitate the objectives stated in paragraph (3) of this subsection.

(2) In accordance with State and federal law and to facilitate the objectives stated in paragraph (3) of this subsection, the State–designated health information exchange may provide the information submitted under paragraph (1) of this subsection to:

(i) A health care provider;

(ii) An authorized health information exchange user;

(iii) A health information exchange authorized by the Maryland Health Care Commission;

(iv) A federal official; and

(v) A State official.

(3) (i) If approved by the Maryland Health Care Commission, the information submitted under paragraph (1) of this subsection may be combined with other data maintained by the State–designated health information exchange to facilitate:

1. A State health improvement program;

2. Mitigation of a public health emergency;

3. Improvement of patient safety; and

4. The participation of the State in the Center for Medicare and Medicaid Innovation's States Advancing All–Payer Health Equity Approaches and Development (AHEAD) Model and any successor models.

(ii) The information submitted by a nursing home under paragraph (1) of this subsection may be used only to facilitate the objectives stated in subparagraph (i) of this paragraph and may not be used for any other purpose, including licensing and certification.

(g) (1) The State–designated health information exchange shall:

(i) Participate in the advisory committee established under § 13–4306(a)(1) of this article; and

(ii) Maintain a data set for the Maryland Commission on Health Equity and provide data from the data set consistent with the parameters defined by the advisory committee.

(2) If approved by the Maryland Commission on Health Equity, the State–designated health information exchange may use the data set maintained under paragraph (1) of this subsection to improve health outcomes for patients.

(h) (1) An electronic health network shall provide electronic health care transactions to the State–designated health information exchange for the following public health and clinical purposes:

(i) A State health improvement program;

(ii) Mitigation of a public health emergency;

(iii) Improvement of patient safety; and

(iv) The participation of the State in the Center for Medicare and Medicaid Innovation's States Advancing All–Payer Health Equity Approaches and Development (AHEAD) Model and any successor models.

(2) An electronic health network may not charge a fee to a health care provider, health care payor, or to the State–designated health information exchange for providing the information as required under paragraph (1) of this subsection.

(3) The State–designated health information exchange shall develop and implement policies and procedures to implement paragraph (1) of this subsection that are consistent with regulations adopted by the Maryland Health Care Commission.

(i) The Maryland Health Care Commission:

(1) Shall adopt regulations for implementing the connectivity to the State–designated health information exchange required under this section; and

(2) Shall seek, through any regulations adopted under item (1) of this subsection, to promote technology standards and formats that conform to those specified by the Office of the National Coordinator for Health Information Technology.

(j) (1) The Maryland Health Care Commission shall adopt regulations that:

(i) Specify the scope of clinical information to be exchanged or sent under this section; and

(ii) Provide for a uniform, gradual implementation of the exchange of clinical information under this section.

(2) Any regulations adopted under paragraph (1) of this subsection shall limit the scope of the clinical information to purposes that:

(i) Improve treatment, including improved access to clinical records by treating clinicians;

(ii) Promote uses of the State–designated health information exchange important to public health; or

(iii) The protection of the electronic health information of a person in interest who has opted out of having electronic health information shared or disclosed by a health information exchange.

(3) Regulations adopted under paragraph (1) of this subsection:

(i) Shall limit redisclosure of financial information, including billed or paid amounts available in electronic claims transactions;

(ii) May not restrict the State's use of financial information, including billed or paid amounts available in electronic claims transactions, for public health purposes related to the participation of the State in the Center for Medicare and Medicaid Innovation's States Advancing All–Payer Health Equity Approaches and Development (AHEAD) Model and any successor models;

(iii) Shall restrict data of patients who have opted out of records sharing through the State–designated health information exchange or a health information exchange authorized by the Maryland Health Care Commission;

(iv) Shall restrict data from health care providers that possess sensitive health care information; and

(v) Shall restrict data of patients who have obtained legally protected health care.

(k) This section does not:

(1) Require an entity to which this section applies to collect clinical information or obtain any authorizations, not otherwise required by federal or State law, relating to information to be sent or received through the State–designated health information exchange;

(2) Prohibit an entity to which this section applies from directly receiving or sending information to providers or subscribers outside of the State–designated health information exchange; or

(3) Prohibit an entity to which this section applies from connecting and interoperating with the State–designated health information exchange in a manner and scope beyond that required under this section.

§4–302.3. // EFFECTIVE DECEMBER 31, 2030 PER CHAPTER 615 OF 2025 //

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

(2) "Electronic health care transactions" means health care transactions that have been approved by a nationally recognized health care standards development organization to support health care informatics, information exchange, systems integration, and other health care applications.

(3) "Electronic health network" means an entity:

(i) Involved in the exchange of electronic health care transactions between a payor, health care provider, vendor, and any other entity; and

(ii) Certified by the Maryland Health Care Commission.

(4) "Nursing home" has the meaning stated in § 19–1401 of this article.

(5) "Standard request" means a request for clinical information from a health information exchange that conforms to the major standards version specified by the Office of the National Coordinator for Health Information Technology.

(b) This section applies to:

(1) Except for the State–designated health information exchange, a health information exchange operating in the State; and

(2) A payor that:

(i) Holds a valid certificate of authority issued by the Maryland Insurance Commissioner; and

(ii) Acts as, operates, or owns a health information exchange.

(c) An entity to which this section applies shall connect to the State–designated health information exchange in a manner consistent with applicable federal and State privacy laws.

(d) When a standard request for clinical information is received through the State–designated health information exchange, an entity to which this section applies shall:

(1) Respond to the request to the extent authorized under federal and State privacy laws; and

(2) Transmit the response to the State–designated health information exchange in the manner specified in the regulations adopted under subsection (g) of this section.

(e) A consent from a patient to release clinical information to a provider obtained by an entity to which this section applies shall apply to information transmitted through the State–designated health information exchange or by other means.

(f) (1) On request of the Department, a nursing home shall submit electronically clinical information to the State–designated health information exchange to facilitate the objectives stated in paragraph (3) of this subsection.

(2) In accordance with State and federal law and to facilitate the objectives stated in paragraph (3) of this subsection, the State–designated health information exchange may provide the information submitted under paragraph (1) of this subsection to:

(i) A health care provider;

(ii) An authorized health information exchange user;

(iii) A health information exchange authorized by the Maryland Health Care Commission;

(iv) A federal official; and

(v) A State official.

(3) (i) If approved by the Maryland Health Care Commission, the information submitted under paragraph (1) of this subsection may be combined with other data maintained by the State–designated health information exchange to facilitate:

1. A State health improvement program;

2. Mitigation of a public health emergency; and

3. Improvement of patient safety.

(ii) The information submitted by a nursing home under paragraph (1) of this subsection may be used only to facilitate the objectives stated in subparagraph (i) of this paragraph and may not be used for any other purpose, including licensing and certification.

(g) (1) The State–designated health information exchange shall:

(i) Participate in the advisory committee established under § 13–4306(a)(1) of this article; and

(ii) Maintain a data set for the Maryland Commission on Health Equity and provide data from the data set consistent with the parameters defined by the advisory committee.

(2) If approved by the Maryland Commission on Health Equity, the State–designated health information exchange may use the data set maintained under paragraph (1) of this subsection to improve health outcomes for patients.

(h) (1) An electronic health network shall provide electronic health care transactions to the State–designated health information exchange for the following public health and clinical purposes:

(i) A State health improvement program;

(ii) Mitigation of a public health emergency; and

(iii) Improvement of patient safety.

(2) An electronic health network may not charge a fee to a health care provider, health care payor, or to the State–designated health information exchange for providing the information as required under paragraph (1) of this subsection.

(3) The State–designated health information exchange shall develop and implement policies and procedures to implement paragraph (1) of this subsection that are consistent with regulations adopted by the Maryland Health Care Commission.

(i) The Maryland Health Care Commission:

(1) Shall adopt regulations for implementing the connectivity to the State–designated health information exchange required under this section; and

(2) Shall seek, through any regulations adopted under item (1) of this subsection, to promote technology standards and formats that conform to those specified by the Office of the National Coordinator for Health Information Technology.

(j) (1) The Maryland Health Care Commission shall adopt regulations that:

(i) Specify the scope of clinical information to be exchanged or sent under this section; and

(ii) Provide for a uniform, gradual implementation of the exchange of clinical information under this section.

(2) Any regulations adopted under paragraph (1) of this subsection shall limit the scope of the clinical information to purposes that:

(i) Improve treatment, including improved access to clinical records by treating clinicians;

(ii) Promote uses of the State–designated health information exchange important to public health; or

(iii) The protection of the electronic health information of a person in interest who has opted out of having electronic health information shared or disclosed by a health information exchange.

(3) Regulations adopted under paragraph (1) of this subsection shall:

(i) Limit redisclosure of financial information, including billed or paid amounts available in electronic claims transactions;

(ii) Restrict data of patients who have opted out of records sharing through the State–designated health information exchange or a health information exchange authorized by the Maryland Health Care Commission;

(iii) Restrict data from health care providers that possess sensitive health care information; and

(iv) Restrict data of patients who have obtained legally protected health care.

(k) This section does not:

(1) Require an entity to which this section applies to collect clinical information or obtain any authorizations, not otherwise required by federal or State law, relating to information to be sent or received through the State–designated health information exchange;

(2) Prohibit an entity to which this section applies from directly receiving or sending information to providers or subscribers outside of the State–designated health information exchange; or

(3) Prohibit an entity to which this section applies from connecting and interoperating with the State–designated health information exchange in a manner and scope beyond that required under this section.

§4–302.4.

The existence of a health information exchange does not, in itself, create a new cause of action against a health information exchange or a health care provider.

§4–302.5.

(a) Subject to subsection (d)(3)(ii) of this section, this section applies to disclosures of health information to recipients located in the State and outside the State.

(b) Subject to subsection (d)(3)(ii) of this section, beginning December 1, 2023, a health information exchange or electronic health network may not disclose Mifepristone data or the diagnosis, procedure, medication, or related codes for abortion care and other sensitive health services as determined by the Secretary under subsection (d) of this section to a treating provider, a business entity, another health information exchange, or another electronic health network unless the disclosure is:

(1) For the adjudication of claims; or

(2) To a specific treating provider at the written request of and with the consent of:

(i) A patient, for services for which the patient can provide consent under State law; or

(ii) A parent or guardian of a patient, for services for which the parent or guardian can provide consent under State law.

(c) (1) Beginning June 1, 2024, a person who knowingly violates this section is guilty of a misdemeanor and on conviction is subject to a fine not to exceed $10,000 per day.

(2) In determining the fine to be imposed under paragraph (1) of this subsection, the following factors shall be considered:

(i) The extent of actual or potential public harm caused by the violation;

(ii) The cost of investigating the violation; and

(iii) Whether the person previously violated this section.

(d) (1) The Secretary shall determine for abortion care and sensitive health services the procedure, diagnosis, medication, and other related codes that are subject to the restrictions on disclosure established under subsection (b) of this section due to a substantial risk to patients or health care providers that would result from disclosure.

(2) A determination made under paragraph (1) of this subsection shall:

(i) Follow applicable guidelines of the American College of Obstetricians and Gynecologists, the World Health Organization, and the Society of Family Planning; and

(ii) For sensitive health services, be based on the recommendations of the Protected Health Care Commission established under § 4–310 of this subtitle.

(3) (i) The Secretary shall adopt regulations to restrict the disclosure of abortion care and other sensitive health services information by diagnosis, procedure, medication, or related codes under subsection (b) of this section.

(ii) Except as provided in subparagraph (iii) of this paragraph, the Secretary may adopt restrictions on the disclosure of abortion care or other sensitive health services under subparagraph (i) of this paragraph that are applicable only to disclosures by health information exchanges or electronic health networks to out–of–state treating providers, out–of–state business entities, other health information exchanges, or other electronic health networks.

(iii) Any regulations adopted by the Secretary to implement restrictions on the disclosure of Mifepristone data under subsection (b) of this section shall apply to disclosures of data to recipients located in the State and outside the State.

§4–302.6.

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

(2) "Business associate" has the meaning stated in 45 C.F.R. § 160.103.

(3) "Electronic health care transactions" has the meaning stated in § 4–302.3 of this subtitle.

(4) "Electronic health network" has the meaning stated in § 4–302.3 of this subtitle.

(5) "Nursing home" has the meaning stated in § 19–1401 of this article.

(b) (1) If a nursing home contracts with or uses an electronic health network or electronic medical record vendor, the nursing home may direct the electronic health network or electronic medical record vendor to release patient medical records or electronic health care transactions held by the electronic health network or electronic medical record vendor to a business associate of the nursing home.

(2) An electronic health network or electronic medical record vendor releasing patient medical records or electronic health care transactions under paragraph (1) of this subsection:

(i) Shall release the patient medical records or electronic health care transactions in an electronic format that conforms to the specifications of the Office of the National Coordinator for Health Information Technology or another form required by the State–designated health information exchange;

(ii) Shall make the patient medical records or electronic health care transactions available on a regular basis and release the information in a timely manner to support patient care and monitoring; and

(iii) May not restrict, limit, or charge a fee for the release of the patient medical records or electronic health care transactions.

§4–303.

(a) A health care provider shall disclose a medical record on the authorization of a person in interest in accordance with this section.

(b) Except as otherwise provided in subsections (c) and (d) of this section, an authorization shall:

(1) Be in writing, dated, and signed by the person in interest;

(2) State the name of the health care provider;

(3) Identify to whom the information is to be disclosed;

(4) State the period of time that the authorization is valid, which may not exceed 1 year, except:

(i) In cases of criminal justice referrals, in which case the authorization shall be valid until 30 days following final disposition; or

(ii) In cases where the patient on whom the medical record is kept is a resident of a nursing home, in which case the authorization shall be valid until revoked, or for any time period specified in the authorization; and

(5) Apply only to a medical record developed by the health care provider unless in writing:

(i) The authorization specifies disclosure of a medical record that the health care provider has received from another provider; and

(ii) The other provider has not prohibited redisclosure.

(c) A health care provider shall disclose a medical record on receipt of a preauthorized form that is part of an application for insurance.

(d) A health care provider shall disclose a medical record on receipt of an authorization for the release of relevant medical information that is included with the claim application form filed with the Workers' Compensation Commission in accordance with § 9–709(a), § 9–710(b), or § 9–711(a) of the Labor and Employment Article.

(e) (1) Except in cases of criminal justice referrals, a person in interest may revoke an authorization in writing.

(2) A revocation of an authorization becomes effective on the date of receipt by the health care provider.

(3) A disclosure made before the effective date of a revocation is not affected by the revocation.

(f) A copy of the following shall be entered in the medical record of a patient or recipient:

(1) A written authorization;

(2) Any action taken in response to an authorization; and

(3) Any revocation of an authorization.

§4–304.

(a) (1) Except as otherwise provided in this subtitle, a health care provider shall comply within a reasonable time after a person in interest requests in writing:

(i) To receive a copy of a medical record; or

(ii) To see and copy the medical record.

(2) If a medical record relates to a psychiatric or psychological problem and the attending health care provider, with any available and feasible input from a primary provider of mental health services, believes disclosure of any portion of the medical record to be injurious to the health of a patient or recipient, the health care provider may refuse to disclose that portion of the medical record to the patient, recipient, or person in interest but, on written request, shall:

(i) Make a summary of the undisclosed portion of the medical record available to the patient, recipient, or person in interest;

(ii) Insert a copy of the summary in the medical record of the patient or recipient;

(iii) Permit examination and copying of the medical record by another health care provider who is authorized to treat the patient or recipient for the same condition as the health care provider denying the request; and

(iv) Inform the patient or recipient of the patient's or recipient's right to select another health care provider under this subsection.

(b) (1) A health care provider shall establish procedures for a person in interest to request an addition to or correction of a medical record.

(2) A person in interest may not have any information deleted from a medical record.

(3) Within a reasonable time after a person in interest requests a change in a medical record, the health care provider shall:

(i) Make the requested change; or

(ii) Provide written notice of a refusal to make the change to the person in interest.

(4) A notice of refusal shall contain:

(i) Each reason for the refusal; and

(ii) The procedures, if any, that the health care provider has established for review of the refusal.

(5) If the final determination of the health care provider is a refusal to change the medical record, the provider:

(i) Shall permit a person in interest to insert in the medical record a concise statement of the reason that the person in interest disagrees with the record; and

(ii) May insert in the medical record a statement of the reasons for the refusal.

(6) A health care provider shall give a notice of a change in a medical record or a copy of a statement of disagreement:

(i) To any individual the person in interest has designated to receive the notice or statement; and

(ii) To whom the health care provider has disclosed an inaccurate, an incomplete, or a disputed medical record within the previous 6 months.

(7) If a health care provider discloses a medical record after an addition, correction, or statement of disagreement has been made, the provider shall include with the medical record a copy of each addition, correction, or statement of disagreement.

(c) (1) (i) In this subsection, "medical record" includes a copy of a medical bill that has been requested by an individual.

(ii) The provisions of this subsection do not apply to x–rays.

(2) A health care provider may require a person in interest or any other authorized person who requests a copy of a medical record to pay for the cost of copying:

(i) For State facilities regulated by the Maryland Department of Health, as provided in § 4–206 of the General Provisions Article; or

(ii) For all other health care providers, a reasonable cost–based fee for providing the information requested.

(3) (i) Except as provided in subparagraph (iii) of this paragraph, for a copy of a medical record requested by a person in interest or any other authorized person under paragraph (2)(ii) of this subsection, a health care provider may charge a fee for copying and mailing not exceeding 76 cents for each page of the medical record.

(ii) In addition to the fee charged under subparagraph (i) of this paragraph, a hospital or a health care provider may charge:

1. Subject to the fee limitations that apply to persons in interest under 45 C.F.R. 164.524 and any guidance on those limitations issued by the U.S. Department of Health and Human Services, a preparation fee not to exceed $22.88 for medical record retrieval and preparation; and

2. The actual cost for postage and handling of the medical record.

(iii) Subject to the fee limitations that apply to persons in interest under 45 C.F.R. 164.524 and any guidance on those limitations issued by the U.S. Department of Health and Human Services, a hospital or a health care provider that uses or maintains the requested medical records in an electronic format may charge for an electronic copy of a medical record in an electronic format requested by a person in interest or any other authorized person:

1. A preparation fee not to exceed $22.88 for electronic format medical records retrieval and preparation;

2. A per–page fee of 75% of the per–page fee charged by a health care provider under subparagraph (i) of this paragraph that may not exceed $80; and

3. The actual cost for postage and handling of the electronic format medical records.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, the fees charged under paragraph (3) of this subsection may be adjusted annually for inflation in accordance with the Consumer Price Index.

(ii) The preparation fee charged for medical record retrieval and preparation under paragraph (3)(ii)1 of this subsection and for retrieval and preparation of a medical record in an electronic format under paragraph (3)(iii)1 of this subsection may not be adjusted annually for inflation in accordance with the Consumer Price Index.

(5) A health care provider or a representative of the health care provider may not charge a fee for providing copies of a medical record:

(i) Requested by:

1. The patient;

2. The patient's personal representative;

3. An employee or other representative of a nonprofit legal services entity or other volunteer or nonprofit program representing the patient; or

4. An attorney representing the patient; and

(ii) That will be used for the purpose of filing a claim regarding or appealing a denial of Social Security disability income or Social Security benefits under Title II or Title XVI of the Social Security Act.

(6) (i) Except as provided in subparagraph (ii) of this paragraph, a health care provider may charge a fee, as authorized under paragraphs (3) and (4) of this subsection, for the retrieval, copying, preparation, mailing, and actual cost of postage and handling of a medical record disclosed under § 4–306 of this subtitle.

(ii) If a government unit or agency or court–appointed guardian ad litem in a criminal or juvenile delinquency court proceeding makes a request for the disclosure of a medical record under § 4–306 of this subtitle, a health care provider may not charge the government unit or agency or court–appointed guardian ad litem a fee for the retrieval, copying, preparation, mailing, and actual cost of postage and handling of the medical record.

(7) Notwithstanding any other provision of law, a health care provider may not charge a person in interest, except for an attorney appointed in writing by a person in interest, who requests a copy of a medical record of an individual enrolled in the Maryland Medical Assistance Program a fee that exceeds $20, adjusted annually for inflation in accordance with the Consumer Price Index, for each 100 pages or portion of 100 pages copied.

(8) Notwithstanding any other provision of law, any person or entity who is not subject to the provisions of this subsection and who obtains a medical record from a health care provider or the provider's agent may not charge a fee for any subsequent copies of that medical record that exceeds the fee authorized under paragraph (3)(i) of this subsection.

(d) Except for an emergency request from a unit of State or local government concerning a child protective services case or adult protective services case, a health care provider may withhold copying until the fee for copying is paid.

§4–305.

(a) This section may not be construed to impose an obligation on a health care provider to disclose a medical record.

(b) A health care provider may disclose a medical record without the authorization of a person in interest:

(1) (i) To the provider's authorized employees, agents, medical staff, medical students, or consultants for the sole purpose of offering, providing, evaluating, or seeking payment for health care to patients or recipients by the provider;

(ii) To the provider's legal counsel regarding only the information in the medical record that relates to the subject matter of the representation; or

(iii) To any provider's insurer or legal counsel, or the authorized employees or agents of a provider's insurer or legal counsel, for the sole purpose of handling a potential or actual claim against any provider if the medical record is maintained on the claimant and relates to the subject matter of the claim;

(2) If the person given access to the medical record signs an acknowledgment of the duty under this Act not to redisclose any patient identifying information, to a person for:

(i) Educational or research purposes, subject to the applicable requirements of an institutional review board;

(ii) Evaluation and management of health care delivery systems; or

(iii) Accreditation of a facility by professional standard setting entities;

(3) Subject to the additional limitations for a medical record developed primarily in connection with the provision of mental health services in § 4–307 of this subtitle, to a government agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress;

(4) Subject to the additional limitations for a medical record developed primarily in connection with the provision of mental health services in § 4–307 of this subtitle, to another health care provider for the sole purpose of treating the patient or recipient on whom the medical record is kept;

(5) If a claim has been or may be filed by, or with the authorization of a patient or recipient on behalf of the patient or recipient, for covered insureds, covered beneficiaries, or enrolled recipients only, to third party payors and their agents, if the payors or agents have met the applicable provisions of §§ 15–10B–01 to 15–10B–18 of the Insurance Article, including nonprofit health service plans, health maintenance organizations, fiscal intermediaries and carriers, the Department and its agents, the United States Department of Health and Human Services and its agents, or any other person obligated by contract or law to pay for the health care rendered for the sole purposes of:

(i) Submitting a bill to the third party payor;

(ii) Reasonable prospective, concurrent, or retrospective utilization review or predetermination of benefit coverage;

(iii) Review, audit, and investigation of a specific claim for payment of benefits; or

(iv) Coordinating benefit payments in accordance with the provisions of the Insurance Article under more than one sickness and accident, dental, or hospital and medical insurance policy;

(6) If a health care provider makes a professional determination that an immediate disclosure is necessary, to provide for the emergency health care needs of a patient or recipient;

(7) To immediate family members of the patient or any other individual with whom the patient is known to have a close personal relationship, provided that:

(i) The disclosure is limited to information that is directly relevant to the individual's involvement in the patient's health care; and

(ii) 1. If the patient is present or otherwise available before the disclosure and has the capacity to make health care decisions:

A. The patient has been provided with an opportunity to object to the disclosure and the patient has not objected; or

B. The health care provider reasonably infers from the circumstances that, based on the health care provider's professional judgment, the patient does not object to the disclosure; or

2. If the patient is not present or otherwise available before the disclosure is made, or providing the patient with an opportunity to object to the disclosure is not practicable because of the patient's incapacity or need for emergency care or treatment, the health care provider determines, based on the health care provider's professional judgment, that the disclosure is in the best interests of the patient;

(8) To an appropriate organ, tissue, or eye recovery agency under the restrictions of § 5–408 of this article for a patient whose organs and tissues may be donated for the purpose of evaluating the patient for possible organ and tissue donation;

(9) To the Department or an organ, tissue, or eye recovery agency designated by the Department for the purpose of conducting death record reviews under § 19–310 of this article;

(10) Subject to subsection (c) of this section, if the purpose of the medical record disclosure is for the coordination of services and record retention within the Montgomery County Department of Health and Human Services; or

(11) To a carrier, as defined in § 15–1301 of the Insurance Article, or an accountable care organization, as defined in § 3022 of the Patient Protection and Affordable Care Act, for the sole purposes of enhancing or coordinating patient care, provided that:

(i) A disclosure under this item is subject to the additional limitations in § 4–307 of this subtitle on disclosure of a medical record developed primarily in connection with the provision of mental health services;

(ii) A medical record may be disclosed only in accordance with the federal Health Insurance Portability and Accountability Act of 1996, any regulations adopted under the Act, and any other applicable federal privacy laws, and disclosures under this item may not be made in violation of the prohibited uses or

disclosures under the federal Health Insurance Portability and Accountability Act of 1996;

(iii) A disclosure under this item may not be used for underwriting or utilization review purposes;

(iv) A health care provider that discloses a medical record in accordance with this item shall provide a notice consistent with the requirements of 45 C.F.R. § 164.520 specifying the information to be shared, with whom it will be shared, and the specific types of uses and disclosures that the health care provider may make in accordance with this item;

(v) The notice required by item (iv) of this item shall include an opportunity for the individual to opt out of the sharing of the individual's medical record with a carrier or an accountable care organization for the purposes identified in this item;

(vi) If a health care provider discloses medical information or medical data to a carrier or accountable care organization through an infrastructure that provides organizational and technical capabilities for the exchange of protected health information among entities not under common ownership, the health care providers are subject to the requirements of §§ 4–302.2 and 4–302.3 of this subtitle; and

(vii) If the disclosure is of abortion care or other sensitive health services information as determined by the Secretary under § 4–302.5(d) of this subtitle, the disclosure is subject to the requirements under § 4–302.5 of this subtitle.

(c) (1) The disclosure of medical records under subsection (b)(10) of this section to a person that is not employed by or under contract with the Montgomery County Department of Health and Human Services shall be conducted in accordance with this subtitle.

(2) Under provisions of State law regarding confidentiality, the Montgomery County Department of Health and Human Services shall be considered to be one agency.

§4–306.

(a) In this section, "compulsory process" includes a subpoena, summons, warrant, or court order that appears on its face to have been issued on lawful authority.

(b) A health care provider shall disclose a medical record without the authorization of a person in interest:

(1) To a unit of State or local government, or to a member of a multidisciplinary team assisting the unit, for purposes of investigation or treatment in a case of suspected abuse or neglect of a child or an adult, subject to the following conditions:

(i) The health care provider shall disclose only the medical record of a person who is being assessed in an investigation or to whom services are being provided in accordance with Title 5, Subtitle 7 or Title 14, Subtitle 3 of the Family Law Article;

(ii) The health care provider shall disclose only the information in the medical record that will, in the professional judgment of the provider, contribute to the:

1. Assessment of risk;

2. Development of a service plan;

3. Implementation of a safety plan; or

4. Investigation of the suspected case of abuse or neglect; and

(iii) The medical record may be redisclosed as provided in §§ 1–201, 1–202, 1–204, and 1–205 of the Human Services Article;

(2) Subject to the additional limitations for a medical record developed primarily in connection with the provision of mental health services in § 4–307 of this subtitle, to health professional licensing and disciplinary boards, in accordance with a subpoena for medical records for the sole purpose of an investigation regarding:

(i) Licensure, certification, or discipline of a health professional; or

(ii) The improper practice of a health profession;

(3) To a health care provider or the provider's insurer or legal counsel, all information in a medical record relating to a patient or recipient's health, health care, or treatment which forms the basis for the issues of a claim in a civil action initiated by the patient, recipient, or person in interest;

(4) Notwithstanding any privilege in law, as needed, to a medical review committee as defined in § 1–401 of the Health Occupations Article or a dental review committee as defined in § 4–501 of the Health Occupations Article;

(5) To another health care provider as provided in § 10–807 or § 19–308.2 of this article;

(6) Subject to the additional limitations for a medical record developed primarily in connection with the provision of mental health services in § 4–307 of this subtitle and except as otherwise provided in items (2), (7), and (8) of this subsection, in accordance with compulsory process, if the health care provider receives:

(i) 1. A written assurance from the party or the attorney representing the party seeking the medical records that:

A. In a Child in Need of Assistance proceeding pursuant to Title 3, Subtitle 8 of the Courts and Judicial Proceedings Article, a person in interest has not objected to the disclosure of the designated medical records and 15 days have elapsed since the notice was sent;

B. In all other proceedings, a person in interest has not objected to the disclosure of the designated medical records within 30 days after the notice was sent; or

C. The objections of a person in interest have been resolved and the request for disclosure is in accordance with the resolution;

2. Proof that service of the subpoena, summons, warrant, or court order has been waived by the court for good cause; or

3. A copy of an order entered by a court expressly authorizing disclosure of the designated medical records;

(ii) For disclosures made under item (i)1A of this item, copies of the following items that were mailed by certified mail to the person in interest by the person requesting the disclosure at least 15 days before the records are to be disclosed:

1. The subpoena, summons, warrant, or court order seeking the disclosure or production of the records;

2. This section; and

3. A notice in the following form or a substantially similar form:

_____ In the
Plaintiffs _____

v. For

_____ _____
Defendants

Case No.:_____

NOTICE TO (Patient Name)
IN COMPLIANCE WITH § 4–306 OF THE HEALTH – GENERAL ARTICLE,
ANNOTATED CODE OF MARYLAND

TAKE NOTE that medical records regarding (Patient Name), have been subpoenaed from the (Name and address of Health Care Provider) pursuant to the attached subpoena and § 4–306 of the Health – General Article, Annotated Code of Maryland. This subpoena _____ does _____ does not (mark one) seek production of mental health records.

Please examine these papers carefully. IF YOU HAVE ANY OBJECTION TO THE PRODUCTION OF THESE DOCUMENTS, YOU MUST FILE A MOTION FOR A PROTECTIVE ORDER OR A MOTION TO QUASH THE SUBPOENA ISSUED FOR THESE DOCUMENTS UNDER MARYLAND RULES 2–403 AND 2–510 NO LATER THAN FIFTEEN (15) DAYS FROM THE DATE THIS NOTICE IS MAILED. For example, a protective order may be granted if the records are not relevant to the issues in this case, the request unduly invades your privacy, or causes you specific harm.

Also attached to this form is a copy of the subpoena duces tecum issued for these records.

If you believe you need further legal advice about this matter, you should consult your attorney.

_____
Attorney
(Firm Name
Attorney address
Attorney phone number)

Attorneys for (Name of Party Represented)

Certificate of Service

I hereby certify that a copy of the foregoing notice was mailed, first–class postage prepaid, this ___ day of _____, 20__ to

_____
Patient

_____
Each Counsel in Case

_____
Attorney

(iii) For disclosures made under item (i)1B of this item, copies of the following items that were mailed by certified mail and by mail sent first–class postage prepaid to the person in interest and, if applicable, by mail sent first–class postage prepaid to the court and parties in a criminal or juvenile delinquency case by the person requesting the disclosure at least 30 days before the records are to be disclosed:

1. The subpoena, summons, warrant, or court order seeking the disclosure or production of the records;

2. This section; and

3. A notice in the following form or a substantially similar form:

_____ In the
Plaintiffs _____

v. For

_____

_____
Defendants

Case No.:_____

NOTICE TO (Patient Name)
IN COMPLIANCE WITH § 4–306 OF THE HEALTH – GENERAL ARTICLE, ANNOTATED CODE OF MARYLAND

TAKE NOTE that medical records regarding (Patient Name), have been subpoenaed from the (Name and address of Health Care Provider) pursuant to the

attached subpoena and § 4–306 of the Health – General Article, Annotated Code of Maryland. This subpoena ____ does ____ does not (mark one) seek production of mental health records.

Please examine these papers carefully. IF YOU HAVE ANY OBJECTION TO THE PRODUCTION OF THESE DOCUMENTS, YOU MUST FILE A MOTION FOR A PROTECTIVE ORDER OR A MOTION TO QUASH THE SUBPOENA ISSUED FOR THESE DOCUMENTS UNDER MARYLAND RULES 2–403, 2–510, OR 4–266 NO LATER THAN THIRTY (30) DAYS FROM THE DATE THIS NOTICE IS MAILED. For example, a protective order may be granted if the records are not relevant to the issues in this case, the request unduly invades your privacy, or causes you specific harm.

Also attached to this form is a copy of the subpoena duces tecum issued for these records.

If you believe you need further legal advice about this matter, you should consult your attorney.

_____
Attorney
(Firm Name
Attorney address
Attorney phone number)

Attorneys for (Name of Party Represented)

Certificate of Service

I hereby certify that a copy of the foregoing notice was mailed, first–class postage prepaid, this ___ day of _____, 20__ to

_____
Patient

_____
Each Counsel in Case

_____
Attorney

(7) Subject to the additional limitations for a medical record developed primarily in connection with the provision of mental health services in § 4–307 of this subtitle, and the limitations on patient overdose information under § 13–3602(e) of this article, to grand juries, prosecution agencies, law enforcement agencies or their agents or employees to further an investigation or prosecution, pursuant to a subpoena, warrant, or court order for the sole purposes of investigating

and prosecuting criminal activity, provided that the prosecution agencies and law enforcement agencies have written procedures to protect the confidentiality of the records;

(8) To the Maryland Insurance Administration when conducting an investigation or examination pursuant to Title 2, Subtitle 2 of the Insurance Article, provided that the Insurance Administration has written procedures to maintain the confidentiality of the records;

(9) To a State or local child fatality review team established under Title 5, Subtitle 7 of this article as necessary to carry out its official functions;

(10) To a local domestic violence fatality review team established under Title 4, Subtitle 7 of the Family Law Article as necessary to carry out its official functions;

(11) To a local drug overdose fatality review team established under Title 5, Subtitle 9 of this article as necessary to carry out its official functions, subject to:

(i) The additional limitations under § 4–307 of this subtitle for disclosure of a medical record developed primarily in connection with the provision of mental health services; and

(ii) Any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2; or

(12) To a guardian ad litem appointed by a court to protect the best interests of a minor or a disabled or elderly individual who is a victim of a crime or a delinquent act, for the sole purpose and use of the guardian ad litem in carrying out the guardian ad litem's official function to protect the best interests of the minor or the disabled or elderly individual in a criminal or juvenile delinquency court proceeding as permitted under 42 C.F.R. § 164.512(e).

(c) (1) Subject to paragraphs (2) through (4) of this subsection, a health care provider shall disclose medical and legal records without the authorization of an individual to a public defender who states in writing that the Office of the Public Defender represents the individual in:

(i) An involuntary admission proceeding under Title 10, Subtitle 6 of this article;

(ii) A release proceeding under Title 10, Subtitle 8 of this article; or

(iii) A commitment or release proceeding under Title 3 of the Criminal Procedure Article.

(2) Legal records required to be disclosed under paragraph (1) of this subsection include:

(i) An emergency petition;

(ii) An application for involuntary admission; and

(iii) A certification for involuntary admission.

(3) The records disclosed under paragraph (1) of this subsection shall be limited to those records needed by the public defender to represent the individual in the proceedings listed in paragraph (1) of this subsection.

(4) Records provided under paragraph (1)(i) of this subsection shall be provided:

(i) Within 24 hours after the health care provider receives a written request for the records from the public defender; and

(ii) Only if the individual has not yet retained private counsel.

(d) When a disclosure is sought under this section:

(1) A written request for disclosure or written confirmation by the health care provider of an oral request that justifies the need for disclosure shall be inserted in the medical record of the patient or recipient; and

(2) Documentation of the disclosure shall be inserted in the medical record of the patient or recipient.

(e) (1) Subject to paragraph (2) of this subsection, a health care provider shall disclose a medical record in accordance with compulsory process not later than 30 days after receiving:

(i) The documentation required under subsection (b)(6) of this section; and

(ii) Any fees owed to the health care provider by the party or the attorney representing the party seeking the medical record for the retrieval, copying, preparation, mailing, and actual cost of postage and handling of the medical record under § 4–304(c) of this subtitle.

(2) On a showing of good cause, a health care provider may request up to 30 additional days beyond the date by which disclosure is required under paragraph (1) of this subsection to disclose a medical record.

§4–307.

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

(2) "Case management" means an individualized recipient centered service designed to assist a recipient in obtaining effective mental health services through the assessing, planning, coordinating, and monitoring of services on behalf of the recipient.

(3) "Core service agency" has the meaning stated in § 7.5–101 of this article.

(4) "Director" means the Director of the Behavioral Health Administration or the designee of the Director.

(5) "Mental health director" means the health care professional who performs the functions of a clinical director or the designee of that person in a health care, detention, or correctional facility.

(6) (i) "Personal note" means information that is:

1. The work product and personal property of a mental health provider; and

2. Except as provided in subsection (d)(3) of this section, not discoverable or admissible as evidence in any criminal, civil, or administrative action.

(ii) Except as provided in subsection (d)(2) of this section, a medical record does not include a personal note of a mental health care provider, if the mental health care provider:

1. Keeps the personal note in the mental health care provider's sole possession for the provider's own personal use;

2. Maintains the personal note separate from the recipient's medical records; and

3. Does not disclose the personal note to any other person except:

A. The mental health provider's supervising health care provider that maintains the confidentiality of the personal note;

B. A consulting health care provider that maintains the confidentiality of the personal note; or

C. An attorney of the health care provider that maintains the confidentiality of the personal note.

(iii) "Personal note" does not include information concerning the patient's diagnosis, treatment plan, symptoms, prognosis, or progress notes.

(b) The disclosure of a medical record developed in connection with the provision of mental health services shall be governed by the provisions of this section in addition to the other provisions of this subtitle.

(c) When a medical record developed in connection with the provision of mental health services is disclosed without the authorization of a person in interest, only the information in the record relevant to the purpose for which disclosure is sought may be released.

(d) (1) To the extent a mental health care provider determines it necessary and appropriate, the mental health care provider may maintain a personal note regarding a recipient.

(2) A personal note shall be considered part of a recipient's medical records if, at any time, a mental health care provider discloses a personal note to a person other than:

(i) The provider's supervising health care provider;

(ii) A consulting health care provider;

(iii) An attorney of the health care provider; or

(iv) A recipient under paragraph (3) of this subsection.

(3) The provisions of this subsection do not prohibit the disclosure, discovery, or admissibility of a personal note regarding a recipient who has initiated an action for malpractice, an intentional tort, or professional negligence against the health care provider.

(e) (1) Except as otherwise provided in paragraphs (3), (4), and (5) of this subsection, if the disclosure of a portion of a medical record relating to a psychological test would compromise the objectivity or fairness of the test or the testing process, a mental health care provider may not disclose that portion of the medical record to any person, including a subject of the test.

(2) The raw test data relating to a psychological test is only discoverable or admissible as evidence in a criminal, civil, or administrative action on the determination by the court or administrative hearing officer that the expert witness for the party seeking the raw test data is qualified by the appropriate training, education, or experience to interpret the results of that portion of the raw test data relating to the psychological test.

(3) (i) A recipient who has been the subject of a psychological test may designate a psychologist licensed under Title 18 of the Health Occupations Article or a psychiatrist licensed under Title 14 of the Health Occupations Article to whom a health care provider may disclose the medical record.

(ii) The recipient shall:

1. Request the disclosure authorized under this paragraph in writing; and

2. Comply with the provisions of § 4–304 of this subtitle.

(4) A health care provider may disclose a medical record relating to a psychological test as provided under § 4–305(b)(2)(i) of this subtitle.

(5) The provisions of this subsection may not restrict access to or affect the disclosure of a medical record which is also an education record under the federal Individuals with Disabilities Education Act, the federal Family Educational Rights and Privacy Act, or any federal and State regulations that have been adopted to implement those laws.

(f) Notwithstanding any other provision of this subtitle, a person in interest shall have the right to obtain a medical record of a recipient that is developed in conjunction with a mental health evaluation relating to obtaining or continuing

employment, if the evaluation has been performed at the request of or on behalf of an employer or prospective employer:

(1) In connection with a civil action or U.S. Equal Employment Opportunity Commission complaint initiated by the person in interest; or

(2) On a written authorization of the employer or prospective employer.

(g) A health care provider may disclose a medical record that relates to and identifies more than one recipient in group or family therapy only:

(1) On the authorization of a person in interest for each recipient;

(2) As provided in this subtitle; or

(3) As otherwise provided by law.

(h) This section may not be construed to prevent the disclosure of a medical record that relates to the provision of mental health services between or among the health care providers that participate in the approved plan of a core service agency or local behavioral health authority for the delivery of mental health services, if a recipient:

(1) Has received a current list of the participating providers; and

(2) Has signed a written agreement with the core service agency or local behavioral health authority to participate in the client information system developed by the agency.

(i) If an individual given access to a medical record that relates to the provision of mental health services signs an acknowledgment of the duty under this Act not to redisclose personal identifying information about a recipient, this section may not be construed to prevent the disclosure of the medical record for rate review, auditing, health planning, licensure, approval, or accreditation of a facility by governmental or professional standard setting entities.

(j) (1) A health care provider may disclose a medical record without the authorization of a person in interest:

(i) To the medical or mental health director of a juvenile or adult detention or correctional facility if:

1. The recipient has been involuntarily committed under State law or a court order to the detention or correctional facility requesting the medical record; and

2. After a review of the medical record, the health care provider who is the custodian of the record is satisfied that disclosure is necessary for the proper care and treatment of the recipient;

(ii) As provided in § 5–609 of the Courts Article;

(iii) 1. If a health care provider is a facility as defined in § 10–101 of this article, to a law enforcement agency concerning a recipient who:

A. Has been admitted involuntarily or by court order to the facility; and

B. Is on an unauthorized absence or has otherwise left the facility without being discharged or released;

2. The facility director may disclose to the law enforcement agency identifying information and only such further information that the director believes is necessary to aid the law enforcement agency in locating and apprehending the recipient for the purpose of:

A. Safely returning the recipient to custody; or

B. Fulfilling the provisions of subparagraph (ii) of this paragraph;

(iv) If a health care provider is a facility as defined in § 10–101 of this article, the facility director may confirm or deny the presence in the facility of a recipient to a parent, guardian, next of kin, or any individual who has a significant interest in the status of the recipient if that individual has filed a missing persons report regarding the recipient; and

(v) To allow for the service of process or a court order in a facility when appropriate arrangements have been made with the facility director so as to minimize loss of confidentiality.

(2) When a disclosure is made under this subsection, documentation of the disclosure shall be inserted in the medical record of the recipient.

(k) (1) A health care provider shall disclose a medical record without the authorization of a person in interest:

(i) To the medical or mental health director of a juvenile or adult detention or correctional facility or to another inpatient provider of mental health services in connection with the transfer of a recipient from an inpatient provider, if:

1. The health care provider with the records has determined that disclosure is necessary for the continuing provision of mental health services; and

2. The recipient is transferred:

A. As an involuntary commitment or by court order to the provider;

B. Under State law to a juvenile or adult detention or correctional facility; or

C. To a provider that is required by law or regulation to admit the recipient;

(ii) To the State designated protection and advocacy system for mentally ill individuals under the federal Protection and Advocacy for Mentally Ill Individuals Act of 1986, as amended, if:

1. The State designated protection and advocacy system has received a complaint regarding the recipient or the director of the system has certified in writing to the chief administrative officer of the health care provider that there is probable cause to believe that the recipient has been subject to abuse or neglect;

2. The recipient by reason of mental or physical condition is unable to authorize disclosure; and

3. A. The recipient does not have a legal guardian or other legal representative who has the authority to consent to the release of health care information; or

B. The legal guardian of the recipient is a representative of a State agency;

(iii) To another health care provider or legal counsel to the other health care provider prior to and in connection with or for use in a commitment proceeding in accordance with Title 10, Subtitle 6 or Title 12 of this article;

(iv) In accordance with a court order, other than compulsory process compelling disclosure, as permitted under § 9–109(d), § 9–109.1(d), or § 9–121(d) of the Courts Article, or as otherwise provided by law, to:

1. A court;

2. An administrative law judge;

3. A health claims arbitrator; or

4. A party to a court, administrative, or arbitration proceeding;

(v) In accordance with a subpoena for medical records on specific recipients:

1. To health professional licensing and disciplinary boards for the sole purpose of an investigation regarding licensure, certification, or discipline of a health professional or the improper practice of a health profession; and

2. To grand juries, prosecution agencies, and law enforcement agencies under the supervision of prosecution agencies for the sole purposes of investigation and prosecution of a provider for theft and fraud, related offenses, obstruction of justice, perjury, unlawful distribution of controlled substances, and of any criminal assault, neglect, patient abuse or sexual offense committed by the provider against a recipient, provided that the prosecution or law enforcement agency shall:

A. Have written procedures which shall be developed in consultation with the Director to maintain the medical records in a secure manner so as to protect the confidentiality of the records; and

B. In a criminal proceeding against a provider, to the maximum extent possible, remove and protect recipient identifying information from the medical records used in the proceeding; or

(vi) In the event of the death of a recipient, to the office of the medical examiner as authorized under § 5–309 or § 10–713 of this article.

(2) If a recipient believes that a medical record has been inappropriately obtained, maintained, or disclosed under paragraph (1)(vi) of this subsection, the recipient may petition the State prosecutor for an investigation of the allegation.

(3) Except in a proceeding relating to payment for the health care of a recipient, the medical record of a recipient and any information obtained as a result of disclosure under paragraph (1)(vi) of this subsection is disclosable, notwithstanding any privilege in law, but may not be used in any proceeding against the recipient.

(4) A written request for disclosure or written confirmation of an oral request in an emergency that justifies the need for disclosure shall be inserted in the medical record of the recipient.

(5) Documentation of the disclosure shall be inserted in the medical record of the recipient.

(6) This subsection may not preclude a health care provider, a recipient, or person in interest from asserting in a motion to quash or a motion for a protective order any constitutional right or other legal authority in opposition to disclosure.

(l) (1) Subject to paragraphs (2) through (4) of this subsection, a health care provider shall disclose medical and legal records without the authorization of an individual to a public defender who states in writing that the Office of the Public Defender represents the individual in:

(i) An involuntary admission proceeding under Title 10, Subtitle 6 of this article;

(ii) A release proceeding under Title 10, Subtitle 8 of this article; or

(iii) A commitment or release proceeding under Title 3 of the Criminal Procedure Article.

(2) Legal records required to be disclosed under paragraph (1) of this subsection include:

(i) An emergency petition;

(ii) An application for involuntary admission; and

(iii) A certification for involuntary admission.

(3) The records disclosed under paragraph (1) of this subsection shall be limited to those records needed by the public defender to represent the individual in the proceedings listed in paragraph (1) of this subsection.

(4) Records provided under paragraph (1)(i) of this subsection shall be provided:

(i) Within 24 hours after the health care provider receives a written request for the records from the public defender; and

(ii) Only if the individual has not yet retained private counsel.

§4–308.

A health care provider, who in good faith discloses or does not disclose a medical record, is not liable in any cause of action arising from the disclosure or nondisclosure of the medical record.

§4–309.

(a) If a health care provider knowingly refuses to disclose a medical record within a reasonable time but no more than 21 working days after the date a person in interest requests the disclosure, the health care provider is liable for actual damages.

(b) A health care provider may not refuse to disclose a medical record on the request of a person in interest because of the failure of the person in interest to pay for health care rendered by the health care provider.

(c) A health care provider or any other person is in violation of this subtitle if the health care provider or any other person:

(1) Requests or obtains a medical record under false pretenses or through deception; or

(2) Discloses a medical record in violation of this subtitle.

(d) Except as otherwise provided in subsection (e) of this section, a health care provider or any other person, including an officer or employee of a governmental unit, who knowingly and willfully violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for the first offense and not exceeding $5,000 for each subsequent conviction for a violation of any provision of this subtitle.

(e) (1) A health care provider or any other person, including an officer or employee of a governmental unit, who knowingly and willfully requests or obtains a medical record under false pretenses or through deception or knowingly and willfully discloses a medical record in violation of this subtitle is guilty of a misdemeanor and on conviction is subject to the following penalties:

(i) A fine not exceeding $50,000, imprisonment for not more than 1 year, or both;

(ii) If the offense is committed under false pretenses, a fine not exceeding $100,000, imprisonment for not more than 5 years, or both; and

(iii) If the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, a fine not exceeding $250,000, imprisonment for not more than 10 years, or both.

(2) This subsection does not apply to an officer or employee of a governmental unit that is conducting a criminal investigation.

(f) A health care provider or any other person who knowingly violates any provision of this subtitle is liable for actual damages.

§4–310.

(a) There is a Protected Health Care Commission.

(b) The purpose of the Commission is to make recommendations to the Secretary regarding sensitive health services that should be determined by the Secretary to be legally protected health care under this subtitle.

(c) The Commission consists of the following members:

(1) The Attorney General or the Attorney General's designee;

(2) The Executive Director of the Maryland Health Care Commission or the Executive Director's designee; and

(3) The following members appointed by the Secretary:

(i) A resident of the State who is a licensed physician and nominated by the American College of Obstetricians and Gynecologists;

(ii) A resident of the State who is a licensed clinician who provides reproductive health care and nominated by the Reproductive Health Access Project;

(iii) A resident of the State who is a certified nurse–midwife nominated by the Maryland affiliate of the American College of Nurse Midwives;

(iv) A resident of the State who is a representative of Physicians for Reproductive Health;

(vi) Two residents of the State who are consumer representatives with expertise in consumer data privacy; and

(vii) A resident of the State with expertise in health information.

(d) The Commission shall:

(1) Select a chair of the Commission each year; and

(2) Meet at least four times a year.

(e) The Department shall provide staff for the Commission.

(f) (1) The Commission shall identify sensitive health services information by diagnosis, procedural, medication, or related codes for which disclosure by a health information exchange or electronic health network to a treating provider, business entity, another health information exchange, or another electronic health network would create a substantial risk to patients or health care providers.

(2) In carrying out its work, the Commission may consult with:

(i) Organizations with expertise in legal issues impacting providers of legally protected health care;

(ii) Organizations with expertise in consumer health privacy;

(iii) Organizations with expertise in health information technology; and

(iv) Other organizations with clinical, policy, or legal expertise related to the work of the Commission.

(g) (1) The Commission shall issue semiannual reports to the Secretary on recommendations regarding sensitive health services that should be determined by the Secretary to be legally protected health care under this subtitle or for which the Secretary should rescind a previous determination.

(2) The reports shall include an assessment of the potential risk to patients and health care providers that would result from the disclosure of the sensitive health services that are addressed in the reports.

(3) Within 60 days after receiving a semiannual report under paragraph (1) of this subsection, the Secretary shall submit a written response to the report that includes the findings and determinations of the Secretary to:

(i) The Commission; and

(ii) In accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

§4–401.

(a) In this section, "provider" means:

(1) An acupuncturist;

(2) A chiropractor;

(3) A dentist;

(4) A nurse;

(5) An optometrist;

(6) A physician;

(7) A podiatrist; or

(8) A person who is employed by or under contract with a hospital, nursing institution, or other health care provider.

(b) A provider may not knowingly or willfully destroy, damage, alter, obliterate, or otherwise obscure a medical record, hospital report, laboratory report, X-ray report, or other information about a patient in an effort to conceal the information from use as evidence in an administrative, civil, or criminal proceeding.

(c) A provider who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 1 year or both.

§4–402.

On admission of a patient, a hospital, related institution, or mental health outpatient clinic shall record on the medical record whether the patient is a veteran of the uniformed services.

§4–403.

(a) (1) In this section, a "health care provider" means:

(i) An acupuncturist;

(ii) An audiologist;

(iii) A chiropractor;

(iv) A dietitian;

(v) A dentist;

(vi) An electrologist;

(vii) A health care facility that is:

1. A freestanding ambulatory care facility as defined under § 19–3B–01 of this article;

2. A freestanding medical facility as defined under § 19–3A–01 of this article;

3. A health care facility as defined under § 10–101 of this article;

4. A health maintenance organization as defined under § 19–701 of this article;

5. A hospital as defined under § 19–301 of this article;

6. A limited service hospital as defined under § 19–301 of this article;

7. A related institution as defined in § 19–301 of this article; and

8. A residential treatment center as defined under § 19–301 of this article;

(viii) A massage therapist;

(ix) A mortician;

(x) A nurse;

(xi) A nutritionist;

(xii) An occupational therapist;

(xiii) An optometrist;

(xiv) A physical therapist;

(xv) A physician;

(xvi) A podiatrist;

(xvii) A professional counselor;

(xviii) A psychologist;

(xix) A social worker;

(xx) A speech–language pathologist; and

(xxi) A pharmacist.

(2) "Health care provider" includes an agent, employee, officer, or director of any entity listed under paragraph (1) of this subsection.

(b) Except for a minor patient, unless a patient is notified, a health care provider may not destroy a medical record or laboratory or X–ray report about a patient for 7 years after the record or report is made.

(c) In the case of a minor patient, a medical record or laboratory or X–ray report about a minor patient may not be destroyed until the patient attains the age of majority plus 7 years, unless:

(1) The parent or guardian of the minor patient is notified; or

(2) If the medical care documented in the record was provided under § 20–102(c) or § 20–103(c) of this article, the minor patient is notified.

(d) (1) The notice under subsection (b) or (c) of this section shall:

(i) Be made by:

1. First–class mail to the last known address of the patient; or

2. Subject to paragraph (2) of this subsection, e–mail to the last known e–mail address of:

A. The patient; or

B. If the patient is a minor and the medical care documented in the record was not provided under § 20–102(c) or § 20–103(c) of this article, the parent or guardian of the patient;

(ii) Include the date on which the record of the patient shall be destroyed; and

(iii) Include a statement that the record or synopsis of the record, if wanted, must be retrieved at a designated location.

(2) If notice is provided under paragraph (1)(i)2 of this subsection and no response or delivery receipt is obtained from the e–mail address to which notice was provided, the health care provider shall provide notice under paragraph (1)(i)1 of this subsection at least 10 days before the date on which the record is to be destroyed.

(e) The health care provider shall make the record or report available for retrieval:

(1) By the patient or the parent or guardian of the minor patient within 60 days before the date of destruction; and

(2) At the location designated in the notice of destruction of the record or report.

(f) After the death, retirement, surrender of the license, or discontinuance of the practice or business of a health care provider, the health care provider, the administrator of the estate, or a designee who agrees to provide for the maintenance of the medical records of the practice or business and who states, in writing to the appropriate health occupation board within a reasonable time, that the records will be maintained in compliance with this section, shall forward the notice required in this section before the destruction or transfer of medical records to:

(1) The patient; or

(2) For a minor patient, the parent or guardian of the minor patient unless the medical care documented in the record was provided under § 20–102(c) or § 20–103(c) of this article.

(g) (1) After consulting with the Maryland Hospital Association, the Maryland State Medical Society, and other interested parties, including consumers and payors, the Secretary shall adopt regulations governing the destruction of medical records.

(2) The regulations adopted under this subsection shall:

(i) Specify the manner in which a health care provider shall maintain and store medical records to:

1. Ensure confidentiality; and

2. Provide limited access to the medical records until the records are destroyed; and

(ii) Ensure that the method of destruction renders the medical records unreadable.

(3) The regulations adopted under this subsection may not:

(i) Require or encourage the destruction of medical records; or

(ii) Be inconsistent with any provision of law applicable to the maintenance or destruction of medical records.

(h) (1) A health care provider or any other person who knowingly violates any provision of this subtitle is liable for actual damages.

(2) (i) In addition to any other penalties provided under this article, a health care facility that knowingly violates this section is subject to an administrative fine not exceeding $10,000 for all violations cited in a single day.

(ii) 1. In addition to any other penalties provided under this article, an individual who knowingly violates this section is subject to the fines provided in subsubparagraph 2 of this subparagraph if the individual is:

A. A health care provider, as defined under subsection (a)(1)(i) through (vi) or (viii) through (xx) of this section; or

B. An agent, employee, officer, or director of a health care provider.

2. The administrative fines applicable to an individual covered under subsubparagraph 1 of this subparagraph shall be assessed as follows:

A. The first fine assessed or first set of fines assessed concurrently for all violations cited in a single day may not exceed $1,000;

B. The second fine assessed or second set of fines assessed concurrently for all violations cited in a single day may not exceed $2,500; and

C. The third or subsequent fine assessed or third or subsequent set of fines assessed concurrently for all violations cited in a single day may not exceed $5,000.

§5–101.

In this title, "body" means a dead human body.

§5–201.

Notwithstanding any other law, a pronouncement of death under this subtitle shall be used for all purposes in this State, including the trials of civil and criminal cases.

§5–202.

(a) An individual is dead if, based on ordinary standards of medical practice, the individual has sustained either:

(1) Irreversible cessation of circulatory and respiratory functions; or

(2) Irreversible cessation of all functions of the entire brain, including the brain stem.

(b) (1) This subsection does not apply to the removal of a vital organ while the individual is alive, if the individual gives informed consent to the removal.

(2) A pronouncement of death under this section shall be made before any vital organ is removed for transplantation.

§5–301.

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

(b) "Committee" means the Postmortem Examiners Advisory Committee.

(c) "Medical examiner's case" means a death that a medical examiner is required by law to investigate.

(d) "Office" means the Office of the Chief Medical Examiner.

§5–302.

(a) There is an Office of the Chief Medical Examiner in the Department.

(b) The Office shall:

(1) As allowed by staffing, advance forensic science through medical education and research; and

(2) Carry out any other duty established in law.

§5–303.

(a) There is a Postmortem Examiners Advisory Committee.

(b) The Committee consists of the following members:

(1) The Baltimore City Commissioner of Health;

(2) The head of the Pathology Department of the University of Maryland School of Medicine;

(3) The head of the Pathology Department of Johns Hopkins University School of Medicine;

(4) The Secretary of State Police;

(5) A representative of the Department, chosen by the Secretary; and

(6) Any other individual appointed by the Secretary, in consultation with the Office.

(c) From among the Committee members, the Secretary shall appoint a chair.

(d) The Committee shall advise the Secretary and the Office on:

(1) The implementation of this subtitle; and

(2) Carrying out the Office's duties.

§5–304.

(a) The Committee shall determine the times and places of its meetings.

(b) A member of the Committee may not receive compensation for performing Committee duties.

§5–305.

(a) (1) The Department may employ a staff in accordance with the State budget for the operation of the Office and to maintain accreditation.

(2) The staff shall include:

(i) 1 chief medical examiner;

(ii) 2 deputy chief medical examiners;

(iii) Assistant medical examiners;

(iv) 1 chief State toxicologist, 1 deputy chief State toxicologist, lead toxicologists, and assistant toxicologists;

(v) 1 serologist;

(vi) In accordance with the number of positions approved by the Accreditation Council for Graduate Medical Education, fellow medical doctors who are training in forensic pathology;

(vii) 1 chief forensic investigator, 2 deputy chief forensic investigators, lead forensic investigators, and assistant forensic investigators; and

(viii) 1 autopsy services supervisor, 1 deputy supervisor, lead autopsy technicians, and assistant autopsy technicians.

(3) Notwithstanding any other provision of law, the Department may employ any physician on a contract basis for part–time services or per diem services.

(4) The Department shall ensure that the number of staff employed at the Office does not fall to a level that would constitute a Phase II violation according to the National Association of Medical Examiners.

(b) (1) The Chief Medical Examiner and deputy chief medical examiners shall be board certified in anatomic and forensic pathology by the American Board of Pathology.

(2) Assistant medical examiners appointed on or after October 1, 2008, shall be certified by the American Board of Pathology in anatomic and forensic pathology or obtain that certification within the assistant medical examiner's period of board eligibility provided by the American Board of Pathology.

(3) The Secretary shall consult with the Committee regarding matters related to the employment of the Chief Medical Examiner.

(c) With the approval of the Secretary of Budget and Management, the Department shall set the compensation for personnel appointed under subsection (a)(2) of this section.

(d) The Office shall see that proper equipment is provided for the medical examiners.

(e) The Chief Medical Examiner, a deputy chief medical examiner, or an assistant medical examiner shall be on call at all times to perform the duties set forth in this subtitle.

(f) The State budget shall include an appropriation to carry out this subtitle, including provisions for:

(1) The fee for an authorized pathologist;

(2) The necessary expenses for transportation of a body for examination by a medical examiner or for autopsy; and

(3) In the case of a victim of homicide, the necessary expenses for transportation of the body from the site of the autopsy or examination to a location within the State specified by the victim's family.

§5–306.

(a) This section does not apply to Baltimore City.

(b) (1) Subject to paragraph (2) of this subsection, the Office may appoint one or more deputy medical examiners and forensic investigators for each county.

(2) (i) The Office shall appoint a deputy medical examiner for a county from a list of qualified individuals submitted to the Office by the medical society of the county.

(ii) The number of names on the list shall be at least twice the number of vacancies.

(iii) If a county does not have a medical society or if the medical society does not submit a list of names, the Office may appoint a deputy medical examiner for the county without a list.

(c) Each deputy medical examiner appointed under subsection (b) of this section shall be a physician.

(d) If necessary, a deputy medical examiner may deputize another physician in the county to act as deputy medical examiner.

(e) Each deputy medical examiner is entitled:

(1) For each medical examiner's case that the examiner investigates, to a fee that is set in accordance with the State budget;

(2) If the examiner is called as a witness before a grand jury or in a criminal case, to the fee that the court sets; and

(3) To any additional compensation that a county provides.

§5–307.

The Department, in consultation with the Committee, may adopt rules and regulations to carry out the provisions of this subtitle.

§5–308.

(a) (1) A medical examiner shall investigate the death of a human being if the death occurs:

(i) By violence;

(ii) By suicide;

(iii) By casualty;

(iv) Suddenly, if the deceased was in apparent good health or unattended by a physician; or

(v) In any suspicious or unusual manner.

(2) A medical examiner shall investigate the death of a human fetus if:

(i) Regardless of the duration of the pregnancy, the death occurs before the complete expulsion or extraction of the fetus from the mother; and

(ii) The mother is not attended by a physician at or after the delivery.

(b) If a medical examiner's case occurs, the police or sheriff immediately shall notify the medical examiner and State's Attorney for the county where the body is found and give the known facts concerning the time, place, manner, and circumstances of the death.

(c) Immediately on notification that a medical examiner's case has occurred, the medical examiner or an investigator of the medical examiner shall go to and take charge of the body. The medical examiner or the investigator shall investigate fully the essential facts concerning the medical cause of death and, before leaving the premises, reduce these facts and the names and addresses of witnesses to writing, which shall be filed in the medical examiner's office.

(d) The medical examiner or the investigator shall take possession of and deliver to the State's Attorney or the State's Attorney's designee any object or article that, in the opinion of the medical examiner or the investigator, may be useful in establishing the cause of death.

(e) (1) If the next of kin of the deceased is not present at the investigation, the police officer or sheriff at the investigation or, if a police officer or sheriff is not present, the medical examiner or the investigator shall:

(i) Take possession of all property of value found on the body;

(ii) In the report of the death, make an exact inventory of the property; and

(iii) Deliver the property to the appropriate sheriff or police department.

(2) The sheriff or police department shall surrender the property to the person who is entitled to its possession or custody.

(f) (1) If the case involves the unexpected death of a child, the medical examiner shall notify the chairperson of the local child fatality review team for the county in which the child resided.

(2) If the case involves the death of a child and the death is believed to be caused by abuse or neglect, or there is evidence suggesting that the child was a victim of abuse or neglect, the Office of the Chief Medical Examiner shall orally report the findings and deliver a copy of the child's final autopsy report to the local department of social services and the local law enforcement agency of the county in which the child last resided in accordance with § 5–704 of the Family Law Article.

§5–309.

(a) If the cause of death is established to a reasonable degree of medical certainty, the medical examiner who investigates the case shall file in the medical examiner's office a report on the cause of death within 30 days after notification of the case.

(b) (1) If the medical examiner who investigates a medical examiner's case considers an autopsy necessary, the Chief Medical Examiner, a deputy chief medical examiner, an assistant medical examiner, or a pathologist authorized by the Chief Medical Examiner shall perform the autopsy.

(2) If the family of the deceased objects to an autopsy on religious grounds, the autopsy may not be performed unless authorized by the Chief Medical Examiner or by the Chief Medical Examiner's designee.

(3) (i) In accordance with normal standards of medical practice, the medical examiner performing the autopsy may retain any medical evidence, tissue, or organ needed to carry out the duties of this subtitle.

(ii) The medical examiner shall dispose of any medical evidence, tissue, or organ under subparagraph (i) of this paragraph in accordance with normal standards of medical practice.

(c) (1) A medical examiner shall conduct an autopsy of any fire fighter and any sworn personnel of the State Fire Marshal's Office who dies in the line of duty or as a result of injuries sustained in the line of duty.

(2) The autopsy shall include:

(i) A toxicological analysis for toxic fumes;

(ii) Gross and microscopic studies of heart, lung, and any other tissue involved;

(iii) Appropriate studies of blood and urine; and

(iv) Appropriate studies of body fluids and body tissues.

(3) If the medical examiner determines toxic fumes were the cause of death, the medical examiner shall:

(i) Investigate to the extent possible the source of the fumes; and

(ii) Prepare a written report on the specific effects of the fumes on human tissue.

(4) The autopsy and analysis shall be sufficient to determine eligibility for benefits under the federal Public Safety Officers' Benefits Act of 1976.

(d) (1) (i) The individual who performs the autopsy shall prepare detailed written findings during the progress of the autopsy.

(ii) The findings prepared under subparagraph (i) of this paragraph and the conclusions drawn from them shall be filed in the office of the medical examiner for the county where the death occurred.

(iii) The original copy of the findings and conclusions shall be filed in the Office.

(iv) The Department and the Committee may not interfere with the clinical findings or conclusions prepared under subparagraphs (i) and (ii) of this paragraph.

(2) (i) Except in a case of a finding of homicide, a person in interest as defined in § 4–101 of the General Provisions Article may request the medical examiner to correct findings and conclusions on the cause and manner of death recorded on a certificate of death under § 4–502 of the General Provisions Article within 180 days after the medical examiner files those findings and conclusions.

(ii) 1. If the Chief Medical Examiner denies the request of a person in interest to correct findings and conclusions on the cause and manner of death, the person in interest may appeal the denial to the Secretary, who shall refer the matter to the Office of Administrative Hearings.

2. A contested case hearing under this subparagraph shall be a hearing both on the denial and on the establishment of the findings and conclusions on the cause and manner of death.

(iii) The administrative law judge shall submit findings of fact to the Secretary.

(iv) After reviewing the findings of the administrative law judge, the Secretary, or the Secretary's designee, shall issue an order to:

1. Adopt the findings of the administrative law judge; or

2. Reject the findings of the administrative law judge, and affirm the findings of the medical examiner.

(v) The appellant may appeal a rejection under subparagraph (iv)2 of this paragraph to a circuit court of competent jurisdiction.

(vi) If the final decision of the Secretary, or of the Secretary's designee, or of a court of competent jurisdiction on appeal, establishes a different finding or conclusion on the cause or manner of death of a deceased than that recorded on the certificate of death, the medical examiner shall:

1. Amend the certificate to reflect the different finding or conclusion under §§ 4–212 and 4–214 of this article and § 4–502 of the General Provisions Article; and

2. If the cause or manner of death was amended or corrected to be undetermined or homicide:

A. Provide notice to the State's Attorney and the local law enforcement agency in the jurisdiction where the body was found of the different finding or conclusion on the cause or manner of death of the deceased than that previously recorded on the death certificate; and

B. Request that the Secretary send the person in interest a certified death certificate with the cause or manner of death amended in accordance with item 1 of this subparagraph at no cost to the person in interest.

(vii) The final decision of the Secretary, or the Secretary's designee, or of a court under this paragraph may not give rise to any presumption concerning the application of any provision of or the resolution of any claim concerning a policy of insurance relating to the deceased.

(viii) If the findings of the medical examiner are upheld by the Secretary, the appellant is responsible for the costs of the contested case hearing. Otherwise, the Department is responsible for the costs of the hearing.

(e) The Chief Medical Examiner shall set a reasonable fee for performing an autopsy by an authorized pathologist.

§5–310.

(a) (1) The Office of the Chief Medical Examiner shall keep complete records on each medical examiner's case.

(2) The records shall be indexed properly and include:

(i) The name, if known, of the deceased;

(ii) The place where the body was found;

(iii) The date, cause, and manner of death; and

(iv) All other available information about the death.

(b) The original report of the medical examiner who investigates a medical examiner's case and the findings and conclusions of any autopsy shall be attached to the record of the medical examiner's case.

(c) The Chief Medical Examiner or, if the Chief Medical Examiner is absent or cannot act, the Deputy Chief Medical Examiner or an assistant medical examiner, and each deputy medical examiner promptly shall deliver to the State's Attorney for the county where the body was found a copy of each record that relates to a death for which the medical examiner considers further investigation advisable. A State's Attorney may obtain from the office of a medical examiner a copy of any record or other information that the State's Attorney considers necessary.

(d) (1) In this subsection, "record":

(i) Means the result of an external examination of or an autopsy on a body; and

(ii) Does not include a statement of a witness or other individual.

(2) A record of the Office of the Chief Medical Examiner or any deputy medical examiner, if made by the medical examiner or by anyone under the medical examiner's direct supervision or control, or a certified transcript of that record, is competent evidence in any court in this State of the matters and facts contained in it.

(e) (1) The Office of the Chief Medical Examiner shall charge a reasonable fee for reports as specified in a schedule of fees defined in the regulations of the Office of the Chief Medical Examiner.

(2) A deputy medical examiner may keep any fee collected by the deputy medical examiner.

§5–311.

Subject to the limitations in § 5–310(c) of this subtitle, a medical examiner may administer oaths, take affidavits, and make examinations as to any matter within the medical examiner's jurisdiction.

§5–401.

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

(b) "Board" means the State Anatomy Board.

(c) "Medical study program" means any research or teaching activity conducted at or under the sponsorship of a hospital or other institution devoted to

research, teaching, or study of medicine, dentistry, or any related health profession or advanced human biological science.

(d) "Public officer" means an officer of this State or of a county or other political subdivision of this State.

§5–402.

There is a State Anatomy Board in the Department.

§5–403.

(a) (1) The Board consists of:

(i) 1 member of the Anatomy Department of the University of Maryland School of Dentistry; and

(ii) 2 members of the anatomy department of each medical school in this State.

(2) The administrative officer of each school shall name the members from that school.

(b) (1) From among its members, the Board every 2 years shall elect a chairman and a vice chairman.

(2) The manner of election of officers shall be as the Board determines.

(3) The vice chairman shall act as chairman when the chairman is absent or cannot act.

§5–404.

(a) The Board shall determine the times and places of its meetings.

(b) A member of the Board:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§5–404.1.

In addition to the powers and duties set forth elsewhere in this title, the Board has the following powers and duties:

(1) To adopt regulations to carry out the provisions of this title; and

(2) To set reasonable fees, by regulation, for its services.

§5–405.

(a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that the Board makes under authority specifically delegated by law to the Board.

(b) The power of the Secretary to transfer by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Board.

§5–406.

(a) (1) A public officer who has control of a body immediately shall notify the chairman of the Board if, after a reasonable search, the public officer has not found a person who will take control of the body for its final disposition.

(2) Subject to the limitations imposed on nursing homes under § 10–214 of the Human Services Article, any other person who has control of a body may notify the Board if, after a reasonable search, the person has not found a person who will take control of the body for its final disposition.

(b) (1) Subject to the time limitations in this subsection, when the Board is notified of the existence of a body, the Board may remove the body to a morgue in Baltimore City that the Board designates for that purpose.

(2) If the person who notifies the Board can refrigerate the body suitably, the body may be removed only at the expiration of 72 hours after death.

(3) If the person who notifies the Board cannot refrigerate the body suitably, the body may be removed as soon as feasible after death, and, on arrival at the morgue, shall be refrigerated until the expiration of 72 hours after death.

(c) (1) On expiration of 72 hours after death, the body shall be under the exclusive control of the Board and may be embalmed.

(2) If the body is embalmed, it shall be embalmed in a proper manner by an individual whom the Board designates.

(3) Any relative or friend of the deceased may claim the body and, on payment to the Board of its cost of moving and embalming the body, shall receive it.

(4) The Board may waive its costs under this section upon a showing of hardship by the relative or friend.

§5–406.1.

(a) Any person who has custody of a donated body immediately shall notify the chairman of the Board.

(b) When the Board is notified of the existence of a donated body, the Board may remove the body to a designated morgue in Baltimore City.

(c) (1) The donated body shall be under the exclusive control of the Board and may be embalmed.

(2) If the body is embalmed, it shall be embalmed in a proper manner by an individual whom the Board designates.

§5–407.

The Board shall first distribute bodies or body parts that are under its exclusive control equitably among the schools described in § 5-403 of this subtitle, and then, at the Board's discretion, distribute bodies or body parts to other medical study programs. These bodies or body parts may be used only for the promotion and application of medical sciences.

§5–408.

(a) (1) A person may not sell or buy any body or any part of a body that is under the exclusive control of the Board.

(2) A person other than a nonprofit organization that qualifies under § 501(c)(3) of the Internal Revenue Code, may not sell, buy, or act as a broker for a profit in the transfer of any human organ that:

(i) Is removed from a human body that is alive or dead at the time of removal; and

(ii) Is not under the exclusive control of the Board.

(3) In this section, "human organ" does not include blood and plasma.

(b) (1) Except as provided in paragraphs (2) and (3) of this subsection, a person may not send, transport, or permit or cause to be sent or transported out of the State any body or any part of a body that is under the exclusive control of the Board.

(2) The Board may authorize, by regulation, the transporting of human specimens under its exclusive control to an out–of–state medical study program, provided that:

(i) The needs of the schools of the State are met;

(ii) The requesting party demonstrates the need for a specimen;

(iii) The circumstances of the request are that:

1. No other sufficient source of specimens within the requesting state exists; or

2. A preexisting organ tissue donation was made by an individual in compliance with the Maryland Revised Uniform Anatomical Gift Act;

(iv) The requesting party bears the responsibility for transporting and the specialized care of the specimen and all associated costs; and

(v) The Board retains the right of exclusive control of the specimen including the final disposition when appropriate or necessary to fulfill an obligation to return the remains of a donated specimen to the donor's family.

(3) The Board may authorize a physician, teacher, demonstrator, or investigator of advanced human biological sciences to send or transport human specimens out of the State for use by medical study programs.

§5–408.1.

Except as provided in § 5–408(a)(2) of this subtitle, this subtitle does not deny the right of a donor to provide by a document described in § 5–509 of this title for the ultimate disposition and repose of the donor's last remains.

§5–409.

(a) A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 1 year or both.

(b) A public officer or an officer or employee of any institution who neglects or refuses to comply with the provisions of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 for each offense.

§5–501.

(a) Consent for a postmortem examination of a body by a physician is sufficient if the consent is given as provided in this section.

(b) (1) The consent may be given by any one of the following persons if that person, whether alone or with another, has assumed control of the body for its final disposition:

(i) A parent;

(ii) A spouse;

(iii) A domestic partner;

(iv) A child;

(v) A guardian;

(vi) A next of kin; or

(vii) In the absence of these persons, any other person.

(2) If a person does not assume control of a body under paragraph (1) of this subsection, the consent may be given by the State Anatomy Board.

(c) The consent may be in the form of:

(1) A written document;

(2) A telegram; or

(3) A recorded telephonic or other recorded message.

§5–502.

(a) This section does not apply to the disposition of a body by a school of medicine or dentistry.

(b) Except as otherwise provided in this section, a person may not cremate or initiate alkaline hydrolysis or natural organic reduction of a body until it has been identified by:

(1) The next of kin;

(2) A person who is authorized to arrange for final disposition of the body under §§ 5–508 through 5–512 of this subtitle; or

(3) A medical examiner.

(c) If a person who is authorized to arrange for final disposition of a body is not available to identify the body and authorize cremation, reduction by alkaline hydrolysis, or natural organic reduction, that person may delegate that authority to another person by sending to the delegate an electronic communication that contains the name, address, and relationship of the sender to the deceased and the name and address of the individual to whom authority is delegated. Written authorization shall follow by mail but does not take precedence over the electronic communication authorizing the identification and cremation.

§5–503.

A person may not cremate or initiate alkaline hydrolysis or natural organic reduction of a body until at least 12 hours after death.

§5–504.

A person may not transport a body to a crematory or reduction facility without using a cot and pouch or receptacle.

§5–505.

(a) Except as provided in subsection (b) of this section, a person may not require that a cremation be performed with a casket. However, the use of a simple container may be required.

(b) The person arranging for final disposition of a body may specify that a casket:

(1) Be used before cremation;

(2) Be consumed during cremation;

(3) Be used after cremation; or

(4) Not be used before, during, or after cremation.

§5–506.

(a) A health officer may take control of a body that is being kept in a room where an individual lives and that is in a condition that endangers an individual in the house where the body is kept if:

(1) At least 3 individuals living near the house or a physician asks the health officer, in writing, to order final disposition of the body;

(2) The health officer issues an order for final disposition, within a time period stated in the order; and

(3) Final disposition of the body is not made within that time.

(b) A person may not obstruct the carrying out of an order of a health officer under this section.

§5–507.

(a) A person who violates any provision of § 5-502, § 5-503, § 5-504, or § 5-505 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

(b) A person who violates any provision of § 5-506(b) of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $200 or imprisonment not exceeding 6 months.

§5–508.

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

(b) "Alkaline hydrolysis" has the meaning stated in § 7–101 of the Health Occupations Article.

(c) "Authorizing agent" means the individual who has legal authority to arrange for and make decisions regarding the final disposition of a dead human body, including by cremation, alkaline hydrolysis, or natural organic reduction.

(d) "Cremation" means the disposition of a dead human body by means of incineration.

(e) "Crematory" has the meaning stated in § 7–101 of the Health Occupations Article.

(f) "Decedent" means a dead human being.

(g) "Natural organic reduction" has the meaning stated in § 7–101 of the Health Occupations Article.

(h) "Practitioner" means a person who is licensed by the State as a funeral director, mortician, or surviving spouse licensee to practice mortuary science.

(i) "Pre–need contract" means an agreement prior to the time of death between a consumer and a practitioner to provide any goods and services regarding the final disposition of a dead human body.

(j) "Reduction facility" has the meaning stated in § 7–101 of the Health Occupations Article.

(k) "Soil remains" has the meaning stated in § 7–101 of the Health Occupations Article.

§5–509.

(a) (1) Any individual who is 18 years of age or older may decide the disposition of the individual's own body after that individual's death without the predeath or post–death consent of another person by:

(i) Executing a document that expresses the individual's wishes regarding disposition of the body, including a document designating a person to act as authorizing agent; or

(ii) Entering into a pre–need contract.

(2) The person designated on a United States Department of Defense Record of Emergency Data (DD Form 93), or its successor form, as the person authorized to direct disposition may serve as the authorizing agent for a decedent, if the decedent:

(i) Died while serving in the uniformed services; and

(ii) Executed the United States Department of Defense Record of Emergency Data (DD Form 93), or its successor form.

(3) An authorizing agent is bound by any valid document executed under this subsection in making decisions regarding the final disposition of the decedent's body.

(b) In order to be valid, any document executed under subsection (a) of this section must be written and signed by the individual in the presence of a witness, who, in turn, shall sign the document in the presence of the individual.

(c) The following persons, in the order of priority stated, have the right to serve as the authorizing agent for a decedent:

(1) If the decedent executed a valid document under subsection (a) of this section:

(i) The person designated on the United States Department of Defense Record of Emergency Data (DD Form 93), or its successor form, as the person authorized to direct disposition; or

(ii) The person designated as an authorizing agent by a decedent in the valid document executed under subsection (a)(1) of this section; or

(2) Unless a person has knowledge that contrary directions have been given by the decedent, if a decedent has not executed a document under subsection (a) of this section:

(i) The surviving spouse or domestic partner of the decedent;

(ii) An adult child of the decedent;

(iii) A parent of the decedent;

(iv) An adult brother or sister of the decedent;

(v) An adult grandchild of the decedent;

(vi) A person acting as a representative of the decedent under a signed authorization of the decedent that does not meet the requirements of subsection (b) of this section;

(vii) The guardian of the person of the decedent at the time of the decedent's death, if one has been appointed; or

(viii) In the absence of any person under items (i) through (vii) of this item, any other person willing to assume the responsibility to act as the authorizing agent, including the personal representative of the decedent's estate, after attesting in writing that a good faith effort has been made to no avail to contact the individuals under items (i) through (vii) of this item.

(d) (1) Subject to paragraph (2) of this subsection, if a decedent has more than one survivor under subsection (c)(2)(i) through (v) of this section, any adult child, parent, adult brother or sister, or adult grandchild of the decedent who confirms in writing to a practitioner that all of the other members of the same class have been notified may serve as the authorizing agent for purposes of § 5–502 of this subtitle unless the practitioner receives a written objection to the cremation from another member of that class within 24 hours.

(2) If a decedent has more than one survivor under subsection (c)(2)(i) through (v) of this section, the majority of a class may serve as the authorizing agent.

(e) In the case of an individual whose final disposition is the responsibility of the State or any of its instrumentalities, a public administrator, medical examiner, coroner, State–appointed guardian, or any other public official charged with arranging the final disposition of the decedent may serve as the authorizing agent.

(f) In the case of an individual who has donated the individual's body to medical science or whose death occurred in a nursing home or other private institution, a representative of the institution to which the body was donated or in which the decedent died shall authorize cremation for purposes of § 5–502 of this subtitle if the decedent executed cremating authorization forms and the institution is charged with making arrangements for the final disposition of the body.

(g) (1) This subsection may not be construed to require a licensed mortician, licensed funeral director, or licensed funeral establishment to make any notification regarding the right of disposition.

(2) A person shall forfeit the right of final disposition of the body of a decedent under subsection (c) of this section and the right shall pass to the next qualifying person, if the person:

(i) Does not exercise the right of disposition within 7 days after notification by a funeral establishment of the death of the decedent, or within 10 days after the decedent's death, whichever is earlier;

(ii) Subject to paragraph (3) of this subsection, is charged with first– or second–degree murder or voluntary manslaughter in connection with the decedent's death and the charges are known to the funeral director; or

(iii) Is the subject of an active interim, temporary, or final protective order and the decedent was a person eligible for relief, as defined under § 4–501 of the Family Law Article, under the order and a copy of the order is presented to the funeral director.

(3) A person whose right of disposition was forfeited under paragraph (2)(ii) of this subsection shall have the right restored, if:

(i) The criminal charges are dismissed; or

(ii) The person is acquitted of the criminal charges.

(4) A person may waive the right of final disposition of the body of a decedent under subsection (c) of this section and the right shall pass to the next qualifying person, if:

(i) The person waives the right of disposition in writing; and

(ii) The writing is submitted to the practitioner or funeral establishment.

(5) A practitioner or funeral establishment may not be held civilly liable for acting in reliance on this subsection.

§5–510.

(a) (1) If the majority of individuals under § 5-509(c) of this subtitle cannot agree on the arrangements, any individual specified in § 5-509(c) of this subtitle or the practitioner who has custody of the body, or both, may file a petition in the circuit court for the county in which the decedent was domiciled at the time of death or the county in which the body is located requesting the court to decide the final disposition of the body.

(2) The practitioner may add the court costs associated with a petition under this subsection to the costs of final disposition.

(b) In the event of a disagreement under subsection (a) of this section, a practitioner is not liable for refusing to accept the body or to inter or otherwise dispose of the body of the decedent or complete the arrangements for the final disposition of the body until the practitioner receives a court order or other written agreement

signed by the parties in the disagreement that decides the final disposition of the body.

(c) If the practitioner retains the body for final disposition in accordance with a court order or written agreement among the parties, the practitioner may embalm or refrigerate and shelter the body, or both, in order to preserve it while awaiting the final decision and may add the costs of embalming and refrigeration and sheltering to the final disposition costs.

(d) (1) This section may not be construed to require or to impose a duty upon a practitioner to bring an action under this section.

(2) A practitioner may not be held criminally or civilly liable for choosing not to bring an action under this section.

§5–511.

(a) A practitioner and an operator of a crematory or reduction facility may rely on the representations made by an authorizing agent and are not guarantors of the reliability of those representations.

(b) A practitioner and an operator of a crematory or reduction facility have no responsibility to contact or to independently investigate the existence of any next of kin of the decedent.

(c) An individual may file a petition with the appropriate court to obtain the authority to be authorizing agent:

(1) If the individual alleges that permitting one or more of the individuals with priority under § 5-509(c) of this subtitle to authorize arrangements for the final disposition of the body of a decedent may cause substantial injustice; or

(2) If, considering all the circumstances, an individual other than an individual with priority under § 5-509(c) of this subtitle had a closer personal affinity to the decedent and should be allowed to make the arrangements.

(d) Pending the outcome of a petition filed under this section, a practitioner shall suspend any arrangements with the individuals under § 5-509(c) of this subtitle.

§5–512.

(a) A practitioner or an operator of a crematory or reduction facility may not require an authorizing agent to obtain appointment as personal representative of the decedent's estate as a condition precedent to making final arrangements or

authorizing cremation, alkaline hydrolysis, or natural organic reduction of a decedent.

(b) A person may not authorize cremation, alkaline hydrolysis, or natural organic reduction when a decedent has left instructions in a document that the decedent does not wish to be cremated or be subject to alkaline hydrolysis or natural organic reduction.

§5–513.

(a) On taking custody of the body of a decedent in accordance with all authorizations required by law, a funeral establishment, crematory, or reduction facility shall maintain the body in a manner that provides for complete coverage of the body and prevents leakage or spillage except during:

(1) Identification, embalming, or preparation of an unembalmed body for final disposition;

(2) Restoration and dressing of a body in preparation for final disposition;

(3) If applicable, placement inside a contained chamber or vessel without an external visual exposure during the process of alkaline hydrolysis or natural organic reduction; and

(4) Viewing during a visitation or funeral service.

(b) If the unembalmed body of a decedent is to be stored for more than 48 hours before final disposition, a funeral establishment, crematory, or reduction facility shall maintain the body with refrigeration and at a temperature determined by regulation.

(c) (1) If a funeral establishment, crematory, or reduction facility cannot secure the body of a decedent or cannot store the body as required in subsection (b) of this section due to an unforeseen circumstance, the funeral establishment, crematory, or reduction facility shall notify the State Board of Morticians and Funeral Directors or the Office of Cemetery Oversight and the person authorized to arrange for the final disposition of the body under § 5–509 of this subtitle.

(2) The notification required under paragraph (1) of this subsection shall:

(i) Be made within 24 hours after the occurrence of the unforeseen circumstance; and

(ii) Include the name and location of the facility where the body is being transferred, the reason for the transfer, and the method of storage.

(d) The body of a decedent may not be embalmed or artificially preserved without:

(1) The express permission of the person authorized to arrange for the final disposition of the body under § 5–509 of this subtitle; or

(2) A court order.

(e) A funeral establishment, crematory, or reduction facility shall store the body of a decedent until final disposition at:

(1) A funeral establishment licensed under Title 7 of the Health Occupations Article;

(2) A crematory or reduction facility licensed under Title 7 of the Health Occupations Article;

(3) A crematory or reduction facility permitted under Title 5 of the Business Regulation Article; or

(4) Another facility that has passed an inspection with the State Board of Morticians and Funeral Directors or the Office of Cemetery Oversight within the past 2 years.

(f) A funeral establishment, crematory, reduction facility, or transportation service may not transport or store the body of a decedent together with animal remains in the same confined space.

(g) (1) Except as provided in paragraph (2) of this subsection, while the body of a decedent is in the custody of a funeral establishment, crematory, or reduction facility in the State, the body may not be transported for preparation or storage to a facility that is not within the jurisdiction of the State, licensed by the State Board of Morticians and Funeral Directors, or permitted by the Office of Cemetery Oversight.

(2) The body of a decedent may be transported for preparation or storage to a facility that is not within the jurisdiction of the State, licensed by the State Board of Morticians and Funeral Directors, or permitted by the Office of Cemetery Oversight if:

(i) The facility has entered into a written agreement with the State Board of Morticians and Funeral Directors or the Office of Cemetery Oversight to allow the State to make unannounced inspections of the facility; and

(ii) The person authorized to arrange for the final disposition of the body under § 5–509 of this subtitle:

1. Has given written permission for the body to be transported to the facility; or

2. A. Has given oral permission for the body to be transported to the facility; and

B. Within 36 hours after giving oral permission, provides written verification of the oral permission.

§5–514.

(a) An individual may not bury or dispose of a body except:

(1) In a family burial plot or other area allowed by a local ordinance;

(2) In a crematory;

(3) In a cemetery;

(4) In a reduction facility;

(5) By donating the body to medical science; or

(6) By removing the body to another state for final disposition in accordance with the laws of the other state.

(b) A person may not use or dispose of soil remains produced by natural organic reduction:

(1) On public or private property without the prior written permission of:

(i) The owner of the public property;

(ii) The surviving owners of public record of the private property; or

(iii) If the decedent was sole owner of the property at death, the authorizing agent;

(2) By using the soil remains to grow food for consumption by humans or livestock;

(3) By selling or reselling the soil remains to a third party; or

(4) By combining or incorporating the soil remains into compost offered for sale to consumers or for commercial or agricultural purchasers.

(c) Unless a funeral establishment or cemetery has otherwise agreed in writing, a reduction facility that produces soil remains is responsible for providing for the final disposition and disposal of the soil remains in accordance with written direction given by an authorizing agent.

(d) Except for acts of gross negligence or reckless disregard of the prohibitions under subsection (b) of this section, a practitioner or reduction facility operator is not liable for:

(1) Transferring possession of soil remains at a reduction facility; or

(2) Delivering soil remains to another location according to the written direction provided by an authorizing agent.

(e) An individual who violates this section is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $5,000 or both.

§5–601.

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

(b) "Advance directive" means:

(1) A witnessed written or electronic document, voluntarily executed by the declarant in accordance with the requirements of this subtitle;

(2) A witnessed oral statement, made by the declarant in accordance with the provisions of this subtitle; or

(3) An electronic document, voluntarily executed by the declarant, in which the declarant's identity is authenticated in accordance with the guidelines described in § 5–602(c)(3) of this subtitle.

(c) "Agent" means an adult appointed by the declarant under an advance directive made in accordance with the provisions of this subtitle to make health care decisions for the declarant.

(d) "Attending physician" means the physician who has primary responsibility for the treatment and care of the patient.

(e) "Best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment, taking into account:

(1) The effect of the treatment on the physical, emotional, and cognitive functions of the individual;

(2) The degree of physical pain or discomfort caused to the individual by the treatment, or the withholding or withdrawal of the treatment;

(3) The degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment result in a severe and continuing impairment of the dignity of the individual by subjecting the individual to a condition of extreme humiliation and dependency;

(4) The effect of the treatment on the life expectancy of the individual;

(5) The prognosis of the individual for recovery, with and without the treatment;

(6) The risks, side effects, and benefits of the treatment or the withholding or withdrawal of the treatment; and

(7) The religious beliefs and basic values of the individual receiving treatment, to the extent these may assist the decision maker in determining best interest.

(f) "Competent individual" means a person who is at least 18 years of age or who under § 20–102(a) of this article has the same capacity as an adult to consent to medical treatment and who has not been determined to be incapable of making an informed decision.

(g) "Declarant" means a competent individual who makes an advance directive while capable of making and communicating an informed decision.

(h) "Electronic" has the meaning stated in § 4–101 of the Estates and Trusts Article.

(i) "Electronic presence" has the meaning stated in § 4–101 of the Estates and Trusts Article.

(j) "Electronic signature" has the meaning stated in § 4–101 of the Estates and Trusts Article.

(k) "Emergency medical services 'do not resuscitate order'" means a physician's, physician assistant's, or nurse practitioner's written order in a form established by protocol issued by the Maryland Institute for Emergency Medical Services in conjunction with the State Board of Physicians which, in the event of a cardiac or respiratory arrest of a particular patient, authorizes certified or licensed emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation including cardiac compression, endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life–sustaining procedures.

(l) "End–stage condition" means an advanced, progressive, irreversible condition caused by injury, disease, or illness:

(1) That has caused severe and permanent deterioration indicated by incompetency and complete physical dependency; and

(2) For which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

(m) "Health care practitioner" means:

(1) An individual licensed or certified under the Health Occupations Article or § 13–516 of the Education Article to provide health care; or

(2) The administrator of a hospital or a person designated by the administrator in accordance with hospital policy.

(n) (1) "Health care provider" means a health care practitioner or a facility that provides health care to individuals.

(2) "Health care provider" includes agents or employees of a health care practitioner or a facility that provides health care to individuals.

(o) (1) "Incapable of making an informed decision" means the inability of an adult patient to make an informed decision about the provision, withholding, or

withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision.

(2) For the purposes of this subtitle, a competent individual who is able to communicate by means other than speech or with other support, including supported decision making in accordance with Title 18 of the Estates and Trusts Article, may not be considered incapable of making an informed decision.

(p) (1) "Life–sustaining procedure" means any medical procedure, treatment, or intervention that:

(i) Utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function; and

(ii) Is of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition, persistent vegetative state, or end–stage condition.

(2) "Life–sustaining procedure" includes artificially administered hydration and nutrition, and cardiopulmonary resuscitation.

(q) "Medically ineffective treatment" means that, to a reasonable degree of medical certainty, a medical procedure will not:

(1) Prevent or reduce the deterioration of the health of an individual; or

(2) Prevent the impending death of an individual.

(r) "Nurse practitioner" means an individual licensed to practice registered nursing in the State and who is certified as a nurse practitioner by the State Board of Nursing under Title 8 of the Health Occupations Article.

(s) "Persistent vegetative state" means a condition caused by injury, disease, or illness:

(1) In which a patient has suffered a loss of consciousness, exhibiting no behavioral evidence of self–awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response; and

(2) From which, after the passage of a medically appropriate period of time, it can be determined, to a reasonable degree of medical certainty, that there can be no recovery.

(t) "Physical presence" has the meaning stated in § 4–101 of the Estates and Trusts Article.

(u) "Physician" means a person licensed to practice medicine in the State or in the jurisdiction where the treatment is to be rendered or withheld.

(v) "Physician assistant" means an individual who is licensed under Title 15 of the Health Occupations Article to practice as a physician assistant.

(w) "Signed" means bearing a manual or electronic signature.

(x) "Terminal condition" means an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life–sustaining procedures, there can be no recovery.

§5–601.1.

For purposes of this Part I of this subtitle, an electronic signature shall have the same effect as a manual signature if the electronic signature:

(1) Uses an algorithm approved by the National Institute of Standards and Technology;

(2) Is unique to the individual using it;

(3) Is capable of verification;

(4) Is under the sole control of the individual using it;

(5) Is linked to data in such a manner that if the data are changed, the electronic signature is invalidated;

(6) Persists with the document and not by association in separate files; and

(7) Is bound to a digital certificate.

§5–602.

(a) (1) Any competent individual may, at any time, make a written or electronic advance directive regarding the provision of health care to that individual, or the withholding or withdrawal of health care from that individual.

(2) Notwithstanding any other provision of law, in the absence of a validly executed or witnessed advance directive, any authentic expression made by an individual while competent of the individual's wishes regarding health care for the individual shall be considered.

(b) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Disqualified person" means:

1. An owner, operator, or employee of a health care facility from which the declarant is receiving health care; or

2. A spouse, parent, child, or sibling of an owner, operator, or employee of a health care facility from which the declarant is receiving health care.

(iii) "Person eligible for relief" has the meaning stated in § 4–501 of the Family Law Article.

(2) Any competent individual may, at any time, make a written or electronic advance directive appointing an agent to make health care decisions for the individual under the circumstances stated in the advance directive.

(3) (i) A disqualified person may not serve as a health care agent unless the person:

1. Would qualify as a surrogate decision maker under § 5–605(a) of this subtitle; or

2. Was appointed by the declarant before the date on which the declarant received, or contracted to receive, health care from the facility.

(ii) An individual may not serve as a health care agent if:

1. The individual is the subject of an interim, temporary, or final protective order and the declarant is a person eligible for relief under the order; or

2. Except as provided in subparagraph (iii) of this paragraph, the individual is the spouse of the declarant and:

A. The individual and declarant have executed a separation agreement; or

B. The individual or declarant has filed an application for divorce.

(iii) An individual may serve as a health care agent for a declarant after the date of the execution of a separation agreement or the filing of an application for divorce if the declarant:

1. Is able to make a decision about the individual's appointment as the declarant's health care agent; or

2. Has otherwise indicated an intent to have the individual serve as the declarant's health care agent.

(4) An agent appointed under this subtitle has decision making priority over any individuals otherwise authorized under this subtitle to make health care decisions for a declarant.

(5) A person who obtains new information that would prohibit an individual from serving as a declarant's health care agent under paragraph (3)(ii) of this subsection shall provide the information to any health care provider or health care facility providing services to the declarant.

(c) (1) (i) Except as provided in subparagraph (ii) of this paragraph or paragraph (3) of this subsection, a written or electronic advance directive shall be dated, signed by or at the express direction of the declarant, and subscribed by two witnesses in the physical presence or electronic presence of the declarant.

(ii) A written or electronic advance directive signed and witnessed in conformance with the provisions of Executive Order 20.04.10.01, authorizing remote witnessing and electronic signing of certain documents, shall be deemed to have been signed and witnessed in conformity with this subsection if the advance directive was signed and witnessed during the time that the executive order was in effect.

(2) (i) Except as provided in subparagraphs (ii) and (iii) of this paragraph, any competent individual may serve as a witness to an advance directive, including an employee of a health care facility, nurse practitioner, physician assistant, or physician caring for the declarant if acting in good faith.

(ii) The health care agent of the declarant may not serve as a witness.

(iii) At least one of the witnesses must be an individual who is not knowingly entitled to any portion of the estate of the declarant or knowingly entitled to any financial benefit by reason of the death of the declarant.

(3) The State–designated health information exchange may accept as valid an unwitnessed electronic advance directive in the form of a video record or file to state the declarant's wishes regarding health care for the declarant or to appoint an agent if the video record or file:

(i) Is dated; and

(ii) Is stored in an electronic file by an electronic advance directives service recognized by the Maryland Health Care Commission.

(d) (1) Any competent individual may make an oral advance directive to authorize the providing, withholding, or withdrawing of any life–sustaining procedure or to appoint an agent to make health care decisions for the individual.

(2) An oral advance directive shall have the same effect as a written or electronic advance directive if made in the presence of the attending physician, physician assistant, or nurse practitioner and one witness and if the substance of the oral advance directive is documented as part of the individual's medical record. The documentation shall be dated and signed by the attending physician, physician assistant, or nurse practitioner and the witness.

(e) (1) Unless otherwise provided in the document, an advance directive shall become effective when the declarant's attending physician and a second physician certify in writing that the patient is incapable of making an informed decision.

(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician is not required under paragraph (1) of this subsection.

(f) (1) It shall be the responsibility of the declarant to notify the attending physician that an advance directive has been made. In the event the declarant becomes comatose, incompetent, or otherwise incapable of communication, any other person may notify the physician of the existence of an advance directive.

(2) An attending physician who is notified of the existence of the advance directive shall promptly:

(i) If the advance directive is written or electronic, make the advance directive or a copy of the advance directive a part of the declarant's medical records; or

(ii) If the advance directive is oral, make the substance of the advance directive, including the date the advance directive was made and the name of the attending physician, a part of the declarant's medical records.

(g) It shall be the responsibility of the declarant to notify a health care agent that the agent has been named in an advance directive to act on the declarant's behalf.

(h) Unless otherwise provided in the patient's advance directive, a patient's agent shall act in accordance with the provisions of § 5–605(c) of this subtitle.

(i) The absence of an advance directive creates no presumption as to the patient's intent to consent to or refuse life–sustaining procedures.

§5–602.1.

(a) In this section, "mental health services" has the meaning stated in § 4–301(k)(1) of this article.

(b) An individual who is competent may make an advance directive to outline the mental health services which may be provided to the individual if the individual becomes incompetent and has a need for mental health services either during, or as a result of, the incompetency.

(c) (1) An individual making an advance directive for mental health services shall follow the procedures for making an advance directive provided under § 5–602 of this subtitle.

(2) The procedures provided under § 5–604 of this subtitle for the revocation of an advance directive shall apply to the revocation of an advance directive for mental health services.

(d) An advance directive for mental health services may include:

(1) The designation of an agent to make mental health services decisions for the declarant;

(2) The identification of mental health professionals, programs, and facilities that the declarant would prefer to provide mental health services;

(3) A statement of medications preferred by the declarant for psychiatric treatment; and

(4) Instruction regarding the notification of third parties and the release of information to third parties about mental health services provided to the declarant.

§5–603.

Maryland Advance Directive:

Planning for Future Health Care Decisions

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back–up agents) about this important role**. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end–stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____
Address: _____
_____
Telephone Numbers: _____
(home and cell)

B. Selection of Back–up Agents
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:
_____
Address:
_____
_____
__
Telephone
Numbers:_____
(home and cell)

2. If my primary agent and my first back–up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:
_____
Address:
_____
_____
__
Telephone
Numbers:_____
(home and cell)

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

I also want my agent to:

1. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

2. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

_____
__
_____
__
_____
__
_____
__
_____
__
_____
__

D. How My Agent Is to Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

Name(s) Telephone Number(s)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

F. In Case of Pregnancy
(Optional, for women of child–bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____
__
_____
__
_____
__

G. Access to My Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA–related materials.

H. Effectiveness of This Part
(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

_____

((or))

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability **temporarily**, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

_____

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, use Part II. Also consider becoming an organ donor, using the separate form for that.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values
(Optional; form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____

—

_____
__
_____
__
_____
__
_____
__
_____
__

B. Preference in Case of Terminal Condition
(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life–sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

_____

((or))

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

_____

((or))

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

_____

C. Preference in Case of Persistent Vegetative State

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

_____

((or))

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

_____

((or))

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

_____

D. Preference in Case of End–Stage Condition
(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end–stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

_____

((or))

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

_____

((or))

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

_____

E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

_____

F. In Case of Pregnancy
(Optional, for women of child–bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life–sustaining procedures shall be modified as follows:

_____
__
_____
__
_____
__
_____
__

G. Effect of Stated Preferences
(Read both of these statements carefully. Then, initial one only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

_____

((or))

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

_____

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____

_____

(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

_____

_____

(Signature of Witness) (Date)

_____

Telephone Number(s)

_____

_____

(Signature of Witness) (Date)

_____

Telephone Number(s)

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does **not** require this document to be notarized.)

AFTER MY DEATH

(This form is optional. Fill out only what reflects your wishes.)

By:_____ Date of Birth:_____
(Print Name) (Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want.)

Upon my death I wish to donate:

Any needed organs, tissues, or eyes. _____

Only the following organs, tissues, or eyes: _____

_____
__

_____
__

_____
__

_____
__

I authorize the use of my organs, tissues, or eyes:

For transplantation
_____

For therapy
_____

For research

_____

For medical education

_____

For any purpose authorized by law

_____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. **This document is not intended to change anything about my health care while I am still alive**. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

_____

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

(Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. _____

((or))

This person:

Name:

_____

Address:

_____

_____
__

_____
__

Telephone
Numbers:_____

(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

_____
__

_____
__

_____
__

_____
__

_____
__

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

_____

_____

(Signature of Donor) (Date)

The Donor signed or acknowledged signing this donation document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

_____

_____
(Signature of Witness) (Date)

_____
Telephone Number(s)

_____

_____
(Signature of Witness) (Date)

_____
Telephone Number(s)

§5–604.

(a) (1) Except as provided in paragraph (2) of this subsection, an advance directive may be revoked at any time by a declarant by a signed and dated written or electronic document, by physical cancellation or destruction, by an oral statement to a health care practitioner or by the execution of a subsequent directive.

(2) A declarant, knowingly and voluntarily, may elect in an advance directive to waive the right under paragraph (1) of this subsection to revoke any part or all of the advance directive, including the appointment of an agent, during a period in which the declarant has been certified incapable of making an informed decision under § 5–602(e) of this subtitle.

(b) If a declarant revokes an advance directive by an oral statement to a health care practitioner, the practitioner and a witness to the oral revocation shall document the substance of the oral revocation in the declarant's medical record.

(c) It shall be the responsibility of the declarant, to the extent reasonably possible, to notify any person to whom the declarant has provided a copy of the directive.

§5–604.1.

(a) An advance directive may contain a statement by a declarant that the declarant consents to the gift of all or any part of the declarant's body for any one or more of the purposes specified in Title 4, Subtitle 5 of the Estates and Trusts Article.

(b) Notwithstanding any other provision of law, an anatomical gift in an advance directive is valid and effective for all purposes under Title 4, Subtitle 5 of the

Estates and Trusts Article, including the immunity from civil or criminal liability set forth in § 4–514 of the Estates and Trusts Article.

§5–605.

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

(ii) "Person eligible for relief" has the meaning stated in § 4–501 of the Family Law Article.

(iii) "Unavailable" means:

1. After reasonable inquiry, a health care provider is unaware of the existence of a health care agent or surrogate decision maker;

2. After reasonable inquiry, a health care provider cannot ascertain the whereabouts of a health care agent or surrogate decision maker;

3. A health care agent or surrogate decision maker has not responded in a timely manner, taking into account the health care needs of the individual, to a written or oral message from a health care provider;

4. A health care agent or surrogate decision maker is incapacitated; or

5. A health care agent or surrogate decision maker is unwilling to make decisions concerning health care for the individual.

(2) Subject to paragraph (4) of this subsection, the following individuals or groups, in the specified order of priority, may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent in accordance with this subtitle or whose health care agent is unavailable. Individuals in a particular class may be consulted to make a decision only if all individuals in the next higher class are unavailable:

(i) A guardian for the patient, if one has been appointed;

(ii) The patient's spouse or domestic partner;

(iii) An adult child of the patient;

(iv) A parent of the patient;

(v) An adult brother or sister of the patient; or

(vi) A friend or other relative of the patient who meets the requirements of paragraph (3) of this subsection.

(3) A friend or other relative may make decisions about health care for a patient under paragraph (2) of this subsection if the person:

(i) Is a competent individual; and

(ii) Presents an affidavit to the attending physician stating:

1. That the person is a relative or close friend of the patient; and

2. Specific facts and circumstances demonstrating that the person has maintained regular contact with the patient sufficient to be familiar with the patient's activities, health, and personal beliefs.

(4) An individual may not make decisions about health care for a patient under paragraph (2) of this subsection if:

(i) The individual is the subject of an interim, temporary, or final protective order and the patient is a person eligible for relief under the order; or

(ii) The individual is the spouse of the patient and:

1. The individual and patient have executed a separation agreement; or

2. The individual or patient has filed an application for divorce.

(5) The attending physician shall include the affidavit presented under paragraph (3) of this subsection in the patient's medical record.

(6) A person who obtains new information that would prohibit an individual from making health care decisions for a patient under paragraph (4) of this subsection shall provide the information to any health care provider or health care facility providing services to the patient.

(b) (1) If persons with equal decision making priority under subsection (a) of this section disagree about a health care decision, and a person who is incapable

of making an informed decision is receiving care in a hospital or related institution, the attending physician or an individual specified in subsection (a) of this section shall refer the case to the institution's patient care advisory committee, and may act in accordance with the recommendation of the committee or transfer the patient in accordance with the provisions of § 5–613 of this subtitle. A physician who acts in accordance with the recommendation of the committee is not subject to liability for any claim based on lack of consent or authorization for the action.

(2) If a person who is incapable of making an informed decision is not in a hospital or related institution, a physician may not withhold or withdraw life–sustaining procedures if there is not agreement among all the persons in the same class.

(c) (1) Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient and, if the wishes of the patient are unknown or unclear, on the patient's best interest.

(2) In determining the wishes of the patient, a surrogate shall consider the patient's:

(i) Current diagnosis and prognosis with and without the treatment at issue;

(ii) Expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments;

(iii) Relevant religious and moral beliefs and personal values;

(iv) Behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally;

(v) Reactions to the provision of, or the withholding or withdrawal of, a similar treatment for another individual; and

(vi) Expressed concerns about the effect on the family or intimate friends of the patient if a treatment were provided, withheld, or withdrawn.

(3) The decision of a surrogate regarding whether life–sustaining procedures should be provided, withheld, or withdrawn shall not be based, in whole or in part, on either a patient's preexisting, long–term mental or physical disability, or a patient's economic disadvantage.

(4) A surrogate shall inform the patient, to the extent possible, of the proposed procedure and the fact that someone else is authorized to make a decision regarding that procedure.

(d) A surrogate may not authorize:

(1) Sterilization; or

(2) Treatment for a mental disorder.

§5–606.

(a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician, nurse practitioner, or physician assistant, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.

(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician, nurse practitioner, or physician assistant is not required under paragraph (1) of this subsection.

(3) When authorization is sought for treatment of a mental illness, the second physician, nurse practitioner, or physician assistant may not be otherwise currently involved in the treatment of the person assessed.

(4) The cost of an assessment to certify incapacity under this subsection shall be considered for all purposes a cost of the patient's treatment.

(b) A health care provider may not withhold or withdraw life–sustaining procedures on the basis of an advance directive where no agent has been appointed or on the basis of the authorization of a surrogate, unless:

(1) The patient's attending physician and a second physician, nurse practitioner, or physician assistant have certified that the patient is in a terminal condition or has an end–stage condition; or

(2) Two physicians, one of whom is a neurologist, neurosurgeon, or other physician who has special expertise in the evaluation of cognitive functioning, certify that the patient is in a persistent vegetative state.

§5–607.

A health care provider may treat a patient who is incapable of making an informed decision, without consent, if:

(1) The treatment is of an emergency medical nature;

(2) A person who is authorized to give the consent is not available immediately; and

(3) The attending physician determines that:

(i) There is a substantial risk of death or immediate and serious harm to the patient; and

(ii) With a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent.

§5–608.

(a) (1) Certified or licensed emergency medical services personnel shall be directed by protocol to follow emergency medical services "do not resuscitate orders" pertaining to adult patients in the outpatient setting in accordance with protocols established by the Maryland Institute for Emergency Medical Services Systems in conjunction with the State Board of Physicians.

(2) Emergency medical services "do not resuscitate orders" may not authorize the withholding of medical interventions, or therapies deemed necessary to provide comfort care or to alleviate pain.

(3) A health care provider, other than certified or licensed emergency medical services personnel, who sees, in a valid form, an emergency medical services "do not resuscitate order" described in paragraph (1) of this subsection that is not superseded by a subsequent physician's order:

(i) May, before a patient's cardiac or respiratory arrest, provide, withhold, or withdraw treatment in accordance with the emergency medical services "do not resuscitate order"; and

(ii) Shall, after a patient's cardiac or respiratory arrest, withhold or withdraw treatment in accordance with the emergency medical services "do not resuscitate order".

(4) An order contained in a "Medical Orders for Life–Sustaining Treatment" form that resuscitation not be attempted shall be given the same effect as emergency medical services "do not resuscitate orders" described in paragraph (1) of this subsection.

(b) This section does not authorize emergency medical services personnel to follow an emergency medical services "do not resuscitate order" for any patient who, prior to cardiac or respiratory arrest, is able to, and does, express to those personnel the desire to be resuscitated.

(c) This section does not authorize emergency medical services personnel in the outpatient setting to follow an emergency medical services "do not resuscitate order" that is in any form other than:

(1) An emergency medical services "do not resuscitate order" described in subsection (a) of this section;

(2) An oral emergency medical services "do not resuscitate order" provided by an online, emergency medical services medical command and control physician;

(3) An oral emergency medical services "do not resuscitate order" provided by a physician, a physician assistant, or a nurse practitioner who is physically present on the scene with the patient and the emergency medical services personnel in the outpatient setting; or

(4) An order contained in a "Medical Orders for Life–Sustaining Treatment" form.

(d) (1) Except as provided in paragraph (2) of this subsection, in addition to the immunity provided in § 5–609 of this subtitle and any other immunity provided by law, an emergency medical services provider is not subject to criminal or civil liability, or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing or certifying authority, arising out of a claim concerning the provision of health care if:

(i) The claim is based on lack of consent or authorization for the health care;

(ii) Subsection (a) of this section would ordinarily apply; and

(iii) The emergency medical services provider:

1. Acts in good faith in providing the health care; and

2. Believes reasonably that subsection (a)(1) of this section does not apply.

(2) This subsection does not apply if the patient is wearing a valid, legible, and patient–identifying emergency medical services "do not resuscitate order" in bracelet form.

§5–608.1.

(a) In this section, "health care facility" means:

(1) An assisted living program;

(2) A home health agency;

(3) A hospice;

(4) A hospital;

(5) A kidney dialysis center; or

(6) A nursing home.

(b) (1) (i) The Department, in conjunction with the Maryland Institute for Emergency Medical Services Systems and the State Board of Physicians, shall develop and revise periodically a "Medical Orders for Life–Sustaining Treatment" form and instructions for completing and using the form.

(ii) The "Medical Orders for Life–Sustaining Treatment" form and the instructions for its completion and use shall be developed in consultation with:

1. The Office of the Attorney General;

2. The State Board of Nursing;

3. The State Advisory Council on Serious Illness Care; and

4. Any other individual or group the Department determines is appropriate.

(2) The "Medical Orders for Life–Sustaining Treatment" form developed under paragraph (1) of this subsection shall be suitable for containing a physician's, physician assistant's, or nurse practitioner's written medical orders relating to a patient's medical condition, including:

(i) The use of life–sustaining procedures;

(ii) The use of medical tests;

(iii) Transfer of the patient to a hospital from a nonhospital setting; and

(iv) Any other matter considered appropriate by the Department to implement treatment preferences and orders regarding life–sustaining treatments across health care settings.

(3) The "Medical Orders for Life–Sustaining Treatment" form is not an advance directive.

(c) (1) A health care facility shall:

(i) 1. Accept a completed "Medical Orders for Life–Sustaining Treatment" form during the admission process for each patient being admitted to the health care facility; and

2. Update the form as indicated in the instructions for the completion and use of the form; or

(ii) Complete a "Medical Orders for Life–Sustaining Treatment" form:

1. For a health care facility that is not a hospital, during the admission process for each patient being admitted to the health care facility; or

2. For a hospital, during an inpatient hospital stay for patients who are being discharged to another health care facility.

(2) When a health care facility updates or completes a "Medical Orders for Life–Sustaining Treatment" form under paragraph (1) of this subsection, the health care facility shall:

(i) Offer the patient, health care agent, or surrogate decision maker the opportunity to participate in updating or completing the form;

(ii) Note in the medical record when a patient, health care agent, or surrogate decision maker declines to participate in updating or completing the form, indicating the date and with whom the form was discussed;

(iii) On request of the patient, offer any physician, physician assistant, or nurse practitioner selected by the patient the opportunity to participate in updating or completing the form; and

(iv) Inform the patient, health care agent, or surrogate decision maker that the form will become a part of the patient's medical record and can be accessed through the procedures used to access a medical record.

(3) Except as provided for a treatment that has been certified as medically ineffective in accordance with § 5–611 of this subtitle, the "Medical Orders for Life–Sustaining Treatment" form shall be consistent with:

(i) The known decisions of:

1. The patient if the patient is a competent individual; or

2. A health care agent or surrogate decision maker as authorized by this subtitle; and

(ii) Any known advance directive of the patient if the patient is incapable of making an informed decision.

(d) (1) A health care provider other than a health care facility may choose to use a "Medical Orders for Life–Sustaining Treatment" form.

(2) A health care provider who chooses to use a "Medical Orders for Life–Sustaining Treatment" form shall offer a patient, health care agent, or surrogate decision maker the opportunity to participate in the completion of the form.

(e) The original or a copy of a "Medical Orders for Life–Sustaining Treatment" form shall:

(1) Be kept by a health care provider in the patient's medical record;

(2) Physically accompany the patient or be transmitted electronically or by facsimile in accordance with the instructions for the use of the form when the patient is transferred to a health care facility; and

(3) Be given to the patient, health care agent, or surrogate decision maker within 48 hours of completion of the form or sooner if the patient is transferred or discharged.

(f) Except as provided in § 5–611 or § 5–613 of this subtitle, a health care facility shall comply with all medical orders contained in a "Medical Orders for Life–Sustaining Treatment" form regardless of whether the physician, physician assistant, or nurse practitioner who signed the form has admitting privileges or is otherwise credentialed at the health care facility.

(g) In the event of a conflict between more than one "Medical Orders for Life–Sustaining Treatment" form, the most recent form shall be followed.

(h) A health care provider may rely in good faith on the presumed validity of a "Medical Orders for Life–Sustaining Treatment" form.

(i) (1) The Department shall adopt regulations that specify the "Medical Orders for Life–Sustaining Treatment" form and the instructions for the completion and use of the form that are developed as required by subsection (b) of this section, including instructions on how a "Medical Orders for Life–Sustaining Treatment" form is revised or revoked.

(2) Regulations adopted under paragraph (1) of this subsection shall be consistent with the Health Care Decisions Act.

(j) The Department shall make the "Medical Orders for Life–Sustaining Treatment" form and the instructions for the completion and use of the form, including instructions on how the form is revised or revoked, available on its website and may print and distribute the form, the instructions, and training materials.

§5–609.

(a) (1) A health care provider is not subject to criminal prosecution or civil liability or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing authority as a result of withholding or withdrawing any health care under authorization obtained in accordance with this subtitle.

(2) A health care provider providing, withholding, or withdrawing treatment under authorization obtained under this subtitle does not incur liability arising out of any claim to the extent the claim is based on lack of consent or authorization for the action.

(b) A person who authorizes the provision, withholding, or withdrawal of life–sustaining procedures in accordance with a patient's advance directive, a

"Medical Orders for Life–Sustaining Treatment" form, or as otherwise provided in this subtitle is not subject to:

(1) Criminal prosecution or civil liability for that action; or

(2) Liability for the cost of treatment solely on the basis of that authorization.

(c) (1) The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the provision, withholding, or withdrawal of life–sustaining procedures in accordance with this subtitle did not, in good faith, comply with the provisions of this subtitle.

(2) The distribution to patients of written advance directives in a form provided in this subtitle and assistance to patients in the completion and execution of such forms does not constitute the unauthorized practice of law.

(d) An advance directive made in accordance with this subtitle shall be presumed to have been made voluntarily by a competent individual. Authorization for the provision, withholding, or withdrawal of life–sustaining procedures in accordance with this subtitle shall be presumed to have been made in good faith.

§5–610.

(a) Any person who willfully conceals, cancels, defaces, obliterates, or damages the advance directive of another without the declarant's or patient's consent or who falsifies or forges a revocation of the advance directive of another, thereby causing life-sustaining procedures to be utilized in contravention of the previously expressed intent of the patient, shall be guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding 1 year or both.

(b) Any person who falsifies or forges the advance directive of another, or falsifies or forges an affidavit under § 5-605 of this subtitle, or willfully conceals or withholds personal knowledge of the revocation of an advance directive with the intent to cause a withholding or withdrawal of life-sustaining procedures, contrary to the wishes of the declarant and thereby, because of such act, directly causes life-sustaining procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding 1 year or both.

(c) The penalties provided in this section shall be in addition to any other penalties provided by law.

§5–611.

(a) Except as provided in § 5–613(a)(3) of this subtitle, nothing in this subtitle may be construed to require a physician or physician assistant to prescribe or render medical treatment to a patient that the physician or physician assistant determines to be ethically inappropriate.

(b) (1) Except as provided in § 5–613(a)(3) of this subtitle, nothing in this subtitle may be construed to require a physician or physician assistant to prescribe or render medically ineffective treatment.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, a patient's attending physician may withhold or withdraw as medically ineffective a treatment that under generally accepted medical practices is life–sustaining in nature only if the patient's attending physician and a second physician certify in writing that the treatment is medically ineffective and the attending physician informs the patient or the patient's agent or surrogate of the physician's decision.

(ii) If the patient is being treated in the emergency department of a hospital and only one physician is available, the certification of a second physician is not required.

(c) Nothing in this subtitle may be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(d) A health care provider shall make reasonable efforts to provide an individual with food and water by mouth and to assist the individual as needed to eat and drink voluntarily.

(e) (1) Nothing in this subtitle is intended to preclude a separate decision by a health care agent or surrogate regarding the provision of or the withholding or withdrawal of nutrients and fluids administered by artificial means.

(2) Nothing in this subtitle authorizes any action with respect to medical treatment, if the health care provider is aware that the patient for whom the health care is provided has expressed disagreement with the action.

§5–612.

(a) (1) A health care provider for an individual incapable of making an informed decision who believes that an instruction to withhold or withdraw a life-sustaining procedure from the patient is inconsistent with generally accepted standards of patient care shall:

(i) Petition a patient care advisory committee for advice concerning the withholding or withdrawal of the life-sustaining procedure from the patient if the patient is in a hospital or related institution; or

(ii) File a petition in a court of competent jurisdiction seeking injunctive or other relief relating to the withholding or withdrawal of the life-sustaining procedure from the patient.

(2) In reviewing a petition filed under paragraph (1) of this subsection, the court shall follow the standards set forth in §§ 13-711 through 13-713 of the Estates and Trusts Article.

(b) On petition of the patient's spouse, domestic partner, a parent, adult child, grandchild, brother, or sister of the patient, or a friend or other relative who has qualified as a surrogate under § 5–605 of this subtitle to a circuit court of the county or city in which the patient for whom treatment will be or is currently being provided, withheld, or withdrawn under this subtitle resides or is located, the court may enjoin that action upon finding by a preponderance of the evidence that the action is not lawfully authorized by this subtitle or by other State or federal law.

(c) Except for cases that the court considers of greater importance, a proceeding under this section, including an appeal, shall:

(1) Take precedence on the docket;

(2) Be heard at the earliest practicable date; and

(3) Be expedited in every way.

§5–613.

(a) A health care provider that intends not to comply with an instruction of a health care agent or a surrogate shall:

(1) Inform the person giving the instruction that:

(i) The health care provider declines to carry out the instruction;

(ii) The person may request a transfer to another health care provider; and

(iii) The health care provider will make every reasonable effort to transfer the patient to another health care provider;

(2) Assist in the transfer; and

(3) Pending the transfer, comply with an instruction of a competent individual, or of a health care agent or surrogate for an individual who is incapable of making an informed decision, if a failure to comply with the instruction would likely result in the death of the individual.

(b) Nothing in this section authorizes a health care provider to provide health care to:

(1) A competent individual over the objection of that individual; or

(2) An individual incapable of making an informed decision over the objection of another person authorized by law to consent to the provision of health care for the individual.

§5–614.

(a) The withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this subtitle shall not, for any purpose, constitute a suicide.

(b) (1) The making of an advance directive under this subtitle does not affect the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance.

(2) A policy of life insurance shall not be legally impaired or invalidated by the withholding or withdrawal of life-sustaining procedures from an insured patient in accordance with this subtitle, notwithstanding any term of the policy to the contrary.

(c) A person may not be required to make an advance directive as a condition for being insured for, or receiving, health care services.

(d) Any declaration of a patient or any designation of an agent made prior to October 1, 1993 shall be given full force and effect as provided in this subtitle.

§5–615.

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

(2) "Advance care planning document" has the meaning stated in § 19–145 of this article.

(3) "Electronic advance care planning document" has the meaning stated in § 19–145 of this article.

(4) "Electronic platform" means the platform developed in accordance with § 19–145(b)(2)(i) of this article to make electronic advance care planning documents accessible.

(5) "Health care facility" has the meaning stated in § 19–114 of this article.

(b) (1) Each health care facility shall provide each individual on admittance to the facility information concerning the rights of the individual to make decisions concerning health care, including the right to accept or refuse treatment, and the right to make an advance directive, including a living will.

(2) Except as provided in paragraph (4) of this subsection, on admittance of an individual to a health care facility, the health care facility shall:

(i) Use the electronic platform to identify if the individual has uploaded or saved any electronic advance care planning documents;

(ii) If the individual has uploaded or saved any electronic advance care planning documents, attempt to verify the contents and update the documents as necessary; and

(iii) If the individual has not uploaded or saved any electronic advance care planning documents:

1. Offer the individual the opportunity to scan any paper advance care planning documents the individual brought to the health care facility and upload or save them to the electronic platform; or

2. Provide the individual with an information sheet developed in accordance with this section.

(3) If a health care facility maintains a website, after the tab on the State–designated health information exchange website required under § 19–145(b)(2)(iv) of this article is developed, the health care facility shall provide a link to the webpage that is accessed through the tab.

(4) Paragraph (2) of this subsection does not apply to:

(i) A community provider as defined in § 7–307 of this article;

(ii) A home health agency as defined in § 19–401 of this article;

(iii) An assisted living facility as defined in § 19–1801 of this article; and

(iv) A hospice as defined in § 19–901 of this article.

(c) (1) The Department, in consultation with the Office of the Attorney General, shall develop an information sheet that provides information relating to advance directives, which shall include:

(i) Written statements informing an individual that an advance directive:

1. Can be updated or revoked by the individual at any time;

2. Is a useful, legal, and well established way for an individual to communicate the preferences of the individual for medical care, including the designation of a health care agent;

3. Allows an individual to specify the medical care that the individual may receive and can alleviate conflict among family members and health care providers;

4. Can help ensure that an individual's religious beliefs are considered if medical care is provided;

5. Can be more effective if discussed with family members, or legal and religious advisors, if an individual desires;

6. Is available in many forms, including model forms developed by religious organizations, estate planners, and lawyers;

7. Does not have to be on any specific form and can be personalized;

8. If completed, should be copied for an individual's family members, physicians, and legal advisors and, at the discretion of the individual, be uploaded or saved to the electronic platform; and

9. Is most effective if it is uploaded or saved to the electronic platform; and

(ii) The following written statements:

1. That an individual is not required to complete an advance directive;

2. That an individual should discuss the appointment of a health care agent with the potential appointee;

3. That advance directives are for individuals of all ages; and

4. That in the absence of an appointed health care agent, the next of kin make an individual's health care decisions when the individual is incapable of making or communicating those decisions.

(2) The information sheet developed by the Department under this subsection shall be provided by:

(i) The Department, in accordance with § 15–109.1 of this article;

(ii) The Motor Vehicle Administration, in accordance with § 12–303.1 of the Transportation Article;

(iii) A carrier, in accordance with § 15–122.1 of the Insurance Article;

(iv) The Maryland Health Benefit Exchange, in accordance with § 31–108(g) of the Insurance Article;

(v) A licensed physician to a patient at an appropriate time during a scheduled appointment;

(vi) A managed care organization in accordance with § 15–103.1(i)(1)(xvii) of this article;

(vii) A health care facility in accordance with subsection (b) of this section;

(viii) A nursing facility in accordance with § 19–301 of this article;

(ix) An assisted living facility in accordance with § 19–1801 of this article; and

(x) The State–designated health information exchange in accordance with § 19–145(b)(2)(iv) of this article.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, the information sheet developed by the Department under this subsection may not contain or promote a specific advance directive form or an electronic advance directive technology or service.

(ii) The information sheet shall include links to:

1. Websites for electronic advance directives services that the Maryland Health Care Commission has recognized under § 19–144 of this article; and

2. After the tab on the State–designated health information exchange website required under § 19–145(b)(2)(iv) of this article is developed, the webpage that is accessed through the tab.

(4) The information sheet developed by the Department under this subsection at a minimum shall:

(i) Educate the public on the use of electronic advance directives;

(ii) Encourage the use of electronic advance directives;

(iii) Provide information about developing an electronic advance directive;

(iv) Describe how electronic advance directives are made available at the point of care;

(v) Indicate that the use of an electronic advance directive is not required;

(vi) Indicate that individuals do not have to pay to have their electronic advance directives honored; and

(vii) Emphasize the importance of uploading or saving an electronic advance directive to the electronic platform.

§5–615.1.

The Department shall:

(1) Encourage the use of electronic advance directives;

(2) Carry out appropriate educational and outreach efforts to increase public awareness of electronic advance directives; and

(3) Encourage the following persons and entities to engage in outreach efforts regarding electronic advance directives:

(i) The Maryland Department of Aging;

(ii) County ombudspersons;

(iii) Local health departments;

(iv) Senior living facilities;

(v) Academic institutions;

(vi) Religious organizations;

(vii) Hospitals; and

(viii) Other similar persons or entities.

§5–615.2.

(a) The Department shall develop and implement a public awareness campaign to encourage the use of mental health advance directives in the State.

(b) The public awareness campaign shall include awareness initiatives to encourage and support outreach efforts by the following persons and government agencies to inform present or future recipients of mental health services and members of their families, health care providers, and other behavioral health care partners about mental health advance directives:

(1) The Department of Public Safety and Correctional Services;

(2) The Department of State Police;

(3) The Department of Veterans and Military Families;

(4) Local health departments;

(5) Local behavioral health authorities;

(6) Behavioral health programs;

(7) Practicing psychiatrists, psychologists, professional counselors and therapists, and social workers;

(8) Health care facilities;

(9) Academic institutions;

(10) Religious organizations; and

(11) Other persons who encounter present or future recipients of mental health services.

§5–616.

(a) The provisions of this subtitle are cumulative with existing law regarding an individual's right to consent or refuse to consent to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the provision, withholding, or withdrawal of life–sustaining procedures under the common law or statutes of the State.

(b) A valid living will or durable power of attorney for health care made prior to October 1, 1993, shall be given effect as provided in this article, even if not executed in accordance with the terms of this article.

§5–617.

An advance directive, an emergency medical services "do not resuscitate order", or an order regarding life–sustaining treatment executed in another state shall be deemed to be validly executed for the purposes of this subtitle if executed in compliance with the laws of Maryland or the laws of the state where executed. Advance directives, emergency medical services "do not resuscitate orders", or an order regarding life–sustaining treatment executed in another state shall be construed to give effect to the patient's wishes to the extent permitted by the laws of Maryland.

§5–618.

The provisions of this Part I of this subtitle shall be known and may be cited as the "Health Care Decisions Act".

§5–619.

(a) In this Part II of this subtitle the following words have the meanings indicated.

(b) "Advance directive" has the meaning stated in § 5–601 of this subtitle.

(c) "Registrant" means an individual who registers an advance directive with an electronic advance directives service recognized by the Maryland Health Care Commission.

§5–620.

There is an Advance Directive Program in the Department.

§5–621.

The Secretary may adopt regulations to ensure the efficient operation of the Advance Directive Program.

§5–622.

(a) (1) To facilitate the use of cloud–based technology for electronic advance directives, the Department shall issue a request for proposals from and contract with an electronic advance directives service or multiple electronic advance directives services to connect with health care providers at the point of care through the State–designated health information exchange.

(2) An electronic advance directives service shall:

(i) Be approved by the Maryland Health Care Commission; and

(ii) Meet the technology, security, and privacy standards set by the Maryland Health Care Commission.

(b) The Department shall carry out appropriate educational and outreach efforts to increase public awareness of an electronic advance directives service recognized by the Maryland Health Care Commission.

§5–623.

(a) An individual may register an advance directive with an electronic advance directives service recognized by the Maryland Health Care Commission.

(b) (1) The registrant shall notify the electronic advance directives service recognized by the Maryland Health Care Commission if the registrant has amended or revoked a registered advance directive.

(2) A health care provider that becomes aware that a registrant has amended or revoked a registered advance directive shall, at the request of the registrant, provide the registrant with information on how to notify the electronic advance directives service recognized by the Maryland Health Care Commission.

(c) (1) Except as provided in paragraph (2) of this subsection, an individual is not required to submit an advance directive to an electronic advance directives service recognized by the Maryland Health Care Commission.

(2) An individual shall submit an electronic advance directive that is not witnessed to an electronic advance directives service that is recognized by the Maryland Health Care Commission.

(d) Nothing in this Part II of this subtitle affects the validity of an advance directive that is not submitted to an electronic advance directives service recognized by the Maryland Health Care Commission.

§5–625.

A health care provider is not subject to criminal prosecution or civil liability or deemed to have engaged in unprofessional conduct as determined by the appropriate licensing authority for:

(1) Failure to access an electronic advance directives service recognized by the Maryland Health Care Commission; or

(2) Relying on information provided by an electronic advance directives service recognized by the Maryland Health Care Commission.

§5–626.

(a) In this section, "Fund" means the Advance Directive Program Fund.

(b) There is an Advance Directive Program Fund.

(c) The purpose of the Fund is to provide funding to carry out the purposes of the Advance Directive Program established under § 5–620 of this subtitle.

(d) The Department shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Money transferred to the Fund under § 6–103.1 of the Insurance Article;

(2) Interest earned under subsection (h) of this section; and

(3) Any other money received from any other lawful source accepted for the benefit of the Fund.

(g) (1) Except as provided in paragraph (2) of this subsection, money in the Fund may be used only to carry out the purposes of the Advance Directive Program established under § 5–620 of this subtitle.

(2) In fiscal year 2027 only, $1,000,000 of the Fund may be used for maternal and child health quality initiatives in the Department.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

§5–701.

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

(b) "Child" means an individual under the age of 18 years.

(c) "Child death review case reporting system" means a national, standardized, web–based reporting system for the confidential collection, analysis, aggregation, and reporting of child death data that is maintained and operated by a national center for child death review.

(d) "Data use agreement" means a contract between the Department and a national center for child death review that establishes the terms and conditions for the State and local child fatality review teams' participation in a child death review case reporting system.

(e) "Health care provider" means:

(1) An individual licensed or certified under the Health Occupations Article to provide health care; or

(2) A facility that provides health care to individuals.

(f) "Local team" means the multidisciplinary and multiagency child fatality review team established for a county.

(g) "Meeting" includes meetings through telephone conferencing.

(h) "National center for child death review" means a public, private, nonprofit, or governmental organization or entity that is funded or otherwise recognized by the United States Department of Health and Human Services and is responsible for:

(1) Developing a child death review case reporting system;

(2) Training and serving as a liaison to State agencies participating in the system; and

(3) Disseminating national child death review data generated by the system.

(i) "State Team" means the State Child Fatality Review Team.

(j) "Unexpected child death" means a death of a child investigated by the office of the Chief Medical Examiner as required by § 5–309 of this title.

§5–702.

(a) There is a State Child Fatality Review Team.

(b) The State Team is part of the Department for budgetary and administrative purposes.

§5–703.

(a) The State Team shall be a multidisciplinary and multiagency review team, composed of at least 25 members, including:

(1) The Attorney General or the Attorney General's designee;

(2) The Chief Medical Examiner or the Chief Medical Examiner's designee;

(3) The Secretary of Human Services or the Secretary's designee;

(4) The Secretary of Health or the Secretary's designee;

(5) The State Superintendent of Schools or the Superintendent's designee;

(6) The Secretary of Juvenile Services or the Secretary's designee;

(7) The Special Secretary of the Governor's Office for Children or the Special Secretary's designee;

(8) The Secretary of State Police or the Secretary's designee;

(9) The president of the State's Attorneys' Association or the president's designee;

(10) The chief of the Division of Vital Records of the Department or the chief's designee;

(11) A representative of the Center for Infant and Child Loss;

(12) The Director of the Behavioral Health Administration of the Department or the Director's designee;

(13) Two pediatricians with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the Governor from a list submitted by the State Chapter of the American Academy of Pediatrics; and

(14) Eleven members of the general public with interest or expertise in child safety and welfare, appointed by the Governor, including child advocates, CASA volunteers, health and mental health professionals, and attorneys who represent children.

(b) The members described under subsection (a)(1) through (12) of this section may designate representatives from their departments or offices to represent them on the State Team.

(c) The State Team may employ a staff in accordance with the State budget. Each member of the Team under subsection (a)(1) through (12) of this section shall provide sufficient staff support to complete the State Team's responsibilities.

(d) Members of the State Team shall serve without compensation, but may be reimbursed for reasonable expenses incurred in the performance of their duties in accordance with the Standard State Travel Regulations and as provided in the State budget.

(e) The State Team shall select a chairperson from among its members.

(f) The State Team shall meet not less than once every 3 months.

§5–704.

(a) The purpose of the State Team is to prevent child deaths by:

(1) Developing an understanding of the causes and incidence of child deaths;

(2) Developing plans for and implementing changes within the agencies represented on the State Team to prevent child deaths; and

(3) Advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths.

(b) To achieve its purpose, the State Team shall:

(1) Undertake annual statistical studies of the incidence and causes of child fatalities in the State, including an analysis of community and public and private agency involvement with the decedents and their families before and after the deaths;

(2) Review reports from local teams;

(3) Provide training and written materials to the local teams established under § 5–705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams;

(4) In cooperation with local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions;

(5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol;

(6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State or local laws in the annual report required by item (12) of this subsection;

(7) Consider local and statewide training needs, including cross–agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs;

(8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children from preventable deaths, and include proposals for changes to statutes in the annual report required by item (12) of this subsection;

(9) Examine the policies and procedures of State and local agencies and specific cases that the State Team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:

(i) The State plan under 42 U.S.C. § 5106a(b);

(ii) The child protection standards set forth in 42 U.S.C. § 5106a(b); and

(iii) Any other criteria that the State Team considers important to ensure the protection of children;

(10) Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths;

(11) Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams;

(12) Provide the Governor, the public, and subject to § 2–1257 of the State Government Article, the General Assembly, with annual written reports, which shall include the State Team's findings and recommendations; and

(13) In consultation with local teams:

(i) Define "near fatality"; and

(ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

(c) The State Team shall coordinate its activities under this section with the State Citizens Review Board for Children, local citizens review panels, and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort.

(d) (1) Except as provided in paragraph (2) of this subsection, members and staff of the State Team:

(i) May not disclose to any person or government official any identifying information about any specific child protection case about which the State Team is provided information; and

(ii) May make public other information unless prohibited by law.

(2) (i) In carrying out the responsibilities under this section and subject to subparagraph (ii) of this paragraph, the members and staff of the State Team may provide identifying information to a national center for child death review in accordance with a data use agreement that:

1. Authorizes access to identifiable information only to the members and staff of the State Team;

2. Authorizes the national center for child death review to access only de–identified information; and

3. Requires the national center for child death review to act as a fiduciary agent of the State and local teams.

(ii) Information provided to a national center for child death review in accordance with this subsection is confidential and subject to the same confidentiality and discovery protections that apply to the State and local teams as set forth in § 5–709 of this subtitle.

(e) In addition to any other penalties provided by law, the Secretary may impose on any person who violates subsection (d) of this section a civil penalty not exceeding $500 for each violation.

§5–705.

(a) (1) Except as provided in paragraph (2) of this subsection, there shall be a multidisciplinary and multiagency child fatality review team in each county.

(2) Instead of a local team in each county, two or more counties may agree to establish a single multicounty local team.

(3) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

(b) The local team membership shall be drawn from the following individuals, organizations, agencies, and areas of expertise, when available:

(1) The county health officer;

(2) The director of the local department of social services;

(3) The State's Attorney;

(4) The superintendent of schools;

(5) A State, county, or municipal law enforcement officer;

(6) The director of the county substance abuse treatment program;

(7) The chief attorney who represents the local department of social services in child welfare proceedings;

(8) The Early Childhood Development Division in the State Department of Education;

(9) The director of the county mental health agency or core service agency;

(10) A pediatrician with experience in diagnosing and treating injuries and child abuse and neglect, appointed by the county health officer;

(11) A psychiatrist or psychologist with experience in child abuse and neglect or child injury, appointed by the director of the county mental health agency, core service agency, or local behavioral health authority;

(12) A member of the general public with interest or expertise in the prevention and treatment of child abuse and neglect, appointed by the county health officer; and

(13) Any other individual necessary to the work of the local team, recommended by the local team and appointed by the county health officer.

(c) The members described under subsection (b)(1) through (9) of this section may designate representatives from their departments or offices to represent them on the local team.

(d) From among its members, each local team shall elect a chairperson by majority vote.

§5–706.

(a) The purpose of the local team is to prevent child deaths by:

(1) Promoting cooperation and coordination among agencies involved in investigations of child deaths or in providing services to surviving family members;

(2) Developing an understanding of the causes and incidence of child deaths in the county;

(3) Developing plans for and recommending changes within the agencies the members represent to prevent child deaths; and

(4) Advising the State Team on changes to law, policy, or practice to prevent child deaths.

(b) To achieve its purpose, the local team shall:

(1) In consultation with the State Team, establish and implement a protocol for the local team;

(2) Set as its goal the investigation of child deaths in accordance with national standards;

(3) Meet at least quarterly to review the status of child fatality cases, recommend actions to improve coordination of services and investigations among member agencies, and recommend actions within the member agencies to prevent child deaths;

(4) Collect and maintain data as required by the State Team;

(5) Provide requested reports to the State Team, including discussion of individual cases, steps taken to improve coordination of services and investigations, steps taken to implement changes recommended by the local team within member agencies, and recommendations on needed changes to State and local law, policy, and practice to prevent child deaths; and

(6) In consultation with the State Team:

(i) Define "near fatality"; and

(ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

(c) In addition to the duties specified in subsection (b) of this section, a local team may investigate the information and records of a child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality described in § 5–707 of this subtitle.

§5–707.

Upon request of the chair of the local team and as necessary to carry out the local team's purpose and duties, the local team shall be immediately provided:

(1) Access to information and records, including information on prenatal care, maintained by a health care provider regarding:

(i) A child whose death is being reviewed by the local team; or

(ii) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; and

(2) Access to all information and records maintained by any State or local government agency, including birth certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to:

(i) A child whose death is being reviewed by the local team;

(ii) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; or

(iii) The family of a child described in item (i) or (ii) of this paragraph.

§5–708.

(a) Meetings of the State Team and of local teams shall be closed to the public and not subject to Title 3 of the General Provisions Article when the State Team or local teams are discussing individual cases of child deaths.

(b) Except as provided in subsection (c) of this section, meetings of the State Team and of local teams shall be open to the public and subject to Title 3 of the General Provisions Article when the State Team or local team is not discussing individual cases of child deaths.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased child;

(ii) A family member, guardian, or caretaker of a deceased child;

(iii) An alleged or suspected perpetrator of abuse or neglect upon a child; or

(iv) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(2) During a public meeting, information may not be disclosed regarding the involvement of any agency with:

(i) A deceased child;

(ii) A family member, guardian, or caretaker of a deceased child;

(iii) An alleged or suspected perpetrator of abuse or neglect upon a child; or

(iv) A child convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(d) This section does not prohibit the State Team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

(e) Violation of this section is a misdemeanor and is punishable by a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§5–709.

(a) All information and records acquired by the State Team or by a local team, in the exercise of its purpose and duties under this subtitle, are confidential, exempt from disclosure under Title 4 of the General Provisions Article, and may only be disclosed as necessary to carry out the team's duties and purposes.

(b) Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.

(c) Reports of the State Team and of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.

(d) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting that is not public under § 5-708 of this subtitle or any information the disclosure of which is prohibited by this section.

(e) Members of a team, persons attending a team meeting, and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting. This subsection does not prohibit a person from testifying to information obtained independently of the team or that is public information.

(f) (1) Except as provided in paragraph (2) of this subsection, information, documents, and records of the State Team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence

through those sources solely because they were presented during proceedings of the team or are maintained by a team.

(g) Violation of this section is a misdemeanor and is punishable by a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§5–801. IN EFFECT

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

(b) "Aggregate incident data" means information or statistics maintained by the Office of Health Care Quality on the reported incidents of Level III serious injuries at health care facilities.

(c) "Committee" means the Mortality and Quality Review Committee.

§5–801. // EFFECTIVE DECEMBER 31, 2032 PER CHAPTER 221 OF 2022 //

In this subtitle, "Committee" means the Mortality Review Committee.

§5–802. IN EFFECT

(a) There is a Mortality and Quality Review Committee established within the Department.

(b) The purpose of the Committee is to prevent avoidable injuries and avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.

§5–802. // EFFECTIVE DECEMBER 31, 2032 PER CHAPTER 221 OF 2022 //

(a) There is a Mortality Review Committee established within the Department.

(b) The purpose of the Committee is to prevent avoidable deaths and to improve the quality of care provided to persons with developmental disabilities.

§5–803. IN EFFECT

The Committee shall:

(1) Evaluate causes or factors contributing to deaths in facilities or programs:

(i) Operated or licensed by the Developmental Disabilities Administration;

(ii) Licensed by the Behavioral Health Administration to provide mental health services and identified in § 10–713(a) of this article; or

(iii) Operating by waiver under § 7–903(b) of this article;

(2) Review aggregate incident data regarding facilities or programs that are licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7–903(b) of this article;

(3) Identify patterns and systemic problems and ensure consistency in the review process; and

(4) Make recommendations to the Secretary and the Secretary of Disabilities to prevent avoidable injuries and avoidable deaths and improve quality of care.

§5–803. // EFFECTIVE DECEMBER 31, 2032 PER CHAPTER 221 OF 2022 //

The Committee shall:

(1) Evaluate causes or factors contributing to deaths in facilities or programs:

(i) Operated or licensed by the Developmental Disabilities Administration;

(ii) Licensed by the Behavioral Health Administration to provide mental health services and identified in § 10–713(a) of this article; or

(iii) Operating by waiver under § 7–903(b) of this article;

(2) Identify patterns and systemic problems and ensure consistency in the review process; and

(3) Make recommendations to the Secretary to prevent avoidable deaths and improve quality of care.

§5–804.

(a) The Committee shall consist of 18 members appointed by the Secretary, including the following:

(1) A licensed physician who is board certified in an appropriate specialty;

(2) A psychopharmacologist;

(3) A licensed physician on staff with the Department;

(4) Two specialists, one in the field of developmental disabilities and one in the field of mental health;

(5) Two licensed providers of community services, one for persons with developmental disabilities and one for persons with mental illnesses;

(6) Two consumers, one with a developmental disability and one with a mental illness;

(7) Two family members, one representing a consumer with a developmental disability and one representing a consumer with a mental illness;

(8) The Deputy Secretary for Behavioral Health or the Deputy Secretary's designee;

(9) The Director of the Office of Health Care Quality;

(10) A licensed physician representative from the Medical Examiner's Office;

(11) A licensed nurse who works with persons with developmental disabilities in a program operated by a State licensed provider in the community;

(12) A member of an advocacy group for persons with disabilities; and

(13) Two members of advocacy groups, one for persons with developmental disabilities and one for persons with mental illnesses.

(b) (1) The term of each member appointed under subsection (a)(1), (2), (4), (5), (6), and (10) of this section is 3 years.

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

(3) A member may not be appointed for more than two consecutive full terms.

(4) The terms of the members are as follows:

(i) One–third of the members shall be appointed for terms of 3 years commencing October 1, 2000;

(ii) One–third of the members shall be appointed for terms of 2 years commencing October 1, 2000; and

(iii) One–third of the members shall be appointed for terms of 1 year commencing October 1, 2000.

(5) At the end of a term, a member continues to serve until a successor is appointed.

(c) The Secretary may remove any member of the Committee for good cause.

(d) A member of the Committee:

(1) May not receive compensation for service on the Committee; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) The Committee shall be staffed by the Department.

(f) (1) An employee of the Developmental Disabilities Administration or the Behavioral Health Administration may not be a member of the Committee or any subcommittee of the Committee.

(2) The Director of the Office of Health Care Quality may not serve on a subcommittee of the Committee or vote on the disposition of an individual mortality review that was previously reviewed by the Office of Health Care Quality.

(g) The Secretary shall select a chair from among the members of the Committee.

(h) A quorum of the Committee shall be a majority of the appointed membership of the Committee.

(i) The Committee shall meet not less than three times a year.

§5–805.

(a) (1) Except as provided in paragraph (3) of this subsection, the Office of Health Care Quality shall review each death of an individual with developmental disabilities or with a mental illness who, at the time of death, resided in or was receiving services from any program or facility licensed or operated by the Developmental Disabilities Administration or operating by waiver under § 7–903(b) of this article, or any program approved, licensed, or operated by the Department under § 10–406 of this article or any program identified in § 10–713(a) of this article.

(2) The Office of Health Care Quality may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services at that individual's home.

(3) Unless a member of the Committee requests a review, the Office of Health Care Quality may choose not to review a death if the circumstances, based on reasonable judgment, are readily explained and require no further investigation.

(b) Within 14 days of the completion of each investigation, the Office of Health Care Quality shall submit to the Committee its final report for each death.

(c) The Committee shall:

(1) Review each death report provided by the Office of Health Care Quality; or

(2) Appoint a subcommittee of at least four members, one of whom shall be a licensed physician or nurse, to review death reports and report and make recommendations to the full Committee.

(d) (1) On review of the death report, if the Committee or its subcommittee determines that further investigation is warranted, the Committee or subcommittee may request additional information, including consumer records, medical records, autopsy reports, and any deficiency statements and plans of correction.

(2) The Committee or subcommittee may choose to prepare questions for the provider, State residential center director, or other relevant person or may request the attendance of the provider, director, or other relevant person at a Committee or subcommittee meeting.

(3) Except as provided in paragraph (2) of this subsection, Committee members may not communicate directly with the provider, a State residential center director, a State psychiatric superintendent, or a family member or guardian of the individual who is the subject of a death report.

§5–806.

Upon request of the chair of the Committee or subcommittee, and as necessary to carry out the purpose of the Committee, the following shall immediately provide the Committee or subcommittee with access to information and records regarding an individual whose death is being reviewed:

(1) A provider of medical care, including dental and mental health care;

(2) A State or local government agency; and

(3) A provider of residential or other services.

§5–806.1. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2032 PER CHAPTER 221 OF 2022 //

(a) (1) The Office of Health Care Quality shall provide aggregate incident data to the Committee once every 3 months.

(2) When providing aggregate incident data to the Committee, to the extent practicable, the Office of Health Care Quality shall identify trends and patterns that may threaten the health, safety, or well–being of an individual.

(b) The Committee shall review the aggregate incident data and make findings and recommendations to the Department on system quality assurance needs.

(c) The Committee may consult with experts as needed to carry out the provisions of this section.

§5–807.

A person shall have the immunity from liability under § 5-637 of the Courts Article for any action as a member of the Committee or for giving information to, participating in, or contributing to the function of the Committee or subcommittee.

§5–808. IN EFFECT

(a) (1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a review of aggregate incident data, a summary of the Committee's activities, and summary findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(5) The Developmental Disabilities Administration shall provide the report to the facilities or programs that are operated or licensed by the Developmental Disabilities Administration or operating by waiver under § 7–903(b) of this article.

(b) (1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary, the Secretary of Disabilities, the Director of the Developmental Disabilities Administration, the Director of the Behavioral Health Administration, or to the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under § 1–401 of the Health Occupations Article.

§5–808. // EFFECTIVE DECEMBER 31, 2032 PER CHAPTER 221 OF 2022 //

(a) (1) At least once in a calendar year, the Committee shall prepare a report for public distribution.

(2) The report shall include aggregate information that sets forth the numbers of deaths reviewed, the ages of the deceased, causes and circumstances of death, a summary of the Committee's activities, and summary findings.

(3) Summary findings shall include patterns and trends, goals, problems, concerns, final recommendations, and preventative measures.

(4) Specific individuals and entities may not be identified in any public report.

(b) (1) In addition to the public report issued under subsection (a) of this section, the Committee or its subcommittee may at any time issue preliminary findings or make preliminary recommendations to the Secretary or to the Director of the Office of Health Care Quality.

(2) Preliminary findings or recommendations shall be confidential and not discoverable or admissible under § 1–401 of the Health Occupations Article.

§5–809.

(a) The Committee shall maintain records of its deliberations including any recommendations.

(b) (1) Except for the public report issued under § 5-808(a) of this subtitle, any records of deliberations, findings, or files of the Committee shall be confidential and are not discoverable under § 1-401 of the Health Occupations Article.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

(c) (1) Members of the Committee or a subcommittee of the Committee, persons attending a Committee or subcommittee meeting, and persons who present information to the Committee or subcommittee may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information obtained independently of the Committee or subcommittee or that is public information.

(d) (1) Except as necessary to carry out the Committee's purpose and duties, members of the Committee or subcommittee and persons attending a Committee or subcommittee meeting may not disclose:

(i) What transpired at a meeting that is not public under this subtitle; or

(ii) Any information that is prohibited for disclosure by this section.

(2) This subsection does not prohibit the discovery of material, records, documents, or other information that was not prepared by the Committee or its subcommittee and was obtained independently of the Committee or subcommittee.

§5–810.

Meetings of the Committee and subcommittees shall be closed to the public and not subject to Title 10, Subtitle 5 of the State Government Article.

§5–901.

In this subtitle, "local team" means the multidisciplinary and multiagency drug overdose fatality review team established for a county.

§5–902.

(a) (1) Subject to paragraph (2) of this subsection, there may be a multidisciplinary and multiagency drug overdose fatality review team in each county.

(2) Instead of a local team in each county, two or more counties may agree to establish a single multicounty local team.

(3) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

(b) The local team membership shall be drawn, if available, from the following individuals, organizations, agencies, and areas of expertise:

(1) The county health officer, or the officer's designee;

(2) The director of the local department of social services, or the director's designee;

(3) The State's Attorney, or the State's Attorney's designee;

(4) The superintendent of schools, or the superintendent's designee;

(5) A State, county, or municipal law enforcement officer;

(6) The director of behavioral health services in the county, or the director's designee;

(7) An emergency medical services provider in the county;

(8) A representative of a hospital;

(9) A health care professional who specializes in the prevention, diagnosis, and treatment of substance use disorders;

(10) A representative of a local jail or detention center;

(11) A representative from parole, probation, and community corrections;

(12) The Secretary of Juvenile Services, or the Secretary's designee;

(13) A member of the public with interest or expertise in the prevention and treatment of drug overdose deaths, appointed by the county health officer; and

(14) Any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer.

(c) Each local team shall elect a chair from among its members.

§5–903.

(a) The purpose of each local team is to prevent drug overdose deaths by:

(1) Promoting cooperation and coordination among agencies involved in investigations of drug overdose deaths or in providing services to surviving family members;

(2) Developing an understanding of the causes and incidence of drug overdose deaths in the county;

(3) Developing plans for and recommending changes within the agencies represented on the local team to prevent drug overdose deaths; and

(4) Advising the Department on changes to law, policy, or practice, including the use of devices that are programmed to dispense medications on a schedule or similar technology, to prevent drug overdose deaths.

(b) To achieve its purpose, each local team shall:

(1) In consultation with the Department, establish and implement a protocol for the local team;

(2) Set as its goal the investigation of drug overdose deaths in accordance with national standards;

(3) Meet at least quarterly to review the status of drug overdose death cases and information on nonfatal overdoses, recommend actions to improve

coordination of services and investigations among member agencies, and recommend actions within the member agencies to prevent drug overdose deaths;

(4) Collect and maintain data as required by the Department; and

(5) Provide requested reports to the Department, including:

(i) Discussion of individual cases;

(ii) Steps taken to improve coordination of services and investigations;

(iii) Steps taken to implement changes recommended by the local team within member agencies; and

(iv) Recommendations on needed changes to State and local laws, policies, or practices to prevent drug overdose deaths.

(c) In addition to the duties specified in subsection (b) of this section, a local team may investigate the information and records of an individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality described in § 5–904 of this subtitle.

§5–904.

(a) On request of the chair of a local team and as necessary to carry out the purpose and duties of the local team, the local team shall be immediately provided with:

(1) Access to information and records, including information about physical health, mental health, and treatment for substance abuse, maintained by a health care provider for:

(i) An individual whose death or near fatality is being reviewed by the local team; or

(ii) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; and

(2) Access to information and records maintained by a State or local government agency, including death certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency, if the agency provided services to:

(i) An individual whose death or near fatality is being reviewed by the local team;

(ii) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality; or

(iii) The family of an individual described in item (i) or (ii) of this item.

(b) Substance abuse treatment records requested or provided under this section are subject to any additional limitations on disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2.

§5–905.

(a) Meetings of local teams shall be closed to the public and are not subject to Title 3 of the General Provisions Article when the local teams are discussing individual cases of overdose or drug overdose deaths.

(b) Except as provided in subsection (c) of this section, meetings of local teams shall be open to the public and are subject to Title 3 of the General Provisions Article when the local team is not discussing individual cases of overdose or drug overdose deaths.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased individual;

(ii) An individual who has experienced an overdose;

(iii) A family member, guardian, or caretaker of a deceased individual or of an individual who has experienced an overdose; or

(iv) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(2) During a public meeting, information may not be disclosed about the involvement of any agency with:

(i) A deceased individual;

(ii) An individual who has experienced an overdose;

(iii) A family member, guardian, or caretaker of a deceased individual or of an individual who has experienced an overdose; or

(iv) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(d) This section does not prohibit a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.

(e) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§5–906.

(a) Subject to subsection (b) of this section, all information and records acquired by a local team in the exercise of its purpose and duties under this subtitle are confidential, exempt from disclosure under Title 4 of the General Provisions Article, and may be disclosed only as necessary to carry out the team's purpose and duties.

(b) (1) Mental health records are subject to the additional limitations under § 4–307 of this article for disclosure of a medical record developed primarily in connection with the provision of mental health services.

(2) Substance abuse treatment records are subject to any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2.

(c) Statistical compilations of data that do not contain any information that would permit the identification of any person to be ascertained are public records.

(d) Reports of a local team that do not contain any information that would permit the identification of any person to be ascertained are public information.

(e) Except as necessary to carry out a local team's purpose and duties, members of a local team and persons attending a local team meeting may not disclose:

(1) What transpired at a meeting that is not public under § 5–905 of this subtitle; or

(2) Any information the disclosure of which is prohibited by this section.

(f) (1) Members of a local team, persons attending a local team meeting, and persons who present information to a local team may not be questioned in any civil or criminal proceeding about information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information that is obtained independently of a local team or that is public information.

(g) (1) Except as provided in paragraph (2) of this subsection, information, documents, or records of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, or records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of a local team or are maintained by a local team.

(h) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§5–1001.

In this subtitle, "State team" means the Maryland Suicide Fatality Review Committee.

§5–1002.

(a) There is a Maryland Suicide Fatality Review Committee, also referred to as the State team.

(b) The purpose of the State team is to identify and address the factors contributing to suicide deaths and facilitate system changes in the State to prevent suicide deaths.

(c) (1) The State team shall include the following members, who shall serve on an ex officio basis:

(i) The Secretary, or the Secretary's designee;

(ii) The Deputy Secretary of the Behavioral Health Administration, or the Deputy Secretary's designee; and

(iii) The Chair of the Governor's Commission on Suicide Prevention.

(2) The Secretary may include in the State team the Chief Medical Examiner, or the Chief Medical Examiner's designee.

(3) The Secretary may include the following members in the State team, as designated by the Secretary:

(i) A suicidologist or an academic with a specialty in the study and prevention of suicide;

(ii) One representative of health care providers;

(iii) One representative of an organization having expertise in suicide prevention;

(iv) One representative of an organization having expertise in the treatment and prevention of substance abuse;

(v) One representative of an organization that advocates for individuals with mental illness;

(vi) One representative of law enforcement or correctional services; and

(vii) Any additional members determined to be necessary by the Secretary to carry out the purpose of this subtitle, which may include representatives from relevant disciplines and relevant community–based organizations.

(d) The State team shall elect the chair of the State team by a majority vote.

(e) The Department shall provide staff for the State team.

(f) All members of the State team shall be voting members.

(g) (1) Each member designated under subsection (c)(3) of this section shall serve on the State team for a term of 3 years and may be reappointed.

(2) At the end of a term, a member designated under subsection (c)(3) of this section continues to serve until a successor is appointed.

(3) All vacancies shall be filled by the designating authority in accordance with this section.

(h) A member of the State team:

(1) May not receive compensation for service on the State team; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(i) To the extent that funds are available, the State team may hire staff or consultants to assist the State team in carrying out its duties.

§5–1003.

(a) The State team shall:

(1) Meet at least quarterly to review suicide deaths, consistent with the requirements of this subtitle;

(2) Make determinations regarding:

(i) The following issues related to individuals at risk for suicide:

1. Trends;

2. Risk factors;

3. Current best practices in suicide prevention;

4. Lapses in systemic responses; and

5. Barriers to safety and well–being; and

(ii) Strategies for the prevention of suicide deaths;

(3) Report at least annually to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on:

(i) The State team's activities; and

(ii) The State team's recommendations on:

1. Changing any law or policy in a manner that would promote the prevention of suicide deaths; and

2. Improving the availability of sources of information relating to the investigation of reported suicide fatalities;

(4) Undertake annual statistical studies of:

(i) The incidents and causes of suicide mortality in the State; and

(ii) Trends and patterns of suicide deaths in the State; and

(5) Disseminate findings and recommendations based on the studies conducted under item (4) of this subsection to policymakers, health care providers, health care facilities, and the public.

(b) The State team may periodically make available, in a general manner that does not reveal confidential information about individual cases, only the aggregate findings of the State team's reviews and their recommendations for preventive actions.

§5–1004.

A person shall have the immunity from liability under § 5–637 of the Courts Article for any action as a member of the State team or for giving information to, participating in, or contributing to the function of the State team.

§5–1005.

(a) The State team is a public health authority, as defined in 45 C.F.R. § 164.501, conducting public health activities in accordance with the federal Health Insurance Portability and Accountability Act.

(b) On request of the chair of the State team and as necessary to carry out the State team's purpose and duties, a health care provider or a State or local government agency immediately shall provide to the State team any records of the health care provider or State or local government agency necessary to complete the review of a specific fatality, including:

(1) Hospital records;

(2) Outpatient clinic, health care provider, and laboratory records;

(3) Police investigation data;

(4) Medical examiner investigative data;

(5) Cause–of–death information in vital records;

(6) Social services records; and

(7) Other records from State offices, agencies, and departments.

(c) The State team may request that a person with direct knowledge of circumstances surrounding a fatality provide the State team with information necessary to complete the review of the particular fatality, including information from:

(1) A health care provider or staff involved in the care of the decedent; and

(2) The person who first responded to a report concerning the decedent.

(d) The State team:

(1) May share information with other public health authorities or their designees as the State team determines necessary to carry out the purposes of this subtitle; and

(2) Shall coordinate with the State's Child Fatality Review and Drug Overdose Fatality Review teams to share and receive information relevant to the State team's findings and to ensure efficiency in the work of the teams.

(e) (1) Except as provided in paragraph (2) of this subsection, all information and records acquired by the State team in the exercise of its duties:

(i) Shall be confidential;

(ii) Shall be exempt from disclosure under the Public Information Act; and

(iii) May not be subject to discovery or introduction into evidence in any proceedings.

(2) Information may be disclosed as necessary and in a manner consistent with this subtitle to carry out the purposes of this subtitle.

(f) Mental health records are subject to the additional limitations under § 4–307 of this article for disclosure of a medical record developed primarily in connection with the provision of mental health services.

§5–1006.

(a) Meetings of the State team shall be closed to the public and are not subject to the Open Meetings Act.

(b) A member of the State team or an attendee of a State team meeting may not:

(1) Release to the public or the news media information discussed at meetings; or

(2) Except as provided in § 5–1007 of this subtitle, testify in any proceeding about details of a State team meeting, including any information presented at the meeting, or about opinions formed by the individual because of the meeting.

(c) Each member of the State team and any attendee of a meeting of the State team shall sign a statement indicating an understanding of and adherence to the State team's confidentiality requirements, including any potential civil or criminal consequences for a breach of confidentiality under this section.

§5–1007.

This subtitle may not be construed to prohibit a person from:

(1) Testifying in a civil or criminal action about matters that occurred in a State team meeting if the testimony will be based on the person's independent knowledge; or

(2) Investigating or reviewing a suicide death under any other provision of law.

§5–1008.

The Department may adopt regulations to carry out this subtitle, including regulations on:

(1) The procedures by which health care providers, health care facilities, and other persons identify and report suicide deaths to the Department or as directed by the Department;

(2) The protocols, procedures, methods, manner, and extent of all investigations and reviews by the State team; and

(3) The manner in and extent to which information shall be disseminated under this subtitle.

§5–1009.

This subtitle may be cited as the Maryland Suicide Mortality Review and Prevention Act.

§5–1101.

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

(b) "Local team" means a multidisciplinary and multiagency suicide fatality review team established under § 5–1103 of this subtitle.

(c) "State Team" means the Maryland Suicide Fatality Review Committee.

§5–1102.

This subtitle may not be construed to supersede, limit, interfere with, or otherwise affect the authority or duties of a local child fatality review team under Subtitle 7 of this title.

§5–1103.

(a) Subject to subsection (b) of this section, a county or municipality may establish a multidisciplinary and multiagency suicide fatality review team.

(b) Two or more counties may establish a single multicounty local team.

(c) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

(d) The local team membership shall be drawn, if available, from the following individuals, organizations, agencies, and areas of expertise:

(1) The county health officer, or the officer's designee;

(2) The director of the local department of social services, or the director's designee;

(3) The director of the local behavioral health authority or the director's designee;

(4) The superintendent of schools for the county, or the superintendent's designee;

(5) A State, county, or municipal law enforcement officer;

(6) The director of behavioral health services in the county, or the director's designee;

(7) An emergency medical services provider in the county;

(8) A representative of a hospital;

(9) A health care professional who specializes in the prevention, diagnosis, and treatment of mental health or behavioral health conditions;

(10) A member of the public with interest or expertise in suicide prevention, appointed by the county health officer; and

(11) Any other individual necessary for the work of the local team, recommended by the local team and appointed by the county health officer.

(e) Each local team shall elect a chair from among its members.

(f) Each local team shall:

(1) Meet at least quarterly to:

(i) Review the status of suicide fatality cases;

(ii) Recommend actions to improve the coordination of services and investigations among agencies; and

(iii) Recommend actions to relevant agencies to prevent suicide deaths;

(2) Collect and maintain data as required by the State Team;

(3) Ensure safe and secure storage for protected information and records held by the local team;

(4) Provide any reports required by the State Team, including:

(i) Reports on individual cases;

(ii) Steps taken to improve coordination of services and investigations among agencies;

(iii) Steps taken to implement the recommendations of local teams by applicable agencies; and

(iv) Recommendations for changes to State and local law, policy, and practices designed to prevent suicide deaths;

(5) Subject to § 5–1104(c) of this subtitle, coordinate with local child fatality review teams, and local drug overdose fatality review teams to ensure the efficiency of each local team's operations;

(6) Coordinate with the State Suicide Fatality Review Committee established under Subtitle 10 of this title, including to establish operating protocols; and

(7) Operate subject to State and national standards, and subject to guidance issued by the State Suicide Fatality Review Committee.

§5–1104.

(a) The purpose of a local team is to prevent suicide deaths by:

(1) Reviewing suicide deaths of residents of the county or that occur within the county;

(2) Identifying systemic, service, and policy factors associated with risk of suicide;

(3) Promoting coordination between entities involved in suicide prevention, crisis response, treatment, and postvention; and

(4) Developing recommendations to prevent suicide.

(b) A local team may:

(1) Examine trends in suicide and factors that contribute to suicide risk;

(2) Share information with other public health authorities or their designees as the local team determines necessary to carry out the purposes of this subtitle;

(3) Identify gaps in systems of care or coordination between entities involved in suicide prevention, crisis response, treatment, and postvention; and

(4) Submit recommendations to the State Suicide Fatality Review Committee established under Subtitle 10 of this title, or other local entities as determined appropriate by the local team.

(c) A local child fatality review team:

(1) For a suicide death involving an individual under the age of 18 years, shall retain the primary authority to conduct the review in accordance with Subtitle 7 of this title; and

(2) May coordinate or conduct a joint review with the local team.

§5–1105.

A person shall have the immunity from liability under § 5–637 of the Courts Article for any action as a member of the local team for giving information to, participating in, or contributing to the function of the local team.

§5–1106.

(a) A local team may request records under this section under the authority of the State Team.

(b) On request of the chair of a local team and as necessary to carry out the purpose and duties of the local team, a health care provider or a local government agency shall immediately provide to the local team any records of the health care provider or local government agency necessary to complete the review of a specific fatality, including:

(1) Hospital records;

(2) Outpatient clinic, health care provider, and laboratory records;

(3) Police investigative data;

(4) Medical examiner investigative data;

(5) Cause of death information in vital records;

(6) Social services records; and

(7) Other records from local offices, agencies, and departments.

(c) The local team may request that a person with direct knowledge of circumstances surrounding a fatality provide the local team with the information necessary to complete review of the particular fatality, including information from:

(1) A health care provider or staff involved in the care of the decedent; and

(2) The person who first responded to a report concerning the decedent.

§5–1107.

A local team is a public health authority, as defined in 45 C.F.R. § 164.501, conducting public health activities in accordance with the federal Health Insurance Portability and Accountability Act.

§5–1108.

(a) Meetings of local teams shall be closed to the public and are not subject to the Open Meetings Act when the local teams are discussing individual cases of suicide.

(b) Except as provided in subsection (c) of this section, meetings of local teams shall be open to the public and are subject to the Open Meetings Act when the local team is not discussing individual cases of suicide.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased individual;

(ii) An individual who has experienced suicide or a suicide attempt;

(iii) A family member, guardian, or caretaker of an individual described in item (i) or (ii) of this paragraph; or

(iv) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(2) During a public meeting, information may not be disclosed about the involvement of an agency with:

(i) A deceased individual;

(ii) An individual who has experienced suicide or a suicide attempt;

(iii) A family member, guardian, or caretaker of a deceased individual or of an individual described in item (i) or (ii) of this paragraph; or

(iv) An individual convicted of a crime or adjudicated as having committed a delinquent act that caused a death or near fatality.

(d) This section does not prohibit a local team from requesting the attendance of a person who has information relevant to the local team's exercise of its purpose and duties at a team meeting.

(e) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§5–1109.

(a) Except as otherwise provided in this section, all information and records acquired by a local team in the exercise of its purpose and duties under this subtitle:

(1) Are confidential;

(2) Are exempt from disclosure under the Public Information Act;

(3) Are not subject to discovery and may not be introduced as evidence in any proceeding; and

(4) May be disclosed only as necessary to carry out the local team's purpose and duties.

(b) (1) Mental health records are subject to the additional limitations under § 4–307 of this article for disclosure of a medical record developed primarily in connection with the provision of mental health services.

(2) Substance abuse treatment records are subject to any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law, 42 U.S.C. § 290dd–2, or 42 C.F.R. Part 2.

(c) Statistical compilations of data that do not contain any information that would allow the identification of any person to be ascertained are public records.

(d) Reports of a local team that do not contain any personally identifiable information are public records.

(e) Except as necessary to carry out a local team's purpose and duties, members of a local team and persons attending a local team meeting may not disclose:

(1) Any proceeding at a nonpublic meeting under § 5–1108 of this subtitle; or

(2) Any information that may not be disclosed under this section.

(f) (1) Members of a local team, persons attending a local team meeting, and persons who present information to a local team may not be questioned in any civil or criminal proceeding about information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit a person from testifying to information that is obtained independently of a local team or that is public information.

(g) (1) Except as provided in paragraph (2) of this subsection, information, documents, or records of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, or records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of a local team or are maintained by a local team.

(h) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§5–1110.

The Department may adopt regulations to carry out this subtitle, including:

(1) Protocols, procedures, and methods for, and the manner and extent of investigations and reviews by local teams;

(2) The manner in which data provided by the Department is to be stored and secured;

(3) The manner in which, and extent to which, information based on data provided by the Department may be disseminated.

§6–101.

(a) In this title, "domestic partnership" means a relationship between two individuals who:

(1) Are at least 18 years old;

(2) Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;

(3) Are not married or in a civil union or domestic partnership with another individual; and

(4) Agree to be in a relationship of mutual interdependence in which each individual contributes to the maintenance and support of the other individual and the relationship, even if both individuals are not required to contribute equally to the relationship.

(b) An individual who asserts a domestic partnership under subsection (a) of this section may be required to provide:

(1) An affidavit signed under penalty of perjury by two individuals stating that they have established a domestic partnership; and

(2) Proof of any two of the following documents:

(i) Joint liability of the individuals for a mortgage, lease, or loan;

(ii) The designation of one of the individuals as the primary beneficiary under a life insurance policy on the life of the other individual or under a retirement plan of the other individual;

(iii) The designation of one of the individuals as the primary beneficiary of the will of the other individual;

(iv) A durable power of attorney for health care or financial management granted by one of the individuals to the other individual;

(v) Joint ownership or lease by the individuals of a motor vehicle;

(vi) A joint checking account, joint investments, or a joint credit account;

(vii) A joint renter's or homeowner's insurance policy;

(viii) Coverage on a health insurance policy;

(ix) Joint responsibility for child care, such as guardianship or school documents; or

(x) A relationship or cohabitation contract.

§6–201.

(a) A hospital, related institution, or residential treatment center, as defined in § 19–301 of this article, shall allow a patient's or resident's domestic partner, the children of the patient's or resident's domestic partner, and the domestic partner of the patient's or resident's parent or child to visit, unless:

(1) No visitors are allowed;

(2) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, resident, or member of the facility staff; or

(3) The patient or resident or the patient's or resident's personal representative tells the facility staff that the patient or resident does not want a particular person to visit.

(b) This section does not prohibit a hospital, related institution, or residential treatment center from establishing reasonable restrictions on visitation, including restrictions on the hours of visitation and number of visitors.

§6–202.

In the case of a medical emergency, two adults shall be treated as domestic partners if one of the adults, in good faith, tells the emergency medical provider or hospital personnel that the adults are in a mutually interdependent relationship, for the following purposes only:

(1) Allowing one adult to accompany the ill or injured adult being transported to a hospital in an emergency vehicle; and

(2) Visitation with the ill or injured adult admitted to a hospital on an emergency basis on the same basis as a member of the ill or injured adult's immediate family.

§6–203.

Notwithstanding any provisions of this title or any other provision of law, if a domestic partner has selected a health care agent in accordance with Title 5, Subtitle 6 of this article, that health care agent retains the authority to make any decisions for the domestic partner that are provided for in the selection of the health care agent until the health care agency has been revoked in accordance with the provisions of Title 5, Subtitle 6 of this article.

§7–101.

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

(b) "Administration" means the Developmental Disabilities Administration.

(c) (1) "Admission" means the process by which an individual with an intellectual disability is accepted as a resident in a State residential center.

(2) "Admission" includes the physical act of the individual entering the facility.

(d) (1) "Alternative living unit" means a residence that:

(i) Provides residential services for individuals who, because of developmental disability, require specialized living arrangements;

(ii) Admits not more than 3 individuals; and

(iii) Provides 10 or more hours of supervision per unit, per week.

(2) "Alternative living unit" does not include a residence that is owned or rented by:

(i) 1 or more of its residents; or

(ii) A person who:

1. Is an agent for any of the residents; but

2. Is not a provider of residential supervision.

(e) "Claim" has the meaning stated in § 2–601 of this article.

(f) "Deputy Secretary" means the Deputy Secretary for Developmental Disabilities.

(g) "Developmental disability" means a severe chronic disability of an individual that:

(1) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;

(2) Is manifested before the individual attains the age of 22;

(3) Is likely to continue indefinitely;

(4) Results in an inability to live independently without external support or continuing and regular assistance; and

(5) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual.

(h) "External support" means:

(1) Periodic monitoring of the circumstances of an individual with respect to:

(i) Personal management;

(ii) Household management; and

(iii) The use of community resources; and

(2) Rendering appropriate advice or assistance that may be needed.

(i) "Fee–for–service" means a method for payment that requires a person to submit a claim for payment to the Department for each service performed.

(j) "Group home" means a residence that:

(1) Provides residential services for individuals who, because of developmental disability, require specialized living arrangements;

(2) Admits at least 4 but not more than 8 individuals; and

(3) Provides 10 or more hours of supervision per home, per week.

(k) "Habilitation" means a process by which a provider of services enables an individual to acquire and maintain life skills to cope more effectively with the demands of the individual's own person and environment and to raise the level of the individual's mental, physical, social, and vocational functioning.

(l) (1) "Individual–directed and family–directed goods and services" means services, equipment, activities, or supplies for individuals who self–direct services that:

(i) Relate to a need or goal identified in the person–centered plan of service;

(ii) Maintain or increase independence;

(iii) Promote opportunities for community living and inclusion; and

(iv) Are not available under another waiver service or services provided under the State plan established in Subtitle 3 of this title.

(2) "Individual–directed and family–directed goods and services" includes all goods or services authorized by regulations adopted or guidance issued

by the federal Centers for Medicare and Medicaid Services under § 1915(c) of the Social Security Act.

(m) (1) "Individual support services" means an array of services that are designed to increase or maintain an individual's ability to live alone or in a family setting.

(2) "Individual support services" include:

(i) In–home assistance with meals and personal care;

(ii) Counseling;

(iii) Physical, occupational, or other therapies;

(iv) Architectural modification; and

(v) Any other services that the Administration considers appropriate to meet the individual's needs.

(3) "Individual support services" does not include full day or residential services.

(n) "Intellectual disability" means a developmental disability that is evidenced by significantly subaverage intellectual functioning and impairment in the adaptive behavior of an individual.

(o) "Knowingly" has the meaning stated in § 2–601 of this article.

(p) "Live independently" means:

(1) For adults:

(i) Managing personal care, such as clothing and medication;

(ii) Managing a household, such as menu planning, food preparation and shopping, essential care of the premises, and budgeting; and

(iii) Using community resources, such as commercial establishments, transportation, and services of public agencies; or

(2) For minors, functioning in normal settings without the need for supervision or assistance other than supervision or assistance that is age appropriate.

(q) "Meaningful day services" means employment supports or home– and community–based supports, other than residential services, that assist an individual in developing and maintaining skills, interests, and personalized connections that may create opportunities for paid employment, increased independence, or meaningful relationships with other individuals in the community.

(r) "Person–centered plan of service" means that a plan for services and supports:

(1) Is developed with a focus on the individual having control over the services and supports;

(2) Ensures that the individual is the primary contributor to the plan and may receive support from other persons selected by the individual in developing the plan;

(3) Identifies and addresses, to the extent practicable:

(i) The individual's preferences and interests related to achieving the individual's desired lifestyle; and

(ii) The supports required to achieve the individual's desired lifestyle and provided in a manner that enables the individual to have control over the individual's daily life and maintains the individual's health and welfare; and

(4) Aligns services and supports to ensure that the individual has access to the full benefits of community living in a manner that emphasizes the individual's quality of life, well–being, and informed choice.

(s) "Provider" means an individual who is licensed or certified under Subtitle 9 of this title and provides services to:

(1) A recipient; or

(2) An individual with a developmental disability who receives funding for services from a source other than the Administration.

(t) "Recipient" means an individual who receives services funded by the Administration under this title.

(u) "Release" means a permanent, temporary, absolute, or conditional release of an individual from a State residential center.

(v) "Residential services" means individualized support and services that assist an individual in developing and maintaining skills in living in the community.

(w) (1) "Self–directed services" means waiver program services:

(i) For which participants or their representatives have decision–making authority over and take direct responsibility for management of the services with the assistance of available supports chosen by the participant or the participant's representative; and

(ii) That are provided in a manner that:

1. Furthers the right of individuals and their representatives, as applicable, to make choices about and direct all aspects of their lives, including by choosing and controlling the delivery of waiver services, who provides the services, and how services are provided; and

2. Recognizes that all individuals have the capacity to make choices and may be supported in making choices.

(2) "Self–directed services" includes services that:

(i) Provide an individual with:

1. The decision–making employer authority to recruit, hire, train, supervise, and dismiss the employees and vendors who furnish the individual's services; and

2. The budget authority over how funds in a budget are spent within the total approved annual budget;

(ii) Maximize the opportunities of an individual to live as independently as possible in the most inclusive community–based setting of the individual's choice;

(iii) Empower an individual to exercise choice and control over needed long–term services and supports; and

(iv) Help to maintain and improve the individual's health and quality of life in the individual's community.

(x) "Services" means residential, day, or other services that provide for evaluation, diagnosis, treatment, care, supervision, assistance, or attention to

individuals with developmental disability and that promote habilitation of these individuals.

(y) "Services coordination" means a service that consists of the following 3 major functions that are designed to assist an individual in obtaining the needed services and programs that the individual desires in order to gain as much control over the individual's own life as possible:

(1) Planning services;

(2) Coordinating services; and

(3) Monitoring service delivery to the individual.

(z) "State residential center" means a licensed facility operated by the State that provides residential and habilitation services to individuals with an intellectual disability who are at least 18 years old and meet the criteria set forth in § 7–502 of this title.

(aa) "Support broker" means a person who works at the direction of and for the benefit of an individual who uses self–directed services, including by assisting the individual or another individual chosen by the individual with:

(1) Making informed decisions in arranging for, directing, and managing services the individual receives, including decisions related to personnel requirements and resources needed to meet the requirements;

(2) Accessing and managing identified supports and services for the individual; and

(3) Performing other tasks as assigned by the individual and as authorized by regulations adopted or guidance issued by the federal Centers for Medicare and Medicaid Services under § 1915(c) of the Social Security Act.

(bb) "Support services" means supports that assist an individual to maintain or improve the individual's functional abilities, enhance interactions, or engage in meaningful relationships in the home or community.

(cc) "Treatment" means any education, training, professional care or attention, or other program that is given to an individual with developmental disability.

(dd) "Vocational services" means a service that provides job training and placement, supported employment and training in acceptable work behaviors, and vocationally–related social and other skills.

(ee) "Waiver program" means each Medicaid Home– and Community–Based Services Waiver funding program submitted by the Department and approved by the federal Centers for Medicare and Medicaid Services in accordance with § 1915(c) of the Social Security Act that is overseen and administered by the Administration.

(ff) "Waiver program services" means services funded by the Administration in accordance with a waiver program, including:

(1) Meaningful day services;

(2) Residential services; and

(3) Support services.

§7–102.

To advance the public interest, it is the policy of this State:

(1) To promote, protect, and preserve the human dignity, constitutional rights and liberties, social well-being, and general welfare of individuals with developmental disability in this State;

(2) To encourage the full development of the ability and potential of each individual with developmental disability in this State, no matter how severe the individual's disability;

(3) To promote the economic security, standard of living, and meaningful employment of individuals with developmental disability;

(4) To foster the integration of individuals with developmental disability into the ordinary life of the communities where these individuals live;

(5) To support and provide resources to operate community services to sustain individuals with developmental disability in the community, rather than in institutions;

(6) To require the Administration to designate sufficient resources to foster and strengthen a permanent comprehensive system of community programming for individuals with developmental disability as an alternative to institutional care;

(7) To recognize the right of those individuals with developmental disability who need residential services to live in surroundings as normal as possible and to provide adequate facilities for this purpose;

(8) To provide appropriate social and protective services for those individuals with developmental disability who are unable to manage their own affairs with ordinary prudence;

(9) To protect the rights of parents and to help parents and guardians in planning for and assisting those individuals with developmental disability who are unable to manage their own affairs;

(10) To promote and provide for the development, maintenance, and coordination of all programs for individuals with developmental disability;

(11) To advance research and professional training related to developmental disability; and

(12) To promote public understanding of these policies and programs provided in this title.

§7–103.

(a) This title shall be construed in a manner consistent with the policy stated in this subtitle.

(b) This title does not prevent individuals with developmental disability from being eligible for services provided by any agency.

§7–201.

There is a Developmental Disabilities Administration in the Department.

§7–202.

(a) The head of the Administration is the Deputy Secretary.

(b) The Deputy Secretary shall appoint the number of directors, assistant directors, and administrative heads provided in the State budget.

§7–203.

The Secretary may delegate to an individual any of the authority, powers, and duties granted to the Secretary under this title.

§7–204.

(a) In this section, "direct care staff" means an individual who is directly involved in the day–to–day education, training, habilitation, assistance, counseling, care, or attention of an individual with a developmental disability.

(b) (1) The Developmental Disabilities Administration shall assure that all direct care staff in State residential and community–based programs are provided with in–service training.

(2) The in–service training program shall include training in:

(i) The theory and practical application of normalization principles;

(ii) The individualization of programming;

(iii) General characteristics and needs of individuals served;

(iv) First aid and cardiopulmonary resuscitation (CPR);

(v) The fundamental rights of persons with developmental disabilities; and

(vi) Other training components as deemed necessary.

(c) Each direct care staff member shall participate in the in–service training curriculum within 3 months from the date of the staff member's employment.

(d) The Developmental Disabilities Administration shall develop standards for in–service training in accordance with recognized standards for direct care staff.

§7–205.

(a) (1) There is a continuing, nonlapsing Waiting List Equity Fund in the Maryland Department of Health.

(2) The purpose of the Waiting List Equity Fund is to ensure that:

(i) When individuals leave State residential centers, the net average cost of serving them in the State residential center, as defined in subsection (d)(2) of this section, shall follow them to community–based services; and

(ii) Any funds remaining after the individuals leaving State residential centers are served, are used to provide community–based services to individuals eligible for, but not receiving, the community–based services listed in subsection (c) of this section.

(b) Subject to the appropriation process in the annual operating budget, the Department shall use the Waiting List Equity Fund for providing community–based services to individuals eligible for, but not receiving, services from the Developmental Disabilities Administration.

(c) For individuals eligible for, but not receiving, services from the Developmental Disabilities Administration in the Department, the Waiting List Equity Fund shall be used to provide:

(1) Individualized supported living arrangements services;

(2) Respite care;

(3) Individual and family support services;

(4) Supported employment; and

(5) Individualized community integration day services.

(d) (1) The Waiting List Equity Fund shall consist of:

(i) Subject to the appropriation process in the annual operating budget, funds which are equal to the cost of providing services to an individual in a State residential center for each fiscal year, or part of a fiscal year, that the individual is no longer served in a State residential center and is provided community–based services as defined in paragraph (2) of this subsection;

(ii) The net proceeds from contributions under the income tax checkoff system established under § 2–113 of the Tax – General Article; and

(iii) Any other money from any other source accepted for the benefit of the Fund.

(2) In determining funding for the Waiting List Equity Fund, the cost of providing services to an individual in a State residential center shall be calculated by:

(i) Dividing the State residential center's appropriation by the daily average census reported in the State residential center's annual operating budget for the last full fiscal year the individual was served in the State residential center prorated over the number of months the individual is served in the community; and

(ii) Subtracting the following:

1. The average annual itemized expenses associated with institutional services and administrative overhead costs that are demonstrated to be directly attributable to serving individuals remaining in the State residential center;

2. The cost for new admissions certified in accordance with the provisions of §§ 7–502 and 7–503 of this title;

3. The cost for respite care in accordance with § 7–509 of this title;

4. The cost for court–ordered commitments; and

5. Reimbursable federal revenues under TEFRA attributable to direct client costs.

(e) (1) The Department shall adopt regulations for the management and use of the money in the Fund.

(2) The regulations shall authorize the use of money in the Fund to provide services to individuals:

(i) Who are in crisis and need emergency services; and

(ii) Who are not in crisis and do not need emergency services.

(f) (1) On or before January 1 of each year the Secretary shall prepare a report to be submitted to the General Assembly and the Department of Legislative Services on the Waiting List Equity Fund.

(2) The report shall include:

(i) An accounting of all receipts and expenditures to and from the Fund;

(ii) The number of individuals who left and entered State residential centers during the previous year;

(iii) The number of additional persons who were on the waiting list for developmental disabilities services during the previous year; and

(iv) An accounting of each of the factors used in determining the cost of providing services to an individual in a State residential center in accordance with the provisions of subsection (d)(2) of this section.

(g) Any unspent portions in the Waiting List Equity Fund and any interest earned on money in the Waiting List Equity Fund may not be transferred or revert to the General Fund of the State, but shall remain in the Waiting List Equity Fund to be used for the purposes specified in this section.

§7–206.

(a) (1) Upon notification of the death of an individual in a program or facility funded or operated by the Administration, the administrative head of the program or facility shall report the death:

(i) Immediately to the sheriff, police, or chief law enforcement official in the jurisdiction in which the death occurred;

(ii) Immediately to the Secretary; and

(iii) By the close of business the next working day to:

1. The Deputy Secretary;

2. The health officer in the jurisdiction where the death occurred; and

3. The designated State protection and advocacy system.

(2) A report may be:

(i) Oral if followed by a written report within 5 working days from the date of the death; or

(ii) Written.

(3) A written report shall contain:

(i) The name, age, and sex of the deceased;

(ii) The time of discovery of the death;

(iii) The deceased's place of residence at the time of death;

(iv) The location where the body was discovered;

(v) The name of the person who took custody of the body;

(vi) The name of the person evaluating the death, if known;

(vii) Whether or not an autopsy is being performed, if known;

(viii) The name, address, and telephone number of the next of kin or legal guardian, if known; and

(ix) Any other information the administrative head of the service or program determines should be provided to the medical examiner and the persons listed in paragraph (1) of this subsection on the deaths occurring:

1. By violence;

2. By suicide;

3. By casualty;

4. Suddenly, if the deceased was in apparent good health; or

5. In any suspicious or unusual manner.

(b) The sheriff, police, or chief law enforcement officer shall inform a medical examiner in accordance with § 5–309(b) of this article, and the medical examiner, if necessary, shall conduct an investigation in accordance with the provisions of that section.

§7–207.

Beginning October 1, 2020, the Administration may not fund providers that pay individuals less than the minimum wage under a certificate that the United States Department of Labor issues to a work activities center or other sheltered workshop to allow the work activities center or workshop to pay an individual less than the wage otherwise required for the individual under federal law.

§7–208.

(a) In this section, "medical and psychological records" includes:

(1) Medical documentation;

(2) Psychological information;

(3) School documentation; and

(4) Any other relevant information.

(b) The Developmental Disabilities Administration and the Division of Rehabilitation Services shall enter into a memorandum of understanding, the terms of which shall include a data sharing agreement for the medical and psychological records of mutual clients in order to expedite decisions regarding eligibility for services.

§7–301.

In this subtitle, "State plan" means the plan established by the Secretary to provide services to individuals eligible for services under this title.

§7–302.

The purpose of the State plan is to identify the populations in need of services, the current state of needed services, and the priorities for new services, including the reallocation of resources.

§7–303.

(a) Through the Developmental Disabilities Administration, the Secretary shall establish and carry out a State plan to provide the following training and habilitation services:

(1) For individuals with developmental disability:

(i) Day habilitation services;

(ii) Family support services;

(iii) Individual support services;

(iv) Prevention and early detection of disabilities;

(v) Residential services in community-based settings;

(vi) Services coordination;

(vii) Services in State residential centers;

(viii) Services to insure protection of the individual rights and liberties of individuals with developmental disability;

(ix) Vocational services;

(x) Community supported living arrangements services; and

(xi) Any other services that may be necessary to permit delivery of the services under this subsection.

(2) For individuals without developmental disability, but who meet the eligibility requirements of § 7-403 of this title, individual support services.

(b) The Secretary periodically shall revise the State plan, but not less than every 2 years, to reflect changes in need, current available services, priorities, and any other changes that may affect the need for or scope of care and services.

§7–305.

Through the State plan, the Secretary shall:

(1) Provide or encourage by consultation, cooperation, contract, or direct operation, services and facilities that are needed for the early detection, accurate evaluation, proper referral, protection of individual rights and liberties, and the optimal care and development of individuals with developmental disability who need treatment or services; and

(2) Encourage coordination of services with other public and private agencies that have responsibility for serving individuals with developmental disability.

§7–306.

The Secretary shall implement the State plan through:

(1) The provision of direct services;

(2) The purchase of services; or

(3) Other appropriate means.

§7–306.1. IN EFFECT

** IN EFFECT UNTIL CONTINGENCY MET PER CHAPTER 648 OF 2014**

(a) The Administration shall develop and implement a funding system for the distribution of State funds to private providers that are under contract with the Administration to provide community–based services to individuals with disability in accordance with the State plan.

(b) Funds received for services that are fee–for–service or that have rates set by regulation shall be subject to recovery by the Administration only for the following purposes:

(1) Client attendance;

(2) Client fees; or

(3) Sanctions allowed through regulations.

(c) (1) Under the funding system developed under subsection (a) of this section, the Administration shall notify each private provider at least 30 days before the beginning of the fiscal year of the billing rate or amount of funds to be paid to the provider for the provision of community–based services to an individual with developmental disability or a group of individuals with developmental disability for the coming fiscal year.

(2) For rates that are set in regulation, the Administration shall include the cost centers used to determine the funding amount of each rate.

(3) (i) A private provider may request an administrative resolution of a billing rate set under paragraph (1) of this subsection except for rates set in regulation.

(ii) Within 60 days after receipt of the provider's request, the Administration shall make a decision on the request for an administrative resolution.

(iii) If an administrative resolution cannot be reached between the provider and the Administration, the provider may request an evidentiary hearing or an oral hearing in accordance with regulations of the Department.

(d) Subject to the provisions of subsections (e), (f), and (g) of this section, the Administration shall provide payment to private providers for the services provided from the funds designated in subsection (c) of this section in accordance with the following payment schedule:

(1) On or before the third business day of the fiscal quarter beginning July 1, 33% of the total annual amount to be paid to the provider;

(2) On or before the third business day of the fiscal quarter beginning October 1, 25% of the total annual amount to be paid to the provider;

(3) On or before the third business day of the fiscal quarter beginning January 1, 25% of the total annual amount to be paid to the provider; and

(4) On or before the third business day of the fiscal quarter beginning April 1, 17% of the total annual amount to be paid to the provider.

(e) The Administration may deviate from the payment schedule provided under subsection (d) of this section for any provider:

(1) That is reimbursed through the fee payment system and fails to submit properly completed program attendance reports within 15 days of the beginning of each month;

(2) That provides services under the medical assistance program and fails to submit the designated forms used by the medical assistance program to claim federal fund participation within 30 days after the end of each month; or

(3) That fails to submit a cost report for rate–based payment systems or wage surveys as required under subsection (k) of this section.

(f) A deviation from the payment schedule as provided under subsection (e) of this section may occur only if the Administration has:

(1) Advised the provider that:

(i) An attendance report which has been submitted on time is in need of correction;

(ii) A designated medical assistance form which has been submitted on time is in need of correction;

(iii) A cost report for rate–based payment systems has not been submitted within 6 months from the close of the fiscal year or, if submitted, is in need of correction; or

(iv) A wage survey requested under subsection (l) of this section has not been submitted by the later of 60 days from the date of receipt of the request or within 60 days after the last day of the pay period for which the data was requested or, if submitted, is in need of correction;

(2) Allowed the provider at least 5 working days to submit, resubmit or correct the report or form; and

(3) Not in any way contributed to the delay of or error on a report or form.

(g) The amount of a reduction of payments to a provider pursuant to subsections (e) and (f) of this section may not:

(1) Exceed the amount of lost federal revenue attributable to the delay or error; or

(2) In the case of cost reports for rate–based payment systems or wage surveys, exceed $500 per day per report for each day the report is not submitted past the given due date or corrected.

(h) The Administration:

(1) Shall place sufficient funds in a specially designated account with the Office of the Comptroller to meet its financial obligations under subsection (d) of this section;

(2) Shall disburse funds from the account in accordance with the payment schedule provided in subsection (d) of this section;

(3) May not use the funds in the account for any other purpose except for the purpose of reimbursing private providers for the provision of community–based services to individuals with developmental disability;

(4) Within 1 year after receipt of a private provider's year–end report and cost report for rate–based payment systems, shall reconcile the report and shall provide the provider with a written approval of the report or a written explanation of any items in dispute; and

(5) Shall conduct an audit of each private provider every 4 years.

(i) The Administration shall accept as final the private provider's year–end report and cost report for rate–based payment systems if:

(1) The Administration fails to provide written approval or a written explanation of any items in dispute within 1 year after receiving the report; or

(2) The Administration fails to reconcile the year–end report and cost report for rate–based payment systems within 1 year after receiving the report.

(j) If the Administration fails to conduct an audit of a private provider as required in subsection (h)(5) of this section, the Administration may not audit the private provider for any fiscal year that began more than 48 months before the Administration's notification of audit, unless the Administration suspects fraud or misappropriation of funds.

(k) Private providers shall provide the year–end report to the Administration no later than 6 months after the end of the State fiscal year.

(l) Private providers shall submit to the Administration:

(1) Cost reports for rate–based payment systems no later than 6 months after the end of the State fiscal year; and

(2) Wage surveys by the later of:

(i) 60 days after the last day of the pay period for which the data is requested; or

(ii) 60 days after receipt of a request from the Administration for wage survey information.

§7–306.2.

(a) The Administration shall:

(1) Conduct an independent cost–driven, rate–setting study to set provider rates for community–based services that includes a rate analysis and an

impact study that considers the actual cost of providing community–based services, including:

(i) The cost of transportation across all service types;

(ii) Appropriate wage and benefit levels for direct support and supervisory staff; and

(iii) Rates that incorporate the fiscal impact of absence days;

(2) Develop and implement a plan incorporating the findings of the rate–setting study conducted under item (1) of this subsection, including projected costs of implementation and recommendations to address any potential shortfall in funding;

(3) Develop a strategy for assessing the needs of an individual receiving services that conforms with the findings of the rate–setting study conducted under item (1) of this subsection;

(4) Provide for adequate working capital payments to providers;

(5) Develop a sound fiscal billing and payment system that is tested for adequacy and efficiency in payment of providers;

(6) Establish a payment schedule that ensures the timely and efficient reimbursement of providers for services provided; and

(7) Consult with stakeholders, including providers and individuals receiving services, in conducting the rate–setting study and developing the payment system required by this subsection.

(b) The Administration, on or before September 30, 2017, shall complete the study required under subsection (a) of this section.

(c) The Administration shall adopt regulations to implement the payment system required by this section.

§7–306.3. IN EFFECT

// EFFECTIVE UNTIL CONTINGENCY MET PER CHAPTER 648 OF 2014 //

(a) (1) Beginning in fiscal 2014, the wage survey required under § 7–306.1 of this subtitle shall be submitted by a community provider in a format that:

(i) Meets the requirements of this subsection; and

(ii) Is approved by the Department.

(2) The wage survey shall:

(i) Allow the Department to accurately assess the level of wages and benefits paid by a community provider to direct support employees who provide services funded by the Administration;

(ii) At a minimum, include:

1. The starting wage and the average wage paid by the community provider to direct support employees;

2. The expenditures made annually by the community provider for direct support employee wages;

3. The costs and expenditures for mandatory and voluntary fringe benefits; and

4. The average tenure and turnover of direct support employees; and

(iii) Include an attestation by an independent certified public accountant that the data in the wage survey is accurate.

(3) At the request of the Department, a community provider shall make available to the Department individualized payroll information for each direct support employee of the community provider.

(b) (1) (i) Except as provided in subparagraph (ii) of this paragraph, this subsection applies in fiscal year 2016 and each fiscal year thereafter before the earlier of:

1. The implementation of the payment system required under § 7–306.2 of this subtitle; or

2. The end of fiscal year 2019.

(ii) This subsection does not apply in any fiscal year in which the rate increase for community service providers is less than 3.0% over the funding

provided in the legislative appropriation for Object 08 Contractual Services Program M00M01.02 Community Services in the prior fiscal year.

(2) The percentage of a community provider's total reported operating expenses, excluding interest on capital and other capital expenses, that is spent on direct support employee salaries, wages, and fringe benefits for a fiscal year, as reported to the Department by the provider in its fiscal year cost report data form, may not be less than the percentage of the community provider's total reported operating expenses spent on direct support employee salaries, wages, and fringe benefits for the last fiscal year in which the rate increase for community service providers is less than 3.0% over the funding provided in the legislative appropriation for Object 08 Contractual Services in Program M00M01.02 Community Services in the prior fiscal year.

(3) If the Department determines that the proportion of a community provider's expenses for direct support employee salaries, wages, and fringe benefits for a fiscal year falls below the level required under paragraph (2) of this subsection, the Department shall notify the community provider of the determination in writing.

(4) A community provider shall have 45 days after receiving notice of the determination under paragraph (3) of this subsection to:

(i) Contest the determination;

(ii) Provide information to the Department demonstrating mitigating circumstances justifying the community provider's noncompliance with paragraph (2) of this subsection, which may include proof that the average wage paid to direct support employees by the community provider increased in proportion to the rate increase to the community provider for the fiscal year; or

(iii) Submit a plan of correction to the Department.

(5) The Department shall notify a community provider in writing of its final determination after affording the community provider the opportunity to contest the determination, demonstrate mitigating circumstances, or submit a plan of correction under paragraph (4) of this subsection.

(6) (i) The Department shall recoup funds from a community provider that have not been expended as required under paragraph (2) of this subsection through a reconciliation process if:

1. A community provider fails to respond to a determination of the Department within the time provided under paragraph (4) of this subsection;

2. The Department does not find mitigating circumstances; or

3. The Department does not accept a plan of correction submitted by the community provider.

(ii) The amount of funds recouped by the Department under this paragraph shall be the difference between the actual funds spent by the community provider on direct support employee salaries, wages, and fringe benefits during the fiscal year at issue and the amount of funds that the community provider was required to spend on direct support employee salaries, wages, and fringe benefits under paragraph (2) of this subsection.

(7) The Department may contract with an independent consultant to implement this subsection.

(c) (1) On or before December 1, 2015, the Department shall submit, in accordance with § 2–1257 of the State Government Article, to the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Appropriations Committee, and the House Health and Government Operations Committee a report summarizing the range of total funding spent by community providers on direct support employee salaries, wages, and fringe benefits as a percentage of total reported operating expenses, excluding interest on capital and other expenses, for fiscal year 2014.

(2) The report required under this subsection shall include an analysis of data to explain any significant outliers in spending patterns among community providers.

§7–307.

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

(2) "Community direct service worker" means an employee of a community provider that provides treatment or services to developmentally disabled individuals.

(3) "Community provider" means a community–based agency or program funded by the Administration to serve individuals with developmental disabilities.

(4) "Rate" means the reimbursement rate paid by the Department to a community provider from the State General Fund, Maryland Medical Assistance Program funds, other State or federal funds, or a combination of funds.

(b) Notwithstanding the provisions of this title or any other provision of law, the Department shall reimburse community providers as provided in this section.

(c) Subject to subsection (d) of this section, the Department shall increase the rate of reimbursement for community service providers each fiscal year by the amount of rate increase included in the State budget for that fiscal year.

(d) (1) The Governor's proposed budget for fiscal year 2019 shall include a 3.5% rate increase for community service providers over the funding provided in the legislative appropriation for Object 08 Contractual Services in Program M00M01.02 Community Services for fiscal year 2018.

(2) The Governor's proposed budget for fiscal year 2021 shall include a 4% rate increase for community service providers over the funding provided in the legislative appropriation for Object 08 Contractual Services in Program M00M01.02 Community Services for fiscal year 2020.

(3) The Governor's proposed budget for fiscal year 2022 shall include a 4% rate increase for community service providers over the funding provided in the legislative appropriation for Object 08 Contractual Services in Program M00M01.02 Community Services for fiscal year 2021.

(4) The Governor's proposed budget for fiscal year 2023 shall include a 4% rate increase for community service providers over the funding provided in the legislative appropriation for Object 08 Contractual Services in Program M00M01.02 Community Services for fiscal year 2022.

(5) The Governor's proposed budget for fiscal year 2024 shall include a 4% rate increase for community service providers over the funding provided in the legislative appropriation for Object 08 Contractual Services in Program M00M01.02 Community Services for fiscal year 2023.

(e) The Governor's proposed budget for fiscal year 2016 and thereafter for community service providers shall be presented in the same manner, including object and program information, as provided for in the fiscal year 2015 budget.

(f) A portion of the funds in subsection (e) of this section may be allocated to address the impact of an increase in the State minimum wage on wages and benefits of direct support workers employed by community providers licensed by the Developmental Disabilities Administration.

§7–308.

(a) In this section, "pilot program" means the fee–for–service payment pilot program.

(b) The Department shall establish a fee–for–service payment pilot program.

(c) A provider that provides waiver program services to individuals with a developmental disability who are eligible for services under Subtitle 4 of this title may participate in the pilot program.

(d) The Department shall:

(1) Determine and establish rates for waiver program services; and

(2) Publish the rates for waiver program services, and any subsequent changes to those rates, in regulation.

(e) (1) A provider participating in the pilot program shall submit a claim for payment to the Department on a form that the Department requires.

(2) Payment for a claim is subject to the following limitations:

(i) Payment may not be made for a claim that is received by the Department more than 1 calendar year after the date the services were provided; and

(ii) A claim that is not submitted within the time period required under item (i) of this paragraph may not be charged to the recipient of services.

(f) A provider may not knowingly submit to the Department:

(1) A false or fraudulent claim for payment; or

(2) Documentation supporting a claim that contains false information.

(g) (1) A provider that participates in the pilot program must complete and submit to the Department each year financial statements for each fiscal year that were audited by an independent certified public accountant.

(2) A provider participating in the pilot program shall submit information required by the Department, on a form approved by the Department, relating to wages and benefits paid to direct support professionals.

(3) The Department may require a provider participating in the pilot program to submit information related to the provision of services to individuals with a developmental disability as it relates to the execution of the pilot program.

(h) The Department may:

(1) Conduct an audit of any records supporting a claim for payment of a provider participating in the pilot program; and

(2) Recover overpayments from a provider.

(i) A provider participating in the pilot program shall comply with all applicable laws and regulations governing financial documentation, reporting, and other payment–related requirements for Medicaid providers.

§7–309.

(a) The Department shall ensure that providers of and individuals who receive Administration services are not adversely impacted when using the Long Term Services and Supports software system or the Electronic Visit Verification function.

(b) (1) An individual receiving Administration services who receives notice from the Department that the individual has lost eligibility to receive Maryland Medical Assistance Program services may appeal the determination.

(2) If an individual appeals a loss of eligibility within the time period required under § 42 C.F.R. 431.231, Administration services for the individual shall continue uninterrupted until the outcome of the appeal is complete.

(3) The Department shall ensure that providers of Administration services to an individual affected by a loss of eligibility are notified of the individual's loss of eligibility when notice is sent to the individual.

(4) The Department shall ensure that providers, including coordinators of community services, have the ability to automatically exchange electronic data with the Department through an application program interface with the Department's Long Term Services and Supports software system.

§7–401.

(a) The Secretary shall adopt rules and regulations that contain criteria for:

(1) Appropriate evaluations;

(2) Allocation of services; and

(3) Acceptance of individuals for services.

(b) The rules and regulations for individuals with developmental disability and for individuals without developmental disability, but who are eligible solely for individual support services, shall be separate.

§7–402.

Application for services may be made as provided in this subtitle:

(1) By the individual, if the individual is an adult; or

(2) By any other person who has a legitimate interest in the welfare of the individual.

§7–403.

(a) (1) Except as otherwise provided in this title, an applicant for services provided or funded, wholly or partly, by this State shall submit an application to the Department in writing.

(2) The application shall contain the information that the Department requires.

(b) Within 60 days after the Department receives an application for services for an individual, the Secretary, on the basis of the application, shall:

(1) Determine whether there is a reasonable likelihood that the individual:

(i) Has developmental disability; or

(ii) Does not have developmental disability, but may be eligible for individual support services under subsection (c) of this section; and

(2) If a positive determination is made under item (1)(i) or (ii) of this subsection:

(i) Approve the application;

(ii) Determine the nature of the disability;

(iii) Determine the nature of services that the individual may require;

(iv) Determine the type of environment in which any needed services could be provided with the least restriction on the liberty of the individual;

(v) Determine what types of evaluations, if any, the individual requires;

(vi) Inform the individual of these determinations; and

(vii) Inform the individual that these determinations are preliminary and may be subject to modification as a result of further evaluation.

(c) To be eligible for individual support services, an individual shall have a severe chronic disability that:

(1) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments; and

(2) Is likely to continue indefinitely.

(d) If the Secretary determines, based on the application, that the individual has a sole diagnosis of mental disorder, the Secretary shall refer the individual to the Behavioral Health Administration.

§7–404.

(a) Before an individual whose application for services has been approved by the Secretary is accepted for services, the individual is required to receive an evaluation in accordance with the rules and regulations adopted under § 7-401(a)(1) of this subtitle.

(b) The Secretary may not accept an individual for services unless the results of the evaluation are that the individual:

(1) Has developmental disability; or

(2) Does not have developmental disability, but does meet the eligibility requirements for individual support services.

(c) (1) From among the individuals whose applications for services have been approved and who have been found eligible for services as a result of the required evaluation, the Secretary shall determine in accordance with the rules and regulations adopted under § 7-401(a)(2) and (3) of this subtitle the nature, extent, and timing of the services to be provided to individuals.

(2) In making a determination under paragraph (1) of this subsection, the Secretary shall consider:

(i) The results of the required evaluation;

(ii) The needs of the individual; and

(iii) The needs of the family unit of the applicant.

§7–404.1.

(a) In this section, "legal resident" means an individual who maintains the State as the individual's principal establishment, home of record, or permanent home and to where, whenever absent due to uniformed services obligation, the individual intends to return.

(b) A dependent of a legal resident of the State who is determined eligible to receive services from the Administration under this title shall retain eligibility for the services:

(1) Regardless of whether the legal resident leaves the State due to the legal resident's uniformed services assignment outside the State; and

(2) If the dependent is otherwise eligible for the services.

(c) If a dependent of a legal resident is on a waiting list for services to be provided under this title, the Administration shall allow the dependent to remain on the waiting list for services while the legal resident is outside the State due to the legal resident's uniformed services assignment outside the State.

(d) The Administration shall reinstate services provided under this title to a dependent of a legal resident who resides with the legal resident while the legal resident is outside the State due to the legal resident's uniformed services assignment outside the State:

(1) On the relocation of the dependent to the State; and

(2) If a request for services is made.

§7–404.2. NOT IN EFFECT

** TAKES EFFECT JULY 1, 2027 PER CHAPTER 184 OF 2026 **

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

(2) "Dependent" means an individual with disabilities who:

(i) Relies on support from an immediate family member who is a resident of the State; or

(ii) Has an immediate family member who is a resident of the State and acts as the individual's legal guardian.

(3) "Immediate family member" means a spouse, a parent, an adoptive parent, a stepparent, a grandparent, a stepgrandparent, a sibling, a stepsibling, a child, or a stepchild.

(b) The Department shall provide an expedited Medicaid eligibility determination for developmental disabilities services for purposes of enrollment in the Community Pathways waiver to an individual if:

(1) The individual:

(i) Is a dependent;

(ii) Received home– and community–based waiver services or similar services under a similar assistance program in another state for the immediately preceding 10 years; and

(iii) Moved to the State to live with the immediate family member on the death or incapacitation of the individual's caretaker in the other state; and

(2) The immediate family member on whom the individual is dependent has resided in the State for the immediately preceding 2 years.

(c) (1) In providing expedited eligibility determinations under subsection (b) of this section, the Department shall:

(i) Prioritize completed applications for review on receipt;

(ii) To the extent authorized by law, rely on documentation, diagnostic evaluations, eligibility determinations from the individual's previous state of residence, and any other documentation that the Department relies on when making other determinations under this title; and

(iii) Complete each expedited eligibility determination within 60 business days after the receipt of a complete application.

(2) In providing an expedited eligibility determination under subsection (b) of this section, the Department may not waive substantive eligibility requirements established under this title or requirements established by regulation for the assignment of a service priority category.

(d) If an individual has been determined under this section to be eligible to receive services, the individual shall be:

(1) Placed in the crisis resolution category; and

(2) Given access to waiver services through the most appropriate reserve category as determined based on the services the individual received in the individual's previous state of residence.

(e) If the Department determines that an individual who has not yet established residency in the State meets the criteria established under subsection (b)(1)(i) and (ii) and (2) of this section, the Department shall determine whether the individual has a developmental disability as defined under § 7–101(g) of this title.

§7–405.

(a) Acceptance for services under this title does not affect an individual's eligibility for services provided by any other public or private agencies.

(b) If the Secretary determines that an individual who is eligible for services under this title also may be eligible for services provided by another agency, the Secretary shall refer the individual to that agency.

§7–406.

(a) The Secretary shall provide notice and an opportunity for a Medicaid fair hearing in accordance with Title 10, Subtitle 2 of the State Government Article and federal Medicaid law to:

(1) An applicant for Administration Medicaid waiver services who is denied eligibility for the services;

(2) An applicant for Administration Medicaid waiver services who contests the priority category assigned to the applicant for the services; and

(3) A recipient of Administration Medicaid waiver services:

(i) Whose claim for Administration Medicaid waiver services is denied or is not acted on with reasonable promptness; or

(ii) Who believes the Administration has taken an action erroneously.

(b) (1) Except as provided in subsection (a) of this section, an applicant for services or a recipient of services under this title may:

(i) Request an informal hearing before the Secretary's designee on any action or inaction of the Secretary made under this title; and

(ii) Request the Secretary to review the decision of the informal hearing.

(2) After the Secretary receives a request for a review, the Secretary shall conduct the review in accordance with Title 10, Subtitle 2 of the State Government Article.

§7–407.

Any person aggrieved by a final decision of the Secretary in a contested case, as defined in § 10-202 of the State Government Article, may take an appeal as allowed in §§ 10-222 and 10-223 of the State Government Article.

§7–408.

(a) The Administration, in consultation with stakeholders, shall establish and provide training materials to coordinators of community services specifically on the self–directed services model of receiving services, including training materials on self–directed services, procedures, policies, and resources.

(b) As part of the process of developing a person–centered plan of service for a recipient, a coordinator of community services shall educate the recipient on all models of service available to the recipient, including self–directed services, traditional services, and provider–managed services, to assist the recipient and the

recipient's family or representative in making an informed choice on which services the recipient would like to receive:

(1) When the individual begins receiving services from a coordinator of community services; and

(2) At least once each year that the individual is receiving services from a coordinator of community services.

(c) A coordinator of community services shall report to the Administration, in the form and manner required by the Administration, that the coordinator provided information on self–directed services, traditional services, and provider–managed services to an individual in accordance with this section.

§7–409.

(a) The Administration shall provide to a recipient who receives self–directed services:

(1) Individual–directed and family–directed goods and services in an amount based on the recipient's needs and included in the recipient's person–centered plan of service as calculated:

(i) On an annual basis; and

(ii) Within the limits of the approved annual budget generated by the Department's Long Term Services and Supports software system or its replacement system;

(2) Access to the recipient's plan of service and budgets for the plan of service through the Department's Long Term Services and Supports software system or its replacement system;

(3) Up to 30 hours of support broker services each month, as needed by the recipient and within the recipient's total approved annual budget;

(4) An option for a family member or legal guardian of the recipient to provide services for the recipient, if:

(i) The recipient or an individual authorized to make care decisions on behalf of the recipient chooses the family member to provide the services; and

(ii) The recipient also hires a support broker;

(5) Reimbursement paid on a per–mile basis to the owner of a specialized, modified, or accessible vehicle driven by an employee of the recipient and for the purpose of the recipient engaging in activities specified in the recipient's person–centered plan of service;

(6) A budget for self–directed services that provides the ability to use funds from the recipient's approved annual budget for the purpose of funding at least one position to assist the recipient in managing the recipient's home, staff, and other administrative duties and pay administrative expenses needed to operate the recipient's plan of service, including Internet service and office equipment;

(7) An option for a recipient who has a demonstrated need for overnight supports provided through personal support services carried out using the recipient's employer or budget authority to direct and choose the employee, vendor, or provider of the overnight supports;

(8) The choice of a vendor to provide fiscal management services from at least three options;

(9) The option to employ a representative, support broker, or team of individuals to support the recipient in directing services; and

(10) Training for a representative, support broker, or team of individuals on self–directed services.

(b) Subject to subsection (a)(3) of this section, the Administration shall provide to a recipient of self–directed services any support broker services that are:

(1) Authorized by regulations adopted or guidance issued by the Centers for Medicare and Medicaid Services in § 1915(c) of the Social Security Act; and

(2) Selected by the recipient.

(c) (1) Subject to paragraph (2) of this subsection, the Administration may not establish a limit on the number of hours of personal support services provided to a recipient who receives self–directed services that:

(i) Are necessary for the health and safety of the recipient; and

(ii) Are authorized by regulations adopted or guidance issued by the federal Centers for Medicare and Medicaid Services under § 1915(c) of the Social Security Act.

(2) A recipient may not receive services or supports in excess of the recipient's annual approved budget.

(d) The State may not require a recipient to demonstrate competency before the Administration authorizes the recipient to receive self–direct services.

§7–410.

(a) The Administration shall provide up to 30 hours of support broker services each month to a recipient of waiver services, as needed by the recipient and within the recipient's total approved annual budget.

(b) Subject to subsection (a) of this section, the Administration shall provide to a recipient of waiver services any support broker services that are authorized by regulations adopted or guidance issued by the Centers for Medicare and Medicaid Services under § 1915(c) of the Social Security Act.

§7–501.

(a) There are State residential centers for individuals with an intellectual disability in the Developmental Disabilities Administration.

(b) The Deputy Secretary shall appoint an administrative head for each State residential center.

(c) Each State residential center shall:

(1) Establish and implement a safety plan for the safety of the individuals served by the State residential center; and

(2) Revise the safety plan not less than every 5 years.

(d) A State residential center may satisfy the requirement under subsection (c) of this section by implementing a safety or emergency plan established for the center for another purpose.

§7–502.

(a) The Secretary shall approve the admission of an individual to a State residential center only if:

(1) The findings of the evaluation are that the individual:

(i) Has an intellectual disability; and

(ii) For adequate habilitation, needs residential services; and

(2) There is no less restrictive setting in which the needed services can be provided and that is available to the individual or will be available to the individual within a reasonable time.

(b) The Secretary may not approve the admission of an individual to a State residential center if:

(1) The findings of the evaluation are that the individual:

(i) Does not have an intellectual disability; or

(ii) Has an intellectual disability but does not need residential services for adequate habilitation; or

(2) There is a less restrictive setting in which the needed services can be provided that is available to the individual or will be available to the individual within a reasonable time.

(c) The Secretary shall provide an individual with the appropriate least restrictive service consistent with the individual's welfare, safety, and plan of habilitation, if the individual:

(1) Has an application for services that has been approved under § 7–404(c) of this title; or

(2) Is considered eligible for transfer under Subtitle 8 of this title by the Deputy Secretary or the Deputy Secretary's designee.

§7–503.

(a) Within 21 days after the admission of an individual to a State residential center, a hearing officer of the Department shall hold a hearing on the admission in accordance with the rules and regulations that the Secretary adopts.

(b) Written notice of the admission of an individual and of the date, time, and place of the individual's hearing on admission shall be given:

(1) On admission, to the individual; and

(2) As soon as possible, but not later than 5 days after the admission, to legal counsel for the individual and to the proponent of admission.

(c) The notice also shall state:

(1) The name of each proponent of the admission;

(2) The right of the individual who has been admitted:

(i) To consult with and be represented by a lawyer; and

(ii) To call witnesses and offer evidence at the hearing on admission;

(3) The availability of the services of the legal aid bureaus, lawyer referral services, and other agencies that exist for the referral of individuals who need legal counsel;

(4) The rights of individuals with developmental disability under Subtitle 10 and § 7–1102 of this title; and

(5) The rights of individuals to release under §§ 7–506, 7–507, and 7–508 of this subtitle.

(d) The Department shall prepare and provide each State residential center with standard forms that set forth, in clear and simple words, the notice provisions of this section.

(e) (1) At the hearing, in order to certify the admission of the individual, it must be affirmatively shown by clear and convincing evidence that the conclusions leading to the decision to admit the individual are supported by the following findings:

(i) The individual has an intellectual disability;

(ii) The individual needs residential services for the individual's adequate habilitation; and

(iii) There is no less restrictive setting in which the needed services can be provided that is available to the individual or will be available to the individual within a reasonable time after the hearing.

(2) If the hearing officer shall find from the admissible evidence that the conclusions leading to the admission are not proved, the hearing officer shall so certify and the individual shall be released from the State residential center.

(3) If the hearing officer shall find from clear and convincing evidence that all of the admission requirements have been proved, the hearing officer shall so certify and the individual's admission shall be considered approved.

(4) If the hearing officer certifies the admission of an individual to a State residential center, the hearing officer shall, at the conclusion of the hearing, write on the certification form any additional services of habilitation that are not included in the evaluation report, but that the hearing officer finds from the evidence are needed by the individual.

(5) If the hearing officer certifies the admission of an individual to a State residential center, the hearing officer shall, at the conclusion of the hearing, advise that individual and the legal counsel of the individual's right to seek judicial release from the State residential center under § 7–507 of this subtitle. The hearing officer shall also advise that individual and the legal counsel of:

(i) The individual's rights under the appeal provisions of §§ 10–222 and 10–223 of the State Government Article; and

(ii) The individual's right to file a petition for habeas corpus under § 7–506 of this subtitle.

§7–504.

The determination of a hearing officer on an admission under this subtitle is a final decision of the Department for the purpose of judicial review of final decisions under Title 10, Subtitle 2 of the State Government Article.

§7–505.

(a) At least once a year, each individual with an intellectual disability who is admitted to a State residential center shall be reevaluated to determine:

(1) Whether the individual continues to meet the requirements of this subtitle for admission to a State residential center;

(2) Whether the services which the individual requires can be provided in a less restrictive setting;

(3) Whether the individual's plan of habilitation as required by § 7–1006 of this title is adequate and suitable; and

(4) Whether the State residential center has complied with and executed the individual's plan of habilitation in accordance with the rules, regulations, and standards that the Secretary adopts.

(b) If the Secretary finds that any individual no longer meets the admission requirements of this subtitle, the Secretary shall begin appropriate proceedings for release or transfer of that individual.

§7–506.

Any individual who has been admitted to a State residential center or any person on behalf of the individual may apply at any time to a court of competent jurisdiction for a writ of habeas corpus to determine the cause and the legality of the detention.

§7–507.

(a) Subject to the limitations in this section, a petition for the release of an individual who is held under this subtitle from a State residential center may be filed, at any time, by:

(1) The individual; or

(2) Any person who has a legitimate interest in the welfare of the individual.

(b) The petition shall be filed in a circuit court for the county:

(1) Where the individual resides or resided at the time of the admission; or

(2) Where the State residential center is located.

(c) The Administration shall be the respondent in a petition under this section.

(d) The petition shall be in the form and contain the information that the Maryland Rules require.

(e) If the petitioner requests trial by jury, the trial shall be held with a jury as in a civil action at law.

(f) The trier of fact shall determine:

(1) Whether the individual has an intellectual disability;

(2) Whether for adequate habilitation, the individual needs residential services; and

(3) Whether there is a less restrictive setting in which the needed services can be provided that is available to the individual or will be available to the individual within a reasonable time.

(g) (1) The court shall remand the individual to the custody of the State residential center, if the trier of fact determines that:

(i) The individual has an intellectual disability;

(ii) For adequate habilitation the individual needs residential services; and

(iii) There is no less restrictive setting in which those services needed can be provided and which is available to the individual or will be available to the individual within a reasonable time.

(2) The court shall order that appropriate less restrictive services be offered to an individual, if the trier of fact determines that:

(i) The individual has an intellectual disability;

(ii) For adequate habilitation the individual needs residential services; and

(iii) There is a less restrictive setting in which the service can be provided, and which from evidence submitted by the Director is available or will be available to the individual within a reasonable time.

(3) The individual shall be released from the State residential center, if the trier of fact determines that:

(i) The individual does not have an intellectual disability;

(ii) For adequate habilitation the individual does not need residential services; or

(iii) There is a less restrictive setting in which the needed services can be provided that is available to the individual or will be available to the individual within a reasonable time.

(h) Any party may appeal from a decision on the petition as in any other civil case.

(i) Appropriate records of the proceeding under this section shall be made a permanent part of the individual's record.

(j) (1) After a determination on the merits of a petition under this section, a court may not hear a later petition for the individual within 1 year after that determination, unless:

(i) The petition is verified, and alleges an improvement in the condition of the individual with an intellectual disability after the determination; and

(ii) The court, after review of the verified petition, determines that the matter should be reopened.

(2) If the matter is reopened, the petition shall be heard as provided in this section.

§7–508.

(a) At the direction of the Secretary, an individual who has been admitted under this subtitle shall be released from a State residential center if:

(1) The individual is not an individual with an intellectual disability;

(2) The individual is an individual with an intellectual disability but does not need residential services; or

(3) There is an available, less restrictive kind of service that is consistent with the welfare and safety of the individual.

(b) (1) At the direction of the Secretary, any individual who has been admitted under this subtitle may be released conditionally from a State residential center for individuals with an intellectual disability, if, in the judgment of the Secretary, the individual:

(i) Would be cared for properly by the individual or another person; and

(ii) Would not endanger the individual or the person or property of another.

(2) The Secretary may set the conditions for release that the Secretary considers reasonable. The conditions may relate to:

(i) The duration of the release;

(ii) Treatment during release; or

(iii) Placement under supervised care in an approved setting.

(3) An individual with an intellectual disability released conditionally is considered to be held by the State residential center from which the individual was released.

(c) Each determination of any release of an individual, whether full or conditional, including a summary of the reasons for the determination, shall be made a permanent part of the individual's record.

§7–509.

(a) In this section, "respite care" means care that is made available for an individual with an intellectual disability in a State residential center to provide relief for the person with whom the individual ordinarily lives.

(b) Under regulations that the Department adopts, each State residential center shall reserve at least 2 percent, but not more than 4 percent, of its total beds for respite care.

(c) Respite care for an individual may not exceed 45 days within any 1–year period or 28 consecutive days.

§7–510.

In Part II of this subtitle, "board" means a citizens' advisory board for a State residential center.

§7–511.

There is a citizens' advisory board for each State residential center.

§7–512.

(a) (1) Each board consists of 7 members appointed by the Governor.

(2) The board for each State residential center shall reflect adequately the composition of the community that the State residential center serves.

(3) Of the 7 members of the board for a State residential center:

(i) At least 2 shall be parents or other relatives or guardians of residents of that State residential center; and

(ii) Each of the others shall be individuals who:

1. Are known for their interest in civic and public affairs; and

2. Have expressed an active interest in the care of individuals with an intellectual disability, or generally in intellectual disability endeavors.

(4) The Governor shall appoint the members from a list of qualified individuals submitted to the Governor by the Secretary. The number of names on the list shall be at least twice the number of vacancies.

(b) Each member of the board for a State residential center shall be a resident of the region that the State residential center serves.

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

(2) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(4) A member who serves 2 consecutive full 4-year terms may not be reappointed for 4 years after the completion of those terms.

§7–513.

(a) From among its members, each board shall elect a chairperson and other officers that the board considers necessary.

(b) The manner of election of officers and their terms of office shall be as the board determines.

§7–514.

(a) Each board shall meet at least 4 times a year, at the times and places that it determines.

(b) A member of a board:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§7–515.

(a) Each board may adopt regulations for the conduct of its meetings.

(b) (1) Each board serves in an advisory capacity.

(2) Each board shall:

(i) Submit to the Secretary an annual report on:

1. The needs of individuals with an intellectual disability; and

2. The extent to which its State residential center meets these needs;

(ii) Advise the administrative head of the State residential center on its goals, programs, and policies;

(iii) Help in evaluating the degree to which these goals are achieved;

(iv) Review and make recommendations about the annual budget of the State residential center;

(v) Assume leadership in developing community understanding of the needs of individuals with an intellectual disability; and

(vi) Carry out any other responsibility that the administrative head of the State residential center requests.

§7–516.

The administrative head for each State residential center may appoint any employee as a law–enforcement officer and, while the employee holds a special police commission issued by the Governor, the employee may:

(1) Return an individual with an intellectual disability to the State residential center from which the individual has left without approved leave; and

(2) Be used to protect individuals or property at the State residential center.

§7–517.

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

(2) "ICF–ID income" means all revenues received by an ICF–ID from any source providing ICF–ID services to residents of the facility.

(3) "Intermediate care facility for individuals with an intellectual disability (ICF–ID)" means a State residential center for individuals with an intellectual disability.

(b) (1) Each ICF–ID operating in Maryland is subject to an assessment of 6% of all ICF–ID income.

(2) The assessment required by this section shall:

(i) Be paid by each ICF–ID in accordance with this section; or

(ii) Terminate if the assessment is not permissible under Section 1903(w) of the Social Security Act.

(c) On or before the 15th day of each quarter of the State fiscal year, each ICF–ID shall pay to the Department 6% of the ICF–ID income received during the previous fiscal quarter.

(d) For fiscal year 2004, the assessment required by this section shall be paid on or before June 20, 2004, based on the ICF–ID income received during the period from April 1, 2003, through March 31, 2004.

(e) The Department may adopt regulations to implement this section.

§7–601.

There are community-based residential programs that provide residential services in public group homes, private group homes, and alternative living units.

§7–602.

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

(b) "Private group home" means a group home that is not a public group home, whether or not public funds are used to finance, wholly or partly, the acquisition, construction, improvement, rehabilitation, maintenance, or operation of the group home.

(c) "Public group home" means a group home that is owned by or leased to the State or a political subdivision of the State, whether or not this group home is maintained and operated by a private, nonprofit person.

§7–603.

(a) This section applies only to public group homes, nonprofit private group homes, and alternative living units.

(b) (1) To avoid discrimination in housing and to afford a natural, residential setting, a group home or an alternative living unit for individuals with developmental disability:

(i) Is deemed conclusively a single-family dwelling;

(ii) Is permitted to locate in all residential zones; and

(iii) May not be subject to any special exception, conditional use permit, or procedure that differs from that required for a single-family dwelling.

(2) The provision of separately identified living quarters for staff may not affect the conclusive designation as a single-family dwelling under paragraph (1)(i) of this subsection.

(3) A general zoning ordinance, rule, or regulation of any political subdivision that conflicts with the provisions of this section or any rule or any regulation that carries out the purpose of this section is superseded by this section to the extent of any conflict.

§7–604.

(a) The Secretary shall, in accordance with the State plan established under Subtitle 3 of this title, determine the need, if any, for one or more public group homes for individuals with developmental disability in each county or multicounty region of the State.

(b) In making the determination, the Secretary shall consult with the following:

(1) The governing body of each county;

(2) The State Board of Education;

(3) County boards of education;

(4) Consumer groups; and

(5) Other public and private agencies.

(c) The part of the State plan that relates to the need for public group homes shall be sent to each county.

§7–605.

(a) (1) If the Secretary certifies that a public group home is needed in a county or multicounty region, the county or counties of the region, in consultation with the local consumer groups, promptly shall choose a site that meets the requirements of the State plan.

(2) Before submitting a proposed site to the Secretary, the governing body of the county where the site is located shall hold at least 1 public hearing in that county.

(b) The Secretary shall cooperate with and help the county or counties to choose a suitable site.

(c) If within 6 months after the Secretary certifies a need for a public group home, a suitable site is not submitted to the Secretary, the Secretary shall declare the county or counties to be in default. However, for good cause shown, the Secretary may extend the 6-month period not more than another 3 months.

(d) Within 3 months after the default by a county or counties, the Secretary shall:

(1) Choose a suitable site; and

(2) After holding a public hearing in the county where the site is located, recommend the site to the Board of Public Works.

§7–606.

(a) (1) If the Board of Public Works approves the site that has been chosen by the Secretary, on a default by a county or counties, the State may:

(i) Acquire the site by lease or purchase, condemnation, or otherwise; and

(ii) Renovate a building or build a public group home that meets the requirements of:

1. The State plan;

2. The regulations issued under § 7–904 of this title relating to community–based residential services; and

3. The program accessibility requirements of the federal regulations (45 C.F.R. §§ 84.21 through 84.23).

(2) Before acquiring the site, the Secretary shall give the governing body for the county where the site is located and the community around the site notice of the intention of the State to acquire and improve the site.

(b) Each public group home that is acquired under this section shall be operated by:

(1) A private, nonprofit person, on terms and conditions as the Secretary approves; or

(2) The State as a provider of last resort on an interim basis until a suitable private operator can be found.

§7–607.

The Secretary shall adopt rules and regulations for issuing certificates of approval for private group homes.

§7–608.

In addition to holding a license required under Subtitle 9 of this title or any other license required by law, a person shall obtain a certificate of approval from the Secretary before the person may establish a private group home.

§7–609.

To qualify for a certificate of approval, an applicant shall satisfy the Secretary that:

(1) The proposed private group home is consistent with the State plan;

(2) The applicant is a proper person to receive a certificate of approval;

(3) The proposed private group home is appropriate for the stated purpose;

(4) The proposed private group home meets or, on completion, will meet the licensing requirements of Subtitle 9 of this title;

(5) The proposed private group home meets or, on completion, will meet all of the general zoning requirements that apply to the site and that relate to:

(i) The height and size of any buildings that are involved;

(ii) The land that may be covered or occupied;

(iii) The open space requirements;

(iv) The density requirements; and

(v) The use of any land or buildings; and

(6) The applicant's facilities meet the federal regulation requirements on program accessibility (45 C.F.R. §§ 84.21 through 84.23).

§7–610.

(a) An applicant for certificate of approval shall submit an application to the Department on the form that the Secretary requires.

(b) The application shall:

(1) Be signed and verified by the applicant; and

(2) Provide the information that the Secretary requires, including:

(i) The name and address of the applicant;

(ii) The street address of the property where the private group home is to be located or, if no address, a description which identifies the property;

(iii) If the applicant does not own the property, the name of the owner;

(iv) A statement that the applicant will comply with the laws, rules, and regulations that relate to the establishing and operating of private group homes under this subtitle;

(v) A statement that the applicant has sufficient resources to establish a private group home, or that those resources are available to the applicant;

(vi) A statement that the applicant's facilities meet the federal regulation requirements on program accessibility (45 C.F.R. §§ 84.21 through 84.23); and

(vii) A statement that the applicant will:

1. Establish and implement a safety plan for the safety of individuals served by the private group home; or

2. Implement a safety or emergency plan established for the private group home for another purpose.

§7–611.

(a) When an application for certificate of approval is filed, the Department shall have an investigation made of:

(1) The applicant;

(2) The private group home for which approval is sought;

(3) The facts stated in the application;

(4) The number of other group homes or alternative living units in the neighborhood;

(5) The public utilities and services available; and

(6) The access to transportation, shopping and recreational facilities, and health-related services.

(b) When an application for certificate of approval is filed, the Secretary shall hold a public hearing on the application.

(c) (1) The Secretary shall publish a notice of the hearing within 60 days of receipt of the completed application.

(2) The notice shall state:

(i) The name of the applicant;

(ii) The type of approval that is sought;

(iii) The location of the proposed private group home; and

(iv) The time and place that the Secretary sets for the hearing, which shall be at least 7 but not more than 15 days after the last publication of the notice.

(d) The notice shall be published at least twice in 1 week:

(1) In 2 newspapers published in the county where the private group home is to be located;

(2) If only 1 newspaper is published in that county, in that newspaper; or

(3) If a newspaper is not published in that county, any newspaper with substantial circulation in that county.

§7–612.

(a) The Secretary shall issue a certificate of approval to any applicant who meets the requirements under this Part III of this subtitle.

(b) Unless an applicant agrees to extend the time, the Secretary shall approve or deny an application for certificate of approval within 30 days after the hearing required by § 7-611 of this subtitle.

(c) If the Secretary fails to approve or deny the application within that time, the application shall be deemed to be approved, and the Administration shall issue a certificate of approval.

§7–701.

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

(b) "Eligible child" means an individual with developmental disability under the age of 22 years who is:

(1) In an out-of-home placement; or

(2) At immediate risk of out-of-home placement.

(c) (1) "Family" means an eligible child's natural, adoptive, or foster parents.

(2) "Family" includes:

(i) A guardian;

(ii) A person acting as a parent of a child; or

(iii) A relative or stepparent with whom a child lives.

(d) (1) "Family support services" means a program designed to enable a family to provide for the needs of a child with developmental disability living in the home.

(2) "Family support services" includes:

(i) Individual and family counseling;

(ii) Personal care;

(iii) Day care;

(iv) Specialized equipment;

(v) Health services;

(vi) Respite care;

(vii) Housing adaptations;

(viii) Transportation; and

(ix) Other necessary services.

(e) "Program" means the Family Support Services Program.

§7–702.

(a) The General Assembly finds and declares that:

(1) There are over 2,500 disabled children placed outside of their homes by State agencies;

(2) Because of a lack of support services within the community, families are often forced to place their disabled children outside the home and excessive costs are associated with certain residential placements;

(3) The family support services project sponsored by the Maryland State Planning Council on Developmental Disabilities has demonstrated that disabled children can be returned to the community and new residential placements prevented when support services for families are available;

(4) Family support services enable families to provide for the needs of their disabled children in the least restrictive setting; and

(5) Maintaining disabled children with their families has been demonstrated to be cost effective.

(b) The General Assembly declares that it is the policy of this State to enhance the quality of life for children with developmental disability and their families, to preserve family unity, and to promote family stability by:

(1) Providing essential family support services to assist families in caring for children with developmental disability in the home; and

(2) Diminishing the use of residential placements for children with developmental disability.

§7–703.

(a) (1) There is a Family Support Services Program.

(2) The Administration shall contract with private nonprofit community-based organizations for the provision of family support services in each county of the State.

(3) The Administration shall base the amount of a grant to a county upon the needs of the eligible families in each locality in accordance with the data available through the Family Support Services Consortium Project for localities of comparable size.

(b) The Administration shall implement a sliding payment scale for reimbursement from families financially able to pay for all or part of the services under the Program.

(c) (1) Before using Program funds, the Program shall coordinate and assist any eligible child and family in receiving services available under existing programs including:

(i) Respite care under Title 7, Subtitle 2 of the Human Services Article;

(ii) Day care services;

(iii) Homemaker services;

(iv) Personal care;

(v) Services to families with children under § 4–402 of the Family Law Article;

(vi) Children's medical services under § 15–125 of this article;

(vii) Attendant care services under Title 7, Subtitle 4 of the Human Services Article; and

(viii) Other applicable federal and local programs.

(2) The Program shall assist in providing family support services that are not otherwise available.

§7–704.

(a) Beginning July 1, 1986 and each fiscal year thereafter, the Secretary shall request budget support that is sufficient to operate the Program and shall

continue to provide family support services at least for the level in effect on June 30, 1986.

(b) (1) The Secretary shall request budget support that is sufficient to operate the family support services project initiated by the Maryland State Planning Council on Developmental Disabilities and serving Baltimore County and Anne Arundel County by July 1, 1988, and shall assume financial responsibility to the extent that funds are provided by the Governor in the budget.

(2) By July 1, 1990, the Secretary shall request budget support sufficient to provide family support services in every county of the State and Baltimore City. The Department shall assume financial responsibility for the Program to the extent that funds are provided in the budget by the Governor.

§7–705.

For day habilitation and vocational services, the Administration shall also use local funds. The local funds shall be limited to the amount paid by each jurisdiction in fiscal year 1984.

§7–706.

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

(b) "Eligible person" means an individual with a developmental disability that is likely to continue indefinitely or an individual with a severe chronic disability that is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments that is likely to continue indefinitely.

(c) (1) "Individual support services" means a program designed to assist eligible persons in developing their maximum potential and in maintaining themselves in the community.

(2) "Individual support services" includes:

(i) Identification services;

(ii) Training and support for self–advocacy;

(iii) Therapeutic services;

(iv) Individual and family counseling;

(v) Medical equipment purchase, rental, and repair;

(vi) Crisis intervention and follow–up;

(vii) Attendant care;

(viii) Respite services;

(ix) Barrier removal;

(x) Transportation assistance;

(xi) Community integration services;

(xii) Employment related services; and

(xiii) Other services to maximize independence, productivity, and integration within the community.

(d) "Program" means the Individual Support Services Program.

§7–707.

(a) The General Assembly finds and declares that:

(1) Persons with disabilities should be afforded the opportunity to achieve their maximum potential through increased independence, productivity, and integration into the community.

(2) Services provided to persons with disabilities should be provided within a natural home setting in a manner that is responsive to the person's needs and does not overly intrude into the person's life.

(3) Individual support services are flexible, creative services provided in accordance with unique individual needs.

(4) Individual support services promote the development of the individual's inner strengths and encourage informal support networks consisting of family, friends, and the community.

(5) The provision of individual support services is cost effective because reliance upon more expensive day and residential services is diminished.

(6) Although the focus of the Individual Support Services Program is upon the adult with a disability, the provision of individual support services may begin with young adults in adolescence.

(b) The General Assembly declares that it is the policy of this State to promote the independence, productivity, and integration within the community for individuals with severe disabilities by providing an array of individual support services.

§7–708.

(a) There is an Individual Support Services Program.

(b) The Administration shall enter into grant agreements for the provision of individual support services in all counties of the State.

(c) Eligible persons selected for services by the Administration shall be informed of individual support services and encouraged to use them, as appropriate, prior to being offered full day or residential services.

§7–709.

(a) In this Part IV the following words have the meanings indicated.

(b) (1) "Community supported living arrangements services" means services to assist an individual with developmental disabilities in activities of daily living necessary to permit the individual to live in the individual's own home, apartment, family home, or rental unit with no more than 2 other individuals who are recipients of these services.

(2) "Community supported living arrangements services" includes:

(i) Personal assistance;

(ii) Training and habilitation services necessary to assist the individual in achieving increased integration, independence, and productivity;

(iii) 24–hour emergency assistance;

(iv) Assistive technology;

(v) Adaptive equipment;

(vi) Support services necessary to enable the individual to participate in community activities;

(vii) Case management services; and

(viii) Other services, as approved by the Secretary.

(c) "Eligible individual" means an individual who:

(1) Has a developmental disability as defined in § 7–101(g) of this title; or

(2) Is eligible only for individual support services, as provided in § 7–403(c) of this title.

(d) "Program" means the Community Supported Living Arrangements Services Program.

(e) "Support services" means individual support services and family support services as defined in this title.

§7–710.

(a) The General Assembly finds and declares that:

(1) The Developmental Disabilities Administration has funded individuals with developmental disabilities in successful residential programs in the communities of the State;

(2) Recipients of services are capable and eager to determine the services and homes they desire to a greater degree than allowed under the present system;

(3) Currently, to obtain residential service, individuals with developmental disabilities must fit into "slots" available in existing service delivery systems, rather than being supported in their own homes;

(4) Support services can be tailored to the needs of individuals with developmental disabilities, regardless of the nature or severity of their disability, to enable them to live in homes of their own choosing that may include homes owned or rented by the recipient or supplied by parents, relatives, or trusts; and

(5) The provision of community supported living arrangements services promotes the integration and independence of individuals with developmental disabilities and enhances their quality of life.

(b) The General Assembly declares that it is the policy of the State to promote the integration and independence of individuals with developmental disabilities and to enhance the quality of life of these individuals by:

(1) Providing essential community supported living arrangements services to eligible individuals to enable them to:

(i) Receive services from providers of their own choosing; and

(ii) Live in their own home or homes of their own choosing in their own community;

(2) Making community supported living arrangements services available to eligible individuals no matter how severe or profound their disability may be; and

(3) Tailoring community supported living arrangements services to the needs of the individual recipients, rather than requiring individuals to fit into a preexisting residential service delivery system.

§7–711.

(a) The Secretary shall adopt regulations for the licensing of persons who provide community supported living arrangements services to eligible individuals that include standards for:

(1) Licensing providers that include grievance procedures for recipients of community supported living arrangements services; and

(2) The inspection of licensees at least once each year.

(b) The regulations shall ensure that community supported living arrangements services to an eligible individual are provided in accordance with an individual support plan as required by regulation.

§7–712.

(a) The Secretary shall establish and implement a Quality Assurance Program for the Community Supported Living Arrangements Services Program.

(b) The Quality Assurance Program shall include:

(1) A system of external monitoring of providers of community supported living arrangements services by recipients, family members, and other interested parties that focuses on the recipient's quality of life;

(2) Reporting procedures to make information available to the public as required by federal regulations; and

(3) Provisions for the ongoing monitoring of the health and well-being of each recipient.

(c) Any State plan amendment affecting the State Medical Assistance Program regarding community supported living arrangements services, including the Quality Assurance Program, shall be reviewed by the Maryland Developmental Disabilities Council and the Maryland Disability Law Center.

§7–713.

(a) The Secretary shall develop a plan for community supported living arrangements services that addresses:

(1) How services will be structured to meet the needs and preferences of eligible individuals;

(2) The number of eligible individuals estimated to need services and the number of individuals actually provided services sufficient to meet their needs under the Program;

(3) A recipient-based evaluation system on which to base individual and State policy changes to the Program that includes recipient satisfaction with provided services;

(4) Technical assistance and information on how to access and to utilize the Program to recipients, family members of recipients, advocacy organizations, and other interested persons; and

(5) Technical assistance and information to service providers on how to structure services to meet the needs and preferences of recipients.

(b) Community advocacy and provider organizations shall be involved in the development of the State plan for community supported living arrangements services.

(c) In order to offer eligible individuals creative housing alternatives, the Administration shall include in the State plan for community supported living arrangements services a provision for collaboration with the Department of Housing and Community Development and other appropriate agencies and organizations.

(d) (1) In addition to any other provisions required under this section, the State plan for community supported living arrangements services shall provide, to the extent that funds are available, that the first 500 individuals to receive community supported living arrangements services shall be:

(i) Eligible individuals who have applied for community-based residential or support services under this title and are not currently receiving these services; or

(ii) In equal numbers, eligible individuals who are currently receiving residential services and eligible individuals who have applied for community residential or support services and are not currently receiving these services.

(2) After the first 500 individuals have received community supported living arrangements services under paragraph (1) of this subsection, to determine the distribution of available funds, the Secretary shall review:

(i) The needs of eligible individuals who have applied for community-based residential or support services under this title and are not receiving these services; and

(ii) The needs of eligible individuals currently receiving community-based residential or support services.

§7–714.

By December 31, 1991, the Secretary shall adopt regulations necessary to implement the provisions of this part.

§7–717.

(a) (1) In this part, "low intensity support services" means a program designed to:

(i) Enable a family to provide for the needs of a child or an adult who is living in the home and has a severe chronic disability that:

1. Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of physical and mental impairments; and

2. Is likely to continue indefinitely; or

(ii) Support an adult who is living in the community and has a severe chronic disability that:

1. Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of physical and mental impairments; and

2. Is likely to continue indefinitely.

(2) "Low intensity support services" includes the services and items listed in §§ 7–701(d) and 7–706(c) of this subtitle.

(b) There is a Low Intensity Support Services Program in the Administration.

(c) Low intensity support services shall be flexible to meet the needs of individuals or families.

(d) (1) (i) Through fiscal year 2025, the Administration shall establish a cap of no less than $2,000 of low intensity support services per individual per fiscal year to a qualifying individual.

(ii) For fiscal year 2026 and each fiscal year thereafter, the Administration shall establish a cap of no less than $1,000 of low intensity support services per individual per fiscal year to a qualifying individual.

(2) The Administration may waive the cap on low intensity support services provided under paragraph (1) of this subsection.

(e) (1) An individual seeking low intensity support services is not required to:

(i) Submit an application to the Department as provided in § 7–403 of this title; or

(ii) Complete an application for the Medical Assistance Program if the low intensity support services will be provided to a minor.

(2) The Department may develop a simplified application process for low intensity support services.

(f) The Administration shall deliver services to an eligible individual seeking low intensity support services dependent on the availability and allocation of funds provided by the Administration.

§7–801.

(a) The Deputy Secretary may transfer an individual with developmental disability from a public residential program or a public day program to another public residential program or public day program or, if a private provider of services agrees, to that private program, if the Deputy Secretary finds that:

(1) The individual with developmental disability either can receive better treatment in, or would be more likely to benefit from treatment at the other program; or

(2) The safety or welfare of other individuals with developmental disability would be furthered.

(b) The Deputy Secretary may transfer any individual with developmental disability who is a resident of another state to a residential facility in that state if the Deputy Secretary finds that the transfer is feasible.

(c) (1) Any finding that the Deputy Secretary makes under subsection (a) or (b) of this section shall be in writing and filed with the record of the individual with developmental disability.

(2) A copy of the finding and the notice to the private provider of services or program to which the individual with developmental disability is being transferred shall be sent to the proponent of admission, guardian of the person, next of kin, and counsel of the individual with developmental disability.

(3) The Deputy Secretary shall give the individual with developmental disability the opportunity for a hearing on the proposed transfer under this section. A transfer may not take place until a decision is issued as a result of the hearing.

(4) The determination of an administrative law judge as a result of a hearing under this section is a final decision of the Department for the purpose of judicial review of final decisions under Title 10, Subtitle 2 of the State Government Article.

§7–802.

(a) The Developmental Disabilities Administration may ask the Behavioral Health Administration to accept primary responsibility for an individual in or eligible for admission to a State residential center, if the Developmental Disabilities Administration finds that the individual would be provided for more appropriately in a program for individuals with mental disorders.

(b) The Behavioral Health Administration shall determine whether transfer to a mental health program is appropriate.

(c) A dispute over a transfer of an individual from the Developmental Disabilities Administration to the Behavioral Health Administration shall be resolved, in accordance with procedures that the Secretary sets, on request of the Developmental Disabilities Administration or the Behavioral Health Administration.

(d) The Director shall give the individual with developmental disability the opportunity for a hearing on the proposed transfer under this section.

§7–803.

(a) In this section, the term "facility" means an intermediate care facility–intellectual disability consistent with § 1905(d) of the Social Security Act.

(b) A resident of a facility may not be transferred or discharged from the facility involuntarily except for the following reasons:

(1) A medical reason;

(2) The welfare of the resident or other residents;

(3) Knowingly transferring personal assets in violation of a contract provision and only to become eligible for Medicaid benefits;

(4) A nonpayment for a stay; or

(5) The planned closing of the facility.

§7–901.

In this subtitle, "recipient of individual support services" means an individual who receives individual support services.

§7–902.

This subtitle does not limit the right of any person to practice a health occupation that the individual is licensed or otherwise authorized to practice under the Health Occupations Article.

§7–903.

(a) (1) In addition to any other license required by law, a person shall be licensed by the Department before the person may provide services to an individual with developmental disability or a recipient of individual support services.

(2) The Department shall adopt regulations providing for the services requiring licensure under paragraph (1) of this subsection.

(b) (1) If a person is licensed or certified by another State agency or accredited by an organization approved by the Secretary in accordance with § 19–2302 of this article to provide services to an individual with a developmental disability or a recipient of individual support services, the Deputy Secretary may waive the requirement for a license by the Department.

(2) Upon a showing by the Deputy Secretary that the licensed, certified, or accredited person is out of compliance with licensing regulations adopted by the Secretary, the Deputy Secretary may revoke the waiver.

§7–904.

(a) The Secretary shall adopt rules and regulations for the licensing of services for an individual with developmental disability or a recipient of individual support services.

(b) The rules and regulations shall ensure that services to an individual with developmental disability or a recipient of individual support services are provided in accordance with the policy stated in Subtitle 1 of this title.

(c) (1) The rules and regulations shall require that:

(i) At least 75% of the governing body of a licensee shall be residents of the State or reside within a 100–mile radius of the administrative offices of the licensee, which shall be located in the State; and

(ii) No employee of a licensee or immediate family member of an employee of a licensee may serve as a voting member of the governing body of a licensee unless:

1. The employee receives services from the licensee; or

2. The Department explicitly approves the composition of the governing body through an innovative program service plan in accordance with COMAR 10.22.02.09.F.

(2) The requirements of paragraph (1)(i) of this subsection may be waived if a community–based advisory board or committee is established by the licensee and approved by the Department.

(d) The rules and regulations shall also require that an applicant for a license under this section shall demonstrate to the Department the applicant's capability to provide for or arrange for the provision of all applicable services required by this title by submitting, at a minimum, the following documents to the Department:

(1) A business plan that clearly demonstrates the ability of the applicant to provide services in accordance with Maryland regulations and funding requirements;

(2) A summary of the applicant's demonstrated experience in the field of developmental disabilities, in accordance with standards developed by the Department;

(3) Prior licensing reports issued within the previous 10 years from any in–State or out–of–state entities associated with the applicant, including deficiency reports and compliance records on which the State may make reasoned decisions about the qualifications of the applicant; and

(4) A written quality assurance plan, approved by the Developmental Disabilities Administration, to address how the applicant will ensure the health and safety of the individuals served by the applicant and the quality of services provided to individuals by the applicant.

§7–905.

(a) An applicant for a license shall submit an application to the Department on the form that the Department requires.

(b) The application shall provide the information that the Department requires.

§7–906.

When an application for a license is filed, the Department promptly shall investigate the applicant.

§7–907.

(a) An applicant for a license shall meet all requirements in rules and regulations adopted under § 7–904 of this subtitle to be issued a license.

(b) The Department may deny a license:

(1) To any entity that has had a license revoked by the Department within the previous 10 years; or

(2) To any entity that has a corporate officer who has served as a corporate officer for an entity that has had a license revoked by the Department within the previous 10 years.

§7–908.

A license authorizes the licensee to provide services while the license is effective.

§7–909.

(a) In this section, the word "licensee" means a person who is licensed by the Department under this title to provide services.

(b) (1) The Department shall inspect each site or office operated by a licensee at least once annually and at any other time that the Department considers necessary.

(2) The Department shall evaluate periodically the performance of surveyors who carry out inspections under this subsection to ensure the consistent and uniform interpretation and application of licensing requirements.

(c) The Department shall keep a report of each inspection.

(d) The Department shall bring any deficiencies to the attention of:

(1) The executive officer of the licensee; or

(2) In the case of an intermediate care facility–intellectual disability, the State Planning Council and the State–designated protection and advocacy agency.

(e) (1) The Department shall adopt regulations that establish a system of prioritization to respond to and investigate serious reportable incidents, as defined by the Department, in the areas of abuse, neglect, serious injury, and medication errors that threaten the health, safety, and well–being of individuals receiving services funded by the Department in State–operated and in community programs licensed by the Department.

(2) The Department shall seek input from individuals with disabilities and their families, licensees, and advocacy organizations in developing the regulations, prior to publishing the regulations in the Maryland Register for public comment.

(3) The regulations shall define and address:

(i) The procedures and timelines that providers must follow when reporting serious reportable incidents and deaths to the Department;

(ii) The Department's protocol to determine the necessity to investigate a serious reportable incident that takes into account:

1. The severity of the incident;

2. The quality of the licensee's internal investigation; and

3. The number and frequency of serious reportable incidents reported by the licensee to the Department;

(iii) The specific roles and responsibilities of each governmental unit involved in any follow–up investigations that may occur due to a licensee's report of a serious reportable incident or death;

(iv) Methods of investigations, including on–site investigations;

(v) Timelines for response to serious reportable incidents and deaths and investigation of serious reportable incidents and deaths;

(vi) Timelines for issuing specified reports, including corrective action plans, to the Department, licensee, Mortality and Quality Review Committee, Medicaid Fraud Unit, individuals receiving services from the licensee involved in the incident and their guardians or family members, and others; and

(vii) Follow–up protocols for the Department to ensure that corrective action has been implemented by the licensee.

§7–910.

(a) The Department shall deny a license to any applicant or suspend or revoke a license if the applicant or licensee fails to comply with the applicable laws, rules, or regulations of this State.

(b) (1) The Department may impose sanctions, including a civil money penalty, for failure by a licensee to substantially comply with applicable State laws, regulations, or rules.

(2) The Department shall adopt rules and regulations providing for the sanctions to be imposed under this subsection.

(3) A civil money penalty imposed under this subsection may not exceed $5,000.

(4) In establishing the amount of a civil money penalty imposed under this subsection, the Department shall consider, under guidelines established in the regulations adopted under paragraph (2) of this subsection:

(i) The number, nature, and seriousness of the violations;

(ii) The degree of risk caused by the violations to the health, life, or safety of the individual served by the licensee;

(iii) The efforts made by the licensee to correct the violations;

(iv) Any history of similar violations;

(v) Whether the amount of the proposed civil money penalty will jeopardize the financial ability of the licensee to continue serving individuals; and

(vi) Any other reasonable factors as determined by the Department.

(5) If a civil money penalty is proposed, the Department shall offer the licensee an opportunity for informal dispute resolution.

(6) If, following the opportunity for informal dispute resolution, a civil money penalty is imposed, the Department shall provide:

(i) Written notice of:

1. The basis on which the order is made;

2. The deficiency on which the order is based;

3. The amount of the civil money penalty to be imposed; and

4. The manner in which the amount of the civil money penalty was calculated; and

(ii) An opportunity for a hearing as provided under subsection (e) of this section.

(7) The Department shall have the burden of proof with respect to the imposition of a civil money penalty under this subsection.

(c) Any applicant or licensee who knowingly and willfully makes a false statement in connection with an application under this subtitle shall be guilty of a misdemeanor and upon conviction shall be subject to a fine not to exceed $1,000, or imprisonment not exceeding 1 year, or both.

(d) The Department may impose a penalty not exceeding $500 per day per violation for each day a violation occurs on a licensee that fails to comply with the reporting requirements established under § 7–306.1(l) of this title.

(e) Except as otherwise provided in § 10–226 of the State Government Article and subsection (f) of this section, before the Department takes any action against an applicant or a licensee under this section, the Department shall give the applicant or licensee notice and an opportunity for a hearing.

(f) (1) If the Department finds that the public health, safety, or welfare of individuals with disabilities receiving services from a licensee imperatively requires emergency action, the Department may suspend the license or order a licensee to remedy immediately the situation requiring the emergency action.

(2) The order to remedy immediately the situation shall be effective immediately and shall remain in effect until:

(i) The Department rescinds the order; or

(ii) There is a resolution through the administrative hearing process.

(3) If the Department issues an order under paragraph (1) of this subsection, the Department promptly shall give the licensee:

(i) Written notice of the order, the finding, and the reasons that support the finding; and

(ii) An opportunity to be heard.

§7–1001.

In this subtitle, "licensee" means:

(1) A person who is licensed by the Administration to provide services; and

(2) A State residential center.

§7–1002.

(a) "Qualified developmental disability professional" shall be defined by rule and regulation.

(b) It is the policy of this State that, in addition to any other rights, each individual who receives any services provided by the Administration or by a licensee has the following basic rights:

(1) The right to be treated with courtesy, respect, and full recognition of human dignity and individuality;

(2) The right to receive treatment, services, and habilitation in the most integrated setting that is available, adequate, appropriate, and in compliance with relevant laws and regulations;

(3) The right to be free from mental and physical abuse;

(4) The right to be free from chemical restraints, except for minimal restraints that a physician authorizes, in writing, for a clearly indicated medical need and makes a permanent part of the individual's record;

(5) The right to be free from physical restraints except for minimal restraints that are authorized in writing and made a permanent part of the record by

a physician or qualified developmental disability professional and which are clearly indicated for the protection of the individual with developmental disability or others;

(6) The right to privacy;

(7) The right to worship as the individual chooses;

(8) The right to an accounting of any funds of the individual; and

(9) The right to be informed of all of the most integrated setting service options licensed through the Administration.

(c) The Secretary shall issue regulations to enforce the rights enumerated in subsection (b) of this section.

(d) Each licensee shall:

(1) Post, conspicuously in a public place, the policy stated in this section;

(2) Give a copy of the policy:

(i) On admittance, to the individual;

(ii) To the guardian, next of kin, or sponsoring agency of the individual; and

(iii) To a representative payee of the individual;

(3) Keep a receipt for the copy that is signed by the person who received the copy; and

(4) Provide appropriate staff training to carry out the policy.

§7–1003.

(a) To carry out the policy stated in § 7-1002 of this subtitle, the following procedures are required for all services covered under this title.

(b) Each licensee shall:

(1) On or before acceptance of an individual for services, give the individual a written statement of:

(i) The services provided by the licensee, including each service that is required to be offered on an as-needed basis; and

(ii) All charges, including any charges for services that are not covered by Medicare, Medicaid, or reimbursement by a State or local public agency; and

(2) Keep a written receipt for the statement that is signed by the individual or, if the individual is a minor, the parent or guardian of the person.

(c) If a licensee provides an individual with a service, the licensee shall give the individual or the guardian of the person information about the diagnosis, treatment, and prognosis of the individual.

(d) (1) Unless it is medically inadvisable, an individual, or the guardian of the person:

(i) Shall participate in the planning of the medical treatment;

(ii) May refuse medication or treatment; and

(iii) Shall be informed of the medical consequences of these actions.

(2) The licensee shall keep a written acknowledgment of the individual or guardian that the medical consequences are known.

(e) (1) Any case discussion, consultation, examination, or medical treatment of an individual who receives services under this title:

(i) Is confidential; and

(ii) Is not open to a person who is not involved directly in the treatment of the individual who receives services under this title unless the individual or the guardian of the person permits the individual to be present.

(2) Except as necessary for the transfer of an individual from one health care institution to another or as required by law or a 3rd party payment contract, the personal, medical, psychological, and individual treatment and developmental information about an individual is confidential and may not be released without the consent of the individual or the guardian of the person to any individual who:

(i) Is not associated with a licensee; or

(ii) Is associated with a licensee, but does not have a demonstrated need for the information.

(f) If it is feasible to do so and not medically contraindicated, spouses who are both residents of a licensed residential facility shall be given the opportunity to share a room.

(g) An individual who receives services under this title from a licensee alone or with other individuals is entitled to present any grievance or recommend a change in a policy or service to the licensee, the Administration, or any other person, without fear of reprisal, restraint, interference, coercion, or discrimination.

(h) (1) An individual shall have reasonable access to a telephone.

(2) An individual shall have reasonable access to writing instruments, stationery, and postage and may use them to write to anyone.

(3) The correspondence of an individual shall be sent to the addressee without delay and, except under the direction of the addressee, without being opened.

(i) (1) An individual shall be entitled to receive visits:

(i) From a lawyer that the individual chooses;

(ii) From a clergyman that the individual chooses; and

(iii) During reasonable visiting hours that the licensee sets, from any other visitor.

(2) Each married individual in a licensed residential facility shall have privacy during a visit by the spouse.

(3) If, for the welfare of the individual, visits are restricted, the restriction shall be:

(i) Signed by the executive officer or administrative head of the licensee; and

(ii) Made a permanent part of the individual's record.

(4) Visits of an individual's lawyer or clergyman may not be restricted.

(j) (1) An individual shall have the right to possess and use clothing and other personal effects.

(2) For essential medical and safety reasons, the executive officer or administrative head of a licensee may take temporary custody of the personal effects and promptly shall make the action a part of the individual's record.

(k) (1) An individual with developmental disability may not be assigned to do any work for a licensee without personal consent and without written approval of the attending physician or the executive officer or administrative head of the licensee.

(2) This subsection does not apply to the performance of an individual's share of household duties or other tasks ancillary to the individual's habilitation program.

(l) The executive officer or administrative head of a licensee is responsible for carrying out this section.

(m) (1) A person who believes that the rights of an individual with developmental disability have been violated shall report the alleged violation to the executive director or administrative head of a licensee.

(2) The executive officer or administrative head of the licensee shall:

(i) Promptly send the report:

1. To the Deputy Secretary; and

2. To the State–designated protection and advocacy agency;

(ii) Investigate the report; and

(iii) After the investigation, report the findings:

1. To the complainant;

2. To the State–designated protection and advocacy agency; and

3. To the Deputy Secretary.

(3) The State–designated protection and advocacy agency shall seek redress of a violation of the rights stated in this section.

§7–1004.

An individual may not be deprived of the right to vote or to receive, hold, and dispose of property solely because the individual has developmental disability or receives services under this title.

§7–1005.

(a) (1) In this section, "abuse" means:

(i) Any physical injury that is inflicted willfully or with gross recklessness;

(ii) Inhumane treatment; or

(iii) Any of the following kinds of sexual abuse:

1. A sexual act, as defined in § 3–301 of the Criminal Law Article;

2. Sexual contact, as defined in § 3–301 of the Criminal Law Article; or

3. Vaginal intercourse, as defined in § 3–301 of the Criminal Law Article.

(2) In this section, "abuse" does not include:

(i) The performance of:

1. An accepted medical procedure that a physician orders;

2. An accepted behavioral procedure that a licensed psychologist or psychiatrist, as appropriate, orders; or

(ii) An action taken by an employee that complies with applicable State and federal laws and applicable Department policies on the use of physical intervention.

(b) (1) In addition to any other reporting requirement of law, a person who believes that an individual with developmental disability has been abused promptly shall report the alleged abuse to the executive officer or administrative head of the licensee.

(2) The executive officer or administrative head shall report the alleged abuse to an appropriate law–enforcement agency.

(3) A report to the executive officer or administrative head:

(i) May be oral or written; and

(ii) Shall contain as much information as the reporter is able to provide.

(c) (1) The law–enforcement agency shall:

(i) Investigate thoroughly each report of an alleged abuse; and

(ii) Attempt to ensure the protection of the alleged victim.

(2) The investigation shall include:

(i) A determination of the nature, extent, and cause of the abuse;

(ii) The identity of the alleged abuser or abusers; and

(iii) Any other pertinent fact or matter.

(d) As soon as possible, but no later than 10 working days after the completion of the investigation, the law–enforcement agency shall submit a written report of its findings to the State's Attorney, the Deputy Secretary, the State–designated protection and advocacy agency, and the executive officer or administrative head of the licensee.

(e) The Administration shall maintain a central registry of abuse reports and their disposition and shall take appropriate remedial action.

(f) A person shall have the immunity from liability described under § 5–625 of the Courts and Judicial Proceedings Article for:

(1) Making a report under this section;

(2) Participating in an investigation arising out of a report under this section; or

(3) Participating in a judicial proceeding arising out of a report under this section.

§7–1006.

(a) In this section, "resource coordinator" means an independent professional staff person responsible for assisting in the development and review of an individual plan of habilitation designed to meet the individual's needs, preferences, desires, goals, and outcomes in the most integrated setting.

(b) (1) The professional and supportive staff of a licensee who provides residential or day habilitation services shall make a written plan of habilitation for each individual with developmental disability who has been accepted for service by the licensee. The plan shall meet applicable federal standards.

(2) At least once a year, the staff shall reevaluate the effectiveness and adequacy of each plan in consultation with the individual with developmental disability and any person authorized to act on behalf of the individual, and shall revise the plan as needed.

(3) (i) The reevaluation required by paragraph (2) of this subsection shall include a determination of whether the needs of the individual could be met in more integrated settings.

(ii) At the time of the reevaluation, each individual with a developmental disability shall be provided a range of the most integrated setting service options that may be appropriate.

(iii) The information provided under subparagraph (ii) of this paragraph shall be given in a manner approved by the Administration.

(4) At least once a year, the Administration shall review the licensee's execution of the plan of habilitation, and compliance with the rules, regulations, and standards which the Secretary adopts.

(c) (1) (i) The written plan of habilitation for individuals in State residential centers under this section is subject to the requirements described in this subsection.

(ii) The written plan of habilitation shall be developed by the individual, a treating professional, and a resource coordinator who is not employed by or under contract with the State residential center.

(iii) The Developmental Disabilities Administration shall develop the planning protocol and format for the written plan of habilitation to be used by each State residential center.

(iv) On an annual basis and any other time requested by the individual, the treating professional and resource coordinator shall discuss with the individual the service needs of the individual, including identifying community–based Medicaid–waiver services defined in § 15–132 of this article, and any other services that may be appropriate.

(v) The treating professional and resource coordinator shall use communication devices and techniques, including the use of sign language, as appropriate, to facilitate the involvement of the individual in the development of the written plan of habilitation.

(vi) Subsequent to the initial written plan of habilitation for individuals in State residential centers, the written plan of habilitation shall include an annual update on the status and progress toward addressing and resolving the barriers identified in subparagraph (vii)4 of this paragraph.

(vii) The written plan of habilitation for individuals in State residential centers shall include:

1. The treating professional's recommendation on the most integrated setting appropriate to meet the individual's needs;

2. The resource coordinator's recommendation on the most integrated setting appropriate to meet the individual's needs;

3. A description of the services and supports, including residential, day, employment, and technology, that are required for the individual to receive services in the most integrated setting appropriate to meet the individual's needs; and

4. A listing of barriers that prevent an individual from receiving the supports and services required for the individual to live in the most integrated setting appropriate to meet the individual's needs, including community capacity or systems, if community services are determined to be the most integrated setting appropriate to meet the individual's needs.

(2) The treating professional and resource coordinator shall identify and report any rights violations as provided in §§ 7–1002(b) and 7–1003(m) of this subtitle.

(3) On or before December 1 of each year, each State residential center shall provide the information required under paragraph (1)(vi) and (vii) of this subsection to the Developmental Disabilities Administration and to the Department of Disabilities.

(4) (i) On or before July 1 of each year, the Developmental Disabilities Administration and the Department of Disabilities shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, summarizing the statewide and regional information provided by the State residential centers in paragraph (3) of this subsection.

(ii) The data shall be incorporated in the State's Olmstead Plan, with recommendations to address the barriers that prevent individuals from living in the most integrated setting appropriate to meet the individual's needs.

(d) Each individual plan of habilitation shall be reviewed and approved, disapproved, or modified by:

(1) The executive officer or administrative head of the licensee or a qualified developmental disability professional, as defined in § 7–1002(a) of this subtitle, whom the executive officer or administrative head designates; and

(2) One other professional individual who is responsible for carrying out a major program but does not participate in the individual plan of habilitation.

(e) Approval of a plan of habilitation shall be based on the current needs of the individual with developmental disability.

(f) (1) If the Secretary denies Medicaid–waiver services that are to be provided to a recipient under a plan of habilitation, the Secretary shall, within 30 days after the denial, provide to the recipient written notice that includes:

(i) The reason for the denial, including a copy of any Administration evaluation of the recipient that relates to the decision of the Secretary; and

(ii) Instructions for the recipient to appeal the decision under § 7–406 of this title.

(2) An individual who receives written notice of a denial of Medicaid–waiver services under paragraph (1) of this subsection may appeal the decision under § 7–406 of this title.

(g) The Secretary shall:

(1) Adopt rules and regulations to carry out the intent of this section;

(2) Provide appropriate support and technical assistance to the licensee in developing a plan of habilitation required by this section; and

(3) With respect to State residential centers, provide the professional and supportive staff and equipment that are necessary to carry out the plans of habilitation required by this section.

§7–1007.

On request, the licensee shall give to the Deputy Secretary or a designee of the Deputy Secretary:

(1) Any information that the licensee has about an individual served by the licensee;

(2) Access to the records of the licensee;

(3) Access to any individual served;

(4) Access to the records of individuals served by the licensee; and

(5) Access to any part of the premises of the licensee.

§7–1008.

(a) (1) Each licensee shall keep complete records for each individual who is served by the licensee under this title.

(2) The record shall contain all of the information that is required by this title or the Administration.

(b) A licensee shall keep records in a secure area and available for the inspection by any person with the right of access to the records under this title.

§7–1009.

Within 14 days after an individual with developmental disability asks a licensee for information about its records on that individual, the licensee shall advise the individual, in writing, about the records and the procedures for their disclosure.

§7–1010.

(a) Except as otherwise expressly provided in this section, a licensee may not disclose any record that the licensee keeps on an individual who has been served by the licensee, unless the individual gives written, informed consent to the disclosure.

(b) (1) Subject to the limitations of this subsection, a licensee shall disclose a record of an individual who is served by a licensee to:

(i) The individual with developmental disability, if:

1. A person is not authorized to act on behalf of the individual with developmental disability; and

2. The executive officer or administrative head of the licensee determines that disclosure would not be detrimental to the individual with developmental disability;

(ii) A parent or guardian of the person with developmental disability who is:

1. A minor; or

2. Unless the individual with developmental disability asks that disclosure to the parent or guardian not be allowed, an adult;

(iii) A lawyer or other individual who is authorized:

1. By the individual with developmental disability; or

2. By another individual to whom, on behalf of the individual with developmental disability, disclosure of the record is authorized; or

(iv) To the executive director or a designee of the executive director of the State–designated protection and advocacy agency, if:

1. The agency has received a request for an investigation; and

2. There is no other person to whom, on behalf of the individual with developmental disability, the record may be disclosed under this paragraph; or

3. The individual with developmental disability is unable to give written informed consent and the Deputy Secretary determines that disclosure is necessary to protect the rights of the individual with developmental disability.

(2) A licensee shall comply within 14 days after an individual with developmental disability or a person who is authorized to act on behalf of that individual, asks in writing:

(i) To receive a copy of a record; or

(ii) To see and copy the record disclosed.

(c) If a licensee refuses to disclose a record under subsection (b)(1)(i) of this section, the executive officer or administrative head of a licensee shall apply, within 10 working days after the refusal, to the circuit court for the county where the individual making the request resides or where the site of services to the individual occurred for an order to permit the executive officer or administrative head of the licensee to continue to refuse disclosure to the individual with developmental disability.

(d) A licensee shall disclose a record that is sought:

(1) By the staff of the licensee to carry out a purpose for which the record is kept;

(2) By any other person who provides or coordinates services in accordance with the individual's plan of habilitation;

(3) By the Deputy Secretary or a designee of the Deputy Secretary; and

(4) By a person to further the purposes of:

(i) A medical review committee;

(ii) An accreditation board or commission;

(iii) A licensing agency that is authorized by statute to review records;

(iv) A court order;

(v) A representative of the Division of Reimbursement of the Department;

(vi) An auditor of the Department;

(vii) An auditor of the Office of Legislative Audits of the Department of Legislative Services; or

(viii) The Clients' Rights Committee of the licensee unless the individual with developmental disability objects.

(e) (1) A licensee may require a person who asks for a copy of a record to pay a reasonable fee.

(2) The fee may not exceed the cost of copying the record.

(f) (1) Except for a disclosure that is made to the staff for its routine use under subsection (d)(1) of this section, a licensee shall keep a list of all disclosures of a record.

(2) The list shall state:

(i) The date, nature, and purpose of each disclosure; and

(ii) The name and address of each person to whom the disclosure is made.

§7–1011.

(a) An individual with developmental disability or person who is authorized to act on behalf of the individual may:

(1) Contest a record that the licensee keeps on the individual;

(2) Ask for an addition to or other change in the record; and

(3) Contest disclosure of the record.

(b) Within 14 days after a licensee receives a request to change a record, the licensee shall acknowledge receipt of the request.

(c) (1) Within 14 days after a licensee acknowledges receipt of the request, the licensee shall:

(i) Make or refuse to make the requested change; and

(ii) Give the person who requested the change written notice of the licensee's action.

(2) A notice of refusal shall contain:

(i) Each reason for the refusal; and

(ii) Any procedures that the Deputy Secretary has set for review of the refusal.

(d) (1) An individual with developmental disability or person who is authorized to act on behalf of the individual may ask the Deputy Secretary to review the refusal.

(2) Within 45 days after the request for review, the Deputy Secretary shall:

(i) Complete the review;

(ii) Make a final determination; and

(iii) Give the individual with developmental disability or person who is authorized to act on behalf of the individual written notice of the final determination.

(e) If the final determination of the Deputy Secretary is a refusal to change a record, the written notice shall include:

(1) Each reason for the refusal;

(2) The procedure for inserting in the record a concise statement of the reason that the individual with developmental disability or person who is authorized to act on behalf of the individual disagrees with that refusal; and

(3) Information on the right to seek judicial review of the decision of the Deputy Secretary.

§7–1101.

(a) (1) Unless licensed by the Administration under this title, a person may not provide the following services to an individual with developmental disability or to a recipient of individual support services, as defined in § 7-901 of this title:

(i) Day habilitation services;

(ii) Residential services;

(iii) Services coordination;

(iv) Vocational services;

(v) More than 1 family support service, as defined in § 7-701 of this title;

(vi) More than 1 individual support service; and

(vii) More than 1 community supported living arrangements service, as defined in § 7-709 of this title.

(2) The Administration, the Administration's designee, or an agency that receives public funds may not place an individual in a residential group home or other facility that is not operating in compliance with applicable State licensing laws.

(b) A person who provides services in violation of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000.

(c) An employee, officer, or director of a provider of services under this title or any other person who knowingly participates in a violation of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, or imprisonment not exceeding 1 year, or both.

(d) In addition to any other penalties specified in this section, an individual who is admitted or held against the individual's will by a person who is providing services without a license may recover civil damages from that person and from any other person who knowingly participates in the admission or detention.

§7–1102.

(a) A person may not interfere knowingly with the rights of an individual who receives any services under this title.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, or imprisonment not exceeding 2 years, or both.

§7–1103.

(a) In this section, "custodian" means:

(1) Executive officer or administrative head of a licensee, as defined in § 7-1001 of this title;

(2) An individual who is responsible for the area where records on individuals who are served by a licensee, as defined in § 7-1001 of this title, are kept; or

(3) Any individual who has or controls the record.

(b) In addition to any damages recoverable in a court of general jurisdiction, a custodian of a record who discloses the record in violation of § 7-1010 of this title is liable to the individual whose records are disclosed unlawfully for punitive damages in an amount that does not exceed $500 plus reasonable attorney's fees.

§7–1104.

(a) A State employee may not receive or solicit, directly or indirectly, any remuneration for providing services to an individual eligible for services under this title except for compensation provided for in the State budget, those charges provided for in Title 16 of this article, and funds received in accordance with subsection (b) of this section.

(b) (1) A State residential center may accept nonbudgeted funds that are available to it but are not part of the appropriation process in this State.

(2) A State residential center may accept these funds only under the policy or regulations that the Secretary sets.

(c) An employee of a licensee may not receive or solicit, directly or indirectly, any remuneration for providing services within the scope of that employment to an individual eligible for services under this title, other than compensation provided by the licensee.

(d) A person who knowingly violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000.

§7–1201.

(a) In this section, "Advisory Committee" means the Adults with Developmental Disabilities Citizen's Advisory Committee.

(b) There is an Adults with Developmental Disabilities Citizen's Advisory Committee in Prince George's County.

(c) The purposes of the Advisory Committee are to:

(1) Provide the Secretary, the Director, the Director of the Southern Maryland Regional Administration, the Director of the Southern Maryland Regional Division of Rehabilitation Services, and groups in the local community with information regarding the needs of adults with developmental disabilities who reside in Prince George's County;

(2) Advocate for positive systems change related to the services provided to adults with developmental disabilities;

(3) Advocate for a family–friendly relationship with the Administration, the Maryland State Department of Education Division of Rehabilitation Services, and other State and local organizations;

(4) Provide a forum for information sharing and support among adults with developmental disabilities and their families;

(5) Advocate for best practices in providing services to adults with developmental disabilities; and

(6) Seek input from individuals with developmental disabilities, advocates, family members, community partners, service providers, educators, and administrators on local issues related to:

(i) Employment, services, and continuing education for adults with developmental disabilities; and

(ii) The inclusion of adults with developmental disabilities in the community.

(d) The Advisory Committee consists of the following members:

(1) The Director of the Southern Maryland Regional Administration;

(2) The Director of the Southern Maryland Regional Division of Rehabilitation Services;

(3) One representative from the Prince George's County Department of Family Services;

(4) Parents and family members of individuals with developmental disabilities;

(5) Individuals with developmental disabilities;

(6) Representatives from Administration service providers; and

(7) Representatives from other interested groups, including local colleges, disability advocates, transportation providers, literacy organizations, and recreation groups.

(e) The Advisory Committee shall elect officers from among its members.

(f) The regional Administration office shall assist the Advisory Committee in notifying providers and consumers of Administration services of meetings of the Advisory Committee.

(g) A member of the Advisory Committee may not receive compensation as a member of the Advisory Committee.

(h) (1) The Advisory Committee shall meet at least once each month.

(2) Representatives from the Advisory Committee shall meet with:

(i) The Director of the Southern Maryland Regional Administration and the Director of the Southern Maryland Regional Division of Rehabilitation Services at least four times a year; and

(ii) The Secretary and the Director annually.

(i) The Advisory Committee shall:

(1) Provide advice and make recommendations to the Director of the Southern Maryland Regional Administration, the Director of the Southern Maryland Regional Division of Rehabilitation Services, and groups in the local community on the needs of adults with developmental disabilities in Prince George's County;

(2) Provide a forum for input from the residents of Prince George's County on issues related to adults with developmental disabilities; and

(3) Perform any other duty considered appropriate by the Advisory Committee.

§7–12A–01.

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

(b) "Act" means the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000.

(c) "Council" means the Maryland Developmental Disabilities Council.

(d) "State plan" means the strategic plan developed under § 7–12A–02(e) of this subtitle.

§7–12A–02.

(a) There is a Maryland Developmental Disabilities Council.

(b) The Council is an independent unit of State government.

(c) The Council operates and receives funding in accordance with the Act.

(d) The Council has the authority to:

(1) Conduct and support advocacy, systems change, and capacity–building efforts to promote inclusive communities and equity in services for individuals with disabilities in the State;

(2) Research best practices and provide related training and technical assistance to communities in the State; and

(3) Inform State and local leaders about disability issues.

(e) The Council shall:

(1) Develop and implement a 5–year strategic plan in accordance with the Act;

(2) Monitor, review, and annually evaluate the implementation of the State plan;

(3) To the extent practicable, review any plan in the State that relates to programs affecting individuals with developmental disabilities;

(4) On request, submit to the Secretary of the federal Department of Health and Human Services periodic reports on its activities;

(5) Serve as an advocate for individuals with developmental disabilities;

(6) Conduct or support programs, projects, and activities that carry out the purpose of the Act;

(7) Advise the Governor, the General Assembly, State agencies, and other relevant organizations on policies, programs, and issues related to the needs of individuals with developmental disabilities and their families; and

(8) Review and make findings and recommendations regarding programs related to the support and services provided to individuals with developmental disabilities and their families.

(f) A State entity may not interfere with the Council's advocacy, capacity building, systemic change activities, budget, personnel, or State plan development or implementation.

§7–12A–03.

(a) The Council shall hire an executive director.

(b) The executive director may employ additional staff necessary to carry out the Council's functions.

(c) The executive director shall determine the organizational structure and physical location of Council staff.

§7–12A–04.

(a) Members of the Council shall comply with the requirements of the Act.

(b) The Council consists of the following members, appointed by the Governor:

(1) The State Superintendent of Schools, or the Superintendent's designee;

(2) The Assistant State Superintendent of the Division of Rehabilitation Services, or the Assistant State Superintendent's designee;

(3) The Secretary of Disabilities, or the Secretary's designee;

(4) The Deputy Secretary of the Developmental Disabilities Administration, or the Deputy Secretary's designee;

(5) The Secretary of Aging, or the Secretary's designee;

(6) One representative of the Maryland Center for Developmental Disabilities;

(7) One representative of Disability Rights Maryland;

(8) One representative of the Prevention and Health Promotion Administration or any other State entity authorized to administer funds provided under Title V of the federal Social Security Act;

(9) One representative of the Maryland Medical Assistance Program or any other State entity authorized to administer funds provided under Title XIX of the federal Social Security Act;

(10) One representative of a local nongovernmental agency;

(11) One representative of a private nonprofit organization that provides services for individuals with developmental disabilities in the State; and

(12) Any additional individuals necessary to meet the requirements of subsection (c) of this section and the Act.

(c) (1) At least 60% of the members of the Council must be:

(i) Individuals with developmental disabilities;

(ii) Parents or guardians of children with developmental disabilities; or

(iii) Immediate relatives or guardians of adults with developmental disabilities who cannot advocate for themselves.

(2) In addition to the requirements under paragraph (1) of this subsection:

(i) At least one–third of the members must be individuals with developmental disabilities;

(ii) At least one–third of the members must be parents or guardians of children with developmental disabilities or guardians or immediate relatives of adults with developmental disabilities who cannot advocate for themselves; and

(iii) At least one member must be:

1. An individual with a developmental disability who resides or previously resided in an institution; or

2. An immediate relative or guardian of an individual with a developmental disability who resides or previously resided in an institution.

(d) The membership of the Council shall be geographically representative of the State and reflect the diversity of the State with respect to race and ethnicity.

(e) The Council shall elect a chair and vice chair from among its members.

(f) The Council shall adopt bylaws, policies, and operating procedures that are in compliance with the Act and with State law.

§7–12B–01.

In this subtitle, "Council" means the Maryland Developmental Disabilities Administration Waiver Advisory Council.

§7–12B–02.

(a) There is a Maryland Developmental Disabilities Administration Waiver Advisory Council in the Administration.

(b) The purpose of the Council is to:

(1) Advise and provide recommendations to the Administration on system design, service delivery, and quality enhancement strategies for the Medicaid waiver programs operated by the Administration; and

(2) Foster meaningful engagement and establish a feedback loop with all stakeholders while prioritizing input from individuals with lived experience with a Medicaid waiver program.

(c) The Council shall adhere to person–centered thinking, diversity, equity, and inclusion principles, and evidence–based and data–driven discussion and problem solving.

§7–12B–03.

(a) (1) The Council consists of the following voting members, appointed by the Secretary of Health:

(i) 21 individuals with lived experience participating in an Administration program that shall include:

1. Representatives from advocacy groups for individuals with intellectual and developmental disabilities; and

2. Equal representation from individuals who have experienced self–directed delivery models and individuals who have experienced traditional delivery models;

(ii) Two licensed providers of residential and day services;

(iii) Two certified providers of services including employment, personal support, technology, and transportation;

(iv) Two coordination of community services providers;

(v) One financial management and counseling services provider;

(vi) One representative of an ethnic advocacy group in the State;

(vii) One representative of the Maryland Center for Developmental Disabilities;

(viii) One representative of the Maryland Developmental Disabilities Council;

(ix) One representative of the Self–Directed Advocacy Network of Maryland;

(x) One representative of the Parents' Place of Maryland;

(xi) One representative of the Maryland Association of Community Services;

(xii) One representative of The Arc Maryland;

(xiii) One individual who is a support broker;

(xiv) One representative of Service Coordination, Inc.;

(xv) Three family members with experience with self–directed services; and

(xvi) Three family members with experience with traditional services.

(2) The Council consists of the following nonvoting members:

(i) One member of the Senate of Maryland, appointed by the President of the Senate;

(ii) One member of the House of Delegates, appointed by the Speaker of the House;

(iii) The Director of Federal Programs and Integrity in the Administration;

(iv) One representative of the Department of Disabilities, designated by the Secretary of Disabilities;

(v) One representative of the Department of Housing and Community Development, designated by the Secretary of Housing and Community Development;

(vi) One representative of the Department of Human Services, designated by the Secretary of Human Services;

(vii) One representative of the Division of Rehabilitation Services in the State Department of Education, designated by the State Superintendent of Schools;

(viii) The following members, designated by the Secretary of Health:

1. One representative of the Office of Long Term Services and Supports;

2. One representative of the Behavioral Health Administration;

3. One representative of the Office of Health Care Quality;

4. One representative of the Eligibility Determination Division of the Office of Eligibility Services; and

5. One representative of the Maryland Long Term Services and Support system program management office; and

(ix) The following members, appointed by the Secretary of Health:

1. One representative of the National Association of State Directors of Developmental Disabilities Services; and

2. One representative of Applied Self–Direction.

(3) Family members appointed to the Council shall include at least one family member from each region.

(4) The Administration shall establish an application process and review process for members who wish to serve on the Council.

(5) To the extent practicable, the membership of the Council shall reflect the gender, racial, ethnic, and geographical diversity of the State.

(b) (1) The term of a member is 3 years.

(2) The terms of members are staggered as required by the terms provided for the members of the Council on October 1, 2025.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) A member may not serve consecutive terms but may serve for multiple nonconsecutive terms.

(c) (1) The Director of Federal Programs shall serve as a nonvoting cochair.

(2) The Council shall vote for the additional cochair.

(d) (1) The Administration shall provide staff for the Council.

(2) The Department shall include a dedicated Council webpage on the Department's website that includes meeting dates and times, agendas and other meeting documents, and recorded past meetings of the Council.

(e) A member of the Council:

(1) May not receive compensation as a member of the Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Council may provide travel arrangements, as necessary, for members of the Council with disabilities.

§7–12B–04.

(a) (1) The Council shall meet once every 2 months in a location that is made publicly available at least 2 weeks before the meeting.

(2) The Council may hold additional meetings if determined necessary by the cochairs.

(3) Meetings of the Council shall:

(i) Be open to the public and recorded by video;

(ii) Follow agendas that are distributed at least 1 week before the meeting to Council members by e–mail;

(iii) Conclude with a clear understanding of expectations and assignments for future steps;

(iv) Provide accommodations for individuals with disabilities; and

(v) Include time for public comment after meeting agenda items have been addressed.

(4) A meeting of the Council may be held virtually if determined necessary by the cochairs.

(5) The Council shall provide notice of its meetings by e–mail to members at least 1 week before the meeting and shall include an agenda and any documents to be reviewed for the meeting.

(6) The Council shall distribute meeting minutes to members within 2 weeks after each Council meeting.

(b) The Council may form workgroups that may meet as directed by the cochairs.

(c) The Council shall establish a code of conduct for Council meetings.

§7–12B–05.

(a) The Council shall provide advice and make recommendations to the Administration on:

(1) Administration–operated Medicaid waiver program system design, including waiver application regulations and policies;

(2) Service delivery and access to services;

(3) Federal waiver assurances;

(4) Ensuring access to Medicaid services;

(5) Quality enhancement efforts and improvement strategies;

(6) Communication with stakeholders, including a transparent feedback process; and

(7) Collaborative processes with stakeholders.

(b) (1) The Council shall vote on the advice and recommendations to provide to the Administration under subsection (a) of this section.

(2) The Council shall attempt to reach consensus and all members shall be afforded an opportunity to be heard.

(3) If consensus cannot be reached on a particular issue, the Council may vote with a 75% agreement threshold.

(4) (i) A Council member may not vote on another member's behalf.

(ii) A Council member may designate a proxy for the member.

(iii) A Council member's proxy may vote on behalf of a member only if the proxy is attending the meeting for the member.

(iv) A Council member's proxy may not vote on behalf of the proxy.

§7–1301.

This title may be cited as the "Maryland Developmental Disabilities Law".

§7.5–101.

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

(b) (1) "Addictive disorder" means a chronic disorder of the brain's reward–activation system in which the individual pathologically pursues reward or relief by substance use or other behaviors, with diminished control, and the individual persists in the behavior despite adverse consequences.

(2) "Addictive disorder" includes gambling, which is the only nonsubstance–related addictive disorder recognized by Maryland law.

(c) "Administration" means the Behavioral Health Administration.

(d) "Behavioral health" includes substance–related disorders, addictive disorders, and mental disorders.

(e) "Behavioral health care" includes prevention, screening, early intervention, treatment, recovery, support, wraparound, and rehabilitation services, for individuals with substance–related disorders, addictive disorders, mental disorders, or a combination of these disorders.

(f) "Behavioral health program" means a substance–related disorders program, a mental health program, or an addictive disorders program, or a program that consists of more than one of these programs.

(g) "Core service agency" means the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded mental health services.

(h) "Director" means the Director of the Administration.

(i) "Family support services" means a set of nonclinical activities provided by family members of individuals with mental health or substance–related disorders and addictive disorders to support individuals with mental health or substance–related disorders and addictive disorders or their families.

(j) "Local addictions authority" means the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded substance–related disorders and addictive disorder services.

(k) "Local behavioral health authority" means the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded mental health, substance–related disorder, and addictive disorder services.

(l) (1) "Mental disorder" means a behavioral or emotional illness that results from a psychiatric disorder.

(2) "Mental disorder" includes a mental illness that so substantially impairs the mental or emotional functioning of an individual as to make care or treatment necessary or advisable for the welfare of the individual or for the safety of the person or property of another.

(3) "Mental disorder" does not include an intellectual disability.

(m) "Mental health program" means a set of services that consists of community–based treatment, care, or rehabilitation services, or any combination of these, for individuals with a mental disorder.

(n) "Peer support services" means a set of nonclinical activities provided by individuals in recovery from mental disorders, substance–related disorders, or addictive disorders who use their personal, lived experiences and training to support other individuals with mental disorders, substance–related disorders, or addictive disorders.

(o) "Recovery residence" means a service that:

(1) Provides alcohol–free and illicit–drug–free housing to individuals with substance–related disorders or addictive disorders or co–occurring mental disorders and substance–related disorders or addictive disorders; and

(2) Does not include clinical treatment services.

(p) (1) "Substance–related disorder" means:

(i) An alcohol use disorder, alcohol abuse, alcohol dependence, alcohol misuse, alcohol intoxication, or alcohol withdrawal;

(ii) A nonalcohol substance use disorder, drug dependence, drug misuse, nonalcohol substance induced intoxication, or nonalcohol substance withdrawal; or

(iii) Any combination of the disorders listed in items (i) and (ii) of this paragraph.

(2) "Substance–related disorder" includes substance use disorders and substance induced disorders.

(q) "Substance–related disorders program" means a set of services that:

(1) Are community–based, including those services provided by the State or any of its political subdivisions; and

(2) Consist of:

(i) Any combination of treatment, care, or rehabilitation for individuals with a substance–related disorder; or

(ii) Education for individuals known to be at risk of developing substance–related disorders.

§7.5–201.

There is a Behavioral Health Administration in the Department.

§7.5–202.

(a) The head of the Administration is the Director and shall be appointed by the Secretary.

(b) The Director serves at the pleasure of the Secretary.

(c) The Director is entitled to the salary provided in the State budget.

§7.5–203.

(a) (1) The Director exercises the powers, duties, and responsibilities of office subject to the authority of the Secretary.

(2) The Director shall report to the Deputy Secretary for Behavioral Health.

(b) The Secretary may exercise any power or perform any duty of the Administration.

§7.5–204.

(a) The Director is responsible for carrying out the powers, duties, and responsibilities of the Administration.

(b) In addition to the powers set forth elsewhere in this title, the Director may:

(1) Within the amounts made available by appropriation or grant, make any agreement or joint financial arrangement to do or have done anything necessary, desirable, or proper to carry out the purposes of this title and Titles 8 and 10 of this article;

(2) Organize and manage the Administration in a manner that will enable it best to discharge the duties of the Administration;

(3) Appoint the number of assistant directors and staff provided for in the State budget;

(4) Remove an assistant director for incompetence or misconduct; and

(5) Unless expressly provided otherwise by law, assign to any subordinate unit or individual in the Administration any function that is imposed by law on the Director.

(c) In addition to the duties set forth elsewhere in this title, the Director shall do anything necessary or proper to carry out the scope of this title and Titles 8 and 10 of this article.

(d) It is the policy of the State that the Director may collaborate with other State agencies to promote coordinated care and treatment of individuals who have behavioral health disorders.

§7.5–205.

(a) The Secretary shall provide facilities for the care and treatment of individuals who have mental disorders.

(b) The Administration shall:

(1) Supervise the custody, care, and treatment of individuals in State facilities who have mental disorders;

(2) Provide oversight of community–based services for persons with behavioral health disorders; and

(3) Establish programs for research and development of care and treatment for individuals who have behavioral health disorders.

(c) The Administration may provide funds for a public or nonprofit organization to carry out pilot or demonstration projects relating to individuals who have behavioral health disorders.

(d) The Secretary shall adopt regulations to carry out the provisions of this title and Titles 8 and 10 of this article, including provisions for the issuance of licenses.

§7.5–205.1.

(a) The Administration may establish an outpatient civil commitment pilot program to allow for the release of an individual who is involuntarily admitted for inpatient treatment under § 10–632 of this article on condition of the individual's admission into the pilot program.

(b) If the Administration establishes a pilot program under subsection (a) of this section, the Administration shall:

(1) Adopt criteria an individual must meet in order to be admitted into the pilot program;

(2) Establish application, hearing, and notice requirements;

(3) Specify the rights of an individual who may be or who has been admitted into the pilot program;

(4) Allow an eligible individual to request enrollment into the pilot program; and

(5) Allow an immediate family member of an eligible individual to request that the individual be voluntarily enrolled into the pilot program.

(c) If the Administration establishes a pilot program under subsection (a) of this section, on or before December 1 each year the pilot program is in existence, the Administration shall submit to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, a report that includes:

(1) The number of individuals admitted into the pilot program during the immediately preceding 12–month period;

(2) The number of applications for admission into the pilot program submitted during the immediately preceding 12–month period;

(3) The cost of administering the pilot program for the immediately preceding 12–month period;

(4) For individuals admitted into the program voluntarily and involuntarily:

(i) The percentage of individuals admitted into the pilot program who adhered to the treatment plan established for the individual under the pilot program;

(ii) Treatment outcomes; and

(iii) The type, intensity, and frequency of services provided to individuals admitted into the pilot program; and

(5) Any other information that may be useful in determining whether a permanent outpatient civil commitment program should be established.

§7.5–206.

No otherwise–qualified individual with a behavioral health disorder, solely by reason of the individual's status as an individual with a behavioral health disorder, shall be denied the services of, or be subjected to discrimination by, any public or private hospital or community–based treatment program.

§7.5–207.

(a) Subject to subsection (b) of this section, the Administration shall establish crisis treatment centers that provide individuals who are in a mental health or substance use disorder crisis with access to clinical staff who:

(1) Perform assessments and level of care determinations 24 hours a day and 7 days a week; and

(2) Connect the individuals to care immediately.

(b) At least one crisis treatment center shall be established on or before June 1, 2018.

(c) The Administration shall establish the crisis treatment centers required under subsection (a) of this section in a manner that is consistent with the strategic plan developed by the Behavioral Health Advisory Council, as required by Chapters 405 and 406 of the Acts of the General Assembly of 2016.

(d) On or before September 1, 2017, and on or before September 1 each year thereafter until the Administration establishes the crisis treatment centers required under subsection (a) of this section, the Administration shall submit, in accordance with § 2–1257 of the State Government Article, a report on the status of the establishment of crisis treatment centers under this section to the Joint Committee on Behavioral Health and Opioid Use Disorders.

§7.5–208.

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

(2) "Mobile crisis team" has the meaning stated in § 10–1401 of this article.

(3) "Program" means the Behavioral Health Crisis Response Grant Program.

(b) (1) There is a Behavioral Health Crisis Response Grant Program in the Department.

(2) The purpose of the Program is to provide funds to local jurisdictions to establish and expand community behavioral health crisis response systems.

(c) The Department shall administer the Program.

(d) (1) The Program shall award competitive grants to local behavioral health authorities to establish and expand behavioral health crisis response programs and services that:

(i) Serve local behavioral health needs for children, adults, and older adults;

(ii) Meet national standards;

(iii) Integrate the delivery of mental health and substance use treatment; and

(iv) Connect individuals to appropriate community–based care in a timely manner on discharge.

(2) Funds distributed to a local behavioral health authority under the Program:

(i) May be used to establish or expand behavioral health crisis response programs and services, such as:

1. Mobile crisis teams;

2. On–demand walk–in services;

3. Crisis residential beds; and

4. Other behavioral health crisis programs and services that the Department considers eligible for Program funds; and

(ii) Shall be used to supplement, and not supplant, any other funding for behavioral health crisis response programs and services.

(3) A local behavioral health authority may submit a proposal requesting Program funding to the Department.

(4) In awarding grants under this section, the Department shall prioritize proposals that:

(i) Make use of more than one funding source;

(ii) Demonstrate efficiency in service delivery through regionalization, integration of the behavioral health crisis program or service with existing public safety and emergency resources, and other strategies to achieve economies of scale;

(iii) Serve all members of the immediate community with cultural competency and appropriate language access;

(iv) Commit to gathering feedback from the community on an ongoing basis and improving service delivery continually based on this feedback;

(v) Demonstrate strong partnerships with community services that include family member and consumer advocacy organizations and regional stakeholders;

(vi) Evidence a plan of linking individuals in crisis to peer support and family support services after stabilization; and

(vii) Evidence a strong plan for integration into the existing behavioral health system of care and supports to provide seamless aftercare.

(5) In awarding grants under this section, the Department shall require that proposals contain response standards that prioritize mobile crisis units over law enforcement when responding to individuals in crisis.

(6) For each service or program that receives funding under the Program, a local behavioral health authority shall report to the Department and make available to the public all:

(i) Outcome measurement data required by the Department; and

(ii) Public feedback received from the community through a combination of surveys, public comments, town hall meetings, and other methods.

(7) The Department shall establish:

(i) Application procedures;

(ii) A statewide system of outcome measurement to:

1. Assess the effectiveness and adequacy of behavioral health crisis response services and programs; and

2. Produce data that shall be:

A. Collected, analyzed, and publicly reported back at least annually; and

B. Disaggregated by race, gender, age, and zip code;

(iii) Guidelines that require programs to bill third–party insurers and, when appropriate, the Maryland Medical Assistance Program; and

(iv) Any other procedures or criteria necessary to carry out this section.

(e) The Governor shall include in the annual operating budget bill the following amounts for the Program:

(1) $3,000,000 for fiscal year 2020;

(2) $4,000,000 for fiscal year 2021;

(3) $5,000,000 for fiscal year 2022;

(4) $5,000,000 for fiscal year 2023;

(5) $5,000,000 for fiscal year 2024;

(6) $5,000,000 for fiscal year 2025; and

(7) $5,000,000 for each of fiscal years 2027 through 2029.

(f) Beginning in fiscal year 2023, at least one–third of the appropriation required under subsection (e) of this section shall be used to award competitive grants for mobile crisis teams.

(g) On or before December 1 each year beginning in 2020, the Department shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, to the General Assembly a report that includes, for the most recent closed fiscal year:

(1) The number of grants distributed;

(2) Funds distributed by county;

(3) Information about grant recipients and programs and services provided; and

(4) Outcome data reported under the statewide system of measurement required in subsection (d)(7)(ii) of this section.

§7.5–209.

(a) In consultation with interested stakeholders, the Director shall prepare an annual report on behavioral health services for children and young adults in the State.

(b) The report shall include:

(1) The number and the percentage of children and young adults who, during the reported year:

(i) Were eligible for public behavioral health services;

(ii) Used a public behavioral health service, including:

1. An outpatient service;

2. An inpatient service;

3. An emergency room service;

4. A residential treatment center service;

5. An intensive public behavioral health service, including targeted or mental health case management services, respite care services, services provided under § 1915(i) of the Social Security Act, and psychiatric rehabilitation services; and

6. A substance–related disorders program service; and

(iii) Used a public behavioral health service provided through telehealth;

(2) The total expenditure and expenditure per child and young adult using a public behavioral health service, including:

(i) An outpatient service;

(ii) An inpatient service;

(iii) An emergency room service;

(iv) A residential treatment center service;

(v) An intensive community service; and

(vi) A substance–related disorders program service;

(3) The total cost per child or young adult for all behavioral health services provided to the child or young adult;

(4) The total expenditure and expenditure per child and young adult for:

(i) Targeted case management services;

(ii) Respite care services;

(iii) Services provided through a plan under § 1915(i) of the Social Security Act; and

(iv) Psychiatric rehabilitation services;

(5) The median length of time children and young adults spent:

(i) In the hospital emergency room pending psychiatric inpatient hospitalization; and

(ii) Waiting for placement in a residential treatment center from the date of the referral, as determined by the referral source, to the date of the placement;

(6) The number of children and young adults who were readmitted within 30 days at:

(i) The same hospital;

(ii) The same residential treatment center; or

(iii) Any other hospital or residential treatment center;

(7) The median length of stay for children and young adults at:

(i) A residential treatment center;

(ii) A psychiatric unit at a hospital; and

(iii) A residential substance–related disorders program; and

(8) For residential treatment centers:

(i) The total number of children and young adults admitted during the report year; and

(ii) The total number of children and young adults discharged during the report year.

(c) The report shall group the information required under subsection (b) of this section by jurisdiction and by the following age groups:

(1) Birth through 6 years old;

(2) 7 through 12 years old;

(3) 13 through 17 years old;

(4) 18 through 21 years old; and

(5) 22 through 25 years old.

(d) The report shall group the information required under subsection (b) of this section by the following races and ethnic groups:

(1) Hispanic or Latino of any race; and

(2) For individuals who are non–Hispanic or non–Latino:

(i) American Indian or Alaskan Native;

(ii) Asian;

(iii) Black or African American;

(iv) Native Hawaiian or other Pacific Islander;

(v) White; or

(vi) Two or more races.

(e) On or before December 1 each year, the Director shall submit the report required under this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

§7.5–210.

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

(2) "Eligible individual" means:

(i) A service member;

(ii) A veteran;

(iii) The spouse of a service member or veteran;

(iv) A child of a service member or veteran; or

(v) A stepchild of a service member or veteran.

(3) "Program" means the Sheila E. Hixson Behavioral Health Services Matching Grant Program for Service Members and Veterans.

(b) (1) There is a Sheila E. Hixson Behavioral Health Services Matching Grant Program for Service Members and Veterans.

(2) The purpose of the Program is to provide funds to local nonprofit organizations to establish and expand community behavioral health programs to serve service members, veterans, and their families.

(c) The Department shall administer the Program.

(d) The Program shall award competitive matching grants to local nonprofit organizations to establish and expand community behavioral health programs that:

(1) Serve the behavioral health needs of eligible individuals in the locality served by the nonprofit organization;

(2) Meet national standards;

(3) Integrate the delivery of mental health and substance use treatment; and

(4) Connect eligible individuals to appropriate community–based care in a timely manner on discharge from the community behavioral health program.

(e) (1) To be eligible for a grant from the Program, a nonprofit organization must have a mission to:

(i) Provide behavioral health services; or

(ii) Provide services to active service members, veterans, or their families.

(2) An eligible nonprofit organization shall secure contributions for the proposal in an amount of money or other consideration at least equal in value to the amount of money requested from the Program.

(3) (i) In awarding matching grants under the Program, the Department shall develop selection criteria for evaluating applicant proposals.

(ii) The selection criteria developed under this paragraph shall include positive scoring for proposals that:

1. Demonstrate fiscal controls, including by making use of multiple sources of funding;

2. Evidence project effectiveness, including by showing how the grant awarded by the Program will be used to augment existing services to create seamless behavioral health treatment;

3. Show an applicant's previous successful experience administering grants; and

4. Meet any other criteria the Department considers relevant.

(iii) In awarding matching grants under this section, the Department shall give priority to proposals that best meet the selection criteria regardless of the projected cost.

(4) The Department shall establish application procedures that implement the requirements of this subsection.

(f) (1) The Department shall establish a statewide system of outcome measurement to assess the effectiveness and adequacy of services provided by each nonprofit organization receiving a matching grant under the Program.

(2) A nonprofit organization receiving a matching grant under the Program shall submit any information that the Department determines is necessary for the statewide system of outcome measurement.

(g) The Department shall establish:

(1) Guidelines that require nonprofit organizations that receive a matching grant under the Program to bill third–party insurers and, when appropriate, the Maryland Medical Assistance Program; and

(2) Any other procedures necessary to carry out this section.

(h) Beginning in fiscal year 2022, and each fiscal year thereafter, the Governor may include in the annual budget bill an appropriation of $2,500,000 for the Program.

(i) On or before December 1 each year, beginning in 2023, the Department shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report that includes, for the most recently closed fiscal year:

(1) The number of grants distributed;

(2) Funds distributed by county;

(3) Information about grant recipients and the services provided through grant funding; and

(4) Outcome data reported under the statewide system of measurement required under subsection (f) of this section.

§7.5–301.

In this subtitle, "Council" means the Behavioral Health Advisory Council.

§7.5–302.

There is a Behavioral Health Advisory Council in the Office of the Governor.

§7.5–303.

(a) (1) The Council consists of the following members:

(i) One member of the Senate of Maryland, appointed by the President of the Senate;

(ii) One member of the House of Delegates, appointed by the Speaker of the House;

(iii) Five representatives of the Department, including:

1. The Secretary, or the Secretary's designee;

2. The Deputy Secretary for Behavioral Health, or the Deputy Secretary's designee;

3. The Deputy Secretary for Developmental Disabilities, or the Deputy Secretary's designee;

4. The Executive Director of the Maryland Health Benefit Exchange, or the Executive Director's designee; and

5. The Deputy Secretary for Health Care Financing, or the Deputy Secretary's designee;

(iv) The Secretary of Aging, or the Secretary's designee;

(v) The Secretary of Budget and Management, or the Secretary's designee;

(vi) The Secretary of Disabilities, or the Secretary's designee;

(vii) The Secretary of Housing and Community Development, or the Secretary's designee;

(viii) The Secretary of Human Services, or the Secretary's designee;

(ix) The Secretary of Juvenile Services, or the Secretary's designee;

(x) The Secretary of Public Safety and Correctional Services, or the Secretary's designee;

(xi) The Secretary of Labor, or the Secretary's designee;

(xii) The Executive Director of the Governor's Office of Crime Prevention and Policy, or the Executive Director's designee;

(xiii) The Director of the Governor's Office of the Deaf, Deafblind, and Hard of Hearing, or the Director's designee;

(xiv) The Public Defender of Maryland, or the Public Defender's designee;

(xv) Two representatives of the State Superintendent of Schools, or the Superintendent's designee, and the Assistant State Superintendent of the Division of Rehabilitation Services, or the Assistant State Superintendent's designee;

(xvi) Two representatives of the Maryland Judiciary, a District Court judge, and a circuit court judge, appointed by the Chief Justice of the Supreme Court of Maryland;

(xvii) The Executive Director of the Maryland Association of Behavioral Health Authorities, or the Executive Director's designee;

(xviii) The President of the Maryland Association of County Health Officers, or the President's designee;

(xix) Four representatives from county behavioral health advisory councils, one from each region of the State;

(xx) One representative, appointed by the Secretary of Health, from each of the following organizations:

1. Community Behavioral Health Association;

2. Maryland Center of Excellence on Problem Gambling;

3. Maryland Addictions Director's Council;

4. Maryland Association for the Treatment of Opioid Dependence;

5. Maryland Black Mental Health Alliance;

6. Maryland Coalition of Families;

7. Disability Rights Maryland;

8. Maryland Recovery Organization Connecting Communities;

9. Mental Health Association of Maryland;

10. National Alliance on Mental Illness of Maryland;

11. National Council on Alcoholism and Drug Dependence of Maryland;

12. On Our Own of Maryland; and

13. Maryland Association of Boards of Education; and

(xxi) Two individuals representing the mental health and substance use disorder treatment community, appointed by the Governor from each of the following:

1. Academic or research professionals who are not State employees;

2. Medical professionals;

3. Individuals formerly or currently in receipt of behavioral health services;

4. Family members of individuals with mental health or substance use disorders;

5. A parent of a young child with behavioral health disorders;

6. A youth with a behavioral health disorder who is between the ages of 16 and 25 years; and

7. Individuals active in behavioral health issues within their community.

(2) Additional representatives or individuals designated by the Council shall be appointed by the Secretary.

(b) Members appointed by the Governor under subsection (a)(1)(xxi) of this section shall be representative, to the extent practicable, of:

(1) Geographic regions of the State;

(2) At–risk populations;

(3) Ethnic, gender, across–the–lifespan, and cultural diversity; and

(4) Balanced representation from areas of mental health and substance use disorders.

(c) The Council shall appoint a chair from among the membership of the Council.

(d) (1) Members appointed by the Governor under subsection (a)(1)(xxi) of this section:

(i) Serve a 4–year term;

(ii) May serve for a maximum of two consecutive terms;

(iii) After at least 6 years have passed since serving, may be reappointed for terms that comply with items (i) and (ii) of this paragraph;

(iv) At the end of a term, continue to serve until a successor is appointed and qualifies; and

(v) If appointed after a term has begun, serve only for the rest of the term and until a successor is appointed and qualifies.

(2) Ex officio members serve as long as the member holds the specified office or designation.

(3) Notwithstanding any other provisions of this subsection, all members serve at the pleasure of the Governor.

(e) With the consent of the Council, the chair may designate additional individuals with relevant expertise to serve on a committee or task force.

§7.5–304.

(a) (1) The Council may adopt procedures necessary to do business, including the creation of committees or task forces.

(2) The Council may consult with State agencies to carry out the duties of the Council.

(3) The Council shall meet at least six times a year.

(4) A majority of the voting members of the Council is a quorum.

(b) A member of the Council:

(1) May not receive compensation as a member of the Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(c) The Behavioral Health Administration shall provide one full–time project manager for administrative coordination, and other staff as necessary to support the functions of the Council.

§7.5–305. IN EFFECT

The Council shall:

(1) Promote and advocate for:

(i) Planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome–guided and that integrates prevention, recovery, evidence–based practices, and cost–effective strategies that enhance behavioral health services across the State; and

(ii) A culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members; and

(2) Submit, in coordination with the Commission on Behavioral Health Care Treatment and Access, an annual report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on or before December 31 of each year.

§7.5–305. // EFFECTIVE JUNE 30, 2027 PER CHAPTERS 41 AND 42 OF 2024 //

The Council shall:

(1) Promote and advocate for:

(i) Planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome–guided and that integrates prevention, recovery, evidence–based practices, and cost–effective strategies that enhance behavioral health services across the State; and

(ii) A culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members; and

(2) Submit an annual report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on or before December 31 of each year.

§7.5–401.

(a) Except as otherwise provided in this section, a behavioral health program shall be licensed by the Secretary before program services may be provided in this State.

(b) The Secretary may exempt the following persons from the licensure requirements of this section:

(1) A health professional, in either solo or group practice, who is licensed under the Health Occupations Article and who is providing mental health or substance–related disorder services according to the requirements of the appropriate professional board;

(2) Alcoholics Anonymous, Narcotics Anonymous, recovery residences, peer support services, family support services, or other similar organizations, if the organization holds meetings or provides support services but does not provide any type of treatment;

(3) An employees' assistance program of a business entity;

(4) Outpatient behavioral health treatment and rehabilitation services provided in a regulated space in a hospital, as defined in § 19–301 of this article, if the services are accredited by an approved accreditation organization under its behavioral health standards; or

(5) A private therapeutic group home as defined in § 10–920 of this article.

§7.5–402.

(a) Regulations adopted under this subtitle shall include:

(1) The requirements for licensure of a behavioral health program, including a requirement that the behavioral health program:

(i) 1. Establish and implement a safety plan for the safety of the individuals served by the behavioral health program; or

2. Implement a safety or emergency plan established for the program for another purpose; and

(ii) Revise the safety plan not less than every 5 years;

(2) The process for a behavioral health program to apply for a license;

(3) A description of the behavioral health programs that are required to be licensed;

(4) Any requirements for the governance of a behavioral health program, including:

(i) A provision prohibiting a conflict of interest between the interests of the provider and those of the individual receiving services;

(ii) A provision authorizing a behavioral health program licensed as an outpatient mental health center to satisfy any regulatory requirement that the medical director be on site through the use of telehealth by the director; and

(iii) A provision authorizing a psychiatric nurse practitioner to serve as a medical director of an outpatient mental health center accredited in accordance with COMAR 10.63.03.05, including through telehealth;

(5) Provisions for inspections of a behavioral health program, including inspection and copying of the records of a behavioral health program in accordance with State and federal law; and

(6) Provisions for denials, sanctions, suspensions, and revocations of licenses, including imposition of civil monetary penalties, and notice and an opportunity to be heard.

(b) (1) The Secretary may require a behavioral health program to be granted accreditation by an accreditation organization approved by the Secretary under Title 19, Subtitle 23 of this article as a condition of licensure under regulations adopted under this subtitle.

(2) By becoming licensed in accordance with paragraph (1) of this subsection, a program agrees to comply with all applicable standards of the accreditation organization.

(3) If a behavioral health program is required to be granted accreditation as a condition of licensure under paragraph (1) of this subsection and the accreditation organization requires the behavioral health program to adopt a community relations plan, the behavioral health program shall submit the community relations plan to the Administration.

(c) Regulations adopted under this subtitle may include provisions setting reasonable fees for applying for a license and for the issuance and renewal of licenses.

(d) The Administration may authorize a behavioral health program to satisfy the safety plan requirement under subsection (a)(1) of this section by implementing a safety plan established for the behavioral health program for another purpose.

(e) The Department shall adopt regulations under this subtitle that establish food service facility standards that are appropriate to residential programs that have fewer than 17 residents and are licensed under:

(1) COMAR 10.63.03.11;

(2) COMAR 10.63.03.12;

(3) COMAR 10.63.03.13; or

(4) COMAR 10.63.03.14.

§7.5–403.

Each individual served by a behavioral health program is entitled to the rights that are:

(1) Identified in the behavioral health program's accreditation standards; or

(2) Established for nonaccredited behavioral health programs by the Department in regulations.

§7.5–404.

(a) An individual or organization may not operate a behavioral health program in violation of this subtitle.

(b) An individual or organization that operates a behavioral health program without the license required by this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000 for each violation.

(c) The Department may file for and pursue an injunction to prevent an individual or organization from operating a behavioral health program without the license required by this subtitle.

§7.5–501.

(a) The Department shall establish and operate a toll–free Health Crisis Hotline 24 hours a day and 7 days a week.

(b) The Health Crisis Hotline shall assist callers by:

(1) Conducting a comprehensive evidence–based screening for mental health and substance use needs, cognitive or intellectual functioning, infectious disease, and acute somatic conditions;

(2) Conducting a risk assessment for callers experiencing an overdose or potentially committing suicide or a homicide;

(3) Connecting callers to an emergency response system when indicated;

(4) Referring callers for ongoing care; and

(5) Following up with callers to determine if the needs of callers were met.

(c) The Department shall collect and maintain the following information to provide to callers on the Health Crisis Hotline:

(1) The names, telephone numbers, and addresses of:

(i) Residential, inpatient, and outpatient substance use disorder and mental health programs, including information on private programs and programs administered by local health departments and other public entities; and

(ii) Hospitals, including hospital emergency rooms, and other facilities that provide detoxification services;

(2) The levels of care provided by the programs, hospitals, and facilities identified under item (1) of this subsection; and

(3) Whether the programs, hospitals, and facilities identified under item (1) of this subsection:

(i) Accept payment for services from a third–party payor, including Medicare, Medicaid, and private insurance; and

(ii) Provide services:

1. That are specific to pregnant women;

2. That are gender specific;

3. For individuals with co–occurring disorders;

4. To support parents of children with substance use and mental health disorders; and

5. For grief support.

(d) (1) The Department shall provide training for Health Crisis Hotline staff who assist callers on the Health Crisis Hotline to ensure that staff are able to provide sufficient information and respond appropriately to callers who may be in a crisis.

(2) To the extent practicable, the Department shall ensure that information provided to callers on the Health Crisis Hotline is up to date and accurate.

(e) The Department shall disseminate information about the Health Crisis Hotline to the public, both directly and through public and private organizations that serve the public.

§7.5–5A–01. IN EFFECT

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

(b) "Commercial mobile radio service" or "CMRS" means mobile telecommunications service that is:

(1) Provided for profit with the intent of receiving compensation or monetary gain;

(2) An interconnected, two–way voice service; and

(3) Available to the public.

(c) "Commercial mobile radio service provider" or "CMRS provider" means a person authorized by the Federal Communications Commission to provide CMRS in the State.

(d) "Consumer" means a person that purchases prepaid wireless telecommunications service in a retail transaction.

(e) "Fund" means the 9–8–8 Trust Fund.

(f) "Lifeline program" means the federal Lifeline program established by the Federal Communications Commission.

(g) "Prepaid wireless telecommunications service" means a commercial mobile radio service that:

(1) Allows a consumer to dial 9–8–8 to access the 9–8–8 system;

(2) Must be paid for in advance; and

(3) Is sold in predetermined units that decline with use in a known amount.

(h) "Retail transaction" means the purchase of prepaid wireless telecommunications service from a seller for any purpose other than resale.

(i) "Telephone company" has the meaning stated in § 1–101 of the Public Utilities Article.

§7.5–5A–01. ** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 780 AND 781 OF 2024 **

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

(b) "Commercial mobile radio service" or "CMRS" means mobile telecommunications service that is:

(1) Provided for profit with the intent of receiving compensation or monetary gain;

(2) An interconnected, two–way voice service; and

(3) Available to the public.

(c) "Commercial mobile radio service provider" or "CMRS provider" means a person authorized by the Federal Communications Commission to provide CMRS in the State.

(d) "Consumer" means a person that purchases prepaid wireless telecommunications service in a retail transaction.

(e) "Fund" means the 9–8–8 Trust Fund.

(f) "Lifeline program" means the federal Lifeline program established by the Federal Communications Commission.

(g) "Prepaid wireless telecommunications service" means a commercial mobile radio service that:

(1) Allows a consumer to dial 9–8–8 to access the 9–8–8 system;

(2) Must be paid for in advance; and

(3) Is sold in predetermined units that decline with use in a known amount.

(h) "Retail transaction" means the purchase of prepaid wireless telecommunications service from a seller for any purpose other than resale.

(i) "Seller" means a person that sells prepaid wireless telecommunications service to another person.

(j) "Telephone company" has the meaning stated in § 1–101 of the Public Utilities Article.

§7.5–5A–02. IN EFFECT

(a) There is a 9–8–8 Trust Fund.

(b) The purpose of the Fund is to provide reimbursement for costs associated with:

(1) Designating and maintaining 9–8–8 as the universal telephone number for a national suicide prevention and mental health crisis hotline in accordance with the federal National Suicide Hotline Designation Act of 2020; and

(2) Developing and implementing a statewide initiative for the coordination and delivery of the continuum of behavioral health crisis response services in the State, including:

(i) Crisis call centers;

(ii) Mobile crisis team services;

(iii) Crisis stabilization centers; and

(iv) Other acute behavioral health care services.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money from the 9–8–8 fee collected and remitted to the Comptroller under § 7.5–5A–03.1 of this subtitle;

(2) Money appropriated in the State budget to the Fund;

(3) Interest earnings of the Fund; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only for:

(1) Carrying out the purpose of the Fund; and

(2) Any related administrative expenses of the Comptroller.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund for carrying out the purpose of the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated for carrying out the purpose of the Fund.

(j) No part of the Fund may revert or be credited to:

(1) The General Fund of the State; or

(2) Any other special fund of the State.

(k) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

(l) (1) Subject to paragraph (2) of this subsection, the Comptroller shall distribute to an administrative cost account the amount necessary to administer the fees and to cover the expenses of conducting audits under this section from the 9–8–8 fee revenue collected and remitted to the Comptroller under § 7.5–5A–03.1 of this subtitle.

(2) The amount distributed to the administrative cost account may not exceed:

(i) For each of fiscal years 2025, 2026, and 2027, 6% of the fees collected by the Comptroller; and

(ii) For fiscal year 2028 and each fiscal year thereafter, 3% of the fees collected by the Comptroller.

(m) After making the distribution required by subsection (l) of this section, the Comptroller shall deposit the 9–8–8 fee revenue in the Fund.

§7.5–5A–02. ** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 780 AND 781 OF 2024 **

(a) There is a 9–8–8 Trust Fund.

(b) The purpose of the Fund is to provide reimbursement for costs associated with:

(1) Designating and maintaining 9–8–8 as the universal telephone number for a national suicide prevention and mental health crisis hotline in accordance with the federal National Suicide Hotline Designation Act of 2020; and

(2) Developing and implementing a statewide initiative for the coordination and delivery of the continuum of behavioral health crisis response services in the State, including:

(i) Crisis call centers;

(ii) Mobile crisis team services;

(iii) Crisis stabilization centers; and

(iv) Other acute behavioral health care services.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money from the 9–8–8 fee collected and remitted to the Comptroller under § 7.5–5A–03.1 of this subtitle;

(2) Money from the prepaid wireless 9–8–8 fee collected and remitted to the Comptroller under § 7.5–5A–03.2 of this subtitle;

(3) Money appropriated in the State budget to the Fund;

(4) Interest earnings of the Fund; and

(5) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only for:

(1) Carrying out the purpose of the Fund; and

(2) Any related administrative expenses of the Comptroller.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund for carrying out the purpose of the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated for carrying out the purpose of the Fund.

(j) No part of the Fund may revert or be credited to:

(1) The General Fund of the State; or

(2) Any other special fund of the State.

(k) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

(l) (1) Subject to paragraph (2) of this subsection, the Comptroller shall distribute to an administrative cost account the amount necessary to administer the fees and to cover the expenses of conducting audits under this section from the 9–8–8 fee revenue collected and remitted to the Comptroller under §§ 7.5–5A–03.1 and 7.5–5A–03.2 of this subtitle.

(2) The amount distributed to the administrative cost account may not exceed:

(i) For each of fiscal years 2025, 2026, and 2027, 6% of the fees collected by the Comptroller; and

(ii) For fiscal year 2028 and each fiscal year thereafter, 3% of the fees collected by the Comptroller.

(m) After making the distribution required by subsection (l) of this section, the Comptroller shall deposit the 9–8–8 fee revenue in the Fund.

§7.5–5A–03.

The Department, in collaboration with the federal Substance Abuse and Mental Health Services Administration, the National Suicide Prevention Lifeline, the National Veterans Crisis Line, and other appropriate entities, shall work to promote the public messaging of 9–8–8 services in a consistent manner.

§7.5–5A–03.1.

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

(2) "9–8–8–accessible service" means telephone service or another communications service that connects an individual dialing the digits 9–8–8 to the 988 Suicide and Crisis Lifeline.

(3) "9–8–8 fee" means the fee imposed in accordance with this section.

(4) (i) "9–8–8 service carrier" means a provider of CMRS or other 9–8–8–accessible service.

(ii) "9–8–8 service carrier" does not include a telephone company.

(b) This section does not apply to prepaid wireless telecommunications service.

(c) (1) Except as provided in paragraph (2) of this subsection, each subscriber to switched local exchange access service, CMRS, or other 9–8–8–accessible service shall pay a 9–8–8 fee.

(2) A subscriber who is enrolled in the Lifeline program may not be required to pay a 9–8–8 fee.

(d) (1) Subject to paragraphs (2) through (4) of this subsection, the 9–8–8 fee is 25 cents per month payable when the bill for the switched local exchange access service, CMRS, or other 9–8–8–accessible service is due.

(2) Except as provided in paragraphs (3) and (4) of this subsection, if a person is able to make more than one simultaneous outbound call using a 9–8–8–

accessible service, each separate outbound call voice channel capacity, regardless of the technology, shall be considered a separate 9–8–8–accessible service for the purpose of determining the 9–8–8 fee due under paragraph (1) of this subsection.

(3) CMRS provided to multiple devices that share the same telephone number shall be considered a single 9–8–8–accessible service for the purpose of determining the 9–8–8 fee due under paragraph (1) of this subsection.

(4) A broadband connection that is not used as a telephone service may not be considered a separate voice channel capacity for the purpose of determining the 9–8–8 fee due under paragraph (1) of this subsection.

(e) (1) The Public Service Commission shall direct each telephone company to add the 9–8–8 fee to all current bills rendered for switched local exchange access service in the State.

(2) Each telephone company:

(i) Shall act as a collection agent for the Fund with respect to the 9–8–8 fees; and

(ii) Shall remit all money collected to the Comptroller on a monthly basis.

(f) (1) Each 9–8–8 service carrier shall add the 9–8–8 fee to all current bills rendered for CMRS or other 9–8–8–accessible service in the State.

(2) Each 9–8–8 service carrier:

(i) Shall act as a collection agent for the Fund with respect to the 9–8–8 fees;

(ii) Shall remit all money collected to the Comptroller on a monthly basis;

(iii) Shall keep records of 9–8–8 fees collected and remitted under this paragraph for at least 4 years after the fee is remitted; and

(iv) Is entitled to credit, against the money from the 9–8–8 fee to be remitted to the Comptroller, an amount equal to 0.5% of the 9–8–8 fee to cover the expenses of billing, collecting, remitting, and keeping records of the 9–8–8 fees.

(g) The Comptroller shall adopt procedures for auditing fee collection and remittance by telephone companies and CMRS providers.

(h) A CMRS provider that pays or collects 9–8–8 fees under this section has the same immunity from liability for transmission failures as that approved by the Public Service Commission for local exchange telephone companies that are subject to regulation by the Commission under the Public Utilities Article.

(i) The Comptroller shall adopt regulations to carry out this section.

§7.5–5A–03.2. NOT IN EFFECT

** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 780 AND 781 OF 2024 **

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

(2) "Prepaid wireless 9–8–8 fee" means the fee that is required to be collected by a seller from a consumer in the amount established under this section.

(3) "Provider" means a person that provides prepaid wireless telecommunications service under a license issued by the Federal Communications Commission.

(b) (1) The prepaid wireless 9–8–8 fee is 25 cents per retail transaction.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, the seller shall collect the prepaid wireless 9–8–8 fee from the consumer for each retail transaction in the State.

(ii) A seller may not collect a prepaid wireless 9–8–8 fee from a consumer if the consumer is enrolled in the Lifeline program.

(3) A retail transaction occurs in the State if:

(i) The sale or recharge takes place at the seller's place of business located in the State;

(ii) The consumer's shipping address is in the State; or

(iii) No item is shipped, but the consumer's billing address or the location associated with the consumer's mobile telephone number is in the State.

(c) (1) Except as provided in paragraph (2) of this subsection, the prepaid wireless 9–8–8 fee is the liability of the consumer and not of the seller or of any provider.

(2) The seller is liable for remitting all prepaid wireless 9–8–8 fees that the seller collects from consumers as provided in this section.

(d) A seller may deduct and retain 3% of prepaid wireless 9–8–8 fees collected from consumers to cover the expenses of collecting and remitting the prepaid wireless 9–8–8 fee.

(e) A seller shall report and remit to the Comptroller all prepaid wireless 9–8–8 fees collected by the seller in a manner provided for the remitting of the sales and use tax under Titles 11 and 13 of the Tax – General Article.

(f) For the purpose of this section, the audit and appeal procedures established for the sales and use tax under Titles 11 and 13 of the Tax – General Article apply.

(g) Providers and sellers of prepaid wireless telecommunications service have the same immunity from liability for transmission failures as that approved by the Public Service Commission for local exchange telephone companies that are subject to regulation by the Commission under the Public Utilities Article.

(h) A tax, fee, surcharge, or other charge may not be imposed by the State, a political subdivision of the State, or an intergovernmental agency for 9–8–8 funding purposes on a provider, seller, or consumer with respect to the sale, purchase, use, or provision of prepaid wireless telecommunications service.

(i) The Comptroller shall adopt regulations to carry out this section.

§7.5–5A–04. IN EFFECT

On or before December 1 each year, the Department shall submit a report to the Legislative Policy Committee, the Senate Budget and Taxation Committee, and the House Appropriations Committee, in accordance with § 2–1257 of the State Government Article, that includes for the immediately preceding fiscal year a detailed description of:

(1) The amount of funds transferred and distributed from the Fund in accordance with § 7.5–5A–02(b) of this subtitle;

(2) The amount of funds collected and remitted to the Comptroller under § 7.5–5A–03.1 of this subtitle;

(3) The additional services provided by the funding in each local jurisdiction;

(4) The amount of any unspent funds in the Fund; and

(5) The reasons funds identified under item (4) of this section were not spent.

§7.5–5A–04. ** TAKES EFFECT JULY 1, 2027 PER CHAPTERS 780 AND 781 OF 2024 **

On or before December 1 each year, the Department shall submit a report to the Legislative Policy Committee, the Senate Budget and Taxation Committee, and the House Appropriations Committee, in accordance with § 2–1257 of the State Government Article, that includes for the immediately preceding fiscal year a detailed description of:

(1) The amount of funds transferred and distributed from the Fund in accordance with § 7.5–5A–02(b) of this subtitle;

(2) The amount of funds collected and remitted to the Comptroller under § 7.5–5A–03.1 of this subtitle;

(3) The amount of funds collected and remitted to the Comptroller under § 7.5–5A–03.2 of this subtitle;

(4) The additional services provided by the funding in each local jurisdiction;

(5) The amount of any unspent funds in the Fund; and

(6) The reasons funds identified under item (5) of this section were not spent.

§7.5–601.

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

(2) "ASAM Level 3.1 services" means the level of clinically managed, low–intensity residential services for the treatment of addictive, substance–related, and co–occurring conditions described by the American Society of Addiction Medicine.

(3) "Health professional" means a person who:

(i) Is licensed under the Health Occupations Article; and

(ii) Is providing mental health or substance–related disorder services according to the requirements of the appropriate professional board.

(b) Beginning November 1, 2017, a behavioral health program or health professional, when referring an individual to receive services at a recovery residence, shall:

(1) Provide the individual with a list of certified recovery residences operating in the State that is published by the Department under § 19–2503(b) of this article; and

(2) Provide to an individual who has been assessed as in need of ASAM Level 3.1 services information on where the individual may receive those services.

§7.5–801.

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

(b) "Advisory Committee" means the Maryland Mental Health and Substance Use Disorder Registry and Referral System Advisory Committee.

(c) "Registry and Referral System" means the Maryland Mental Health and Substance Use Disorder Registry and Referral System.

(d) "State–designated health information exchange" means the health information exchange designated by the Maryland Health Care Commission under § 19–143 of this article.

§7.5–802.

(a) (1) There is a Maryland Mental Health and Substance Use Disorder Registry and Referral System in the Department.

(2) The purpose of the Registry and Referral System is to provide a statewide system through which health care providers can identify and access available private and State inpatient and outpatient mental health and substance use services for patients in a seamless manner.

(3) Subject to the availability of funds, the Department shall develop and implement the Registry and Referral System, in collaboration with the State–designated Health Information Exchange.

(4) The Registry and Referral System shall include:

(i) A searchable inventory of any private or State provider of mental health and substance use disorder services, including inpatient, crisis, and outpatient services;

(ii) The capability to allow a provider of mental health and substance use disorder services to update registry information including the real–time availability of services; and

(iii) An electronic referral system that is available to any health care provider in the State to facilitate electronic referrals to mental health and substance use disorder providers.

(b) The Department shall:

(1) Determine the appropriate technology to support the operation of the Registry and Referral System; and

(2) To the extent practicable, consider existing technology operated by the State–designated health information exchange, workflow of providers, and practices of providers when determining the appropriate technology for the Registry and Referral System.

(c) (1) There is a Maryland Mental Health and Substance Use Disorder Registry and Referral System Advisory Committee.

(2) The Advisory Committee shall advise the Department on the development and implementation of the Registry and Referral System.

(3) The Advisory Committee shall include:

(i) The Deputy Secretary of Behavioral Health, or the Deputy Secretary's designee;

(ii) The Deputy Secretary for Public Health Services, or the Deputy Secretary's designee;

(iii) The Executive Director of the Health Services Cost Review Commission, or the Executive Director's designee;

(iv) One representative with expertise in health information technology, designated by the Maryland chapter of the Healthcare Information and Management Systems Society;

(v) Providers of mental health and substance use services; and

(vi) Any other representatives considered necessary by the Department to assist in the development and implementation of the Registry and Referral System.

(4) The Advisory Committee shall make recommendations to the Department relating to the design, development, implementation, and funding of the Registry and Referral System on:

(i) Necessary regulations;

(ii) The status of the resource directory and pilot program developed by the Department; and

(iii) Sources of funding, including grant funds and other sources of federal, private, or State funds.

(d) Each private and State hospital shall ensure the availability of staff to identify appropriate and available services for patients in the hospital who are in need of mental health or substance use disorder services and to assist the patient in accessing the services.

(e) The Department shall adopt regulations to carry out this subtitle.

§7.5–901.

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

(b) "Council" means the Opioid Restitution Fund Advisory Council.

(c) "Fund" means the Opioid Restitution Fund established under § 7–331 of the State Finance and Procurement Article.

§7.5–902.

There is an Opioid Restitution Fund Advisory Council in the Department.

§7.5–903.

(a) The Council consists of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Deputy Secretary for Behavioral Health, or the Deputy Secretary's designee;

(4) The Deputy Secretary for Health Care Financing, or the Deputy Secretary's designee;

(5) The Attorney General, or the Attorney General's designee;

(6) The Special Secretary of Overdose Response, or the Special Secretary's designee;

(7) Three individuals appointed by the Governor:

(i) One of whom represents a community–based opioid treatment program;

(ii) One of whom represents a community–based substance use disorder and mental health treatment program; and

(iii) One of whom is a public health expert engaged in harm reduction services;

(8) Three individuals appointed by the Secretary:

(i) One of whom is an individual in recovery from a substance use disorder;

(ii) One of whom is a family member of an individual who has experienced an overdose; and

(iii) One of whom is an individual disproportionately impacted by substance use disorders and disparities in access to care;

(9) One individual designated by the Executive Director of the Maryland Association of Counties; and

(10) One individual designated by the Executive Director of the Maryland Municipal League.

(b) Members appointed by the Governor and by the Secretary under subsection (a) of this section shall, to the extent practicable:

(1) Reflect the geographic regions of the State;

(2) Be representative of at–risk populations; and

(3) Reflect the ethnic, gender, and cultural diversity of the State.

(c) The Council shall designate a chair from among the membership of the Council.

(d) (1) (i) The term of a member appointed by the Governor or the Secretary under subsection (a) of this section is 2 years.

(ii) The terms of the members appointed by the Governor and the Secretary under subsection (a) of this section are staggered as required by the terms provided for members of the Council on October 1, 2022.

(iii) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(2) A member appointed by the Governor or the Secretary under subsection (a) of this section may serve for a maximum of two consecutive terms.

(3) Notwithstanding any other provisions of this subsection, all members serve at the pleasure of the Governor.

(e) A member of the Council:

(1) May not receive compensation as a member of the Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) Subject to § 7.5–904(c) of this subtitle, with the consent of the Council, the chair may designate additional individuals with relevant expertise to serve on a committee of the Council in an advisory capacity.

§7.5–904.

(a) (1) Subject to subsection (c) of this section, the Council may adopt procedures necessary to do business, including the creation of committees.

(2) The Council may consult with State agencies to carry out the duties of the Council.

(3) The Council shall meet at least four times a year.

(4) A majority of the voting members of the Council is a quorum.

(b) Maryland's Office of Overdose Response shall provide appropriate staff necessary to support the functions of the Council.

(c) (1) If required by a court or administrative order or a settlement agreement entered into by the Attorney General, the Attorney General may direct that a Council committee be formed in accordance with the requirements of the court or administrative order or settlement agreement.

(2) The Attorney General shall establish procedures for a committee formed under paragraph (1) of this subsection in order to ensure compliance with the requirements of the court or administrative order or settlement agreement.

(3) (i) Subject to subparagraph (ii) of this paragraph, a committee formed under paragraph (1) of this subsection shall conduct only business related to the purpose of the court or administrative order or settlement agreement that required the formation of the subcommittee.

(ii) A committee may conduct business related to multiple court or administrative orders or settlement agreements if the court or administrative orders or settlement agreements contain identical requirements.

(4) A committee formed under paragraph (1) of this subsection may consist only of members of the Council.

(5) Unless otherwise provided in a court or administrative order or settlement agreement, the chair of the Council, or the chair's designee, shall be chair of a committee formed under paragraph (1) of this subsection.

§7.5–905.

(a) On or before November 1 each year, the Council shall provide specific findings and recommendations in writing to the Governor and the Secretary regarding the allocations of money from the Fund for expenditures consistent with uses of the Fund and considering the following criteria:

(1) The number of people per capita with a substance use disorder in a jurisdiction;

(2) Disparities in access to care in a jurisdiction that may preclude persons;

(3) The number of overdose deaths per capita in a jurisdiction;

(4) The programs, services, supports, or other resources currently available to individuals with substance use disorders in a jurisdiction; and

(5) Disparities in access to care and health outcomes in a jurisdiction.

(b) (1) Within 6 months after receiving the findings and recommendations submitted under subsection (a) of this section, the Secretary shall present to the Council the decisions for the allocations of money from the Fund.

(2) The Department shall post on the Department's website the findings and recommendations of the Council and the decisions for the allocations of money from the Fund.

§7.5–1001.

(a) The Maryland Office of Overdose Response, in collaboration with the Department, shall develop and maintain an interactive dashboard on Opioid Restitution Fund spending for the purpose of sharing prescription opioid–related settlement information with the public.

(b) The dashboard developed and maintained under subsection (a) of this section shall include, disaggregated by State, county, and municipality:

(1) Payment schedule information on estimated payments to the State, county, or municipality from opioid settlements;

(2) Past spending of settlement funds;

(3) Spending plans and priorities; and

(4) A detailed description of any initiative funded with settlement funds, including performance measures if applicable.

(c) If there is a State, county, or municipal website that provides access to additional information on the use of opioid–related settlement funds by the State,

county, or municipality, the dashboard shall include a link to the State, county, or municipal website.

(d) (1) This subsection does not apply to a county or municipality that:

(i) Complies with reporting requirements established in an opioid–related settlement; and

(ii) Shares the data in the reports required under an opioid–related settlement with the appropriate State entity.

(2) A county or municipality receiving settlement funds shall provide to the Department the necessary financial information related to settlement funding to include as information on the dashboard.

(3) Information required to be provided under paragraph (2) of this subsection shall be in compliance with the terms of any opioid–related settlement agreement.

(4) The Department shall upload opioid–related settlement information submitted to the Department by a county or municipality in compliance with the terms of an opioid–related settlement.

(5) The Department shall establish an online portal with instructions for a county or municipality to report or upload required information to the Department for use in the dashboard.

(e) To the extent practicable, the dashboard shall use existing platforms that provide data on opioid use and overdoses in the State.

(f) The dashboard shall be developed and maintained using funds from the Opioid Restitution Fund as appropriated through the State budget.

§8–101.

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

(b) (1) "Addictive disorder" means a chronic disorder of the brain's reward–activation system in which the individual pathologically pursues reward or relief by substance abuse or other behaviors, with diminished control, and the individual persists in the behavior despite adverse consequences.

(2) "Addictive disorder" includes gambling, which is the only nonsubstance–related addictive disorder recognized by Maryland law.

(c) "Administration" means the Behavioral Health Administration.

(d) "Administrator" means the program director or the clinical director of an alcohol or drug abuse treatment facility or a health care facility.

(e) "Alcohol abuse" means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho–social.

(f) "Alcohol dependence" means a disease characterized by:

(1) Alcohol abuse; and

(2) Physical symptoms of withdrawal or tolerance.

(g) "Alcohol misuse" means:

(1) Unlawful use of alcohol;

(2) Alcohol abuse; or

(3) Alcohol dependence.

(h) "Director" means the Director of the Administration.

(i) "Drug" means:

(1) A controlled dangerous substance that is regulated under the Maryland Controlled Dangerous Substances Act;

(2) A prescription medication; or

(3) A chemical substance when used for unintended and harmful purposes.

(j) "Drug abuse" means a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho–social.

(k) "Drug dependence" means a disease characterized by:

(1) Drug abuse; and

(2) Physical symptoms of withdrawal or tolerance.

(l) "Drug misuse" means:

(1) Unlawful use of a drug;

(2) Drug abuse; or

(3) Drug dependence.

(m) "Halfway house" means a clinically managed, low intensity residential treatment service for individuals with substance–related disorders who are capable of self–care but are not ready to return to independent living.

(n) "Large halfway house" means a halfway house that admits at least 9 but not more than 16 individuals.

(o) (1) "Mental disorder" means a behavioral or emotional illness that results from a psychiatric disorder.

(2) "Mental disorder" includes a mental illness that so substantially impairs the mental or emotional functioning of an individual as to make care or treatment necessary or advisable for the welfare of the individual or for the safety of the person or property of another.

(3) "Mental disorder" does not include an intellectual disability.

(p) "Recovery residence" means a service that:

(1) Provides alcohol–free and illicit–drug–free housing to individuals with substance–related disorders or addictive disorders or co–occurring mental disorders and substance–related disorders or addictive disorders; and

(2) Does not include clinical treatment services.

(q) "Small halfway house" means a halfway house that admits at least 4 but not more than 8 individuals.

(r) (1) "Substance–related disorder" means:

(i) Alcohol use disorder, alcohol abuse, alcohol dependence, alcohol misuse, alcohol intoxication, or alcohol withdrawal;

(ii) Nonalcohol substance use disorder, drug dependence, drug misuse, nonalcohol substance induced intoxication, or nonalcohol substance withdrawal; or

(iii) Any combination of the disorders listed in items (i) and (ii) of this paragraph.

(2) "Substance–related disorder" includes substance use disorders and substance induced disorders.

(s) "Withdrawal management" means direct or indirect services for an acutely intoxicated individual to fulfill the physical, social, and emotional needs of an individual by:

(1) Monitoring the amount of alcohol and other toxic agents in the body of the individual;

(2) Managing withdrawal symptoms; and

(3) Motivating an individual to participate in the appropriate substance–related disorder programs.

§8–205.

(a) Each person who is authorized to administer, use professionally, or dispense a drug and each public official who has duties with respect to drugs or to users of them shall report to the Administration any relevant information that the Administration requires to carry out the purposes of this title, subject to the provisions of State and federal laws and regulations governing confidentiality.

(b) An employee or unit of the State or of any of its political subdivisions shall release to the Administration, on its request, information that deals with drug abuse or alcohol abuse or drug dependence or alcohol dependence, including the name of an individual with a drug or alcohol problem if needed to carry out the purposes of this title, subject to the provisions of State and federal laws and regulations governing confidentiality.

§8–206.

(a) With the approval of the Secretary of Budget and Management, the Administration shall accept, on behalf of the State, a conditional or unconditional gift or grant.

(b) The Administration shall pay all funds collected under this section into a special fund of the State Treasury and use the special fund to carry out the provisions of this title.

§8–401.

(a) (1) The Administration shall:

(i) Promote, develop, establish, conduct, certify, and monitor programs for the prevention, treatment, and rehabilitation related to the misuse of alcohol and drugs; and

(ii) Promote and conduct training and research related to the misuse of alcohol and drugs.

(2) (i) In cooperation with the Motor Vehicle Administration, courts, police, and other agencies, the Administration shall approve appropriate programs of alcohol and drug abuse education or treatment for individuals who are convicted under § 21–902 of the Transportation Article.

(ii) The programs under this paragraph shall be coordinated with and integrated into broad planning for comprehensive community health and welfare services.

(3) The Administration shall:

(i) Review and, in accordance with regulations that the Administration shall adopt, approve or disapprove each program that a public or private agency wants to offer under § 6–219(c) or § 6–220(e) of the Criminal Procedure Article;

(ii) Promptly give the Administrative Office of the Courts notice of each program approved under this paragraph;

(iii) Monitor and biennially review each program approved under this paragraph;

(iv) Investigate each complaint made in connection with a program; and

(v) Promptly give the Administrative Office of the Courts notice if the Department withdraws its approval of any program.

(b) The Administration may:

(1) Develop pilot programs;

(2) For these purposes and notwithstanding any other law, establish, direct, and conduct any experimental pilot clinical program for the treatment of alcohol or drug abusers, including any program to administer, under medical supervision and control, maintenance dosages of prescribed drugs;

(3) Either alone or with other public or private agencies, direct and conduct basic research in alcohol or drug abuse, including clinical epidemiological, social science, and statistical research;

(4) In cooperation with the Department of Public Safety and Correctional Services or any other appropriate correctional agency, establish and maintain, in any correctional institution in this State, programs for the prevention and treatment of alcohol and drug abuse and for the rehabilitation of alcohol and drug abusers; and

(5) Require a facility that provides treatment for substance use disorder to:

(i) Provide beds and services for patients' children; and

(ii) Allow a patient's child to be in the presence of the child's parent for the duration of the child's parent's treatment.

§8–405.

(a) A halfway house shall be licensed in accordance with Title 7.5 of this article.

(b) The Secretary shall adopt regulations for establishing, licensing, and operating halfway houses.

§8–406.

(a) A small halfway house:

(1) Is deemed conclusively a single–family dwelling for purposes of zoning; and

(2) Is permitted to locate in all residential zones.

(b) A large halfway house is deemed conclusively a multifamily dwelling and is permitted to locate in zones of similar density.

(c) A halfway house is not subject to any special exception, conditional use permit, or procedure that differs from that required for a single–family dwelling or a multifamily dwelling of similar density in the same zone.

(d) A general zoning ordinance that conflicts with the provisions of this section is superseded by this section, to the extent of the conflict.

§8–407.

(a) The Department shall identify up–to–date, evidence–based, written information about opioid use disorder that:

(1) Has been reviewed by medical experts and national and local organizations specializing in the treatment of opioid use disorder;

(2) Is designed for use by health care providers and individuals with opioid use disorder and their families;

(3) Is culturally and linguistically appropriate for potential recipients of the information; and

(4) Includes information addressing:

(i) The signs and symptoms of opioid use disorder;

(ii) The risks associated with untreated opioid use disorder;

(iii) Appropriate clinical treatment for opioid use disorder, including:

1. Counseling services; and

2. All medications approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder;

(iv) Appropriate use of overdose reversal agents;

(v) Appropriate support services, including:

1. Peer fellowship and support groups, such as Narcotics Anonymous and Alcoholics Anonymous;

2. Community–based services; and

3. Residential or recovery housing services; and

(vi) Appropriate treatments for pain that may be used to reduce or replace opioid medication treatments for chronic pain.

(b) (1) The Department shall provide the information identified by the Department under subsection (a) of this section to health care facilities and health care providers that provide treatment for opioid use disorder.

(2) A health care facility or health care provider shall make the information available to each patient treated by the facility or provider for opioid use disorder.

§8–408.

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

(2) "Community services program" includes a homeless services program.

(3) "Homeless services program" means a program operated by the Department of Housing and Community Development through a local administering agency or service provider for the purpose of providing shelter, food, and services to homeless family units in the State.

(4) "Intensive outpatient program" means a treatment program that addresses substance use disorders or other disorders that do not require detoxification or inpatient supervision and are designated by the American Society of Addiction Medicine as a level 2.1 setting.

(5) "Opioid treatment program" means a program approved by the Department to provide opioid maintenance therapy under regulations adopted by the Department.

(b) On or before June 30, 2024, a community services program that provides services to individuals who have a substance use disorder or an opioid use disorder or are at risk of experiencing a drug overdose shall have a protocol to offer opioid overdose reversal drugs approved by the federal Food and Drug Administration, free of charge, to those individuals who have an opioid use disorder or are at risk of experiencing a drug overdose when the individual receives services from the community services program.

(c) On or before June 30, 2023, each opioid treatment program and each intensive outpatient treatment program shall have a protocol to offer an opioid overdose reversal drug approved by the federal Food and Drug Administration, free of charge, when an individual receives services from the opioid treatment program or intensive outpatient treatment program.

(d) On or before June 30, 2024:

(1) State and local correctional facilities shall have a protocol to offer an opioid overdose reversal drug approved by the federal Food and Drug Administration, free of charge, to sentenced individuals who have an opioid use disorder or who are at risk of experiencing a drug overdose before the individual's release; and

(2) The Division of Parole and Probation shall have a protocol to offer an opioid overdose reversal drug approved by the federal Food and Drug Administration, free of charge, to individuals under supervision who have an opioid use disorder or are at risk of experiencing a drug overdose.

(e) The Secretary may adopt regulations to carry out this section.

§8–501.

(a) (1) In cooperation with State and local police, the Administration may adopt regulations under which personnel other than the police are authorized to exercise the powers under this section whenever feasible so that the exercise of those powers by the police are reduced to a minimum.

(2) The police and other authorized personnel who act under this section are acting within the scope of their official duty.

(b) If a publicly intoxicated individual consents or an individual's health is in immediate danger, the police or other authorized personnel may take or send a publicly intoxicated individual to:

(1) The individual's home;

(2) A detoxification center; or

(3) Any other appropriate health care facility as defined in § 19-114(d) of this article.

(c) Unless a criminal charge is filed, an entry of an action under this section may not be made on the arrest or other criminal record of the intoxicated individual.

(d) An individual taken or sent to a detoxification center or a health care facility under subsection (b) of this section may be admitted to the facility with the consent of the director of the facility or the designee of the director.

§8–502.

(a) After a preliminary evaluation of an individual by the administrator or the designee of the administrator, the individual may be admitted to the facility if it is certified in writing that the individual:

(1) Has acute symptoms of alcohol or drug intoxication or withdrawal; and

(2) (i) Appears to be in imminent danger of harming one's self, or another individual, or the property of another individual; or

(ii) Is willing to be voluntarily admitted.

(b) An individual admitted under this section may be detained up to 72 hours after admission.

(c) An individual detained under this section shall be informed in writing at the time of admission of the right of the individual to leave the facility after 72 hours.

(d) This section does not require a facility to admit an individual when:

(1) Space is not available;

(2) A patient demonstrates medical and psychiatric conditions beyond the certified capabilities of the program staff; or

(3) As a result of an evaluation of an individual, the individual is determined to be an inappropriate admission to the facility.

§8–502.1.

(a) A parent or guardian of the person of a minor may apply, on behalf of the minor, for admission of the minor to a certified inpatient alcohol and drug abuse program or facility or a certified intensive outpatient alcohol and drug abuse program under this section.

(b) A program or facility may not admit an individual under this section unless the program or facility has determined that:

(1) The individual has an alcohol or other drug dependency that necessitates the level of care provided by the program or facility;

(2) The individual would benefit from treatment;

(3) The parent or guardian making application for admission of the individual understands the nature of the request for admission and the nature of the treatment provided by the program or facility; and

(4) Assent to the admission has been given by the Director or the Director's designee of the program or facility.

(c) In order for an individual to be retained for treatment under this section:

(1) The parent or guardian who applied for admission of the individual shall have the right to be actively involved in treatment; and

(2) The program or facility shall note on the application for admission whether or not the minor was admitted in accordance with the provisions of § 20–102(c–1) of this article.

(d) A program or facility has the right to discharge an individual admitted for treatment under this section if the individual is not complying with the treatment program or the facility's policies and procedures.

§8–503.

(a) If, after the police arrest an intoxicated individual for a criminal offense, the individual seems to require emergency medical treatment, the police immediately shall take the individual to a detoxification center or other appropriate health care facility as defined in § 19–114(d) of this article.

(b) (1) If necessary, after medical treatment, the police shall transport the individual to a program that provides detoxification services.

(2) The individual may be admitted to a program that provides detoxification services in accordance with the provisions of § 8–501(d) of this subtitle.

§8–504.

In carrying out §§ 8-501, 8-502, and 8-503 of this subtitle, the police or other authorized personnel shall make every reasonable effort to protect the health and safety of the intoxicated individual.

§8–505.

(a) (1) (i) Except as provided in paragraph (2) of this subsection, before or during a criminal trial, before or after sentencing, or before or during a term of probation, the court may order the Department to evaluate a defendant to determine whether, by reason of drug or alcohol abuse, the defendant is in need of and may benefit from treatment if:

1. It appears to the court that the defendant has an alcohol or drug abuse problem; or

2. The defendant alleges an alcohol or drug dependency.

(ii) A court shall set and may change the conditions under which an examination is to be conducted under this section.

(iii) The Department shall ensure that each evaluation under this section is conducted in accordance with regulations adopted by the Department.

(2) (i) If a defendant is serving a sentence for a crime of violence, as defined in § 14–101 of the Criminal Law Article, a court may not order the Department to evaluate a defendant under this section until the defendant is eligible for parole.

(ii) Nothing in this paragraph may be construed to prohibit a defendant who is serving a sentence for a crime of violence, as defined in § 14–101 of the Criminal Law Article from participating in any other treatment program or receiving treatment under the supervision of the Department under any other provision of law.

(b) On consideration of the nature of the charge, the court:

(1) May require or permit an examination to be conducted on an outpatient basis; and

(2) If an outpatient examination is authorized, shall set bail for the defendant or authorize the release of the defendant on personal recognizance.

(c) (1) If a defendant is to be held in custody for examination under this section:

(i) The defendant may be confined in a detention facility until the Department is able to conduct the examination; or

(ii) The court may order confinement of the defendant in a medical wing or other isolated and secure unit of a detention facility, if the court finds it appropriate for the health or safety of the defendant.

(2) (i) If the court finds that, because of the apparent severity of the alcohol or drug dependency or other medical or psychiatric complications, a defendant in custody would be endangered by confinement in a jail, the court may order the Department to either:

1. Place the defendant, pending examination, in an appropriate health care facility; or

2. Immediately conduct an evaluation of the defendant.

(ii) Unless the Department retains a defendant, the defendant shall be promptly returned to the court after an examination.

(iii) A defendant who is detained for an examination under this section may question at any time the legality of the detention by a petition for a writ of habeas corpus.

(d) (1) If a court orders an evaluation under this section, the evaluator shall:

(i) Conduct an evaluation of the defendant; and

(ii) Submit a complete report of the evaluation within 7 days to the:

1. Court;

2. Department; and

3. Defendant or the defendant's attorney.

(2) On good cause shown, a court may extend the time for an evaluation under this section.

(3) Whenever an evaluator recommends treatment, the evaluator's report shall:

(i) Name a specific program able to immediately provide the recommended treatment; and

(ii) Give an actual or estimated date when the program can begin treatment of the defendant.

(e) (1) The Department shall immediately provide the services required by this section.

(2) A designee of the Department may carry out any of its duties under this section.

(f) Evaluations performed in facilities operated by the Department of Public Safety and Correctional Services shall be conducted by the Administration.

§8–506.

(a) Subject to the eligibility restrictions under § 8–505(a) of this subtitle, a court may commit a defendant to the Department for inpatient evaluation as to drug or alcohol abuse if:

(1) The court finds it is not clinically appropriate for the defendant to be evaluated in a detention facility or an appropriate outpatient facility; and

(2) After an initial evaluation, the Department:

(i) Recommends a comprehensive inpatient evaluation of the defendant;

(ii) Certifies that an appropriate facility is either currently, or within a reasonable time will be able to, conduct the evaluation;

(iii) Provides to the court a date by which the evaluation can be conducted; and

(iv) Gives the court prompt notice when an evaluation can be conducted.

(b) (1) The Department shall provide the services required by this section.

(2) A designee of the Department may carry out any of the Department's duties under this section if appropriate funding is provided.

(c) The Department shall facilitate the prompt evaluation of a defendant under this section and ensure that each evaluation is conducted in accordance with regulations adopted by the Department.

(d) A court may order law enforcement officials, detention center staff, Department of Public Safety and Correctional Services staff, or sheriff's department staff within the appropriate local jurisdiction to transport the defendant to and from an evaluation facility.

(e) (1) A commitment under this section may not require evaluation for more than 7 days unless the medical condition of a defendant warrants an extension of a maximum of 14 days.

(2) Except during the first 72 hours after admission of a defendant to an evaluation facility, the Department may terminate the evaluation if the Department determines that continued evaluation:

(i) Is not in the best interest of the defendant; or

(ii) Does not serve any useful purpose.

(3) Whenever an evaluation recommends treatment, the evaluator's report shall:

(i) Name a specific program able to provide the recommended treatment; and

(ii) Give an actual or estimated date when the program can begin treatment of the defendant.

(f) (1) On completion of an evaluation under this section, the Department shall notify the court.

(2) Before a defendant is released from an evaluation facility under this section, the Department shall give the court that ordered the evaluation and the correctional facility, if any, to whose custody the defendant is to be released notice of the proposed date and time of release and have the defendant returned to the court as provided in the evaluation order.

(g) (1) If a defendant leaves an evaluation facility without authorization, the responsibility of the Department is limited to notification of the court that ordered the defendant's evaluation, as soon as it is reasonably possible.

(2) Notice under this subsection shall constitute probable cause for a court to issue a warrant for the arrest of a defendant.

§8–507.

(a) (1) Except as provided in paragraph (2) of this subsection and subject to the limitations in this section, a court that finds in a criminal case or during a term of probation that a defendant has an alcohol or drug dependency may commit the defendant as a condition of release, after conviction, or at any other time the defendant voluntarily agrees to participate in treatment, to the Department for treatment that the Department recommends, even if:

(i) The defendant did not timely file a motion for reconsideration under Maryland Rule 4–345; or

(ii) The defendant timely filed a motion for reconsideration under Maryland Rule 4–345 which was denied by the court.

(2) (i) If a defendant is serving a sentence for a crime of violence, as defined in § 14–101 of the Criminal Law Article, a court may not order the Department to treat a defendant under this section until the defendant is eligible for parole.

(ii) Nothing in this paragraph may be construed to prohibit a defendant who is serving a sentence for a crime of violence, as defined in § 14–101 of the Criminal Law Article, from participating in any other treatment program or receiving treatment under the supervision of the Department under any other provision of law.

(b) Before a court commits a defendant to the Department under this section, the court shall:

(1) Offer the defendant the opportunity to receive treatment;

(2) Obtain the written consent of the defendant:

(i) To receive treatment; and

(ii) To have information reported back to the court;

(3) Order an evaluation of the defendant under § 8–505 or § 8–506 of this subtitle;

(4) Consider the report on the defendant's evaluation; and

(5) Find that the treatment that the Department recommends to be appropriate and necessary.

(c) Immediately on receiving an order for treatment under this section, the Department shall order a report of all pending cases, warrants, and detainers for the defendant and forward a copy of the report to the court, the defendant, and the defendant's last attorney of record.

(d) (1) The Department shall provide the services required by this section.

(2) A designee of the Department may carry out any of the Department's duties under this section.

(e) (1) A court may not order that the defendant be delivered for treatment until:

(i) Any detainer based on an untried indictment, information, warrant, or complaint for the defendant has been removed; and

(ii) Any sentence of incarceration for the defendant is no longer in effect.

(2) The Department shall facilitate the immediate treatment of a defendant unless the court finds exigent circumstances to delay commitment for treatment for longer than 30 days.

(3) If a defendant who has been committed for treatment under this section is not placed in treatment within 21 days of the order, the court may order the Department to appear to explain the reason for the lack of placement.

(f) For a defendant committed for treatment under this section, a court shall order supervision of the defendant:

(1) By an appropriate pretrial release agency, if the defendant is released pending trial;

(2) By the Division of Parole and Probation under appropriate conditions in accordance with §§ 6–219 through 6–225 of the Criminal Procedure Article and Maryland Rule 4–345, if the defendant is released on probation; or

(3) By the Department, if the defendant remains in the custody of a local correctional facility.

(g) A court may order law enforcement officials, detention center staff, Department of Public Safety and Correctional Services staff, or sheriff's department staff within the appropriate local jurisdiction to transport a defendant to and from treatment under this section.

(h) The Department shall promptly report to a court a defendant's withdrawal of consent to treatment and have the defendant returned to the court within 7 days for further proceedings.

(i) A defendant who is committed for treatment under this section may question at any time the legality of the commitment by a petition for a writ of habeas corpus.

(j) (1) A commitment under this section shall be for at least 72 hours and not more than 1 year.

(2) On good cause shown by the Department, the court, or the State, the court may extend the time period for providing the necessary treatment services in increments of 6 months.

(3) Except during the first 72 hours after admission of a defendant to a treatment program, the Department may terminate the treatment if the Department determines that:

(i) Continued treatment is not in the best interest of the defendant; or

(ii) The defendant is no longer amenable to treatment.

(k) When a defendant is to be released from treatment under this section, the Department shall notify the court that ordered the treatment.

(l) (1) If a defendant leaves treatment without authorization, the responsibility of the Department is limited to the notification of the court that ordered the defendant's treatment as soon as it is reasonably possible.

(2) Notice under this subsection shall constitute probable cause for a court to issue a warrant for the arrest of a defendant.

(m) Nothing in this section imposes any obligation on the Department:

(1) To treat any defendant who knowingly and willfully declines to consent to further treatment; or

(2) In reporting to the court under this section, to include an assessment of a defendant's dangerousness to one's self, to another individual, or to the property of another individual by virtue of a drug or alcohol problem.

(n) Time during which a defendant is held under this section for inpatient evaluation or inpatient or residential treatment shall be credited against any sentence imposed by the court that ordered the evaluation or treatment.

(o) This section may not be construed to limit a court's authority to order drug treatment in lieu of incarceration under Title 5 of the Criminal Law Article.

§8–508.

(a) An individual may ask voluntarily for admission to an outpatient treatment program, whether or not the individual has been admitted to the program before.

(b) After an individual asks for admission to an outpatient treatment program, the administrative head of the program shall determine whether the individual is to be admitted. However, the administrative head may not deny readmission of an individual solely because the individual previously left the program against the advice of the administrative head.

(c) An outpatient treatment program shall use public and private community efforts, including welfare services, vocational rehabilitation, and job replacement, to integrate a chronic alcoholic into society as a productive citizen.

(d) (1) A chronic alcoholic may not be dropped from an outpatient treatment program solely because of a relapse into intoxication.

(2) Every reasonable method of treatment shall be used to prevent a relapse.

(3) If recovery of the chronic alcoholic is unlikely, the outpatient treatment program shall provide supportive services and residential facilities so that the individual may survive in a decent manner.

§8–509.

The Administration shall promote the admission and treatment of intoxicated individuals and alcoholics in private and public hospitals without discrimination.

§8–601.

(a) If any individual seeks counseling, treatment, or therapy, for any form of drug or alcohol abuse, from a health professional licensed under the Health Occupations Article treating patients within the scope of the professional's practice, or hospital, or a person who is certified by the Administration for counseling or treating drug or alcohol abuse, the oral or written statements that the individual makes and the observations and conclusions that the health professional, hospital, or other person derives or the results of an examination to determine the existence of an illegal or prohibited drug in the body of an individual are not admissible in any proceeding against the individual, other than and subject to the federal regulations concerning the confidentiality of alcohol and drug abuse patient records:

(1) A proceeding that relates to parole or probation or conditional release from a not criminally responsible finding, if the examination had been ordered as a condition of parole or probation or the conditional release from a not criminally responsible finding; or

(2) A proceeding under Subtitle 5 of this title, if the examination had been ordered for that proceeding.

(b) The results of a proceeding under Subtitle 5 of this title and evidence in the proceeding may not be used against that individual in any other proceeding.

(c) The disclosure and use of the records of individuals served by alcohol abuse and drug abuse treatment programs shall be governed by the federal regulations on the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2.

§8–6A–01.

(a) In this section, "Fund" means the Maryland Substance Abuse Fund.

(b) (1) There is a Maryland Substance Abuse Fund.

(2) The Fund is a special nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The Fund consists of the fee required under § 6–229 of the Criminal Procedure Article, money appropriated in the State budget to the Fund, all earnings from investment of money in the Fund, and other money accepted for the benefit of the Fund from a governmental or private source.

(4) The State Treasurer shall hold the Fund separately.

(5) The State Comptroller shall account for the Fund.

(6) The Fund shall be invested and reinvested in the same manner as other State funds.

(7) The Comptroller shall pay out money from the Fund as directed by the Administration or as approved in the State budget.

(8) The Fund is subject to audit by the Office of Legislative Audits under § 2–1220 of the State Government Article.

(9) No part of the Fund may revert or be credited to:

(i) The General Fund of the State; or

(ii) Any other special fund of the State.

(c) The Fund shall be used by the Administration for the following purposes in order of priority:

(1) Planning expenses and related costs incurred by local drug and alcohol councils established under Subtitle 10 of this title;

(2) Planning expenses and related costs incurred by any State unit designated to coordinate planning by local drug and alcohol councils and review grant requests from local governments; and

(3) Substance abuse evaluation and treatment services, including services provided through a drug treatment court.

(d) (1) Administrative expenditures under this section may be made only in accordance with the State budget.

(2) The Administration shall administer the Fund in accordance with this section and all other applicable law.

(3) Disbursements from the Fund shall supplement and may not substitute for any other funds appropriated in the State budget for substance abuse evaluation and treatment services.

§8–6C–01.

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

(b) "Eligible functions" includes:

(1) Transportation to and from treatment services;

(2) Treatment, prevention, or coordination staff;

(3) Data sharing services among counties and other appropriate treatment providers;

(4) Education or outreach programs and materials;

(5) In–community emergency behavioral health services or crisis stabilization units; and

(6) Behavioral health programs in schools.

(c) "Eligible population" includes:

(1) Mothers of drug–addicted infants;

(2) Parents of children in need of assistance;

(3) Hospital emergency room admittees;

(4) Needy families receiving temporary cash assistance;

(5) Foster care children and parents;

(6) Children in after–school programs and their parents, including children and parents in programs supported by the Maryland After–School Opportunity Fund;

(7) Adolescents;

(8) Parents subject to arrearages in child support payments;

(9) Drug offenders under the supervision of the Division of Parole and Probation;

(10) Pretrial correctional incarcerated individuals;

(11) Prerelease correctional incarcerated individuals;

(12) The general incarcerated individual population within county–managed correctional facilities;

(13) Parents of children entering out–of–home placements or at risk of entering out–of–home placements; and

(14) Drug offenders under the supervision of the problem solving courts.

(d) "Partnership funding" means money granted from the Substance Abuse Treatment Outcomes Partnership Fund to match local funding.

(e) "Proposal" means a plan under this subtitle to provide new or expanded substance abuse treatment services.

(f) "Request for Partnership funding" means a proposal, submitted by the governing bodies of one or more jurisdictions, to provide substance abuse treatment services to one or more eligible populations or to provide eligible functions within the requesting jurisdiction or jurisdictions.

§8–6C–02.

(a) There shall be a Substance Abuse Treatment Outcomes Partnership Fund, established within the Maryland Department of Health.

(b) The Fund shall be administered according to this subtitle.

(c) (1) The Fund shall receive money as provided by the Governor in the State budget.

(2) The Fund also may accept funds from local, nonprofit, or private organizations.

§8–6C–03.

The Department shall adopt regulations to:

(1) Establish timelines and procedures for requests for Partnership funding, consistent with this subtitle;

(2) Establish guidelines that require programs to bill third–party insurers; and

(3) Manage the Fund and authorize distribution of money from the Fund in accordance with this subtitle.

§8–6C–04.

(a) In this section, "county" includes Baltimore City.

(b) A request for Partnership funding may be submitted to the Department by:

(1) The governing body of a county; or

(2) The governing body of more than one county.

(c) A request for Partnership funding shall be made in accordance with a schedule and format determined by the Department, in consultation with the Task Force to Study Increasing the Availability of Substance Abuse Programs.

(d) In a request for Partnership funding, the applicant or applicants shall include:

(1) A description of the proposal;

(2) (i) An indication of the eligible targeted population or populations that the proposal will serve; or

(ii) The eligible functions that will be funded under the proposal;

(3) A description of the services to be provided under the proposed new or expanded program and an identification of the local providers able to provide those services;

(4) A plan to reach the targeted populations using relevant means of contact;

(5) Performance and outcome indicators to evaluate the program effectiveness, including a description of the expected schedule and methods for measuring performance and outcome; and

(6) A statement of the funds or in–kind contributions that the applicant intends to commit.

(e) In evaluating a request for Partnership funding, the Department shall consider:

(1) The performance and outcome indicators specified;

(2) The degree to which the proposal may reduce the need for other State or local public services or programs intended for the populations targeted by the proposal;

(3) The extent to which the proposal incorporates the use of excess or otherwise available medical–related facilities, including vacant hospital beds;

(4) How the proposal fits into a balanced approach to the State's variety of substance abuse needs and populations that serves different geographic areas of the State with Partnership funding; and

(5) The extent to which the proposal is part of or consistent with a regional strategy for substance abuse treatment programs affecting adjoining jurisdictions.

(f) (1) The Department shall award Partnership funding following the considerations in this section.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, a county granted funding shall be responsible for one–half of the cost of the approved partnership.

(ii) The Department may award Partnership funding that results in a county being responsible for less than one–half of the cost of the approved partnership after considering:

1. The financial hardship of the participating county;

2. Prior contributions of funds for substance abuse treatment programs made by the participating county; or

3. Other relevant considerations deemed appropriate by the Department.

(3) Except as provided in paragraph (4) of this subsection, a participating county:

(i) May use Partnership funds only to supplement levels of spending by the participating county on drug treatment programs; and

(ii) May not use Partnership funds to supplant spending by the participating county on drug treatment programs.

(4) If a participating county began spending county or other non–State funds on eligible functions after October 1, 2010, the participating county may use Partnership funding to continue or expand funding for eligible functions.

§8–6D–01.

(a) There is an Addiction Treatment Divestiture Fund in the Department.

(b) The purpose of the Fund is to support addiction treatment services to persons with substance–related disorders.

(c) The Secretary shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Revenue distributed to the Fund under § 9–804 of the Criminal Law Article;

(2) Money appropriated in the State budget to the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only to support the actions of the Secretary to provide treatment for substance–related disorders.

(g) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

§8–701.

(a) A person may not knowingly have or attempt to have an individual unlawfully or improperly adjudicated to be a drug or alcohol abuser or to have an alcohol or drug dependence under Subtitle 5 of this title.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 3 years or both.

§8–801.

This title may be cited as the Maryland Alcohol and Drug Abuse Act.

§8–901.

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

(b) "Designee" means a nonprofit or quasi-governmental entity designated by the Baltimore City Health Department to receive funds from the Administration to plan, manage, monitor, and disburse funds to substance abuse prevention and treatment programs.

(c) "Nonprofit entity" means:

(1) A land-based organization that qualifies under § 501(c) of the Internal Revenue Code of 1986, as amended; or

(2) Any similar land-based entity that does not operate for profit.

(d) (1) "Quasi-governmental entity" means a land-based organization created by a unit of government to plan for the use of, monitor, disburse, and manage public funds.

(2) "Quasi-governmental entity" includes Baltimore Substance Abuse Systems, Inc.

§8–902.

(a) The Baltimore City Health Department may designate a nonprofit or quasi-governmental entity in Baltimore City to receive funds from the Administration to plan, manage, monitor, and disburse funds to substance abuse prevention and treatment programs.

(b) The Baltimore City Health Department may revoke its designation of a nonprofit or quasi-governmental entity at any time except to the extent that the Administration, the designee, or both have acted in reliance on the designation.

(c) If the Baltimore City Health Department designates a nonprofit or quasi-governmental entity to receive funds, the Administration shall disburse funds budgeted for the Baltimore City Health Department directly to the Department's designee.

(d) The Administration shall have a direct relationship with the designee.

(e) The Administration shall have the same rights and remedies with the designee as it would otherwise have with the Baltimore City Health Department.

§8–1001.

(a) Each county shall have a local drug and alcohol abuse council.

(b) On application from a county, the Governor or the Governor's designee may designate a county criminal justice coordinating council, substance abuse advisory council, or other agency or organization as the local drug and alcohol abuse council for that county.

(c) Except as provided in subsection (b) of this section, a local drug and alcohol abuse council shall consist of the following individuals:

(1) The health officer of the local health department, or the health officer's designee;

(2) The director of the local department of social services, or the director's designee;

(3) The Regional Director of the Department of Juvenile Services, or the Director's designee;

(4) The Regional Director of the Division of Parole and Probation, or the Director's designee;

(5) The State's Attorney for the county, or the State's Attorney's designee;

(6) The district public defender for the district in which the county is located, or the district public defender's designee;

(7) The chief of the county police department, if the county has a police force, or the sheriff, if the county does not have a police force, or that individual's designee;

(8) The president of the local board of education, or the president's designee;

(9) A representative of the county executive, the Mayor of Baltimore City, or the county commissioners or county council in counties with no county executive, as appropriate;

(10) For charter counties and in Baltimore City, a representative of the county council or the city council in Baltimore City, appointed by the chairperson or president of the county council or city council;

(11) The county administrative judge of the circuit court for the county, or the judge's designee;

(12) The administrative judge of the district court for that district, or the judge's designee; and

(13) The following individuals appointed by the county executive, the Mayor of Baltimore City, or the county commissioners or county council in counties with no county executive, as appropriate:

(i) At least one recipient of addictions treatment services;

(ii) Two substance abuse providers, at least one of whom has experience with services to individuals with co-occurring substance abuse and mental health disorders;

(iii) At least one substance abuse prevention provider;

(iv) At least one individual who is knowledgeable and active on substance abuse issues that affect the county;

(v) The superintendent, warden, or director of the local correctional facility located in the county or in Baltimore City the warden of the Baltimore City Detention Center; and

(vi) At least one other individual who is knowledgeable about treatment of substance abuse in the county, including members of civic organizations, the chamber of commerce, health care professional organizations, or the clergy.

(d) (1) The term of a member appointed under subsection (c) of this section is 4 years.

(2) The terms of members are staggered as required by the terms provided for members of the council on July 1, 2004.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(e) The local drug and alcohol abuse council shall:

(1) Determine its own governing structure, including issues relating to appointment of a member to serve as chairman;

(2) Develop and submit a plan to the Administration as required in this section;

(3) Submit a summary report to the Governor or the Governor's designee on or before December 1, 2004, on its membership, organization, rules, progress in developing a plan, and compliance with this section; and

(4) (i) On July 1, 2005, and every 2 years thereafter, submit a local plan as described in subsection (f) of this section to the Governor, or the Governor's designee; and

(ii) Report every 6 months to the Administration on its progress in implementing the plan.

(f) A local plan shall:

(1) Include the plans, strategies, and priorities of the county for meeting the identified needs of the general public and the criminal justice system for alcohol and drug abuse evaluation, prevention, and treatment services;

(2) Include a survey of all federal, State, local, and private funds used in the county for alcohol and drug abuse evaluation, prevention, and treatment; and

(3) Be in a format as prescribed by the Administration.

(g) A county or unit of a county applying for funds from a State unit for any alcohol or drug abuse evaluation, prevention, or treatment services within that county shall submit that application to the local drug and alcohol abuse council for its consideration.

(h) (1) The local drug and alcohol abuse council may recommend to any federal or State unit or private foundation that an application for any funds for drug or alcohol abuse evaluation, prevention, or treatment services in the county be approved.

(2) (i) A local drug and alcohol abuse council shall consider whether the grant application is consistent with the local plan and the strategies and priorities set out in the local plan.

(ii) A recommendation by a local drug and alcohol abuse council may include any additional information the council considers useful to the governmental unit or private foundation in its consideration of the application.

(i) (1) The Administration may provide each local drug and alcohol abuse council with any necessary technical assistance.

(2) The Administration shall provide any funds available from the Maryland Substance Abuse Fund or other sources for operation of a local council on submission of a request for funds and approval of a budget in accordance with Administration regulations.

(j) The planning, reporting, and reviewing requirements for a local drug and alcohol abuse council under this section do not apply unless appropriate State funding for fulfilling the requirements has been provided.

§8–1101.

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

(2) "Health care facility" means:

(i) A hospital;

(ii) A federally qualified health center;

(iii) An outpatient mental health clinic;

(iv) An outpatient or residential addiction treatment provider; and

(v) A local health department.

(3) "Opioid addiction treatment medication" means a medication approved by the federal Food and Drug Administration for the treatment of opioid use disorders.

(b) Each health care facility that is not part of a health care system and each health care system shall make available to patients the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine–containing formulations.

(c) To comply with subsection (b) of this section, a health care facility or a health care system may:

(1) Directly employ, contract with, or refer a patient to a health care provider who is trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine–containing formulations; or

(2) Deliver the services in person or, if appropriate, through telehealth.

§8–1102.

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

(2) "Nonpreferred medication" means a medication prescribed to treat an opioid use disorder that contains methadone, buprenorphine, or naltrexone and is not on the State's preferred drug list.

(3) "Preferred medication" means a medication prescribed to treat an opioid use disorder that contains methadone, buprenorphine, or naltrexone and is on the State's preferred drug list.

(b) The Department shall:

(1) Adopt a reporting system to monitor the prescribing of medications to treat opioid use disorders in the State, including which medications are being prescribed;

(2) Analyze patterns of prescribing medications in the State to identify prescribers who regularly prescribe nonpreferred medications, including a comparison of the patterns to the findings of the report submitted under subsection (d) of this section;

(3) Conduct outreach to individuals authorized to prescribe drugs and devices in the State using educational materials regarding the benefits of prescribing preferred medications; and

(4) Identify barriers to individuals who need medication to treat an opioid use disorder to obtaining the medication in a timely manner.

(c) On or before October 1 each year, beginning in 2023, the Department shall report on its findings and actions taken under subsection (b) of this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(d) On or before October 1, 2022, the Department shall submit a report with an initial analysis of the items listed under subsection (b) of this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

§10–101.

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

(b) "Administration" means the Behavioral Health Administration.

(c) (1) "Admission" means the process by which an individual is accepted as a resident in:

(i) An inpatient facility; or

(ii) A Veterans' Administration hospital in this State that provides care or treatment for individuals who have mental disorders.

(2) "Admission" includes the physical act of the individual entering the facility or Veterans' Administration hospital.

(d) "Behavioral health care" includes prevention, screening, early intervention, treatment, recovery, support, wraparound, and rehabilitation services for individuals with substance–related disorders, addictive disorders, mental disorders, or a combination of these disorders.

(e) "Core service agency" means the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded mental health services.

(f) "Director" means the Director of the Behavioral Health Administration.

(g) (1) Except as otherwise provided in this title, "facility" means any public or private clinic, hospital, or other institution that provides or purports to provide treatment or other services for individuals who have mental disorders.

(2) "Facility" does not include a Veterans' Administration hospital.

(h) "Local behavioral health authority" means the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded mental health, substance–related disorder, and addictive disorder services.

(i) (1) "Mental disorder" means a behavioral or emotional illness that results from a psychiatric disorder.

(2) "Mental disorder" includes a mental illness that so substantially impairs the mental or emotional functioning of an individual as to make care or treatment necessary or advisable for the welfare of the individual or for the safety of the person or property of another.

(3) "Mental disorder" does not include an intellectual disability.

(j) "State Advisory Council" means the Behavioral Health Advisory Council.

(k) "State facility" means a facility that is owned or operated by the Department.

(l) "Treatment" means any professional care or attention that is given in a facility, private therapeutic group home for children and adolescents, or Veterans' Administration hospital to improve or to prevent the worsening of a mental disorder.

§10–102.

It is the policy of this State:

(1) To the best of its ability, to foster and preserve the mental health of its citizens; and

(2) To that end, to provide without partiality care and treatment to citizens who have mental disorders.

§10–103.

This title shall be construed in a manner consistent with the policy stated in this subtitle.

§10–104.

Notwithstanding any other provision of law, this title applies to a person who is licensed under Title 19 of this article if the person provides care or treatment to individuals who have mental disorders.

§10–205.

(a) The Administration may administer a program of nonresidential services for individuals who have mental disorders or have conditions that may lead to mental disorders:

(1) To develop, extend, and improve services for finding these individuals; and

(2) To provide facilities for diagnosis and treatment of nonresidential cases.

(b) The Administration may:

(1) Prepare plans for the program;

(2) Adopt necessary rules and regulations to carry out these plans;

(3) In accordance with these plans, receive and spend any available funds;

(4) Coordinate and supervise the provision of program services that the Administration does not provide directly; and

(5) Cooperate with the federal government and with all other public or private agencies in:

(i) Developing, extending, and improving the services; and

(ii) Carrying out the plans.

§10–206.

(a) The Secretary shall revise periodically the State comprehensive mental health plan.

(b) The State comprehensive mental health plan shall:

(1) Include an inventory of the mental health resources in this State;

(2) Set out the needs of the various areas for services, including community-based services in accordance with the findings and recommendations of the plan described in § 10-207 of this subtitle;

(3) Establish priorities of the different services needed; and

(4) Include any other matter that the Secretary thinks should be covered.

§10–207.

(a) By January 1, 1992, within existing resources, the Director shall update the current Mental Hygiene Administration 3–year plan for mental health, which was submitted to the federal government in response to § 1925 of the Public Health Service Act, in order to plan for those individuals who:

(1) Have a serious mental disorder as defined in the plan; and

(2) Are not receiving the appropriate array of community–based services described in the "total need" section of the 3–year mental health plan that expired on June 30, 1991.

(b) (1) On or after October 1, 1993, within existing resources and in concert with local core service agencies or local behavioral health authorities, the Director shall prepare a comprehensive mental health plan which identifies the needs of all individuals who have a serious mental disorder and who are targeted for services in the "Comprehensive Mental Health Services Plan" submitted by the State to the federal government in accordance with § 1925 of the Public Health Service Act.

(2) The comprehensive mental health plan shall:

(i) Include annual strategic projections, through the year 2000, of resources needed;

(ii) Plan for those individuals who have a serious mental disorder, including those who are presently not being served by the public mental health system, those who are homeless, and those children, adults, and elderly individuals living without services in the community with their families or on their own who are at risk of further institutionalization;

(iii) Plan for individuals who have a serious mental disorder and who are presently residing in a State facility, nursing home, or jail who could appropriately be served in the community if the proper community–based services were available to them;

(iv) Plan for individuals who have a serious mental disorder and who are unable or unwilling to obtain community–based services from existing State–supported programs or from the private sector and assess their need for additional, flexible, individualized, or otherwise more appropriate services;

(v) Plan for the extent of need for the development of additional community–based housing and related support services;

(vi) Plan for the extent of the need for additional community–based support services, including rehabilitation, clinical treatment, case management, crisis and emergency services, mobile treatment, in–home intervention services, school–based, after–school services, respite and family support services, and vocational services in order to implement the orderly transfer of institutionalized individuals who can live in the community and to serve those individuals presently in the community who are now underserved or unserved and at risk of institutionalization;

(vii) Evaluate the role of existing State hospitals and plan for the reallocation to the community of any funds saved through hospital downsizing, consolidation, or closure; and

(viii) Be consistent with the goal of providing comprehensive, coordinated community–based housing and support services for every individual who has a serious mental disorder and who is appropriate for and in need of such services.

(c) The Director shall, in concert with local core service agencies or local behavioral health authorities, implement each plan to the extent that resources are available.

§10–208.

(a) (1) There is a continuing, nonlapsing Mental Health Community–Based Services Fund.

(2) The purpose of the Mental Health Community–Based Services Fund is to ensure that funds realized from the sale or lease of Behavioral Health Administration facilities as the result of downsizing, consolidation, or closure are used to provide community–based services.

(b) Notwithstanding any other provision of law, if any Behavioral Health Administration facility is downsized, consolidated, or closed, all State property associated with the facility that is not transferred to another governmental entity shall be sold or leased at fair market value, and the net proceeds of the sale or lease shall be deposited into the Mental Health Community–Based Services Fund.

(c) (1) If a facility operated by the Behavioral Health Administration is downsized, consolidated, or closed such that the net resident population declines or if a facility is closed or consolidated and bed capacity levels remained unchanged:

(i) State general funds may be appropriated as necessary, in advance, to assist in the downsizing;

(ii) Any funds in the Mental Health Community–Based Services Fund:

1. May not supplant resources for existing community services; and

2. Shall be used to meet the needs of individuals leaving facilities to enter community–based services; and

(iii) Any funds remaining after meeting the needs of individuals identified in subparagraph (ii)2 of this paragraph shall be used to increase the availability of:

1. Affordable housing and employment opportunities for individuals with mental illness; and

2. Community mental health services designed to promote recovery and community integration, including development of the Maryland Mental Health Crisis Response System established under Subtitle 14 of this title.

(2) Funds in the Mental Health Community–Based Services Fund shall be spent in accordance with a plan developed by the Behavioral Health Administration in consultation with consumers, family members, providers, and mental health advocates.

(d) On or before January 1 of each year, the Secretary shall prepare a report to be submitted to the General Assembly and the Department of Legislative Services on the Mental Health Community–Based Services Fund.

(e) Any unspent portions of the Mental Health Community–Based Services Fund and any interest earned on money in the Waiting List Equity Fund may not be transferred or revert to the General Fund of the State but shall remain in the Mental Health Community–Based Services Fund to be used for the purposes specified in this section.

§10–308.

(a) Except as otherwise provided in subsections (c) and (d) of this section, the governing body of each county shall establish a mental health advisory committee.

(b) The purpose of a mental health advisory committee shall be to serve as advocate for a comprehensive mental health system for persons of all ages.

(c) The governing bodies of two or more counties may establish, by agreement, an intercounty mental health advisory committee if:

(1) The population of one of the counties is too small to warrant the establishment of a mental health advisory committee for that county; and

(2) The Director consents.

(d) The governing body of a county may establish a joint mental health and addictions advisory committee.

(e) In Howard County, if a quasi–public authority is established under Subtitle 12 of this title, the governing body may designate the authority as the mental health advisory committee for the county.

(f) In Baltimore City, the governing body may designate Behavioral Health Systems Baltimore the local behavioral health authority for Baltimore City under Subtitle 12 of this title, as the mental health advisory committee for Baltimore City.

(g) In Anne Arundel County, the governing body may designate Anne Arundel County Mental Health Agency, Inc., the core service agency or local behavioral health authority for Anne Arundel County under Subtitle 12 of this title, as the mental health advisory committee for Anne Arundel County.

(h) In Washington County, the governing body may designate Washington County Mental Health Authority, Inc., the core service agency for Washington County under Subtitle 12 of this title, as the mental health advisory committee for Washington County.

§10–309.

(a) (1) The mental health advisory committee of each county shall consist of:

(i) As nonvoting ex officio members, the following individuals or their designees:

1. The health officer for the county;

2. A representative of a State inpatient facility that serves that county, appointed as provided in paragraph (2) of this subsection;

3. The county mental health director;

4. The director of the core service agency or local behavioral health authority, if any; and

5. In jurisdictions with designated State inpatient beds located in local general hospitals, a representative from that facility; and

(ii) As voting members, appointed by the governing body of the county and representative of the county's major socio–economic and ethnic groups:

1. At least 5, but not more than 7, representatives selected from among the following groups or agencies:

A. The governing body;

B. The county department of education;

C. The local department of social services;

D. The practicing physicians;

E. Mental health professionals who are not physicians;

F. The clergy;

G. The legal profession;

H. A local law enforcement agency;

I. A local general hospital that contains an inpatient psychiatric unit;

J. The Department of Aging;

K. The Department of Juvenile Services;

L. The local alcohol and drug abuse agency; and

M. A local community rehabilitation or housing program; and

2. At least 5 individuals selected from among the following groups or organizations and appointed as provided in paragraph (3) of this subsection:

A. At least 2 individuals who are currently receiving or who have in the past received mental health services;

B. Parents or other relatives of adults with mental disorders;

C. Parents or other relatives of children or adolescents with emotional, behavioral, or mental disorders the onset of which occurred during childhood or adolescence;

D. The local mental health association, if any;

E. An individual with experience with mental health care for veterans or individuals serving in the military; and

F. A member of the general public.

(2) If more than one State inpatient facility serves a county, a representative from at least 1 of the facilities shall be appointed by the Director.

(3) At least one–half of the voting members shall be appointed from among the individuals listed in paragraph (1)(ii)2A through C of this subsection.

(4) Notwithstanding paragraphs (1) through (3) of this subsection, if the governing body of Baltimore City or Anne Arundel County designates a core service agency or local behavioral health authority as the mental health advisory committee, the mental health advisory committee shall consist of the governing body of the core service agency or local behavioral health authority.

(b) If an intercounty advisory committee is established, the governing body of each participating county shall appoint at least 4 members of the committee.

(c) Notwithstanding subsection (a)(1)(ii) of this section, if the governing body of a county establishes a joint mental health and addictions advisory committee, the governing body may appoint any additional members as necessary to advise and advocate about addictions issues.

(d) (1) The term of an appointed member is 3 years and begins on July 1.

(2) The terms of one–third of the appointed members of each county advisory committee or intercounty advisory committee end each year.

(3) At the end of a term, a member may continue to serve until a successor is appointed and qualifies.

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

(5) A member who serves 2 consecutive full 3–year terms may not be reappointed for 2 years after completion of those terms.

§10–310.

(a) From among its members, each county advisory committee and each intercounty advisory committee shall elect annually a chairperson and other officers that the committee finds necessary.

(b) A member may not serve as chairperson for more than 2 consecutive years.

(c) The manner of election of officers shall be as each county advisory committee or intercounty advisory committee determines.

§10–311.

(a) Each county advisory committee and intercounty advisory committee shall have no fewer than 6 meetings per year at the times and places that the committee determines.

(b) Except in Montgomery County, staff services for each county advisory committee or intercounty advisory committee shall be provided by the health officer for the appropriate county.

§10–312.

(a) Each county advisory committee and each intercounty advisory committee may:

(1) Create subcommittees; and

(2) Have additional individuals participate as needed.

(b) Each county advisory committee and intercounty advisory committee shall:

(1) Monitor, review and evaluate the allocation and adequacy of publicly funded mental health services within the county through means such as conducting or participating in site visits;

(2) Determine the needs of the county mental health system, including quality of services, gaps in the system, and interagency coordination;

(3) Participate in the development of the local mental health plan and local mental health budget;

(4) (i) Prepare and disseminate an annual report to the following:

1. The health officer;

2. In Montgomery County, the director of the Montgomery County Department of Health and Human Services;

3. The county mental health director;

4. The governing body of the appropriate county;

5. The director of the local core service agency or local behavioral health authority, if any;

6. The regional mental health director;

7. The Director;

8. The Secretary; and

9. The Behavioral Health Advisory Council; and

(ii) Include in the annual report, at a minimum, the following:

1. A description of the progress of the county mental health system;

2. Recommendations on actions needed to improve the system;

3. Recommendations on priorities for allocation of funds; and

4. In accordance with those priorities and after consideration of financial resources, recommendations on appropriate allocation of funds;

(5) Review and comment upon the annual core service agency or county mental health plan and preliminary budget, prior to submission of the budget to the State; and

(6) Review and comment upon the annual fiscal report.

§10–401.

The Director shall supervise generally the operation of all State facilities.

§10–404.

In Part II of this subtitle, "Board" means a citizens' advisory board for a State facility.

§10–405.

Part II of this subtitle does not apply to the Maryland Psychiatric Research Center.

§10–406.

(a) The following State facilities shall be maintained under the direction of the Administration:

(1) Clifton T. Perkins Hospital Center;

(2) Eastern Shore Hospital Center;

(3) Regional Institutes for Children and Adolescents — Baltimore and Rockville;

(4) Springfield Hospital Center;

(5) Spring Grove Hospital Center; and

(6) Thomas B. Finan Hospital Center.

(b) As a facility is built or transferred to the Administration, the facility may be made a State facility.

(c) (1) By January 1, 1985, the Department shall adopt rules and regulations for admission to all Regional Institutes for Children and Adolescents in cooperation with representatives from the advisory committees of the Regional Institutes for Children and Adolescents, the mental health advisory committees in each region, the local education agencies, and the Mental Health Association of Maryland.

(2) In determining these rules and regulations, the Department shall provide that no bona fide candidate for admission may be rejected solely because of residence outside the regular catchment area served by the institution.

(3) In determining these rules and regulations, the Department shall provide that candidates for admission who reside in the regular catchment area served by the institution shall be granted priority in admissions to the institution.

(d) (1) Beginning in fiscal year 2007, the Department may not bill a local board of education for any services provided by the State at a regional institute for children and adolescents.

(2) Notwithstanding paragraph (1) of this subsection:

(i) Beginning in fiscal year 2007, the Department shall continue to provide the same scope of services at regional institutes for children and adolescents that were provided as of January 1, 2005; and

(ii) A local board of education may make a contribution toward the cost of services provided by the State at a regional institute for children and adolescents.

(e) (1) Before a regional institute for children and adolescents may be closed, the Department shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee, justifying the closure.

(2) The report shall address:

(i) The reasons for the closure;

(ii) The plan for serving the regional institute for children and adolescents target population after the closure;

(iii) The budgetary savings anticipated from the closure compared to the costs associated with serving the regional institute for children and adolescents target population in other settings;

(iv) The plan for assisting State employees displaced by the closure in finding other employment; and

(v) The plan for the regional institute for children and adolescents facility.

(3) The committees shall have 60 days to review and comment on the report.

§10–406.1.

(a) The Regional Institutes for Children and Adolescents in Baltimore and Montgomery counties shall be comparable:

(1) In programs by January 1, 1992; and

(2) In facilities by July 1, 1994.

(b) The facilities and programs of an institute may not be reduced to achieve comparability.

(c) In no event shall the level of State funding provided or number of positions authorized to any Regional Institute for Children and Adolescents be reduced in order to attain comparability.

§10–407.

The Director shall set standards for admission to a State facility.

§10–408.

(a) With the advice of the Director, the Secretary shall appoint an administrative head for each State facility.

(b) Each administrative head shall have the qualifications that the Secretary sets for administrative heads.

(c) The Director may remove an administrative head for incompetence or misconduct.

(d) In addition to any other power or duty that the Director or Secretary delegates, the administrative head of a State facility shall:

(1) Supervise generally the State facility;

(2) In accordance with the provisions of the State Personnel and Pensions Article, appoint a staff for the State facility as needed and as provided in the State budget; and

(3) Report to the Director as the Director requires.

§10–409.

The administrative head of the Eastern Shore Hospital Center shall:

(1) Advertise for and receive bids for a contract to provide laundry services; and

(2) Contract for the services with the low bidder unless the administrative head finds that the bidder would not fulfill the contract satisfactorily.

§10–410.

There is a citizens' advisory board for each State facility.

§10–411.

(a) (1) (i) Except for the Eastern Shore Hospital Center, the Spring Grove Hospital Center, and the Clifton T. Perkins Hospital Center, each Board consists of 7 members appointed by the Governor.

(ii) The Board for the Eastern Shore Hospital Center consists of 11 members appointed by the Governor.

(iii) The Board for the Spring Grove Hospital Center consists of 9 members appointed by the Governor.

(iv) The Board for the Clifton T. Perkins Hospital Center consists of 9 members appointed by the Governor.

(2) The Board for each State facility shall reflect adequately the composition of the community that the State facility serves.

(3) Of the members of the Board for a State facility:

(i) At least 2 shall be parents or other relatives of residents or former residents of a State facility; and

(ii) Each of the others shall be individuals who:

1. Are known for their interest in civic and public affairs; and

2. Have expressed an interest in the care of individuals who have a mental disorder or generally in mental health endeavors.

(4) The Governor shall appoint the members from a list of qualified individuals submitted to the Governor by the Secretary.

(b) Each member of a Board shall be a citizen of this State.

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

(2) (i) Except for the Board for the Clifton T. Perkins Hospital Center, the terms of members are staggered as required for members of each Board on July 1, 1982. For the Board for the Clifton T. Perkins Hospital Center, the terms of the members are staggered as required for the members on the Board on October 1, 1994.

(ii) Except for the Boards for the Eastern Shore Hospital Center, the Spring Grove Hospital Center, and the Clifton T. Perkins Hospital Center, the terms of those members end as follows:

1. 1 in 1983;

2. 4 in 1984;

3. 1 in 1985; and

4. 1 in 1986.

(iii) The terms of the members of the Board for the Eastern Shore Hospital Center end as follows:

1. 2 in 1983;

2. 5 in 1984;

3. 2 in 1985; and

4. 2 in 1986.

(iv) The terms of the members of the Board for the Spring Grove Hospital Center end as follows:

1. 1 in 1986;

2. 1 in 1987;

3. 4 in 1988; and

4. 3 in 1989.

(v) The terms of the members of the Board for the Clifton T. Perkins Hospital Center end as follows:

1. 1 in 1996;

2. 5 in 1997; and

3. 3 in 1998.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) (i) Except as provided in subparagraph (ii) of this paragraph, a member who serves 2 consecutive full 4–year terms may not be reappointed for 4 years after completion of those terms.

(ii) An initial member of a Board who serves 3 consecutive full 4–year terms may not be reappointed for 4 years after completion of those terms.

§10–412.

(a) From among its members, each Board shall elect a chairman and other officers that the Board considers necessary.

(b) The manner of election of officers and their terms of office shall be as the Board determines.

§10–413.

(a) Each Board shall meet at least 4 times a year, at the times and places that it determines.

(b) A member of a Board may not receive compensation.

§10–414.

(a) Each Board may adopt rules and regulations for the conduct of its meetings.

(b) (1) Each Board serves in an advisory capacity.

(2) Each Board shall:

(i) Submit to the Secretary an annual report on:

1. The needs of individuals who have a mental disorder; and

2. The extent to which its State facility meets these needs;

(ii) Advise the administrative head of the State facility on its goals, programs, physical plant, and policies;

(iii) Help in evaluating the degree to which these goals are achieved;

(iv) Review and make recommendations about the annual budget of the State facility;

(v) Assume leadership in developing community understanding of the needs of those who have a mental disorder; and

(vi) Carry out any other responsibility that the administrative head of the State facility requests.

§10–415.

(a) (1) In this subsection, "facility" means:

(i) The Clifton T. Perkins Hospital Center;

(ii) The Eastern Shore Hospital Center;

(iii) The Regional Institutes for Children and Adolescents – Baltimore and Rockville;

(iv) The Springfield Hospital Center;

(v) The Spring Grove Hospital Center;

(vi) The Thomas B. Finan Hospital Center; or

(vii) The Office of Health Care Quality.

(2) (i) The pay scale for a "Physician Clinical Specialist" position in a facility shall be the same as a "Psychiatrist Clinical" position in a facility.

(ii) The pay scale for a "Physician Clinical Staff" position in a facility shall be the same as a "Psychiatrist Clinical Graduate" position in a facility.

(3) In a fiscal year in which an upward adjustment to the pay scale is made for initial appointments to a "Registered Nurse" position in a facility, the "Registered Nurse Charge", "Registered Nurse Supervisor", and "Registered Nurse Manager" positions in the same facility shall receive an upward adjustment to their pay scales in an amount at least equal to the adjustment for the employees in a "Registered Nurse" position who report to employees in the "Registered Nurse Charge", "Registered Nurse Supervisor", and "Registered Nurse Manager" positions at the facility.

(b) (1) In a fiscal year in which an upward adjustment to the pay scale is made for initial appointments to a "Registered Nurse Perkins" position at the Clifton T. Perkins Hospital Center, the "Registered Nurse Charge Perkins", "Registered Nurse Supervisor Perkins", "Registered Nurse Manager Perkins", "Assistant Director of Nursing Perkins", and "Director of Nursing Perkins" positions at the Clifton T. Perkins Hospital Center shall receive an upward adjustment to their pay scales in an amount at least equal to the adjustment for the employees in a "Registered Nurse Perkins" position who report to employees in the "Registered Nurse Charge Perkins", "Registered Nurse Supervisor Perkins", "Registered Nurse Manager Perkins", "Assistant Director of Nursing Perkins", and "Director of Nursing Perkins" positions.

(2) (i) This paragraph applies only to employees of the Clifton T. Perkins Hospital Center who are:

1. Employed in a "Security Attendant" position; and

2. Required as a condition of employment to complete a correctional training course approved by the Correctional Training Commission under Title 8, Subtitle 2 of the Correctional Services Article.

(ii) The pay scale for a "Security Attendant" position shall be at least equal to the pay scale for a correctional officer employed by the Department of Public Safety and Correctional Services.

(c) In a fiscal year in which an upward adjustment to the pay scale is made for initial appointments to a "Health Facility Surveyor Nurse I" position in the Office of Health Care Quality, the "Health Facility Surveyor Nurse I" and "Health Facility Surveyor Nurse II" positions in the Office of Health Care Quality shall receive an upward adjustment to their pay scales in an amount equal to the adjustment for the "Health Facility Surveyor Nurse I" position.

§10–417.

(a) In Part III of this subtitle the following words have the meanings indicated.

(b) "Center" means the Maryland Psychiatric Research Center.

(c) "Department of Psychiatry" means the Department of Psychiatry of the University of Maryland School of Medicine.

§10–418.

There is a Maryland Psychiatric Research Center in the Department.

§10–419.

There is an Executive Board for the Center.

§10–420.

The Executive Board consists of the following 5 ex officio members:

(1) The Superintendent of the Center.

(2) The Director of Research and Evaluation of the Department.

(3) The Director of the Behavioral Health Administration.

(4) The Chairman of the Department of Psychiatry.

(5) The Dean of the University of Maryland School of Medicine.

§10–421.

(a) From among its members, the Executive Board shall elect a chairman.

(b) The manner of election of officers and their terms of office shall be as the Executive Board determines.

§10–422.

The Executive Board of the Center shall develop policy for the operations of the Center, including policies on the assignments and responsibilities of the scientific employees and technical employees of the Center.

§10–423.

(a) By joint action, the Director and the Chairman of the Department of Psychiatry shall appoint a superintendent of the Center and may remove the Superintendent.

(b) The Executive Board of the Center shall appoint individuals to scientific positions and technical positions at the Center and may remove these individuals.

(c) (1) The Superintendent of the Center and each individual in a scientific position or technical position shall be in the management service or special appointments in the State Personnel Management System.

(2) The remaining administrative employees and all clerical employees shall be in the skilled service in the State Personnel Management System.

(3) The Executive Board shall determine the status of each position at the Center.

(d) All positions at the Center shall be assigned to the University of Maryland School of Medicine.

(e) Each employee of the Center whom the Executive Board designates as performing scientific duties or technical duties shall be appointed to a faculty position in the Department of Psychiatry.

§10–424.

The Center shall:

(1) Be maintained as a State facility for psychiatric research;

(2) Direct its programs toward prevention, discovery of causes, and treatment of mental disorders and allied conditions; and

(3) Perform the research programs under the written agreements that the Department and the Department of Psychiatry make.

§10–425.

Research programs shall be carried out under the general supervision and direction of the Department of Psychiatry, but subject to the policies of the Executive Board of the Center.

§10–426.

There is a technical review committee in the Center.

§10–427.

(a) The technical review committee consists of the following 11 members:

(1) As ex officio members:

(i) The Superintendent of the Center; and

(ii) The Chairman of the Department of Psychiatry;

(2) 3 psychologists;

(3) 3 physicians who are licensed to practice medicine in this State and devote a substantial amount of professional time to the practice of psychiatry; and

(4) 3 citizens of this State chosen by the Executive Board of the Center from individuals who are interested in and concerned about the care of individuals who have a mental disorder and about research directed toward the prevention, discovery of causes, and treatment of mental disorders and allied conditions.

(b) Of the 3 psychologists and 3 physicians:

(1) 1 shall be chosen by the Executive Board of the Center from the University of Maryland School of Medicine;

(2) 2 shall be chosen by the Executive Board of the Center from the Johns Hopkins University School of Medicine; and

(3) 3 shall be chosen by the Executive Board of the Center from other affiliations, including private practitioners.

§10–428.

(a) From among its members, the technical review committee shall elect a chairman.

(b) The manner of election of officers and their terms of office shall be as the technical review committee determines.

§10–429.

The technical review committee shall:

(1) Provide peer review over research activities at the Center;

(2) Serve in an advisory capacity to the Executive Board and the Superintendent of the Center; and

(3) Submit an annual report to the Executive Board.

§10–501.

In Part I of this subtitle, "license" means a license issued by the Department to operate a private, inpatient facility.

§10–502.

(a) The Secretary shall adopt rules and regulations for licensing private, inpatient facilities.

(b) The rules and regulations shall ensure that care and treatment of individuals who have a mental disorder are provided in accordance with the policy stated in Subtitle 1 of this title.

§10–503.

In addition to holding any other license required by law, a person shall be licensed by the Department before the person may operate a private, inpatient facility.

§10–504.

To qualify for a license, an applicant shall:

(1) Have a certificate of accreditation from the Joint Commission on Accreditation of Hospitals for the private inpatient facility to be operated; or

(2) Meet the requirements that the Secretary adopts under this subtitle.

§10–505.

(a) An applicant for a license shall submit an application on the form that the Secretary requires.

(b) The application shall provide the information that the Secretary requires.

§10–506.

When an application for a license is filed, the Department promptly shall investigate the applicant.

§10–507.

The Department shall issue a license to any applicant who meets the requirements of this subtitle.

§10–508.

A license authorizes the licensee to operate a private facility while the license is effective.

§10–509.

(a) (1) Except as provided in paragraph (2) of this subsection, the Department shall inspect each private, inpatient facility at least once every 6 months and at any other time that the Department considers necessary.

(2) A facility that is accredited by the Joint Commission on Accreditation of Hospitals shall be inspected under § 19-308(b) of this article.

(b) The Department shall keep a report of each inspection.

(c) The Department shall bring any deficiencies to the attention of the management of the private, inpatient facility.

(d) Complaint investigations of private inpatient facilities and psychiatric units of private acute general hospitals shall be performed in accordance with the provisions of § 19-309 of this article.

§10–510.

(a) The Department shall deny a license to any applicant or suspend or revoke a license if the applicant or licensee fails to comply with the applicable laws, rules, or regulations of this State.

(b) Except as otherwise provided in the Administrative Procedure Act, before the Department takes any action under this section, the Department shall give the applicant or licensee notice and an opportunity for a hearing.

§10–511.

Any person aggrieved by a final decision of the Department in a contested case, as defined in the Administrative Procedure Act, may petition for judicial review as allowed by the Administrative Procedure Act.

§10–514.

(a) In Part II of this subtitle the following words have the meanings indicated.

(b) "Large private group home" means a private group home that admits at least 10 but not more than 16 individuals.

(c) "License" means a license issued by the Secretary to operate a private group home.

(d) (1) "Private group home" means a residence in which individuals who have been or are under treatment for a mental disorder may be provided care or treatment in a homelike environment.

(2) "Private group home" does not include:

(i) Any facility that is owned by or leased to this State or any public agency;

(ii) Any facility that is regulated by the Department of Juvenile Services;

(iii) Any facility that is regulated by the Developmental Disabilities Administration;

(iv) Any facility that is organized wholly or partly to make a profit; or

(v) A foster home that is the domicile of the foster parent.

(e) "Small private group home" means a private group home that admits at least 4 but not more than 9 individuals.

§10–516.

(a) A private group home shall be licensed in accordance with Title 7.5 of this article.

(b) The Secretary shall adopt rules and regulations for establishing, licensing, and operating private group homes.

§10–518.

(a) A small private group home:

(1) Is deemed conclusively a single–family dwelling; and

(2) Is permitted to locate in all residential zones.

(b) A large private group home is deemed conclusively a multifamily dwelling and is permitted to locate in zones of similar density.

(c) A private group home is not subject to any special exception, conditional use permit, or procedure that differs from that required for a single–family dwelling or a multifamily dwelling of similar density in the same zone.

(d) A general zoning ordinance that conflicts with the provisions of this section is superseded by this section to the extent of the conflict.

§10–519.

(a) An applicant for a license shall submit an application to the Secretary on the form that the Secretary requires.

(b) The application shall:

(1) Be signed and verified by the applicant; and

(2) Contain:

(i) The name and address of the applicant;

(ii) The street address of the property on which the private group home is to be located or, if it has no street address, a description that identifies the property;

(iii) If the applicant does not own the property, the name of the owner;

(iv) A statement that the applicant will comply with the laws, rules, and regulations that relate to establishing and operating the private group home;

(v) A statement that the applicant has sufficient financial resources to establish and operate the private group home or that those resources are available to the applicant; and

(vi) A description of the proposed program.

§10–524.

Any person aggrieved by a final decision of the Secretary in a contested case, as defined in the Administrative Procedure Act, may petition for judicial review as allowed by the Administrative Procedure Act to the circuit court for the county where the private group home is located or planned.

§10–601.

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

(b) "Clinical social worker" means an individual who is licensed under Title 19 of the Health Occupations Article to practice clinical social work.

(c) "Danger to the life or safety of the individual or of others" means there is, as a result of a mental disorder, a substantial risk, based on conduct that is recent and relevant to the danger that the individual may present and in consideration of the individual's current condition and, if available, recent personal, medical, and psychiatric history, that the individual will:

(1) Cause serious bodily harm to the individual or another individual; or

(2) Be unable, except for reasons of indigence, to provide for the individual's basic needs, including food, clothing, shelter, medical care, self–

protection, or safety, to such a degree as to create a substantial risk of serious bodily harm, serious illness, or death in the near future.

(d) "Electronic record" means a document communicated, received, or stored by electronic means.

(e) "Licensed clinical marriage and family therapist" means an individual who is licensed under Title 17, Subtitle 3A of the Health Occupations Article to practice clinical marriage and family therapy.

(f) "Licensed clinical professional counselor" means an individual who is licensed under Title 17, Subtitle 3A of the Health Occupations Article to practice clinical professional counseling.

(g) "Physician" means an individual who is licensed under Title 14 of the Health Occupations Article to practice medicine in this State.

(h) "Physician assistant" means an individual who is licensed under Title 15 of the Health Occupations Article to practice as a physician assistant.

(i) "Psychiatric nurse practitioner" means an individual who is:

(1) Licensed as a registered nurse and certified as a nurse practitioner under Title 8 of the Health Occupations Article; and

(2) Practicing in the State as a certified registered nurse practitioner–psychiatric mental health.

(j) "Psychologist" means an individual who is licensed under Title 18 of the Health Occupations Article to practice psychology.

§10–602.

A facility or a Veterans' Administration hospital may admit an individual, as provided in this subtitle.

§10–603.

(a) This section does not apply to an individual who is:

(1) Transferred from a facility of another state to a State facility under the Interstate Compact on Mental Health; or

(2) Admitted after an emergency evaluation under Part IV of this subtitle.

(b) In addition to the other requirements of this subtitle, a State facility or a Veterans' Administration hospital may admit an individual who is 65 years old or older only if a geriatric evaluation team determines that there is no available, less restrictive form of care or treatment that is adequate for the needs of the individual.

(c) (1) Each geriatric evaluation shall be done by the geriatric evaluation team of a county health department.

(2) Each geriatric evaluation team consists of the individuals whom the Secretary designates from multiple disciplines.

§10–605.

(a) Within 10 days after admission of an individual to a facility under this title, the facility shall submit to the Department an admission report on the individual.

(b) The report shall:

(1) Be on the form that the Department requires; and

(2) Contain the information that the Department requires.

§10–608.

A veteran may be admitted voluntarily to a Veterans' Administration hospital without regard to this part.

§10–609.

(a) Except as provided in § 10–611 of this subtitle, application for voluntary admission of an individual to a facility may be made under this section by the individual, if the individual is 16 years old or older.

(b) The applicant shall:

(1) Submit a formal, written application that contains the personal information and is on the form required by the Administration; or

(2) Informally request admission.

(c) A facility may not admit an individual under this section unless:

(1) The individual has a mental disorder;

(2) The mental disorder is susceptible to care or treatment;

(3) The individual understands the nature of the request for admission;

(4) The individual is able to give continuous assent to retention by the facility; and

(5) The individual is able to ask for release.

(d) (1) In addition to the limitations in subsection (c) of this section, a State facility may not admit an individual who is 65 years old or older unless a geriatric evaluation team determines that there is no available, less restrictive form of care or treatment that is adequate for the needs of the individual.

(2) If admission is denied because of the determination of the geriatric evaluation team, the team shall:

(i) Inform the individual; and

(ii) Help the individual obtain the less restrictive form of care or treatment that the geriatric evaluation team finds would be adequate for the needs of the individual.

§10–610.

(a) On behalf of a minor, a parent or guardian of the person of the minor may apply, under this section, for admission of the minor to:

(1) Any facility that is not a State facility; or

(2) The following State facilities:

(i) A regional institute for children and adolescents; and

(ii) The child or adolescent unit of a State facility.

(b) The applicant shall submit a formal, written application that contains the personal information and is on the form required by the Administration.

(c) A facility may not admit an individual under this section unless:

(1) The individual has a mental disorder;

(2) The mental disorder is susceptible to care or treatment;

(3) The applicant understands the nature of a request for admission; and

(4) Assent to the admission has been given:

(i) By the admitting physician of the facility; or

(ii) For a child or adolescent unit of a State facility, by:

1. 1 physician and 1 psychologist;

2. 2 physicians;

3. 1 physician and 1 psychiatric nurse practitioner;

4. 1 physician and 1 licensed certified social worker–clinical; or

5. 1 physician and 1 licensed clinical professional counselor.

(d) An admission under this section to a child or adolescent unit of a State facility may not exceed 20 days.

§10–611.

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

(2) "Disabled person" has the meaning stated in § 13–101 of the Estates and Trusts Article.

(3) "Guardian of the person" means a guardian of the person of a disabled person appointed under Title 13, Subtitle 7, Part II of the Estates and Trusts Article.

(4) "Mental disorder" has the meaning stated in § 10–620 of this subtitle.

(b) A disabled person may apply for voluntary admission of the disabled person if:

(1) The disabled person submits a formal, written application that contains the disabled person's personal information and is on the form required by the Administration; and

(2) In accordance with subsections (c) through (e) of this section, either a physician and a psychologist, two physicians, a physician and a psychiatric nurse practitioner, or a physician and a physician assistant certify that:

(i) The disabled person has the capacity to execute an application for voluntary admission; and

(ii) The disabled person understands both the criteria for voluntary admission set forth under this section and the procedure for requesting discharge from the facility.

(c) (1) A certificate for voluntary admission of a disabled person under subsection (b) of this section shall:

(i) Be based on the personal examination of the physician, psychologist, psychiatric nurse practitioner, or physician assistant who signs the certificate; and

(ii) Be in the form that the Secretary of Health adopts, by rule or regulation.

(2) The rules and regulations shall require the form to include an opinion that:

(i) The disabled person has a mental disorder;

(ii) The mental disorder is susceptible to care or treatment;

(iii) The disabled person understands the nature of the request for admission; and

(iv) The disabled person is able to give continuous assent to retention by the facility.

(d) A certificate may not be used for admission if the examination on which the certificate is made was conducted more than 1 week before the certificate is signed.

(e) A certificate may not be used for an admission if the physician, psychologist, psychiatric nurse practitioner, or physician assistant who signed the certificate:

(1) Has a financial interest, through ownership or compensation, in a proprietary facility and admission to that proprietary facility is sought for the disabled person whose status is being certified; or

(2) Is related, by blood or marriage, to the disabled person or the guardian of the person of the disabled person.

(f) A facility may not admit a disabled person under this section unless:

(1) As certified in accordance with subsection (c) of this section, the disabled person satisfies the criteria under subsection (b)(2) of this section; and

(2) The disabled person is able to ask for release.

(g) (1) In addition to the limitations in subsection (f) of this section, a State facility may not admit a disabled person who is 65 years old or older unless a geriatric evaluation team determines that there is no available less restrictive form of care or treatment that is adequate for the needs of the disabled person.

(2) If admission is denied because of the determination of the geriatric evaluation team, the team shall:

(i) Inform the disabled person and the guardian of the person of the disabled person of the denial; and

(ii) Help the disabled person to obtain the less restrictive form of care or treatment that the geriatric evaluation team finds would be adequate for the needs of the individual.

(h) The facility shall notify the guardian of the person of a disabled person admitted to the facility under this section:

(1) That the disabled person has been admitted to the facility; and

(2) If the disabled person requests to be discharged from a facility to which the disabled person was voluntarily admitted.

(i) If at any time a facility reasonably believes that the disabled person no longer meets the criteria for voluntary admission under this section, the facility shall discharge the disabled person unless:

(1) The admission status of the disabled person has been changed to an involuntary admission in accordance with Part III of this subtitle; and

(2) An involuntary commitment proceeding is held.

(j) The execution by a disabled person of an application for voluntary admission under this section does not:

(1) Diminish the rights, duties, or responsibilities conferred on the guardian of the person under § 13–708 of the Estates and Trusts Article; or

(2) Confer any additional power or authority on the guardian of the person, including the power or authority to commit the disabled person to a mental facility, that a court has not otherwise conferred on the guardian of the person under § 13–708 of the Estates and Trusts Article.

§10–613.

In this part, "involuntary admission" includes every admission of a minor to a State facility unless the admission is a voluntary admission authorized under Part II of this subtitle.

§10–614.

(a) Except as provided in subsection (b) of this section, application for involuntary admission of an individual to a facility or Veterans' Administration hospital may be made under this part by any person who has a legitimate interest in the welfare of the individual.

(b) If the Administration agrees to pay the appropriate expenses, application for involuntary admission to a facility of an incarcerated individual in an institution under the Division of Correction or the Patuxent Institution may be made under this part by the Division or the Patuxent Institution.

§10–615.

Each application for involuntary admission to a facility or Veterans' Administration hospital under this part shall:

(1) Be in writing;

(2) Be dated;

(3) Be on the form required by:

(i) The Administration, in the case of a facility; or

(ii) The Veterans' Administration hospital, in the case of a Veterans' Administration hospital;

(4) State the relationship of the applicant to the individual for whom admission is sought;

(5) Be signed by the applicant;

(6) Be accompanied by the certificates of:

(i) 1 physician and 1 psychologist;

(ii) 2 physicians;

(iii) 1 physician and 1 psychiatric nurse practitioner;

(iv) 1 physician and 1 licensed certified social worker–clinical; or

(v) 1 physician and 1 licensed clinical professional counselor; and

(7) Contain any other information that the Administration requires.

§10–616.

(a) (1) A certificate for involuntary admission of an individual under this part shall:

(i) Be based on the personal examination of the physician, psychologist, psychiatric nurse practitioner, licensed certified social worker–clinical, or licensed clinical professional counselor who signs the certificate; and

(ii) Be in the form that the Secretary adopts, by rule or regulation.

(2) The rules and regulations shall require the form to include:

(i) A diagnosis of a mental disorder of the individual;

(ii) An opinion that the individual needs inpatient care or treatment; and

(iii) An opinion that admission to a facility or Veterans' Administration hospital is needed for the protection of the individual or another.

(b) A certificate may not be used for admission if the examination on which the certificate is made was done:

(1) More than 1 week before the certificate is signed; or

(2) More than 30 days before the facility or the Veterans' Administration hospital receives the application for admission.

(c) A certificate may not be used for an admission if the physician, psychologist, psychiatric nurse practitioner, licensed certified social worker–clinical, or licensed clinical professional counselor who signed the certificate:

(1) Has a financial interest, through ownership or compensation, in a proprietary facility and admission to that proprietary facility is sought for the individual whose status is being certified; or

(2) Is related, by blood or marriage, to the individual or to the applicant.

§10–617.

(a) A facility or Veterans' Administration hospital may not admit the individual under this part unless:

(1) The individual has a mental disorder;

(2) The individual needs inpatient care or treatment;

(3) The individual presents a danger to the life or safety of the individual or of others;

(4) The individual is unable or unwilling to be admitted voluntarily; and

(5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

(b) (1) In addition to the limitations in subsection (a) of this section, a State facility may not admit an individual who is 65 years old or older unless a geriatric evaluation team determines that there is no available, less restrictive form of care or treatment that is adequate for the needs of the individual.

(2) If admission is denied because of the determination of the geriatric evaluation team, the team shall:

(i) Inform the applicant; and

(ii) Help the applicant obtain the less restrictive form of care or treatment that the team finds would be adequate for the needs of the individual.

§10–618.

(a) A person who applies for involuntary admission of an individual shall have the immunity from liability described under § 5–623(b) of the Courts Article.

(b) A facility or Veterans' Administration hospital that acts in compliance with the provisions of this part shall have the immunity from liability described under § 5–623(c) of the Courts Article.

(c) An agent or employee of a facility or Veterans' Administration hospital who acts in compliance with the provisions of this part shall have the immunity from liability described under § 5–623(d) of the Courts Article.

§10–619.

Within 12 hours of notification by a physician, licensed psychologist, psychiatric nurse practitioner, licensed certified social worker–clinical, or licensed clinical professional counselor who has certified an individual under this part, a facility operated by the Maryland Department of Health shall receive and evaluate the individual certified for involuntary admission if:

(1) The individual's involuntary admission is not limited by § 10–617 of this subtitle;

(2) An application for admission has been completed;

(3) A certifying physician, psychologist, psychiatric nurse practitioner, licensed certified social worker–clinical, or licensed clinical professional

counselor is unable to place the individual in a facility not operated by the Department; and

(4) The Department is unable to provide for the placement of the person other than in a facility operated by the Department.

§10–620.

(a) In Part IV of this subtitle the following words have the meanings indicated.

(b) "Court" means a district or circuit court of this State.

(c) "Emergency evaluee" means an individual for whom an emergency evaluation is sought or made under Part IV of this subtitle.

(d) (1) "Emergency facility" means a facility that the Department designates, in writing, as an emergency facility.

(2) "Emergency facility" includes a licensed general hospital that has an emergency room, unless the Department, after consultation with the health officer, exempts the hospital.

(e) "Emergency facility personnel" means a physician, physician assistant, nurse practitioner, or other advanced practice professional employed or under contract with the emergency facility.

(f) (1) "Mental disorder" means the behavioral or other symptoms that indicate:

(i) To a lay petitioner who is submitting an emergency petition, a clear disturbance in the mental functioning of another individual; and

(ii) To the following health professionals doing an examination, at least one mental disorder that is described in the version of the American Psychiatric Association's "Diagnostic and Statistical Manual – Mental Disorders" that is current at the time of the examination:

1. Physician;

2. Psychologist;

3. Clinical social worker;

4. Licensed clinical professional counselor;

5. Clinical nurse specialist in psychiatric and mental health nursing (APRN/PMH);

6. Psychiatric nurse practitioner (CRNP–PMH);

7. Physician assistant; or

8. Licensed clinical marriage and family therapist.

(2) "Mental disorder" does not include intellectual disability.

(g) "Peace officer" means a sheriff, a deputy sheriff, a State police officer, a county police officer, a municipal or other local police officer, or a Secret Service agent who is a sworn special agent of the United States Secret Service or Department of Homeland Security authorized to exercise powers delegated under 18 U.S.C. § 3056.

§10–621.

(a) At least once a year, the Department shall:

(1) Publish a list of emergency facilities and their addresses; and

(2) Give the list to each health department, judge of a court, sheriff's office, police station, local behavioral health authority, and Secret Service office in this State.

(b) The list published under subsection (a)(1) of this section may include:

(1) Comprehensive crisis response centers;

(2) Crisis stabilization centers;

(3) Crisis treatment centers established under § 7.5–207 of this article; and

(4) Outpatient mental health clinics.

(c) Before including a facility under subsection (b) of this section in the list of emergency facilities, the Department shall consult with stakeholders to develop a model program structure that ensures that a program wishing to serve as an emergency facility:

(1) Is adequately staffed to provide 24–hour emergency petition services;

(2) Provides the necessary services required for an emergency petition;

(3) Has written procedures in place that provide for involuntary admissions, through an emergency petition, including to a licensed hospital, as necessary;

(4) Provides additional support to respect the due process rights of patients received through the emergency petition process; and

(5) Complies with additional procedures as otherwise determined by the Department.

(d) On or before September 30 each year, the Department shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(1) The number of facilities that have sought to be designated an emergency facility;

(2) The number of the facilities reported under item (1) of this subsection that have attempted to meet the model facility standards developed under subsection (c) of this section;

(3) The progress of the facilities reported under item (2) of this subsection toward meeting the model facility standards;

(4) The development of collaborative models between State, local, and private entities; and

(5) Whether the Department, in consultation with stakeholders, has determined that any changes to the model facility standards are necessary.

§10–622.

(a) A petition for emergency evaluation of an individual may be made under this section only if the petitioner has reason to believe that the individual:

(1) Has a mental disorder; and

(2) Presents a danger to the life or safety of the individual or of others.

(b) (1) The petition for emergency evaluation of an individual may be made by:

(i) A physician, psychologist, physician assistant, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, or health officer or designee of a health officer who has examined the individual;

(ii) A peace officer who personally has observed the individual or the individual's behavior; or

(iii) Any other interested person.

(2) An individual who makes a petition for emergency evaluation under paragraph (1)(i) or (ii) of this subsection may base the petition on:

(i) The examination or observation; or

(ii) Other information obtained that is pertinent to the factors giving rise to the petition.

(c) (1) A petition under this section shall:

(i) Be signed and verified by the petitioner;

(ii) State the petitioner's:

1. Name;

2. Address; and

3. Home and work telephone numbers;

(iii) State the emergency evaluee's:

1. Name; and

2. Description;

(iv) State the following information, if available:

1. The address of the emergency evaluee; and

2. The name and address of the spouse or a child, parent, or other relative of the emergency evaluee or any other individual who is interested in the emergency evaluee;

(v) If the individual who makes the petition for emergency evaluation is an individual authorized to do so under subsection (b)(1)(i) of this section, contain the license number of the individual;

(vi) Contain a description of the behavior and statements of the emergency evaluee or any other information that led the petitioner to believe that the emergency evaluee has a mental disorder and that the individual presents a danger to the life or safety of the individual or of others; and

(vii) Contain any other facts that support the need for an emergency evaluation.

(2) The petition form shall contain a notice that the petitioner:

(i) May be required to appear before a court; and

(ii) Makes the statements under penalties of perjury.

(d) (1) A petitioner who is a physician, psychologist, physician assistant, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, health officer, or designee of a health officer shall give the petition to a peace officer.

(2) The peace officer shall explain to the petitioner:

(i) The serious nature of the petition; and

(ii) The meaning and content of the petition.

§10–623.

(a) If the petitioner under Part IV of this subtitle is not a physician, psychologist, physician assistant, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, health

officer or designee of a health officer, or peace officer, the petitioner shall present the petition to the court for immediate review.

(b) After review of the petition, the court shall endorse the petition if the court finds probable cause to believe that the emergency evaluee has shown the symptoms of a mental disorder and that the individual presents a danger to the life or safety of the individual or of others.

(c) If the court does not find probable cause, the court shall indicate that fact on the petition, and no further action may be taken under the petition.

§10–624.

(a) (1) A peace officer shall take an emergency evaluee to the nearest emergency facility if the peace officer has a petition under Part IV of this subtitle that:

(i) Has been endorsed by a court within the last 5 days; or

(ii) Is signed and submitted by a physician, psychologist, physician assistant, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, health officer or designee of a health officer, or peace officer.

(2) The petition required under paragraph (1) of this subsection may be:

(i) In the form of an electronic record; and

(ii) Transmitted and received electronically.

(3) To the extent practicable, a peace officer shall notify the emergency facility in advance that the peace officer is bringing an emergency evaluee to the emergency facility.

(4) After a peace officer brings the emergency evaluee to an emergency facility, the peace officer need not stay unless, because the emergency evaluee is violent, emergency facility personnel ask the supervisor of the peace officer to have the peace officer stay.

(5) A peace officer shall stay until the supervisor responds to the request for assistance. If the emergency evaluee is violent, the supervisor shall allow the peace officer to stay.

(6) If emergency facility personnel ask that a peace officer stay, a physician shall examine the emergency evaluee as promptly as possible.

(b) (1) If the petition is executed properly, the emergency facility shall accept the emergency evaluee.

(2) The petition required under paragraph (1) of this subsection may be:

(i) In the form of an electronic record; and

(ii) Transmitted and received electronically.

(3) Within 6 hours after an emergency evaluee is brought to an emergency facility, a physician shall examine the emergency evaluee, to determine whether the emergency evaluee meets the requirements for involuntary admission.

(4) Promptly after the examination, the emergency evaluee shall be released unless the emergency evaluee:

(i) Asks for voluntary admission; or

(ii) Meets the requirements for involuntary admission.

(5) An emergency evaluee may not be kept at an emergency facility for more than 30 hours.

§10–625.

(a) If an emergency evaluee meets the requirements for an involuntary admission and is unable or unwilling to agree to a voluntary admission under this subtitle, the examining physician shall take the steps needed for involuntary admission of the emergency evaluee to an appropriate facility, which may be a general hospital with a licensed inpatient psychiatric unit.

(b) (1) If the examining physician is unable to have the emergency evaluee admitted to a facility, the physician shall notify the Department.

(2) Within 6 hours after notification, the Department shall provide for admission of the emergency evaluee to an appropriate facility.

(c) (1) Within 30 hours after the emergency facility completes an application for the involuntary admission of an emergency evaluee, the emergency

facility shall notify the Mental Health Division in the Office of the Public Defender, by e–mail or facsimile, of the completion of the application.

(2) The notice required under paragraph (1) of this subsection shall include any legal documents relating to the acceptance of the emergency evaluee into the emergency facility, including the emergency petition, application for involuntary admission, and certification for involuntary admission.

(3) The notice required under paragraph (1) of this subsection does not apply to a patient who agrees to voluntary admission.

§10–626.

(a) A court may order, at any time, an emergency evaluation under Part IV of this subtitle of an individual who has been arrested, if the court finds probable cause to believe that the individual has a mental disorder and the individual presents a danger to the life or safety of the individual or of others.

(b) The court order for an emergency evaluation shall state the grounds.

(c) Unless the court directs otherwise, an individual who is taken to an emergency facility under this section shall stay in the custody of the peace officer until the individual either is admitted to an appropriate facility or returned to the court or an appropriate jail.

(d) If an individual was detained lawfully before the court ordered an emergency evaluation under this section and the individual does not meet the requirements for involuntary admission under this subtitle:

(1) The examining physician shall send a brief report of the evaluation to the court; and

(2) The peace officer shall:

(i) Return to the court the individual, the court order, and the report of the examining physician; or

(ii) If the court is not in session, take the individual to an appropriate jail and, before the end of the next day that the court is in session, return to the court the individual and the report of the examining physician.

(e) A court order under this section is a detainer against an individual until:

(1) The charges against the individual are dismissed, nol prossed, or stetted; or

(2) The individual appears in court.

§10–627.

On the first work day after admission of an emergency evaluee who is 65 years old or older, the geriatric evaluation team in the county where the emergency evaluee resides shall be informed.

§10–628.

(a) (1) If an emergency evaluee cannot pay or does not have insurance that covers the charges for emergency services, an initial consultant examination by a physician, physician assistant, or nurse practitioner, and transportation to an emergency facility and, for an involuntary admission of the emergency evaluee, to the admitting facility, the Department shall pay the appropriate party the actual cost or a reasonable rate for this service, whichever is lower, except that hospitals shall be paid at rates approved by the Health Services Cost Review Commission.

(2) The reasonable rate for the services provided under an emergency petition shall be calculated by using a methodology established by regulation and reasonably related to the actual cost.

(b) With respect to emergency admissions, the Department shall be subrogated against any insurance coverage available to the patient for charges relating to emergency service, initial consultant examination by a physician or nurse practitioner, and transportation to an emergency facility under Part IV of this subtitle.

§10–629.

(a) Any petitioner who submits or completes a petition under Part IV of this subtitle shall have the immunity from liability described under § 5-624(b) of the Courts and Judicial Proceedings Article.

(b) Any peace officer who acts as a custodian of an emergency evaluee shall have the immunity from liability described under § 5-624(c) of the Courts and Judicial Proceedings Article.

(c) An emergency facility that acts in compliance with the provisions of Part IV of this subtitle shall have the immunity from liability described under § 5-624(d) of the Courts and Judicial Proceedings Article.

(d) An agent or employee of an emergency facility who acts in compliance with the provisions of Part IV of this subtitle shall have the immunity from liability described under § 5-624(e) of the Courts and Judicial Proceedings Article.

§10–630.

(a) All court records relating to a petition for an emergency evaluation made under this subtitle are confidential and the contents may not be divulged, by subpoena or otherwise, except by order of the court on good cause shown.

(b) Except for a court record sealed under subsection (d) of this section, this section does not prohibit review of a court record relating to a petition by:

(1) Personnel of the court;

(2) The petitioner;

(3) The emergency evaluee or counsel for the emergency evaluee;

(4) Authorized personnel of the Department;

(5) Authorized personnel of the local core service agency or local behavioral health authority;

(6) A law enforcement agency; or

(7) A person authorized by a court order on good cause shown.

(c) A petition for an emergency evaluation:

(1) Shall be considered a mental health record under Title 4 of this article; and

(2) May be released by a health care provider, as defined in § 4–301 of this article, only as permitted by law.

(d) (1) An emergency evaluee who was a minor when a petition for emergency evaluation was made or sought concerning the emergency evaluee under this part may file a motion with the court at any time requesting that any court records relating to the petition be sealed.

(2) The court shall have a copy of the motion filed under this subsection served on the petitioner at the address stated for the petitioner in the petition for emergency evaluation.

(3) The court may order court records relating to the petition for emergency evaluation that is the subject of the motion sealed for good cause shown.

(4) (i) The petitioner may file an objection to a motion filed under this subsection.

(ii) If no objection is filed, the court may grant the motion without a hearing.

(iii) If the petitioner files an objection to the motion within 30 days after a copy of the motion is served on the petitioner, the court shall hold a hearing.

(iv) The court may hold a hearing on its own initiative.

(5) If sealed, the court records relating to the petition for emergency evaluation that is the subject of the motion may not be opened, for any purpose, except by order of the court for good cause shown.

§10–631.

(a) The Administration shall prepare and provide each facility with standard forms that provide, in clear and simple words, at least the following information:

(1) Notice of the admission of the individual;

(2) The right of the individual to consult with a lawyer that the individual chooses;

(3) The availability of the services of the legal aid bureaus, lawyer referral services, and other agencies that exist for the referral of individuals who need legal counsel;

(4) The right of the individual to call or write a lawyer or a referral agency or to have someone do so on behalf of the individual; and

(5) In substance:

(i) Those provisions of this subtitle under which the individual is admitted;

(ii) The provisions of this section; and

(iii) The provisions of Subtitle 7 of this title.

(b) (1) Within 12 hours after initial confinement of an individual to any facility or a Veterans' Administration hospital, the form provided for in this section shall be read and given to the individual.

(2) If the individual does not understand the notice required by this section and its legal effect, the notice also shall be given to:

(i) The parent, guardian, or next of kin of the individual;

(ii) The applicant for an involuntary admission of the individual; and

(iii) Any other individual who has a significant interest in the status of the individual.

(3) In any event, if possible, notice of the admission shall be given to the parent, guardian, or next of kin of the individual.

(4) Notice of the admission of a minor shall be given as promptly as possible.

(5) Within 24 hours after the admission of the individual, notice of the admission shall be given to the Mental Health Division in the Office of the Public Defender.

(c) The form shall be read in English or, if the individual does not understand English, in the language or manner best calculated to inform the individual of the applicable provisions of the law.

(d) The facility shall keep in the individual's records a copy of the form and a certification of the administrative head of the facility as to the compliance with this section.

(e) Notice under this section shall be given again to an individual when:

(1) A new application is made under this subtitle for a voluntary admission; and

(2) New certificates are made under this subtitle for an involuntary admission.

§10–632.

(a) Any individual proposed for involuntary admission under Part III of this subtitle shall be afforded a hearing to determine whether the individual is to be admitted to a facility or a Veterans' Administration hospital as an involuntary patient or released without being admitted.

(b) The hearing shall be conducted within 10 days of the date of the initial confinement of the individual.

(c) (1) The hearing may be postponed for good cause for no more than 7 days, and the reasons for the postponement shall be on the record.

(2) A decision shall be made within the time period provided in paragraph (1) of this subsection.

(d) The Secretary shall:

(1) Adopt rules and regulations on hearing procedures; and

(2) Designate an impartial hearing officer to conduct the hearings.

(e) The hearing officer shall:

(1) Consider all the evidence and testimony of record; and

(2) Order the release of the individual from the facility unless the record demonstrates by clear and convincing evidence that at the time of the hearing each of the following elements exist as to the individual whose involuntary admission is sought:

(i) The individual has a mental disorder;

(ii) The individual needs in–patient care or treatment;

(iii) The individual presents a danger to the life or safety of the individual or of others;

(iv) The individual is unable or unwilling to be voluntarily admitted to the facility;

(v) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual; and

(vi) If the individual is 65 years old or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team and no less restrictive form of care or treatment was determined by the team to be appropriate.

(f) A hearing officer may not order the release of an individual who meets the requirements for involuntary admission under subsection (e)(2) of this section on the grounds that a health care provider or an emergency or other facility did not comply with disclosure or notice requirements under § 10–625(c) or § 10–631(b)(5) of this subtitle, § 10–803(b)(2) of this title, or § 4–306(c) or § 4–307(l) of this article.

(g) The hearing officer may not order the release of an individual who meets the requirements for involuntary admission under subsection (e)(2) of this section on the grounds that the individual was kept at an emergency facility for more than 30 hours in violation of § 10–624(b)(4) of this subtitle.

(h) The parent, guardian, or next of kin of an individual involuntarily admitted under this subtitle:

(1) Shall be given notice of the hearing on the admission; and

(2) May testify at the hearing.

(i) If a hearing officer enters an order for involuntary commitment under Part III of this subtitle and the hearing officer determines that the individual cannot safely possess a firearm based on credible evidence of dangerousness to others, the hearing officer shall order the individual who is subject to the involuntary commitment to:

(1) Surrender to law enforcement authorities any firearms in the individual's possession; and

(2) Refrain from possessing a firearm unless the individual is granted relief from firearms disqualification in accordance with § 5–133.3 of the Public Safety Article.

§10–633.

The determination of a hearing officer on an involuntary admission under this subtitle is a final decision of the Department for the purpose of judicial review of a final decision under the Administrative Procedure Act.

§10–6A–01. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

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

(b) "Assisted outpatient treatment" means a specific regimen of outpatient treatment for a serious and persistent mental illness to which an individual is ordered by the court to adhere.

(c) "Care coordination team" means a multidisciplinary team under the oversight of a local behavioral health authority, core service agency, or the Department.

(d) "Harm to others" means an act or attempt at or credible threat of serious violent behavior toward others.

(e) "Harm to the individual" means self–harming behavior or an attempt at suicide.

(f) "Hospital" has the meaning stated in § 19–301 of this article.

(g) "Program" means an assisted outpatient treatment program.

(h) "Serious and persistent mental illness" means a mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to meet the ordinary demands of life, and that may lead to an inability to maintain independent functioning in the community without intensive treatment and support.

(i) "Treatment plan" means a plan developed by a care coordination team that:

(1) Incorporates all outpatient treatment services that are determined to be essential and available for the maintenance of an individual's health and safety; and

(2) Includes, at a minimum:

(i) Services of a treating psychiatrist;

(ii) Case management;

(iii) Services of a certified peer recovery specialist; and

(iv) If clinically appropriate, assertive community treatment services.

§10–6A–02. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) The issuance of an assisted outpatient treatment order against a respondent under this subtitle may not be:

(1) The basis for the involuntary admission of the respondent to a facility under this title; or

(2) Used as evidence of incompetency of the respondent.

(b) This subtitle may not be construed to abridge or modify any civil right of the respondent, including:

(1) Any civil service ranking or appointment;

(2) The right to apply for voluntary admission to a facility under § 10–609 of this title; and

(3) Any right relating to a license, permit, certification, privilege, or benefit under any law.

(c) Any right normally afforded to an individual in a civil or criminal matter shall apply.

§10–6A–03. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) (1) On or before July 1, 2026, a county may establish an assisted outpatient treatment program in accordance with this subtitle.

(2) A county may partner with another county to establish an assisted outpatient treatment program.

(b) An assisted outpatient treatment program established under subsection (a) of this section shall be approved and overseen by the county's local behavioral health authority or core service agency.

(c) (1) On or before July 1, 2026, the Department shall establish an assisted outpatient treatment program in any county that does not opt to establish an assisted outpatient treatment program.

(2) A county in which the Department is required to establish an assisted outpatient treatment program shall reimburse the Department:

(i) Except as provided in paragraph (3) of this subsection, for fiscal year 2028, for 25% of the State share of associated costs;

(ii) For fiscal year 2029, for 50% of the State share of associated costs;

(iii) For fiscal year 2030, for 75% of the State share of associated costs; and

(iv) For fiscal year 2031, for 100% of the State share of associated costs.

(3) (i) On or before August 31, 2026, the Department shall provide to each county the number of assisted outpatient treatment program participants in the county and the estimated annual cost to provide treatment to those participants.

(ii) For fiscal year 2028, the obligation to provide 25% of the State share of associated costs shall be waived for any county that provides a report to the Department on or before January 1, 2027, on the cost–benefit analysis of the implementation of the assisted outpatient treatment program on the county budget and operations.

(d) (1) A care coordination team operating under an assisted outpatient treatment program shall consist of, at a minimum:

(i) A psychiatrist;

(ii) A case manager;

(iii) A certified peer recovery specialist;

(iv) Other treating providers as clinically appropriate, such as an assertive community treatment team and a provider familiar with the health needs of veterans; and

(v) Any other individuals required by the Department in regulation.

(2) The Department shall establish clinical and operational standards for assisted outpatient treatment programs and care coordination teams established under this section.

§10–6A–04. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) A petition for assisted outpatient treatment may be made under this subtitle by the director of a mental health program receiving State funding under Subtitle 9, Part I of this title, or by any individual at least 18 years old who has a legitimate interest in the welfare of the respondent.

(b) The petition for assisted outpatient treatment shall be in writing, signed by the petitioner, and state:

(1) The petitioner's name, address, and relationship, if any, to the respondent;

(2) The name and any known address of the respondent;

(3) That the petitioner has reason to believe the respondent meets the criteria for assisted outpatient treatment in § 10–6A–05 of this subtitle; and

(4) For each criterion for assisted outpatient treatment in § 10–6A–05 of this subtitle, the specific allegations of fact that support the petitioner's belief that the respondent meets the criterion.

(c) The petition for assisted outpatient treatment shall be accompanied by an affidavit or affirmation of a psychiatrist, stating that the psychiatrist is willing and able to testify at the hearing on the petition and has:

(1) Examined the respondent within 30 days before the date of the petition; and

(2) Concluded that the respondent meets the criteria for assisted outpatient treatment in § 10–6A–05 of this subtitle.

(d) (1) A petition for assisted outpatient treatment shall be filed in the circuit court for the county in which the respondent resides or in the county of the last known residence of the respondent.

(2) On the filing of a petition under paragraph (1) of this subsection, the circuit court shall notify the following of the filing of the petition:

(i) The respondent;

(ii) The Mental Health Division in the Office of the Public Defender;

(iii) As applicable, the local behavioral health authority, the county's core service agency, or the Department;

(iv) The county attorney; and

(v) If applicable and known, the respondent's guardian and health care agent.

(e) A petition filed under this subtitle shall be held under seal and may not be published on Maryland Judiciary Case Search.

§10–6A–05. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) The court may order the respondent to receive assisted outpatient treatment on a finding by clear and convincing evidence that:

(1) The respondent is at least 18 years old;

(2) The respondent has a serious and persistent mental illness;

(3) The respondent has demonstrated a lack of adherence with treatment for the serious and persistent mental illness that has:

(i) At least twice within the 36–month period immediately preceding the filing of the petition, been a significant factor in necessitating inpatient

admission to a psychiatric hospital for at least 48 hours or receipt of psychiatric services in a correctional facility; or

(ii) At least once within the 36–month period immediately preceding the filing of the petition, resulted in an act of serious violent behavior toward self or others, or patterns or threats of, or attempts at, serious physical harm to self or others;

(4) In view of the respondent's treatment history and behavior at the time the petition is filed, the respondent is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would create a substantial risk of serious harm to the individual or harm to others;

(5) The respondent is unlikely to adequately adhere to outpatient treatment on a voluntary basis, as demonstrated by the respondent's history of treatment nonadherence in the 36–month period immediately preceding the filing of the petition that is not due to financial, transportation, or language issues in the immediately preceding 36–month period; and

(6) In consideration of items (1) through (5) of this subsection, assisted outpatient treatment is the least restrictive alternative appropriate to maintain the health and safety of the respondent.

(b) Time that the respondent spent hospitalized or incarcerated may not be included when calculating the time period under subsection (a)(3)(i) or (ii) of this section.

§10–6A–06. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) (1) After the filing of the petition with the court under § 10–6A–04 of this subtitle, but not later than the date of the psychiatrist's testimony required under § 10–6A–07 of this subtitle, the care coordination team shall develop a treatment plan and provide a copy in writing to:

(i) The respondent;

(ii) The respondent's attorney; and

(iii) If applicable and known, the respondent's guardian and health care agent.

(2) A treatment plan developed by the care coordination team shall be:

(i) Recovery–oriented; and

(ii) Consistent with evidence–based and evolving best practices in the treatment of serious and persistent mental illness.

(3) For each service listed in the treatment plan, a community–based provider that has agreed to provide the service to the respondent shall be identified to provide the service.

(4) A treatment plan may include medication.

(b) (1) The care coordination team shall give the respondent, the respondent's guardian, the respondent's health care agent, and any individual designated by the respondent a reasonable opportunity to participate in the development of the treatment plan.

(2) If the respondent has executed a mental health advance directive, the care coordination team shall honor any directions included in the advance directive in the development of the treatment plan in accordance with §§ 5–602(a)(2) and 5–611(a) and (b) of this article.

(3) (i) The respondent shall have an opportunity to voluntarily agree to the treatment plan.

(ii) If the respondent voluntarily agrees to the treatment plan, the care coordination team shall:

1. Notify the court that the parties are dismissing the case in accordance with Maryland Rule 2–506; and

2. File a stipulated agreement that includes the treatment plan.

(4) The care coordination team shall provide to the respondent, the county attorney, and the Office of the Public Defender the treatment plan and the providers that are included in the treatment plan.

(5) If the care coordination team changes the treatment plan or the providers included in the treatment plan before the hearing conducted under § 10–6A–07 of this subtitle, the care coordination team shall promptly notify the following of the change and the justification of the change:

(i) The respondent;

(ii) The respondent's attorney;

(iii) The county attorney; and

(iv) If applicable and known, the respondent's guardian and health care agent.

(6) The care coordination team shall assist in connecting the respondent to services that would help the respondent be successful in adhering to a treatment plan, including, if needed, transportation, housing, accessibility services, and other services that would address the health–related social needs of the respondent.

§10–6A–07. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) (1) On receipt of a petition for assisted outpatient treatment that meets the requirements of § 10–6A–04 of this subtitle, the court shall schedule the date for a hearing.

(2) The court may grant a continuance or postponement only for good cause shown.

(3) A hearing shall be scheduled only if the respondent has not agreed to enter voluntary treatment.

(b) (1) The respondent shall be entitled to be represented by counsel of the respondent's choice at the hearing and at all stages of the proceedings.

(2) If the respondent is unable to afford an attorney, or is unable to obtain an attorney due to the respondent's mental illness, representation shall be provided in accordance with §§ 16–204 and 16–208 of the Criminal Procedure Article.

(3) All rules of civil procedure shall apply to cases filed under this subtitle.

(4) Respondents may not be required to give testimony at hearings under this subtitle.

(5) Participation in assisted outpatient treatment may not be used against a respondent in a subsequent legal matter that carries negative collateral consequences.

(c) At the hearing, the respondent shall be given an opportunity to present evidence, to call witnesses on the respondent's behalf, and to cross–examine adverse witnesses.

(d) (1) The petitioner's presentation of evidence shall include the testimony of a psychiatrist whose most recent examination of the respondent occurred within 30 days before the date of the petition.

(2) The psychiatrist shall state the facts and clinical determinations providing the basis for the psychiatrist's opinion that the respondent meets each of the criteria for assisted outpatient treatment in § 10–6A–05 of this subtitle.

(e) (1) The petitioner's presentation of evidence shall include the testimony of a psychiatrist to explain the treatment plan, who:

(i) May be but need not be the examining psychiatrist who testified under subsection (d) of this section; and

(ii) Has met with the respondent or has made a good faith effort to meet with the respondent, is familiar with the relevant history, to the extent practicable, and has examined the treatment plan.

(2) For each category of proposed treatment, the psychiatrist shall state the clinical basis for the determination that the treatment is essential to the maintenance of the respondent's health or safety.

(3) The psychiatrist shall testify as to the participation, if any, of the respondent in the development of the treatment plan.

§10–6A–08. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) If, after hearing all relevant evidence, the court does not find by clear and convincing evidence that the respondent meets the criteria for assisted outpatient treatment, the court shall deny the petition.

(b) (1) If, after hearing all relevant evidence, the court finds by clear and convincing evidence that the respondent meets the criteria for assisted outpatient

treatment, the court shall order the respondent to comply with assisted outpatient treatment for a period not to exceed 1 year.

(2) The order of the court shall incorporate a treatment plan that:

(i) Is limited in scope to the elements included in the treatment plan presented to the court under § 10–6A–06 of this subtitle; and

(ii) Includes only those elements that the court finds by clear and convincing evidence to be essential to the maintenance of the respondent's health or safety.

§10–6A–09. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) In this section, "material change" means an addition or a deletion of a category of services to or from the treatment plan.

(b) At any time during the period of an order for assisted outpatient treatment, a petitioner, a care coordination team member, or a respondent may move that the court stay, vacate, or modify the order.

(c) A respondent under an order under this subtitle is not required to comply with a material change to the treatment plan unless the material change is explicitly authorized in advance by the terms of the order or incorporated by the court on a finding by clear and convincing evidence that the material change is essential to the maintenance of the respondent's health or safety.

(d) (1) Subject to paragraph (2) of this subsection, not later than 30 days after receiving a motion, and any timely responses to the motion, for a material change to the incorporated treatment plan, the court shall issue a ruling on the motion and any timely responses to the motion.

(2) If the respondent informs the court that the respondent agrees to the proposed material change, the court may incorporate the material change into the treatment plan.

(e) A respondent under an assisted outpatient treatment order is required to comply with nonmaterial changes to the treatment plan without further action by the court.

(f) (1) This section may not be construed to require a treating psychiatrist to delay changes to the respondent's treatment plan as circumstances may immediately require.

(2) If a treating psychiatrist makes a change to a treatment plan due to immediate necessity, a care coordination team member shall notify the following:

(i) The respondent;

(ii) The respondent's attorney; and

(iii) If applicable and known, the respondent's guardian and health care agent.

§10–6A–10. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) If the care coordination team has knowledge of a petition for emergency evaluation that was filed for the respondent, a care coordination team member shall notify the court in writing of the reasons for and findings of the evaluation.

(b) In response to the notice or at any time during the period of the assisted outpatient treatment order and on its own motion, the court may convene the parties for a conference to review the progress of the respondent.

(c) To the extent practicable, if a petition for emergency evaluation of the respondent is filed or if the respondent is the subject of other court involvement, the petitioner shall notify the respondent's care coordination team of the petition or other court involvement.

(d) Failure to comply with an order of assisted outpatient treatment is not grounds for a finding of contempt of court or for involuntary admission under this title.

§10–6A–11. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

Within 30 days before the expiration of an order of assisted outpatient treatment, the respondent's care coordination team shall provide the respondent with a plan for continued treatment, if considered necessary.

§10–6A–12. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2030 PER CHAPTERS 703 AND 704 OF 2024 //

(a) On or before December 1 each year, the Administration shall submit to the General Assembly, in accordance with § 2–1257 of the State Government Article, a report on each program established under this subtitle that includes:

(1) The number of individuals who were ordered to receive assisted outpatient treatment during the immediately preceding 12–month period;

(2) For each individual ordered to receive an assisted outpatient treatment during the immediately preceding 12–month period, the de–identified data on the following for the 12–month period immediately preceding the assisted outpatient treatment order and the most recent 12–month period following the assisted outpatient treatment order:

(i) Incidences of hospitalizations, including the number of days spent hospitalized;

(ii) Arrests; and

(iii) Number of days spent incarcerated;

(3) Program statistics for the immediately preceding 12–month period, including:

(i) The number of petitions filed;

(ii) The number of respondents under an order for assisted outpatient treatment, including those under order by stipulated agreement;

(iii) The number of voluntary agreements made by respondents to comply with a treatment plan;

(iv) De–identified demographic data for assisted outpatient treatment program recipients, including, to the extent available:

1. Average age;

2. Living situation at the time of the issuance of the assisted outpatient treatment order;

3. Living situation at the time of the expiration of the assisted outpatient treatment order;

4. Gender;

5. Marital status;

6. Race and ethnicity;

7. Religion;

8. Familial status;

9. National origin;

10. Sexual orientation;

11. Gender identity; and

12. Disability;

(v) De–identified information on diagnoses of assisted outpatient treatment recipients;

(vi) De–identified results from the use of a clinically validated symptom tool to assess responsiveness of respondents to treatment; and

(vii) De–identified results of a survey of the satisfaction of respondents under an order for assisted outpatient treatment;

(4) Any information the Department has about system–wide impacts of assisted outpatient treatment ordered under this subtitle, including any information from hospitals, local detention centers, and counties; and

(5) Information about the costs incurred by the Department, the Administration, and any county that establishes an assisted treatment program under this subtitle, including costs for:

(i) Attorneys;

(ii) Expert witnesses; and

(iii) The provision of services provided under an assisted outpatient treatment order.

(b) Each county shall provide information to the Administration that the Administration determines is necessary for the purpose of complying with subsection (a) of this section.

(c) This section may not be construed to prohibit or prevent the collection of additional data, including additional demographic information or other data necessary for program evaluation or improvement, as requested by the General Assembly or the Executive Branch of State government.

§10–701.

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

(2) (i) "Advocate" means a person who provides support and guidance to an individual in a facility.

(ii) "Advocate" includes a family member or friend.

(iii) "Advocate" does not include an attorney acting in the capacity of legal counsel to an individual in a facility during the treatment planning and discharge planning process.

(3) "Facility" does not include an acute general care hospital that does not have a separately identified inpatient psychiatric service.

(4) (i) "Mental abuse" means any persistent course of conduct resulting in or maliciously intended to produce emotional harm.

(ii) "Mental abuse" does not include the performance of an accepted clinical procedure.

(5) (i) "Prone restraint" means restricting the free movement of all or a portion of an individual's body through the use of physical force or mechanical devices while the individual is in a prone position.

(ii) "Prone restraint" does not include a technique for transitioning an individual to a restraint position that involves momentarily placing the individual face down.

(6) "State facility" means an inpatient facility that is maintained under the direction of the Behavioral Health Administration.

(7) "Trauma–informed care" means mental health treatment that includes:

(i) An appreciation for the high prevalence of trauma experienced by individuals receiving mental health services;

(ii) An understanding of the neurological, biological, psychological, and social effects of trauma and violence, including sexual abuse and exploitation, on an individual; and

(iii) An understanding of the environment, practices, and treatments that may need to be modified to address trauma issues.

(b) It is the policy of this State that each individual with a mental disorder who receives any service in a facility has, in addition to any other rights, the rights provided in this subtitle.

(c) Each individual in a facility shall:

(1) Receive appropriate humane treatment and services in a manner that restricts the individual's personal liberty within a facility only to the extent necessary and consistent with the individual's treatment needs and applicable legal requirements;

(2) Receive treatment in accordance with the applicable individualized plan of rehabilitation or the individualized treatment plan provided for in § 10–706 of this subtitle;

(3) Be free from restraints or seclusions except for restraints or seclusions that are:

(i) Used only during an emergency in which the behavior of the individual places the individual or others at serious threat of violence or injury; and

(ii) 1. Ordered by a physician in writing; or

2. Directed by a registered nurse if a physician's order is obtained within 2 hours of the action;

(4) Be free from prone restraint;

(5) Be free from restraint that:

(i) Applies pressure to the individual's back;

(ii) Obstructs the airway of the individual or impairs the individual's ability to breathe;

(iii) Obstructs a staff member's view of the individual's face; or

(iv) Restricts the individual's ability to communicate distress;

(6) Be free from mental abuse;

(7) Be protected from harm or abuse as provided in this subtitle;

(8) Except as provided in subsection (e) of this section, and subject to subsection (k) of this section, have the right to an advocate of the individual's choice to participate in the treatment planning and discharge planning process; and

(9) Subject to the provisions of § 10–708 of this subtitle, if the individual has an advance directive for mental health services provided for in § 5–602.1 of this article, receive treatment in accordance with the preferences in the advance directive.

(d) A State facility shall ensure that:

(1) All clinical, direct care, and other designated staff with regular patient interaction receive training in trauma–informed care and demonstrate competency in providing trauma–informed care services within 3 months of being hired and on an annual basis;

(2) Any policy or practice followed by the facility is reviewed and revised to conform with trauma–informed care principles; and

(3) The physical environment of the facility is assessed at least annually and modified if the modifications:

(i) Are necessary to ensure conformity with trauma–informed care principles; and

(ii) Can be funded through the State's operating budget or capital budget.

(e) Notwithstanding the provisions of subsection (c)(8) of this section, a facility may prohibit an advocate from participating in the treatment planning or discharge planning process for an individual if:

(1) (i) The individual is a minor or an adult under guardianship in accordance with § 13–705 of the Estates and Trusts Article; and

(ii) The parent of the minor or the legal guardian of the individual has requested that the advocate not participate; or

(2) The advocate has engaged in behavior that:

(i) Is disruptive to the individual, other patients, or staff at the facility; or

(ii) Poses a threat to the safety of the individual, other patients, or staff at the facility.

(f) A facility shall:

(1) Have a written policy specifying the method used to ensure that an individual whose primary language or method of communication is nonverbal is able to effectively communicate distress during a physical restraint or hold; and

(2) Ensure that all staff at the facility who are authorized to participate in a physical restraint or hold of individuals are trained in the method specified in the written policy required under item (1) of this subsection.

(g) Subject to the provisions of §§ 4–301 through 4–309 of this article, the records of each individual in a facility are confidential.

(h) (1) Notwithstanding any other provision of law, when the State designated protection and advocacy agency has received and documented a request for an investigation of a possible violation of the rights of an individual in a facility that is owned and operated by the Department or under contract to the Department to provide mental health services in the community under this subtitle, the executive director of the protection and advocacy agency or the executive director's designee:

(i) Before pursuing any investigation:

1. Shall interview the individual whose rights have been allegedly violated; and

2. Shall attempt to obtain written consent from the individual; and

(ii) If the individual is unable to give written consent but does not object to the investigation:

1. Shall document this fact; and

2. Shall request, in writing, access to the individual's records from the Director of the Behavioral Health Administration.

(2) On receipt of the request for access to the individual's records, the Director of the Behavioral Health Administration shall authorize access to the individual's records.

(3) After satisfying the provisions of paragraphs (1) and (2) of this subsection, the executive director of the protection and advocacy agency, or the executive director's designee, may pursue an investigation and, as part of that investigation, shall continue to have access to the records of the individual whose rights have been allegedly violated.

(i) (1) On admission to a facility, an individual shall be informed of the rights provided in this subtitle in language and terms that are appropriate to the individual's condition and ability to understand.

(2) A facility shall post notices in locations accessible to the individual and to visitors describing the rights provided in this subtitle in language and terms that may be readily understood.

(j) A facility shall implement an impartial, timely complaint procedure that affords an individual the ability to exercise the rights provided in this subtitle.

(k) This section may not be construed to:

(1) Grant the advocate of an individual legal authority that the advocate does not otherwise have under law to make decisions on behalf of the individual regarding treatment or discharge;

(2) Grant the advocate access to the medical records of the individual or other confidential information that the advocate does not otherwise have access to under law; or

(3) Limit the legal authority that an attorney or other person otherwise has under law to participate in the treatment planning and discharge planning process or to otherwise act on behalf of an individual in a facility.

§10–702.

(a) (1) Subject to any reasonable limitation that a facility imposes, each individual in the facility shall have access, at all reasonable hours, to writing instruments, stationery, and postage and may use them to write to anyone.

(2) The correspondence of the individual shall be sent to the addressee without delay, and except under the direction of the addressee, without being opened.

(b) Each individual in a facility shall have reasonable access to a telephone. However, an individual may not telephone anyone who has given the facility written notice of being unwilling to be telephoned.

(c) (1) If, for medical reasons, an individual's access to correspondence, writing instruments, or telephones is limited, the limitation shall be:

(i) Signed by a physician and the reasons for the limitation and the date on which the limitation expires made a permanent part of the individual's record; and

(ii) Reviewed every 30 days if the limitation remains in effect.

(2) If the attending physician believes that, because of the condition of an individual, another individual should be permitted to be present when writing instruments are used, the permission and the reasons for the permission shall be:

(i) Signed by the attending physician;

(ii) Dated as to when the permission expires;

(iii) Made a permanent part of the individual's record; and

(iv) Reviewed every 30 days if the permission remains in effect.

§10–703.

(a) Each individual in a facility shall be entitled to converse privately with and receive visits:

(1) At all reasonable hours, from a lawyer that the individual chooses;

(2) At all reasonable hours, from a clergyman that the individual chooses; and

(3) During reasonable visiting hours that the facility sets, from any other visitor if the individual wishes to see the visitor.

(b) If an individual refuses to see a visitor, the refusal shall be made a permanent part of the individual's record.

(c) (1) If, for medically justified reasons, visits or private conversations are restricted, the restriction and the reasons for the restriction shall be:

(i) Signed by a physician;

(ii) Dated as to when the restriction expires;

(iii) Made a permanent part of the individual's record; and

(iv) Reviewed every 30 days if the restriction remains in effect.

(2) Visits of an individual's lawyer or clergyman may not be restricted during reasonable hours.

§10–704.

An individual may not be deprived of the right to vote or to receive, hold, and dispose of property solely because the individual is in a facility or a Veterans' Administration hospital for a mental disorder.

§10–705.

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

(2) (i) "Abuse" means cruel or inhumane treatment that causes:

1. Any physical injury; or

2. Any of the following kinds of sexual abuse:

A. A sexual act, as defined in § 3–301 of the Criminal Law Article;

B. Sexual contact, as defined in § 3–301 of the Criminal Law Article; or

C. Vaginal intercourse, as defined in § 3–301 of the Criminal Law Article.

(ii) "Abuse" does not include:

1. The performance of an accepted medical procedure that a physician orders in a manner that is consistent with the provisions of this subtitle; or

2. An action taken by an employee that complies with applicable State and federal laws and applicable Department policies on the use of physical intervention.

(3) "Sexual harassment" means intimidation, bullying, or coercion of a sexual nature or unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create a hostile or offensive environment.

(b) (1) A person or any employee of a facility or of the Department who receives a complaint of abuse, or who observes or has reason to believe that abuse has occurred, shall promptly report the alleged abuse to:

(i) An appropriate law enforcement agency; or

(ii) The administrative head of the facility, who promptly shall report the alleged abuse to an appropriate law enforcement agency.

(2) A report:

(i) May be oral or written; and

(ii) Shall contain as much information as the reporter is able to provide.

(3) Within 24 hours after receiving the complaint, a facility that is a licensed residential treatment center, a State facility, or a hospital with a separately identified inpatient psychiatric service shall report a complaint of sexual abuse or sexual harassment of a patient receiving treatment in the residential treatment center or receiving inpatient psychiatric services to:

(i) The Administration and the Office of Health Care Quality;

(ii) If the complaint involves a minor, the Child Protective Services unit in the Department of Human Services; and

(iii) The State designated protection and advocacy system.

(4) The Administration and the Office of Health Care Quality shall collaborate to develop and implement a uniform reporting system to be used by facilities in complying with paragraph (3) of this subsection.

(c) (1) The law enforcement agency shall:

(i) Investigate thoroughly each report of an alleged abuse; and

(ii) Attempt to ensure the protection of the alleged victim.

(2) The investigation shall include:

(i) A determination of the nature, extent, and cause of the abuse, if any;

(ii) The identity of the alleged abuser; and

(iii) Any other pertinent fact or matter.

(d) As soon as possible, but no later than 10 working days after the completion of the investigation, the law enforcement agency shall submit a written report of its findings to the State's Attorney, the State designated protection and advocacy system, and the administrative head of the facility.

(e) A person shall have the immunity from liability described under § 5–626 of the Courts Article for:

(1) Making a report under this section;

(2) Participating in an investigation arising out of a report under this section; or

(3) Participating in a judicial proceeding arising out of a report under this section.

(f) (1) A facility that is a licensed residential treatment center, a State facility, or a hospital with a separately identified inpatient psychiatric service shall:

(i) Develop and implement policies and procedures on making and responding to allegations and complaints of sexual abuse or sexual harassment of patients receiving treatment in the residential treatment center or receiving inpatient psychiatric services;

(ii) Ensure that staff provide assistance to patients who have requested assistance in making complaints about sexual abuse or sexual harassment;

(iii) Develop and oversee training for staff on how to identify and prevent sexual abuse and sexual harassment, how to respond to complaints, and how to support victims in an appropriate manner; and

(iv) Develop and oversee patient education on identifying sexual abuse and sexual harassment and on reporting incidents of sexual abuse and sexual harassment.

(2) The Administration shall ensure that the policies and procedures developed and implemented under paragraph (1) of this subsection are uniform for State facilities.

(g) The Administration shall develop and implement a plan to secure the sleeping quarters of male and female patients at all State facilities that maximizes the use of available resources and infrastructure.

(h) Each facility that is a licensed residential treatment center, a State facility, or a hospital with a separately identified inpatient psychiatric service shall, for patients receiving treatment in the residential treatment center or receiving inpatient psychiatric services:

(1) Use evidence–based screening tools to identify on admission a patient's risk of being a victim of sexual or physical abuse, or being a sexual or physical abuser, and shall consider the assessment of risk in making any unit and room assignment;

(2) Adopt a written protection plan as part of a patient's treatment plan if warranted by the patient's risk of being a victim of sexual or physical abuse or being a sexual or physical abuser;

(3) If possible, reassign any patient accused of sexual assault promptly to another unit and ensure that any alleged victim and the alleged assailant are not housed in the same unit;

(4) Provide a patient who has a history of sexual trauma with treatment and education that is evidence–based or reflective of best practices to reduce the likelihood of the patient being the victim of repeated sexual abuse; and

(5) Ensure that designated clinical staff are trained in at least one trauma recovery modality that is considered to be a best practice.

(i) The Office of Health Care Quality shall enforce this section.

(j) The Department shall adopt regulations to carry out this section.

§10–706.

(a) (1) Except as provided by paragraph (2) of this subsection, promptly after admission of an individual, a facility shall make and periodically update a written plan of treatment for the individual in the facility, in accordance with the provisions of this subtitle.

(2) Promptly after admission of an individual to a psychosocial center, the center shall make and periodically update a written plan of rehabilitation for the individual in the facility, in accordance with the provisions of this subtitle.

(b) The Director shall adopt rules and regulations under this section that include:

(1) Subject to subsection (d) of this section, a description of the nature and content of plans of treatment; and

(2) Subject to subsection (e) of this section, appropriate time periods for the development, implementation, and review of each plan.

(c) An individual shall:

(1) Participate, in a manner appropriate to the individual's condition, in the development and periodic updating of the plan of treatment; and

(2) Be told, in appropriate terms and language, of:

(i) The content and objectives of the plan of treatment;

(ii) The nature and significant possible adverse effects of recommended treatments;

(iii) The name, title, and role of personnel directly responsible for carrying out the treatment for the individual; and

(iv) When appropriate, other available alternative treatments, services, or providers of mental health services.

(d) A plan of treatment shall include:

(1) A long–range discharge goal; and

(2) An estimate of the probable length of inpatient stay the individual requires before transfer to a less restrictive or intensive treatment setting.

(e) Facility staff who work directly with and provide treatment to an individual shall review and reassess the plan of treatment for the individual to determine the individual's progress and any need for adjustments to the plan not less than:

(1) Once every 15 days for the first 2 months after admission of the individual to the facility; and

(2) Once every 60 days for the remainder of the inpatient stay of the individual in the facility.

(f) (1) On the admission of an individual to a facility, the facility shall:

(i) Ask the individual whether the individual consents to family members or any other individuals being informed of and given the opportunity to participate in meetings with the treatment team regarding the development, review, and reassessment of the plan of treatment of the individual; and

(ii) If consent is given under item (i) of this paragraph, at least every 7 days after consent is given, reconfirm the consent and provide the individual at a clinical visit with an opportunity to consent to additional individuals being informed of and given the opportunity to participate in meetings with the treatment team.

(2) If an individual agrees to have family members or other individuals participate in the development, review, and reassessment of the individual's plan of treatment, the facility shall:

(i) Provide a schedule of routine treatment team meetings where the plan of treatment is discussed;

(ii) Establish a process for the authorized individuals to participate in treatment team meetings;

(iii) If the treatment team meeting is being held outside the regular schedule, inform the authorized individuals as soon as the meeting is scheduled; and

(iv) If the treatment team meeting is being held due to an emergency, inform the authorized individuals of the outcome of the meeting as soon as practicable.

(3) The individual may withdraw the consent given under paragraph (1) of this subsection at any time orally or in writing.

(4) A treating provider may withhold information on an individual plan of treatment from a family member or other authorized individual if:

(i) In the treating provider's clinical judgment, the consent given under paragraph (1) of this subsection was provided through coercive means;

(ii) The treating provider believes it is in the best clinical interest of the individual; or

(iii) The individual requests that a specific piece of the plan of treatment be withheld.

(g) (1) If an individual admitted to a facility or any family member or other individual authorized by the individual to participate in the review and reassessment of the plan of treatment for the individual under subsection (f) of this section believes that the plan of treatment is not meeting the needs of the individual, the individual, family member, or other authorized individual has the right to request that the facility review and reassess the plan of treatment.

(2) On receipt of a request under paragraph (1) of this subsection, the facility staff who work directly with and provide treatment to the individual shall:

(i) Conduct a review and reassessment of the plan of treatment;

(ii) Communicate the results of the review and reassessment of the plan of treatment to the patient and individual who requested the review and reassessment, including an explanation of how all issues raised in the request were considered; and

(iii) Include the request for the review and reassessment of the plan of treatment and the outcome of the review and assessment, including the explanation of the outcome, in the medical records of the individual.

(3) If a State facility does not make any changes to the plan of treatment for the individual, the State facility shall provide referral information for the Resident Grievance System established under COMAR 10.21.14.

(h) An individual admitted to a State facility or another individual authorized by the admitted individual may request a reconsideration of the review and reassessment completed under subsection (g) of this section by filing a grievance with the Resident Grievance System under COMAR 10.21.14.

(i) (1) An individual admitted to a State facility or another individual authorized by the admitted individual may appeal the reconsideration of the review and reassessment completed under subsection (h) of this section by filing a request with the Department's Healthcare System's Chief Medical Officer.

(2) The Department shall adopt regulations to establish a process for the appeal of the reconsideration of the review and reassessment under paragraph (1) of this subsection.

(j) If an individual is admitted to a State facility and the State facility is unable to provide the treatment necessary to address the rehabilitation needs of an individual under a plan of treatment for the individual, the State facility shall:

(1) Make arrangements for the individual to receive necessary treatment from another facility or other health care provider outside the State facility; and

(2) Ensure that treatment for the individual is coordinated between the State facility and the other facility or health care provider.

§10–707.

An individual in a facility has the right to refuse to participate as a subject in physically intrusive research conducted at the facility.

§10–708.

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

(2) "Lay advisor" means an individual at a facility, who is knowledgeable about mental health practice and who assists individuals with rights complaints.

(3) "Medication" means psychiatric medication prescribed for the treatment of a mental disorder.

(4) "Panel" means a clinical review panel that determines, under the provisions of this section, whether to approve that medication be administered to an individual who objects to the medication.

(b) Medication may not be administered to an individual who refuses the medication, except:

(1) In an emergency, on the order of a physician where the individual presents a danger to the life or safety of the individual or others; or

(2) In a nonemergency, when the individual is hospitalized involuntarily or committed for treatment by order of a court and the medication is approved by a panel under the provisions of this section.

(c) (1) A panel shall consist of the following individuals appointed by the chief executive officer of the facility or the chief executive officer's designee, one of whom shall be appointed chairperson:

(i) The clinical director of the psychiatric unit, if the clinical director is a physician, or a physician designated by the clinical director;

(ii) A psychiatrist; and

(iii) A mental health professional, other than a physician.

(2) If a member of the clinical review panel also is directly responsible for implementing the individualized treatment plan for the individual under review, the chief executive officer of the facility or the chief executive officer's designee shall designate another panel member for that specific review.

(d) (1) The chief executive officer of the facility or the chief executive officer's designee shall give the individual and the lay advisor written notice at least 24 hours prior to convening a panel.

(2) Except in an emergency under subsection (b)(1) of this section, medication or medications being refused may not be administered to an individual prior to the decision of the panel.

(e) (1) The notice under subsection (d)(1) of this section shall include the following information:

(i) The date, time, and location that the panel will convene;

(ii) The purpose of the panel; and

(iii) A complete description of the rights of an individual under paragraph (2) of this subsection.

(2) At a panel, an individual has the following rights:

(i) To attend the meeting of the panel, excluding the discussion conducted to arrive at a decision;

(ii) To present information, including witnesses;

(iii) To ask questions of any person presenting information to the panel;

(iv) To request assistance from a lay advisor; and

(v) To be informed of:

1. The name, address, and telephone number of the lay advisor;

2. The individual's diagnosis; and

3. An explanation of the clinical need for the medication or medications, including potential side effects, and material risks and benefits of taking or refusing the medication.

(3) The chairperson of the panel may:

(i) Postpone or continue the panel for good cause, for a reasonable time; and

(ii) Take appropriate measures necessary to conduct the panel in an orderly manner.

(f) Prior to determining whether to approve the administration of medication, the panel shall:

(1) Review the individual's clinical record, as appropriate;

(2) Assist the individual and the treating physician to arrive at a mutually agreeable treatment plan; and

(3) Meet for the purpose of receiving information and clinically assessing the individual's need for medication by:

(i) Consulting with the individual regarding the reason or reasons for refusing the medication or medications and the individual's willingness to accept alternative treatment, including other medication;

(ii) Consulting with facility personnel who are responsible for initiating and implementing the individual's treatment plan, including discussion of the current treatment plan and alternative modes of treatment, including medications that were considered;

(iii) Receiving information presented by the individual and other persons participating in the panel;

(iv) Providing the individual with an opportunity to ask questions of anyone presenting information to the panel; and

(v) Reviewing the potential consequences of requiring the administration of medication and of withholding the medication from the individual.

(g) The panel may approve the administration of medication or medications and may recommend and approve alternative medications if the panel determines that:

(1) The medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder;

(2) The administration of medication represents a reasonable exercise of professional judgment; and

(3) Without the medication, the individual is at substantial risk of continued hospitalization because of:

(i) Remaining seriously mentally ill with no significant relief of the mental illness symptoms that:

1. Cause the individual to be a danger to the individual or others while in the hospital;

2. Resulted in the individual being committed to a hospital under this title or Title 3 of the Criminal Procedure Article; or

3. Would cause the individual to be a danger to the individual or others if released from the hospital;

(ii) Remaining seriously mentally ill for a significantly longer period of time with the mental illness symptoms that:

1. Cause the individual to be a danger to the individual or to others while in the hospital;

2. Resulted in the individual being committed to a hospital under this title or Title 3 of the Criminal Procedure Article; or

3. Would cause the individual to be a danger to the individual or others if released from the hospital; or

(iii) Relapsing into a condition in which the individual is unable to provide for the individual's essential human needs of health or safety.

(h) (1) A panel shall base its decision on its clinical assessment of the information contained in the individual's record and information presented to the panel.

(2) A panel may meet privately to reach a decision.

(3) A panel may not approve the administration of medication where alternative treatments are available and are acceptable to both the individual and the facility personnel who are directly responsible for implementing the individual's treatment plan.

(i) (1) A panel shall document its consideration of the issues and the basis for its decision on the administration of medication or medications.

(2) A panel shall provide a written decision on the administration of medication or medications, and the decision shall be provided to the individual, the lay advisor, and the individual's treatment team for inclusion in the individual's medical record.

(3) If a panel approves the administration of medication, the decision shall specify:

(i) The medication or medications approved and the dosage and frequency range;

(ii) The duration of the approval, not to exceed the maximum time provided under subsection (n) of this section; and

(iii) The reason that alternative treatments, including the medication, if any, were rejected by the panel.

(4) If a panel approves the administration of medication, the decision shall contain:

(i) Notice of the right to request a hearing under subsection (l) of this section;

(ii) The right to request representation or assistance of a lawyer or other advocate of the individual's choice; and

(iii) The name, address, and telephone number of the designated State protection and advocacy agency and the Lawyer Referral Service.

(j) A panel shall convene within 9 days after an individual's refusal of medication for a period of at least 72 hours if:

(1) The individual was committed to a hospital under Title 3 of the Criminal Procedure Article because of a mental disorder; and

(2) The treatment plan developed under § 10–706 of this subtitle indicates that there is a substantial likelihood that, without immediate treatment, the individual will remain a danger to self or the person or property of another.

(k) If a panel approves the administration of medication, the lay advisor promptly shall:

(1) Inform the individual of the individual's right to appeal the decision under subsection (l) of this section;

(2) Ensure that the individual has access to a telephone as provided under § 10–702(b) of this subtitle;

(3) If the individual requests a hearing, notify the chief executive officer of the facility or the chief executive officer's designee pursuant to subsection (l)(1) of this section and give the individual written notice of the date, time, and location of the hearing; and

(4) Advise the individual of the provision for renewal of an approval under subsection (n) of this section.

(l) (1) An individual may request an administrative hearing to appeal the panel's decision by filing a request for hearing with the chief executive officer of the facility or the chief executive officer's designee within 48 hours of receipt of the decision of the panel.

(2) Within 24 hours of receipt of a request for hearing, the chief executive officer of the facility or the chief executive officer's designee shall forward the request to the Office of Administrative Hearings.

(3) An initial panel decision authorizing the administration of medication shall be stayed for 48 hours. If a request for hearing is filed, the stay shall remain in effect until the issuance of the administrative decision.

(4) The Office of Administrative Hearings shall conduct a hearing and issue a decision within 7 calendar days of the decision by the panel.

(5) The administrative hearing may be postponed by agreement of the parties or for good cause shown.

(6) The administrative law judge shall conduct a de novo hearing to determine if the standards and procedures in this section are met.

(7) At the hearing, the individual representing the facility:

(i) May introduce the decision of the panel as evidence; and

(ii) Shall prove, by a preponderance of the evidence, that the standards and procedures of this section have been met.

(8) The administrative law judge shall state on the record the findings of fact and conclusions of law.

(9) The determination of the administrative law judge is a final decision for the purpose of judicial review of a final decision under the Administrative Procedure Act.

(m) (1) Within 14 calendar days from the decision of the administrative law judge, the individual or the facility may appeal the decision and the appeal shall be to the circuit court on the record from the hearing conducted by the Office of Administrative Hearings.

(2) The scope of review shall be as a contested case under the Administrative Procedure Act.

(3) (i) Review shall be on the audiophonic tape without the necessity of transcription of the tape, unless either party to the appeal requests transcription of the tape.

(ii) A request for transcription of the tape shall be made at the time the appeal is filed.

(iii) The Office of Administrative Hearings shall prepare the transcription prior to the appeal hearing, and the party requesting the transcription shall bear the cost of transcription.

(4) The circuit court shall hear and issue a decision on an appeal within 7 calendar days from the date the appeal was filed.

(n) (1) Treatment pursuant to this section may not be approved for longer than 90 days.

(2) (i) Prior to expiration of an approval period and if the individual continues to refuse medication, a panel may be convened to decide whether renewal is warranted.

(ii) Notwithstanding the provisions of paragraph (1) of this subsection, if a clinical review panel approves the renewal of the administration of medication or medications, the administration of medication or medications need not be interrupted if the individual appeals the renewal of approval.

(o) When medication is ordered pursuant to the approval of a panel under this section and at a minimum of every 15 days, the treating physician shall document any known benefits and side effects to the individual.

(p) (1) The Administration shall develop and conduct training on the requirements of this section to ensure compliance at all State facilities.

(2) The training is mandatory for all clinical directors and all individuals who are eligible to serve on a panel.

§10–709.

(a) In accordance with § 10-809 of this title, a facility shall prepare a written aftercare plan for an individual who has been accepted as a resident in the facility before that individual is released from the facility.

(b) The aftercare plan prepared under this section shall be offered to individuals who have been accepted as residents in a facility who are scheduled for release from a facility under this title.

(c) The Secretary shall adopt regulations governing the planning and provisions of aftercare plans including:

(1) Procedures to obtain the consent of the individual; or

(2) Procedures to assist an individual who is unable to participate fully in aftercare planning.

§10–710.

(a) Each minor who is being cared for or treated in a residential, State facility shall be placed in a unit for minors and may not be placed in a unit where adults are placed, unless the individual plan of treatment for the minor provides otherwise.

(b) A person, on behalf of the minor, may file a petition in the circuit court for the county where the facility is located, to compel compliance with this section.

§10–711.

On request, the administrative head of each facility shall give to the Director or a representative of the Director:

(1) Any information that the administrative head has about an individual in the facility;

(2) Access to the individual; and

(3) Access to any part of the facility.

§10–712.

(a) (1) Each facility shall keep complete records for each individual who is admitted to the facility under this title.

(2) The records shall contain all of the information that is required by this title or the Administration.

(b) A facility shall keep the records in a separate and secure area at the facility.

§10–713.

(a) (1) In this section, "program or facility" means an inpatient or residential treatment setting, residential crisis service, group home, or residential rehabilitation program.

(2) Upon notification of the death of an individual in a State funded or operated program or facility, the administrative head of the program or facility shall report the death:

(i) Immediately to the sheriff, police, or chief law enforcement official in the jurisdiction in which the death occurred;

(ii) Immediately to the Secretary; and

(iii) By the close of business of the next working day to:

1. The Director;

2. The health officer in the jurisdiction where the death occurred; and

3. The designated State protection and advocacy system.

(3) An initial report:

(i) May be:

1. Oral if followed by a written report within 5 working days from the date of the death; or

2. Written;

(ii) Shall contain the following relevant information:

1. The name, age, and sex of the deceased;

2. The time of discovery of the death;

3. The deceased's place of residence at the time of death;

4. The location of the body at the time of discovery;

5. The place where the body was found;

6. The name of the person who took custody of the body;

7. The name of the person evaluating the death, if known;

8. Whether or not an autopsy is being performed, if known; and

9. The name, address, and telephone number of the next of kin or legal guardian, if known; and

(iii) Shall contain any other information the administrative head of the facility determines should be provided to the medical examiner and the persons listed in paragraph (2) of this subsection on the deaths occurring:

1. By violence;

2. By suicide;

3. By casualty;

4. Suddenly, if the deceased was in apparent good health; or

5. In any suspicious or unusual manner.

(4) The written report shall be available for the Director, the health officer in the jurisdiction where the death occurred, and the designated State protection and advocacy system within 5 working days from the date of the death.

(5) If the death occurred in a program or facility that operates more than one treatment program and where the deceased individual attended more than one treatment program, the facility is required to make only one report.

(6) The sheriff, police, or chief law enforcement officer shall inform the medical examiner in accordance with § 5–309(b) of this article and the medical examiner, if necessary, shall conduct an investigation in accordance with the provisions of that section.

(b) If the death occurred in a nonresidential psychiatric rehabilitation program, the administrative head of the program shall report the death to the Director by the close of business of the next working day.

(c) (1) The Director shall compile annually a status report for the Secretary on patient deaths reported under this subtitle.

(2) At a minimum, the status report shall note:

(i) The number of deaths;

(ii) The location of each death;

(iii) The cause of each death, if known; and

(iv) Other data the Secretary determines to be relevant to the status report.

§10–801.

In this subtitle, "release" means a permanent, temporary, absolute, or conditional release of an individual from a residential facility or a Veterans' Administration hospital.

§10–802.

If the Director finds that any individual is held by a facility in a manner contrary to law, the Director shall begin appropriate proceedings for release of that individual.

§10–803.

(a) An individual who is admitted voluntarily to a facility, on an informal request, may leave the facility at any time between 9 a.m. and 4 p.m., unless the admission status of the individual has been changed to an involuntary admission.

(b) (1) An individual who has been admitted voluntarily, under a formal written application, may not be held for more than 3 days after the individual asks

for release, unless the admission status of the individual has been changed to an involuntary admission.

(2) If the admission status of the individual is changed from a voluntary to an involuntary admission, the facility shall notify the Mental Health Division in the Office of the Public Defender, by e–mail or facsimile, of the involuntary admission within 24 hours after the change in admission status is made.

(c) A minor who has been admitted voluntarily, on the application of a parent or guardian of the minor, may not be held for more than 3 days after the applicant for the admission asks for release, unless the admission status of the minor has been changed to an involuntary admission.

§10–804.

(a) Any individual who has been admitted to a facility or Veterans' Administration hospital or any person on behalf of the individual may apply at any time to a court of competent jurisdiction for a writ of habeas corpus to determine the cause and the legality of the detention.

(b) The Director, in the name of the Administration, may make an application for a writ of habeas corpus to determine whether a facility properly admitted or properly holds an individual. The State's Attorney for the county where the facility is located or the individual is a resident, on behalf of the Administration, shall file the application.

§10–805.

(a) Subject to the limitations in this section, a petition for the release of an individual who is held under this title from the facility or a Veterans' Administration hospital may be filed, at any time by:

(1) The individual; or

(2) Any person who has a legitimate interest in the welfare of the individual.

(b) The petition shall be filed in an equity court in the county where the individual resides or resided at the time of the admission or where the facility is located.

(c) (1) If the individual is in a public facility, the Administration shall be the respondent.

(2) If the individual is in a private facility or a Veterans' Administration hospital, it shall be the respondent.

(d) The petition shall be in the form and contain the information the Maryland Rules require.

(e) If the petitioner requests trial by jury, the trial shall be held with a jury as in a civil action at law.

(f) The trier of fact shall determine:

(1) Whether the individual has a mental disorder; and

(2) If so, whether the individual needs inpatient medical care or treatment for the protection of the individual or another.

(g) (1) If the trier of fact finds that the individual has a mental disorder and needs inpatient medical care or treatment, the court shall remand the individual to the custody of the facility or Veterans' Administration hospital.

(2) If the trier of fact finds that the individual does not have a mental disorder or has a mental disorder, but does not need inpatient medical care or treatment, the individual shall be released from the facility or Veterans' Administration hospital.

(h) Any party may appeal from a decision on the petition as in any other civil case.

(i) Appropriate records of the proceeding under this section shall be made a permanent part of the individual's record.

(j) (1) After a determination on the merits of a petition filed under this section, a court may not hear a later petition for the individual within 1 year after that determination, unless the petition is accompanied by a valid affidavit that the court, after review of the petition and affidavit, determines to show an improvement in the mental condition of the individual after the determination.

(2) An affidavit is not valid if executed by an individual under care or treatment in a facility or Veterans' Administration hospital.

(3) If the matter is reopened, the petition shall be heard as provided in this section.

(4) If the affidavit does not show improvement in the individual's mental condition, the petition shall be dismissed.

§10–806.

(a) In this section, "responsible official" means:

(1) If the individual is held in a Veterans' Administration hospital, the chief officer of the Veterans' Administration hospital; or

(2) If the individual is held in any other facility, the Director or the administrative head of the facility.

(b) At the direction of the responsible official, an individual who has been admitted under this title shall be released from a facility or a Veterans' Administration hospital if the individual:

(1) Does not have a mental disorder; or

(2) Has a mental disorder but:

(i) Does not need inpatient medical care or treatment to protect the individual or another;

(ii) Would not endanger the individual or the person or property of another; and

(iii) Would be cared for properly by the individual or by a responsible person who is able and willing to care for the individual.

(c) (1) At the direction of the responsible official, any individual who has been admitted under this title shall be released conditionally from a State facility within 2 weeks after the responsible official, with the written consent of the individual:

(i) Certifies that the individual:

1. Would not endanger the individual or the person or property of another; and

2. Could live in the community with appropriate assistance under the protective services program provided for in § 14–201 of the Family Law Article; and

(ii) Notifies the provider of the protective services and the local department of social services in the county where the individual would live.

(2) At the direction of the responsible official, any individual who has been admitted under this title may be released conditionally from a facility other than a State facility or from a Veterans' Administration hospital, if, in the judgment of the responsible official, the individual:

(i) Would be cared for properly by the individual or by a responsible person who is able and willing to care for the individual; and

(ii) Would not endanger the individual or the person or property of another.

(3) The responsible official may set the conditions for release that the responsible official considers reasonable. The conditions may relate to:

(i) The duration of the release; or

(ii) Care or treatment during release.

(4) As resources allow, services shall be provided to individuals released from a State facility in accordance with the aftercare plan required by § 10–809 of this subtitle, as follows:

(i) The Behavioral Health Administration shall provide community mental health services that are suitable to the needs of the individual;

(ii) The Division of Rehabilitation Services shall provide, to individuals determined to be eligible, vocational rehabilitation services and occupational placement opportunities consistent with the assessed needs and abilities of the individual; and

(iii) The Department of Human Services shall provide needed case management services and shall make arrangements for housing suitable to the needs of the individual.

(5) For purposes of annual examination and execution of new admission documents, an individual released conditionally is considered to be held by the facility or Veterans' Administration hospital from which the individual was released.

(d) A facility shall release an individual who has been admitted to the facility within 1 year after the admission if, before the expiration of that 1–year period:

(1) The individual, whether admitted on a formal, written application or on informal request, does not execute a new application for the voluntary admission;

(2) The parent or guardian does not execute a new request for the voluntary admission of the minor individual; or

(3) The physician and psychologist or 2 physicians do not execute the new certificates required for involuntary admission of the individual.

(e) Each determination on any release of an individual, whether full or conditional, including a summary of the reasons for the determination, shall be made a permanent part of the individual's record.

§10–807.

(a) In this section, "public facility" means a facility under § 10–406 of this title maintained under the direction of the Administration.

(b) The Director may transfer an individual, who is admitted under Subtitle 6 of this title or committed under Title 3 of the Criminal Procedure Article, from a public facility to the Clifton T. Perkins Hospital Center, if the Director finds that:

(1) The individual either can receive better care or treatment in or would be more likely to benefit from care or treatment at the Clifton T. Perkins Hospital Center; or

(2) The safety or welfare of other individuals would be furthered.

(c) (1) Prior to transferring an individual from a public facility to the Clifton T. Perkins Hospital Center, the Director shall give the individual notice and an opportunity for a hearing before the Office of Administrative Hearings, unless the Director finds that an emergency requires the immediate transfer of the individual.

(2) If the Director determines that an emergency requires the immediate transfer of an individual, the individual may be transferred to the Clifton T. Perkins Hospital Center if the Administration:

(i) Provides notice to the individual; and

(ii) Schedules a post transfer hearing before the Office of Administrative Hearings within 10 calendar days after the transfer.

(3) A hearing requested by an individual under paragraph (1) of this subsection shall be convened at the public facility within 30 calendar days after the individual received notice of the transfer.

(d) If a hearing is requested by the individual in accordance with subsection (c)(1) of this section, the hearing shall be utilized to determine whether the Administration has demonstrated by preponderance of the evidence that the criteria for transfer have been met.

(e) A decision of an administrative law judge under this section shall be the final decision of the Department for the purpose of judicial review of final decisions under Title 10, Subtitle 2 of the State Government Article.

(f) The Director may transfer any individual who is a resident of another state to a facility in that state if the Director finds that the transfer is feasible.

(g) (1) Any finding that the Director makes under this section shall be in writing and filed with the records of the individual involved.

(2) A copy of the finding and the notice to the facility to which the individual is being transferred shall be sent to the guardian or other legal representative of the individual.

(h) The Director may transfer an individual between public facilities, other than the Clifton T. Perkins Hospital Center, without the consent of the individual if the Director finds that administrative or clinical reasons require a transfer of the individual from the facility.

(i) (1) In effecting a transfer of an individual from a unit in a public facility to another unit in the facility or to another public facility, the transferring facility shall provide for the transfer of all the records necessary for continuing the care of the individual on or before the date of transfer to the facility to which the individual is being transferred.

(2) This subsection is not intended to preempt the requirements of § 10–625 of this title.

(j) An individual may not be transported to or from any facility unless accompanied by:

(1) An ambulance attendant or other individual who is authorized by the facility and is of the same sex. However, the chief executive officer of the facility or that officer's designee may designate an ambulance attendant or other person of either sex to provide transportation to an individual, if deemed appropriate; or

(2) The parent, spouse, domestic partner, adult sibling, or adult offspring of the individual.

§10–808.

(a) In this section, "federal agency" means the Department of Veterans Affairs or any other agency of the United States government.

(b) Whenever the transfer of an individual to a federal agency is planned under this section, the Director or administrative head of a facility, with the consent of the individual, shall notify the parent or next of kin of the individual about the transfer. In the case of a minor child or an individual who is assigned a legal guardian, the parent of the minor child or the legal guardian of the individual shall be notified of any planned transfer.

(c) (1) The Director may transfer an individual from a facility to a Veterans' Administration hospital in this State, if the individual is entitled to benefits in that hospital.

(2) After the transfer, the chief officer of the Veterans' Administration hospital has all the powers and rights of the Administration as to that individual.

(d) (1) If a court of competent jurisdiction of any other state commits an individual to a federal agency for care or treatment, the commitment judgment or order affects the individual, while the individual is in this State, to the extent that the judgment or order would affect the individual in the other state.

(2) The courts of the committing state have continuing jurisdiction over the committed individual to inquire into the mental condition of that individual and determine the need to continue commitment.

(3) Retention, custody, transfer, parole, and release of the committed individual are governed by the law of the committing state.

(e) (1) The administrative head of a facility may transfer any individual to a federal agency for care or treatment if the federal agency certifies that facilities are available for the individual and that the individual is eligible for care or treatment.

(2) The facility shall give a proper officer of the court that ordered commitment notice of the transfer when it is made.

(3) An individual may not be transferred under this subsection if the individual is confined under a conviction of a crime or if the individual is committed under Title 12 of this article unless, after appropriate motion and hearing, the court or other authority that committed the individual orders the transfer.

(f) Any individual transferred under this section is deemed to be committed to the federal agency under the original commitment.

(g) This section applies to residents and nonresidents of this State found in this State or on any federal reservation in this State.

§10–809.

(a) Whenever a release of an individual from a facility is planned, the administrative head of the facility or a designee of the administrative head, with the consent of the individual, shall notify the parent or next of kin about the proposed release. In the case of a minor child or an individual who is assigned a legal guardian, the parent of the minor child or the legal guardian of the individual shall be notified of any planned release.

(b) (1) Except as otherwise provided in this section, before a facility releases an individual who has been accepted as a resident in the facility, the administrative head of the facility or a designee of the administrative head shall:

(i) Prepare a written aftercare plan for the individual;

(ii) With the consent of the individual send the plan to the treatment program in the community that the individual chooses; and

(iii) Notify the individual of the advisability of making an advance directive for mental health services, as provided under § 5-602.1 of this article.

(2) If the individual requests assistance in making an advance directive for mental health services, the facility shall assist the individual in making the advance directive or refer the individual to an appropriate community resource to assist the individual in making the advance directive.

(3) When the administrative head of the facility or the designee of the administrative head refers the individual to an appropriate community resource

under paragraph (2) of this subsection, the administrative head or designee shall notify the community resource of the name of and other available nonconfidential identifying information about the individual that has been referred to the community resource and of the individual's interest in making an advance directive for mental health services.

(4) The Department shall provide training, sample forms, and information on advance directives for mental health services to assist facilities in compliance with this section.

(c) (1) In this subsection, "aftercare services" means services:

(i) For individuals who no longer receive inpatient services for a mental disorder; and

(ii) That enhance the opportunity to maintain a mentally ill individual in the community and to assist in the prevention of homelessness.

(2) "Aftercare services" include:

(i) Medical care;

(ii) Psychiatric care;

(iii) Vocational and social rehabilitation;

(iv) Supportive housing; or

(v) Case management services.

(3) The aftercare plan shall be prepared in collaboration with community programs and government agencies that are to provide aftercare services to the individual after release.

(4) The aftercare plan shall include:

(i) Diagnoses, including existing psychiatric, somatic, and dental diagnoses;

(ii) Treatment initiated;

(iii) Medications prescribed, their dosage schedules, the amount of each medication given to the individual on release, and the information

necessary to help the individual to obtain the prescribed medication in the community in accordance with the aftercare plan;

(iv) Date of release;

(v) Location of community placement;

(vi) Plan for continuing treatment; and

(vii) List of referrals indicated, including:

1. Public social services;

2. Legal aid;

3. Educational services;

4. Vocational services; and

5. Medical treatment other than mental health services.

(5) The Secretary shall periodically review selected aftercare plans and make a determination if the services included in the aftercare plans are meeting the needs of the particular individuals.

(6) The Secretary shall designate an existing employee within the Department whose primary function is to help coordinate the Department's programs and services aimed at the prevention of homelessness to mentally ill individuals.

(d) (1) If the individual does not consent to an aftercare plan, a statement to this effect signed by the individual or a parent, guardian, or other representative of the individual shall be placed in the individual's record.

(2) With the consent of the individual, and before an individual who had been accepted as a resident in the facility is released from a facility, the staff of the facility shall assist the individual or the parent, guardian, or other representative of the individual in applying for the federal and State benefits for which the individual may be eligible.

(3) (i) The staff of the facility shall begin assisting the individual or the parent, guardian, or other representative of the individual in the application process for benefits for the individual as early as possible after the individual is accepted as a resident in the facility.

(ii) On acceptance as a resident to the facility, the facility shall provide to each individual, or the parent, guardian, or other representative of the individual, written information regarding federal and State benefits and application processes.

§10–810.

A release under this subtitle shall be made between 9 a.m. and 4 p.m.

§10–811.

An individual who was admitted to a facility from an institution under the Division of Correction or from the Patuxent Institution and who is to be released before the expiration of the sentence to that institution shall be released to the custody of the Division or the Patuxent Institution, as the case may be.

§10–812.

(a) The Behavioral Health Administration may ask the Developmental Disabilities Administration to accept primary responsibility for an individual in or eligible for admission to a mental health residential facility, if the Behavioral Health Administration finds that the individual would be provided for more appropriately in a program for individuals with developmental disability.

(b) The Developmental Disabilities Administration shall determine whether transfer to a program for individuals with developmental disability is appropriate.

(c) A dispute over a transfer of an individual from the Behavioral Health Administration to the Developmental Disabilities Administration shall be resolved, in accordance with procedures that the Secretary sets, on request of:

(1) The Behavioral Health Administration; or

(2) The Developmental Disabilities Administration.

(d) The Director of the Behavioral Health Administration shall give an individual the opportunity for a hearing on the proposed transfer.

§10–813.

The Administration shall compensate case managers or other appropriate community mental health providers for conducting initial assessments of incarcerated individuals who are:

(1) Identified by the Department of Public Safety and Correctional Services as having a serious mental illness; and

(2) Expected to be within 3 months of release**.**

§10–901.1.

(a) A community mental health services program shall submit annually financial statements and salary information in accordance with the Department's regulations.

(b) The Administration may impose a penalty not exceeding $500 per day per violation for each day a violation occurs on a licensee that fails to comply with subsection (a) of this section.

§10–902.

(a) (1) In accordance with the State budget and the rules and regulations that the Secretary adopts, the Secretary may make grants from or agreements for the use of State and federal funds to help public agencies or nonprofit organizations establish and operate local mental health programs to provide the following:

(i) Inpatient services;

(ii) Outpatient services;

(iii) Partial care services, including day care services and night care services;

(iv) 24–hour emergency services;

(v) Aftercare services;

(vi) Consultation services;

(vii) Education services;

(viii) Other preventive or rehabilitation services or treatment; and

(ix) Community residential programs for children and adolescents.

(2) Research and training that are designed to improve or extend these services are proper items of expense.

(b) (1) Services under this section shall be provided by public agencies or, under contract, by nonprofit organizations and private community-based organizations.

(2) Nothing in this section shall prohibit the Secretary from contracting with individual licensed mental health care providers, including psychiatrists, psychologists, social workers, and psychiatric nurses.

§10–902.1.

(a) Notwithstanding any other law or regulation, the Secretary shall continue from July 1, 1998, until June 30, 1999, the transition funding option that was in effect for participating outpatient mental health clinics on July 1, 1997, as specified in the Code of Maryland Regulations 10.21.25.01F.

(b) This section may not be construed to prohibit the Secretary from increasing the rate of reimbursement under the transition funding option that was in effect for outpatient mental health clinics on July 1, 1997, as specified in the Code of Maryland Regulations 10.21.25.01F.

§10–903.

(a) (1) The governing body of any county may apply for assistance to establish a mental health program under this part.

(2) A county shall apply by submitting annually to the Director, for approval by the Secretary, a plan and budget for the next fiscal year.

(b) The governing bodies of two or more counties may apply for assistance to establish a community mental health program for the counties if:

(1) The population of one of the counties is too small to warrant the establishment of an independent community mental health program for that county; and

(2) The Director consents.

(c) A community mental health services program is not eligible for assistance under this part unless:

(1) Its plan and budget conform to the State plan for mental health services and the priorities set under it; and

(2) The qualifications of its professional staff meet the standards that the Secretary sets.

§10–904.

(a) Except in Montgomery County, the health officer for a county is responsible for:

(1) The mental health services program in the county; and

(2) Supervising generally the mental health services and facilities that the county health department provides or supports.

(b) The health officer for a county shall:

(1) With the advice of the regional mental health director, revise annually the county plan for providing or contracting for services, including aftercare, and facilities and for any other matters necessary or desirable to carry out this part;

(2) Prepare annually a budget for carrying out the plan;

(3) Assure that the staff and professional services meet the standards that the Secretary adopts;

(4) Submit to the mental health advisory committee and the governing body for the county an annual report on the county program, including an account of expenditures and an estimate of anticipated needs for the next year;

(5) Facilitate the work of the county or intercounty mental health advisory committee; and

(6) Perform any other duty necessary to carry out this part.

§10–908.

On or before January 1 each year, beginning in 2024, the Department shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(1) The Resident Grievance System established under COMAR 10.21.14; and

(2) The grievances that were received by the Resident Grievance System related to State facilities during the immediately preceding fiscal year.

§10–917.

The administrative head of any facility may appoint any employee as a law enforcement officer and, while the employee holds a special police commission issued by the Governor, the employee may:

(1) Return an individual to the facility from which the individual escaped; and

(2) Be used to protect individuals or property at the facility.

§10–920.

In this part, "private therapeutic group home" means a small private group home as defined in § 10–514(e) of this title that provides residential child care, as well as access to a range of diagnostic and therapeutic mental health services, to be identified under the requirements of § 10–924 of this subtitle, for children and adolescents who are in need of such treatments.

§10–921.

The Director shall:

(1) Supervise the care and residential treatment of and the programs for children and adolescents that have mental disorders; and

(2) Provide or encourage, by consultation, cooperation, or contract, all programs needed to ensure that children and adolescents are evaluated appropriately and provided community-based residential care.

§10–922.

The Secretary shall adopt rules and regulations that:

(1) Ensure that a private therapeutic group home provides mental health care and treatment in accordance with this part; and

(2) Require a private therapeutic group home:

(i) To provide treatment for each child and adolescent in the home;

(ii) To coordinate the treatment in the home with the appropriate public or nonpublic educational program conducted outside of the home; and

(iii) To provide 24–hour supervision for each child and adolescent for the time that the child and adolescent are not participating in a program conducted outside of the home.

§10–923.

(a) Application for placement of a child or adolescent in a private therapeutic group home may be made under this section by:

(1) An individual who is 16 years old or older;

(2) A parent or guardian on behalf of the child or adolescent;

(3) With the consent of the parent or guardian of the child or adolescent, a psychiatrist or psychologist who treats the child or adolescent;

(4) On behalf of a child or adolescent, a local department of social services that has custody or guardianship of the child or adolescent under § 3-819 of the Courts Article;

(5) The Department of Education or the local education agency with the consent of a parent or guardian;

(6) On behalf of a child or adolescent, the Department of Juvenile Services when the Department has custody or guardianship of the child or adolescent under § 3-819 of the Courts Article; or

(7) The circuit court of a county sitting as the juvenile court.

(b) The applicant shall submit a formal, written application to the Director that contains the personal information and is on the form required by the Administration.

(c) A private therapeutic group home may not accept an individual under this section unless:

(1) The individual is under the age of 18 years;

(2) The individual has a mental disorder;

(3) The individual, because of the mental disorder, requires residential services not available in the home;

(4) The individual needs 24-hour supervision in a structured private therapeutic group home;

(5) The individual is or should be receiving treatment for the mental disorder; and

(6) There is no less restrictive form of treatment that is consistent with the welfare and safety of the child or adolescent.

(d) (1) Within 60 days after the Director receives an application for placement of a child or adolescent in a private therapeutic group home, the Director or the county health officer shall determine whether the child or adolescent meets the requirements for placement under this section.

(2) If the Director or county health officer determines that the child or adolescent meets the requirements under this section, the Director or county health officer shall:

(i) Approve the application for placement in a private therapeutic group home; and

(ii) Determine the date of placement in a private therapeutic group home in accordance with the plan submitted under § 10–925 of this subtitle.

§10–924.

(a) Each private therapeutic group home shall make and periodically update a written plan of treatment for each individual in the home, in accordance with rules and regulations that the Director adopts.

(b) (1) The Director shall adopt appropriate rules and regulations to carry out the intent of this section in accordance with current professional practices.

(2) The rules and regulations shall include:

(i) A description of the nature and content of plans of treatment; and

(ii) Appropriate time periods for the development, implementation, and review of each plan.

§10–925.

(a) On or before January 1, 1985, the Director shall prepare and submit a plan to the Governor, the President of the Senate, and the Speaker of the House.

(b) The plan shall include:

(1) The number of children and adolescents in need of placement in private therapeutic group homes;

(2) The number, type, and location of private therapeutic group homes that are needed in the community for the treatment of these children and adolescents;

(3) The resources and procedures that are necessary to establish the private therapeutic group homes;

(4) The feasibility of transferring any resources of a State facility to any private therapeutic group home;

(5) The summaries of the individual plans of treatment;

(6) The schedule for the relocation of children and adolescents where plans indicate that a less restrictive placement is appropriate;

(7) A plan for establishing, developing, and maintaining a system for monitoring community services; and

(8) An evaluation by the Secretary of the feasibility of obtaining reimbursement, under Title XIX of the Social Security Act, for services to be provided to children and adolescents with mental disorders.

(c) The Director shall:

(1) Implement §§ 10–920 through 10–924 and 10–926 of this subtitle upon completion of the plan to be submitted under this section; and

(2) Review and revise periodically the plan submitted under this section.

§10–926.

(a) At least once a year, the Director, in conjunction with a county health officer, shall evaluate each private therapeutic group home.

(b) (1) The Director, in conjunction with a county health officer shall:

(i) Prepare a written report of each evaluation; and

(ii) Distribute a copy of this report to each private therapeutic group home.

(2) The Director shall keep at least 1 copy of the report.

(3) The Secretary shall consider the report when renewing a license of any private therapeutic group home.

§10–929. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 867 OF 2024 //

(a) In this section, "Program" means the Language Assistance Services Pilot Program.

(b) There is a Language Assistance Services Pilot Program.

(c) The purpose of the Program is to:

(1) Provide meaningful access to behavioral health care to children with limited English proficiency; and

(2) Establish a competitive grant process for local behavioral health authorities to provide reimbursement to behavioral health providers for language assistance services, including interpretation and translation services to:

(i) Children with limited English proficiency accessing and receiving behavioral health services; and

(ii) Parents and legal guardians coordinating the provision of behavioral health services and making health care decisions regarding the services on behalf of a child.

(d) The Administration shall administer the Program.

(e) The Administration shall implement the following requirements as part of administering the Program:

(1) A requirement that a grantee document and report:

(i) The number of children who received language assistance services broken down by primary language spoken;

(ii) The number of parents and legal guardians who received language assistance services broken down by primary language spoken; and

(iii) The number of language assistance services that were reimbursed broken down by the type of behavioral health service provided; and

(2) A requirement that, to request and receive a reimbursement from a Program grantee, a health care provider must:

(i) Be a licensed and accredited behavioral health provider; and

(ii) Have a current, written language access plan demonstrating how the provider ensures meaningful access to its programs and activities for individuals with limited English proficiency.

(f) The language access plan required under subsection (e)(2)(ii) of this section shall:

(1) Be provided to the grantee in addition to any request for reimbursement for language assistance services; and

(2) Include:

(i) A self–assessment of the circumstances under which the provider may encounter an individual with limited English proficiency;

(ii) A self–assessment of the number or proportion of individuals with limited English proficiency from each language group in the provider's service area to determine appropriate language assistance services;

(iii) The provider's procedure for identifying an individual's primary language;

(iv) The provider's procedure for providing language assistance services, including oral and written language assistance services;

(v) The provider's procedure for ensuring effective communication with individuals with limited English proficiency in languages encountered less frequently;

(vi) The provider's plan for training staff on the provider's policies and procedures; and

(vii) The provider's procedure for providing notice of language assistance services at no cost to individuals with limited English proficiency.

(g) For each of fiscal years 2025 and 2026, the Governor shall include in the annual budget bill an appropriation of $120,000 to the Program.

(h) The Administration shall award, at a minimum, three grants of $30,000 each in each of fiscal years 2025 and 2026.

(i) On or before December 1, 2025, 2026, and 2027, the Administration shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report on the implementation of the Program that includes:

(1) The total number of individuals with limited English proficiency who received language assistance services broken down by jurisdiction;

(2) The total number of children who received language assistance services broken down by primary language spoken;

(3) The total number of parents and legal guardians who received language assistance services broken down by primary language spoken;

(4) The total number of language assistance services that were reimbursed broken down by the type of behavioral health service provided; and

(5) The total amount in grant money provided to each grantee during the immediately preceding fiscal year.

§10–1001.

(a) A person may not operate a private, inpatient facility unless licensed by the Department.

(b) A person who operates a private, inpatient facility in violation of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000.

(c) An employee, officer, operator, or director of a private, inpatient facility or any other person, who knowingly participates in a violation of this section, is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 1 year or both.

(d) In addition to any other penalties specified in this section, an individual who is admitted or held against the individual's will by a person who is operating a private, inpatient facility without a license may recover civil damages from that person and from any other person who knowingly participates in the admission or detention.

§10–1002.

(a) A person may not:

(1) Knowingly make a false application or certificate in connection with the admission or detention of any individual; or

(2) Detain an individual in a manner contrary to Subtitle 6 or Subtitle 8 of this title.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 2 years or both.

(c) In addition to any other penalties specified in this section, a person who willfully violates any provision of this section is liable for civil damages sustained by the individual who is admitted or detained unlawfully.

§10–1003.

(a) A person may not interfere knowingly with the rights of an individual under § 10-701, § 10-702, § 10-703, § 10-704, § 10-706, or § 10-707 of this title.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 2 years or both.

§10–1004.

A person who fails to comply with any provision of § 10-709 of this title, as to records, is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 2 years or both.

§10–1101.

This title may be cited as the Maryland Mental Health Law.

§10–1201.

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

(b) "Core service agency" has the meaning stated in § 7.5–101 of this article.

(c) "Local addictions authority" has the meaning stated in § 7.5–101 of this article.

(d) "Local behavioral health authority" has the meaning stated in § 7.5–101 of this article.

(e) "Services to persons with mental illnesses" means the health care and community support rendered to a recipient primarily in connection with the diagnosis, evaluation, treatment, case management, rehabilitation, or supervised housing for individuals with serious mental disorders.

§10–1202.

(a) A core service agency, local addictions authority, or local behavioral health authority shall:

(1) Be an agent of a county or Baltimore City government which may include a local health department;

(2) Unless an exception is requested by an individual county and is granted by the Secretary, serve a county or counties with an estimated population of over 80,000 people;

(3) Either purchase services or provide the services directly;

(4) Annually submit a program plan to the secretaries of the affected State departments for review and to the Director for approval; and

(5) Meet the standards required under this subtitle and, as needed, the rules and regulations set by the Secretary.

(b) A core service agency, local addictions authority, or local behavioral health authority may not be a for–profit entity.

(c) Each core service agency, local addictions authority, or local behavioral health authority shall function under the Secretary's authority.

(d) Once established in a jurisdiction, the core service agency, local addictions authority, or local behavioral health authority shall:

(1) Submit, on an annual basis, a program plan to the Director for approval;

(2) Incorporate in its method of governance a mechanism for the local county mental health advisory committee, local drug and alcohol abuse council, or joint mental health and substance–related committee to serve as the advisory committee to the core service agency, local addictions authority, or local behavioral health authority and, if serving more than 1 unit of government, a method of representation serving those jurisdictions;

(3) Implement guidelines developed by the Director which establish or designate the authority of the local mental health advisory committee, local drug and alcohol abuse council, or joint mental health and substance–related committee to advise and assist in the planning and evaluation of the publicly funded mental health and substance–related disorder services;

(4) In accordance with guidelines developed by the Director, develop planning, management, and accountability mechanisms for the delivery of services including:

(i) Case management;

(ii) Data collection which satisfies the Department's requirements for client tracking and incorporates clear outcome measures to enable the local entity to govern itself and monitor and evaluate the system; and

(iii) A yearly summary which includes at a minimum:

1. Relevant financial statements; and

2. Program evaluation reports which articulate the core service agency's, local addictions authority's, or local behavioral health

authority's ability to identify the outcomes of services provided for the target populations and the effects of those services on program planning for the target population;

(5) As an agent of county government, function in any of the following organizational structures:

(i) A unit of county or Baltimore City government;

(ii) A local health department;

(iii) A quasi–public authority; or

(iv) A private, nonprofit corporation;

(6) Be authorized to screen individuals for whom voluntary or involuntary admission is being initiated to determine whether a less restrictive alternative can be provided;

(7) Subject to the availability of funding in the State budget, be authorized to approve funding for a youth's educational costs incurred during a residential treatment center admission made for medical or psychiatric purposes in accordance with item (6) of this subsection if the educational costs are not covered under § 8–406 of the Education Article; and

(8) Provide clear guidelines to avoid either the appearance or occurrence of conflicts of interest in the direction and operation of the core service agency, local addictions authority, or local behavioral health authority or organizations which provide mental health or substance–related services.

§10–1202.1.

(a) This section applies only to Howard County.

(b) (1) The purpose of this section is to authorize the establishment of a quasi–public authority which may be activated by Howard County, if the county decides to designate a quasi–public authority as the core service agency or local behavioral health authority to perform the duties imposed under this subtitle.

(2) This section has no effect on any other form of core service agency or local behavioral health authority, whether it is a unit of Howard County government, a local health department, or a private, nonprofit corporation.

(c) (1) If activated as a quasi–public authority by an ordinance or resolution of the governing body of Howard County, there is established a quasi–public authority in Howard County.

(2) The quasi–public authority shall:

(i) Serve as the core service agency or local behavioral health authority for the jurisdiction; and

(ii) Be a public body, corporate and politic.

(d) The local ordinance activating the quasi-public authority shall include the following:

(1) The name of the quasi-public authority;

(2) The method of appointing individuals to the authority, including whether or not appointments require approval of the chief elected official of the jurisdiction and the legislative body of the jurisdiction;

(3) The number of members of the authority;

(4) The terms of members;

(5) The duties and powers of the authority in accordance with the provisions of this subtitle; and

(6) Specific terms governing the operation of the authority, including, but not limited to financial reporting, budgetary, and personnel requirements, provided that these specific terms may not add powers to the authority which are not included under this subtitle.

(e) The quasi-public authority is exempt from taxation by the State and the county.

(f) Howard County shall send to the Secretary a copy of any ordinance or resolution activating a quasi–public authority which will serve as a core service agency or local behavioral health authority.

§10–1203.

(a) To the extent resources are available, the Director, after consultation with the Behavioral Health Advisory Council as established in Title 7.5, Subtitle 3 of this article and federal requirements mandated under P.L. 99–660, may initiate the

development of core service agencies, local addictions authorities, or local behavioral health authorities as a mechanism for community planning, management, and financing of mental health and substance–related disorder services.

(b) When core service agencies, local addictions authorities, or local behavioral health authorities are initiated, the Director shall:

(1) Define the priority populations to be served by the core service agencies, local addictions authorities, or local behavioral health authorities;

(2) Define the essential mental health, substance–related disorder, and associated support services to be provided under the auspices of the core service agencies, local addictions authorities, or local behavioral health authorities;

(3) Define the essential administrative functions to be carried out by core service agencies, local addictions authorities, or local behavioral health authorities; and

(4) Outline the requirements for the core service agencies', local addictions authorities', or local behavioral health authorities' governance structure.

(c) To assure the continuing provision of appropriate services, the Director shall:

(1) Annually review and may approve the core service agencies', local addictions authorities', or local behavioral health authorities' program plan;

(2) In conjunction with the appropriate authorities, establish and maintain a funding mechanism for the core service agencies, local addictions authorities, or local behavioral health authorities which may include the allocation of funds for inpatient services;

(3) Develop a mechanism whereby any unexpended funds remaining at the end of the year may remain with the core service agencies, local addictions authorities, or local behavioral health authorities or the community providers;

(4) Establish procedures to facilitate intraagency and interagency linkages at State and local levels with the core service agencies, local addictions authorities, or local behavioral health authorities; and

(5) Establish procedures within the Behavioral Health Administration for a process regarding program, policy, or contract disputes that gives all community mental health and substance–related disorder programs regulated by the Administration the right to:

(i) Access the mediation process established by the Administration; and

(ii) If dissatisfied with the outcome of the mediation by the Administration, request a hearing with the Office of Administrative Hearings in accordance with Title 10, Subtitle 2 of the State Government Article.

(d) If a core service agency, local addictions authority, or local behavioral health authority violates any provision of this subtitle, the Director may deny approval of the core service agency, local addictions authority, or local behavioral health authority and, after written notification of denial of approval, cease funding or request the return of unspent funds by the core service agency, local addictions authority, or local behavioral health authority.

(e) If a county elects to terminate its core service agency, local addictions authority, or local behavioral health authority, the county may do so upon 90 days' written notice to the Director.

(f) The Director may not require a core service agency, local addictions authority, or local behavioral health authority to provide services the Department does not provide funding for.

§10–1301.

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

(b) As applied to a request to return any person within the purview of this subtitle to or from the District of Columbia, the words "executive authority", "Governor", and "chief magistrate" respectively include the chief judge of the Superior Court of the District of Columbia and other authority.

(c) "Flee" means to depart:

(1) Voluntarily or involuntarily from the jurisdiction of the court where the proceedings hereinafter mentioned may have been instituted and are still pending, with the effect of avoiding, impeding, or delaying the action of the court in which the proceedings may have been instituted or be pending; or

(2) From the state where one is if one is under detention by law as a person of unsound mind and subject to detention.

(d) "Flight" means the act of fleeing.

(e) "State" includes a state, territory, district, and insular possession or other possession of the United States.

§10–1302.

(a) This section applies to a person alleged to be of unsound mind found in this State, who has fled from another state, in which at the time of the flight the person:

(1) Was under detention by law in a hospital, asylum, or other institution for the insane as a person of unsound mind;

(2) Had been theretofore determined by legal proceedings to be of unsound mind, the finding being unreversed and in full force and effect, and the control of the person having been acquired by a court of competent jurisdiction of the state from which the person fled; or

(3) Was subject to detention in the other state, being then the person's legal domicile (personal service of process having been made) based on legal proceedings there pending to have the person declared of unsound mind.

(b) A person subject to this section shall, on demand of the executive authority of the state from which the person fled, be delivered up to be removed thereto.

§10–1303.

(a) (1) This subsection applies whenever the executive authority of any state:

(i) Demands of the Governor, a fugitive within the purview of § 10-1302 of this subtitle; and

(ii) Produces a copy of the commitment, decree, or other judicial process and proceedings, certified as authentic by the governor or chief magistrate of the state whence the person so charged has fled, with an affidavit made before a proper officer showing the person to be a fugitive.

(2) The Governor shall:

(i) Cause a person subject to this subsection to be apprehended and secured, if found in this State;

(ii) Cause immediate notice of the apprehension to be given to the executive authority making a demand for the person, or to the agent of the executive authority appointed to receive the fugitive; and

(iii) Cause the fugitive to be delivered to the agent when the agent appears.

(b) If an agent does not appear within 30 days from the time of the apprehension, the fugitive may be discharged.

(c) All costs and expenses incurred in the apprehending, securing, maintaining, and transmitting the fugitive to the state making the demand for the fugitive shall be paid by the demanding state.

(d) Any agent so appointed who receives the fugitive into custody shall be empowered to transmit the fugitive to the state from which the fugitive has fled.

(e) On application of any person interested, the Governor may demand the return to this State of any fugitive within the purview of this subtitle.

§10–1304.

Any proceedings under this subtitle shall begin within 1 year after the flight referred to in this subtitle.

§10–1305.

This subtitle shall be interpreted and construed to effectuate its general purpose to make uniform the laws of those states that enact it.

§10–1306.

This subtitle is the Uniform Act for the Extradition of Persons of Unsound Mind.

§10–1401.

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

(b) "Administration" means the Behavioral Health Administration.

(c) "Core service agency" has the meaning stated in § 7.5–101 of this article.

(d) "Crisis Response System" means the Maryland Behavioral Health Crisis Response System.

(e) "Family support services" has the meaning stated in § 7.5–101 of this article.

(f) "Local behavioral health authority" has the meaning stated in § 7.5–101 of this article.

(g) "Mobile crisis team" means a team established by the local behavioral health authority that:

(1) Operates 24 hours a day and 7 days a week to provide assessments, crisis intervention, stabilization, follow–up, and referral to urgent care and to arrange appointments for individuals to obtain behavioral health services;

(2) Incorporates nationally recognized standards and best practices; and

(3) Prioritizes:

(i) Providing connection to services and coordinating patient follow–up, including peer support and family support services after stabilization;

(ii) Serving all members of the immediate community with cultural competency and appropriate language access; and

(iii) Limiting the interaction of law enforcement with individuals in crisis.

§10–1402.

(a) There is a Maryland Behavioral Health Crisis Response System in the Behavioral Health Administration.

(b) The Crisis Response System shall:

(1) Operate a statewide network utilizing existing resources and coordinating interjurisdictional services to develop efficient and effective crisis response systems to serve all individuals in the State, 24 hours a day and 7 days a week;

(2) Provide skilled clinical intervention to help prevent suicides, homicides, unnecessary hospitalizations, and arrests or detention, and to reduce

dangerous or threatening situations involving individuals in need of behavioral health services; and

(3) Respond quickly and effectively to community crisis situations.

(c) The Administration shall consult with consumers of behavioral health services, family members, and behavioral health advocates in the development of the Crisis Response System.

§10–1403.

(a) The Crisis Response System shall include:

(1) A State 9–8–8 Suicide and Crisis Lifeline in each jurisdiction or region to:

(i) Provide a single point of entry to the Crisis Response System;

(ii) Coordinate with the national 9–8–8 Suicide and Crisis Lifeline to provide the full range of services provided by the national 9–8–8 Suicide and Crisis Lifeline, including:

1. Supportive counseling;

2. Suicide prevention;

3. Crisis intervention;

4. Referrals to additional resources; and

5. Direct dispatch or warm hand–offs to mobile crisis response and stabilization services and other immediate services as needed;

(iii) Coordinate with the local core service agency or local behavioral health authority, police, 3–1–1, 2–1–1, or other local mental health hotlines, emergency medical service personnel, and behavioral health providers; and

(iv) Provide other programs that may include:

1. A clinical crisis telephone line for suicide prevention and crisis intervention;

2. A hotline for behavioral health information, referral, and assistance;

3. Clinical crisis walk–in services, including:

A. Triage for initial assessment;

B. Crisis stabilization until additional services are available;

C. Linkage to treatment services and family and peer support groups; and

D. Linkage to other health and human services programs;

4. Critical incident stress management teams, providing disaster behavioral health services, critical incident stress management, and an on–call system for these services;

5. Crisis residential beds to serve as an alternative to hospitalization;

6. A community crisis bed and hospital bed registry, including a daily tally of empty beds;

7. Transportation coordination, ensuring transportation of patients to urgent appointments or to emergency psychiatric facilities;

8. Mobile crisis teams;

9. 23–hour holding beds;

10. Emergency psychiatric services;

11. Urgent care capacity;

12. Expanded capacity for assertive community treatment;

13. Crisis intervention teams with capacity to respond in each jurisdiction 24 hours a day and 7 days a week; and

14. Individualized family intervention teams;

(2) Community awareness promotion and training programs; and

(3) An evaluation of outcomes of services:

(i) In each jurisdiction or region, including an evaluation of:

1. 9–8–8 call, text, and chat volume;

2. 9–8–8 local answer rate;

3. 9–8–8 call, text, and chat resolution data, including:

A. The proportion of crises resolved by phone;

B. The proportion of crises resolved through mobile crisis team dispatch; and

C. The proportion of crises resolved by transfer to 9–1–1;

4. Mobile crisis team dispatch volume;

5. Mobile crisis team response time;

6. Mobile crisis team dispatch resolution data, including:

A. The proportion of crises resolved safely in the community; and

B. The proportion of crises resolved through transfer to a higher level of care;

7. Crisis stabilization center usage; and

8. Crisis stabilization center discharge data, including:

A. The proportion of crises resolved through a discharge to home; and

B. The proportion of crises resolved through a discharge to a higher level of care;

(ii) Through data obtained from consumers and family members who have received services from the Crisis Response System collected through ongoing data collection from 9–8–8 call, text, and chat providers and other crisis providers that is reported annually; and

(iii) Through annual crisis services data collection on the involvement of law enforcement, involuntary status of clients, and diversion from higher levels of care, including hospitals.

(b) The data derived from the evaluation of outcomes of services required under subsection (a)(3) of this section shall be:

(1) Collected, analyzed, and publicly reported on or before December 1 each year, beginning in 2026;

(2) Disaggregated by race, gender, age, and zip code; and

(3) Used to formulate policy recommendations with the goal of decreasing criminal detention and improving crisis diversion programs and linkages to effective community health services.

(c) The Crisis Response System services shall be implemented as determined by the Administration in collaboration with the core service agency or local behavioral health authority serving each jurisdiction and community members of each jurisdiction.

(d) An advance directive for mental health services under § 5–602.1 of this article shall apply to the delivery of services under this subtitle.

(e) This subtitle may not be construed to affect petitions for emergency evaluations under § 10–622 of this title.

§10–1404.

The Administration shall implement the Crisis Response System, in collaboration with core service agencies or local behavioral health authorities, on a regional or jurisdictional basis as federal funding or funding from other sources becomes available.

§10–1405.

The Crisis Response System providers shall contract with service providers who employ individuals who use or have used behavioral health services.

§10–1501.

In this subtitle, "Fund" means the Behavioral Health Workforce Investment Fund established under § 10–1502 of this subtitle.

§10–1502.

(a) There is a Behavioral Health Workforce Investment Fund.

(b) The purpose of the Fund is to provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessionals.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing Fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund shall consist of:

(1) Money appropriated in the State budget to the Fund;

(2) Interest earnings of the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only for carrying out the purpose of the Fund.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund for carrying out the purpose of the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated for carrying out the purpose of the Fund.

(j) Notwithstanding any other provision of law, no part of the Fund may revert or be credited to:

(1) The General Fund of the State; or

(2) Any other special fund of the State.

(k) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

§10–1503.

On or before December 1 each year, beginning in 2024, the Department shall submit a report to the Legislative Policy Committee, the Senate Budget and Taxation Committee, and the House Appropriations Committee, in accordance with § 2–1257 of the State Government Article, that includes:

(1) For the immediately preceding fiscal year, the amount of funds transferred and distributed from the Fund in accordance with § 10–1502 of this subtitle;

(2) For the immediately preceding fiscal year, the number of behavioral health professionals and paraprofessionals educated, trained, recruited, certified, placed, or retained with money from the Fund, aggregated by:

(i) The type of professional or paraprofessional;

(ii) Geographic region;

(iii) Race; and

(iv) Ethnicity;

(3) The amount of any unspent funds in the Fund at the end of the immediately preceding fiscal year; and

(4) If unspent funds are identified under item (3) of this section, the reasons why the funds were not spent.

§11–101.

(a) In the Compact set forth in this title, "article" means an article of the Compact.

(b) The definitions in § 1-101 of this article do not apply to the Compact set forth in this title.

§11–102.

The Interstate Compact on Mental Health is enacted into law and entered into with all other states joining in it in the form substantially as it appears in § 11-103 of this title.

§11–103.

The contracting states solemnly agree that:

Article I

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families, and society as a whole. Further, the party states find that the necessity of and desirability for furnishing such care and treatment bear no primary relation to the residence or citizenship of the patient but that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in terms of such welfare.

Article II

As used in this compact:

(1) "Sending state" shall mean a party state from which a patient is transported pursuant to the provisions of the compact or from which it is contemplated that a patient may be so sent.

(2) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the compact or to which it is contemplated that a patient may be so sent.

(3) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(4) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment, or supervision pursuant to the provisions of this compact.

(5) "After-care" shall mean care, treatment and services provided a patient, as defined herein, on convalescent status or conditional release.

(6) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community.

(7) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.

(8) "State" shall mean any state, territory or possession of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

Article III

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that he would be taken if he were a local patient.

(e) Pursuant to this compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time any such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

Article IV

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive after-care or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state shall have reason to believe that after-care in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the receiving state to investigate the desirability of affording the patient such after-care in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient, and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive after-care or supervision in the receiving state.

(c) In supervising, treating, or caring for a patient on after-care pursuant to the terms of this article, a receiving state shall employ the same standards of visitation, examination, care, and treatment that it employs for similar local patients.

Article V

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a manner reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous

patient, he shall be detained in the state where found pending disposition in accordance with law.

Article VI

The duly accredited officers of any state party to this compact, upon the establishment of their authority and the identity of the patient shall be permitted to transport any patient being moved pursuant to this compact through any and all states party to this compact, without interference.

Article VII

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of and incidental to the transportation of any patient pursuant to this compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state, or between a party state and its subdivisions, as to the payment of costs, or responsibilities therefor.

(d) Nothing in this compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this compact.

(e) Nothing in this compact shall be construed to invalidate any reciprocal agreement between a party state and a non-party state relating to institutionalization, care or treatment of the mentally ill, mentally deficient, or any statutory authority pursuant to which such agreement may be made.

Article VIII

(a) Nothing in this compact shall be construed to abridge, diminish, or in any way impair the rights, duties, and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the

receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion, to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this article shall include any guardian, trustee, legal committee, conservator, or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

Article IX

(a) No provision of this compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

Article X

(a) Each party state shall appoint a "compact administrator" who, on behalf of his state, shall act as general coordinator of activities under the compact in his state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the compact by his state either in the capacity of sending or receiving state. The compact administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the compact or any patient processed thereunder.

(b) The compact administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this compact.

Article XI

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such agreements will improve services, facilities, or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this compact.

Article XII

This compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

Article XIII

(a) A state party to this compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the compact.

(b) Withdrawal from any agreement permitted by Article VII (b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

Article XIV

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

§11–104.

(a) The Secretary or a designee of the Secretary is this State's Compact Administrator of the Interstate Compact on Mental Health.

(b) Acting jointly with compact administrators in other party states, the Compact Administrator may adopt rules and regulations to carry out the terms of the Compact effectively.

(c) To facilitate the proper administration of the Compact and of any supplementary agreement entered into by this State under the Compact, the Compact Administrator shall cooperate with all agencies or officers of this State and its subdivisions.

§11–105.

(a) The Compact Administrator may enter into supplementary agreements with appropriate officials of other states under Articles VII and XI of the Interstate Compact on Mental Health.

(b) If a supplementary agreement requires or contemplates the use of any institution or facility of this State or the provision of any service by this State, the agreement is not effective until approved by the head of the agency under whose jurisdiction the institution or facility is operated or whose agency will be charged with providing the service.

§11–106.

The Compact Administrator may make or arrange for any payment necessary to discharge a financial obligation that is imposed on this State by the Interstate Compact on Mental Health or by any supplementary agreement entered into under the Compact.

§11–107.

The Compact Administrator shall consult with the immediate family of any proposed transferee.

§13–101.

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

(b) "Advisory Council" means the State Advisory Council on Hereditary and Congenital Disorders.

(c) "Commission" means the State Commission on Hereditary and Congenital Disorders.

(d) (1) "Congenital disorder" means a significant structural or functional abnormality of the body that is present at birth.

(2) "Congenital disorder" does not include a condition that results from:

(i) An intrauterine infection; or

(ii) A birth injury.

(e) "Hereditary disorder" means any disorder that:

(1) Is transmitted through the genetic material deoxyribonucleic acid (DNA); or

(2) Arises through the improper processing of the information in the genetic material.

§13–102.

The General Assembly finds that:

(1) Everyone in this State is entitled to the highest level of health care attainable and protection from inadequate health services;

(2) Hereditary and congenital disorders are often costly and tragic and sometimes deadly burdens to the health and well-being of the citizens of this State;

(3) Detection through screening for hereditary and congenital disorders can:

(i) Lead to alleviation of the disability of some hereditary and congenital disorders; and

(ii) Further the understanding of and accumulation of medical knowledge about other hereditary and congenital disorders that may lead to their eventual alleviation or cure;

(4) Hereditary and congenital disorders differ in severity, in that:

(i) Some have little effect on the normal functioning of an individual; and

(ii) Some may be alleviated, wholly or partly, through medical intervention and treatment;

(5) Most, if not all, individuals are carriers of some hereditary disorder and are substantially unaffected by that fact;

(6) A carrier of a hereditary disorder should not be discriminated against or stigmatized;

(7) Medical knowledge of the discovery, diagnosis, treatment, and cure of hereditary and congenital disorders is expanding rapidly and often at an uneven rate, so that hereditary and congenital disorders are discovered long before their treatment or cure can be found;

(8) Legislation designed to alleviate the problems associated with specific hereditary and congenital disorders may tend to be inflexible in the face of rapidly expanding medical knowledge;

(9) The policy of this State on hereditary and congenital disorders should be:

(i) Made with full public knowledge, in light of expert opinion; and

(ii) Reviewed constantly to consider changing medical knowledge and ensure full public protection;

(10) Participation in a hereditary and congenital disorders program should be wholly voluntary, and all information obtained about any individual in a hereditary and congenital disorders program should be kept confidential; and

(11) A commission is needed:

(i) To ensure that the policies and programs of this State for hereditary and congenital disorders comply with the principles established in this subtitle; and

(ii) To preserve and protect the freedom, health, and well-being of the citizens of this State from improper treatment or advice, discrimination,

violation of privacy, or undue anxiety that results from any hereditary and congenital disorders program.

§13–103.

There is a State Advisory Council on Hereditary and Congenital Disorders.

§13–104.

(a) (1) The Advisory Council consists of 11 voting members and 4 nonvoting members.

(2) Of the 11 voting members:

(i) 1 shall be a member of the Senate appointed by the President of the Senate;

(ii) 1 shall be a member of the House of Delegates appointed by the Speaker of the House;

(iii) 4 shall be professional individuals in the field of hereditary or congenital disorders appointed by the Secretary; and

(iv) 5 shall be individuals appointed by the Secretary, none of whom may be:

1. A health professional or spouse of a health professional; or

2. An individual or spouse of an individual involved in the administration or ownership of any health care institution or health insurance organization.

(3) (i) Except as provided in subparagraph (iv) of this paragraph, the Secretary shall appoint 1 professional member from a list of qualified individuals submitted to the Secretary by each of the following organizations:

1. Children's National Health System;

2. The Medical and Chirurgical Faculty of the State of Maryland;

3. The faculty of the University of Maryland School of Medicine; and

4. The faculties of the Johns Hopkins Medical Institutions.

(ii) The number of names on a list shall be 3.

(iii) An organization shall submit its list:

1. At least 3 months before the expiration of the term of the professional member who represents the organization; and

2. If a vacancy is for a reason other than expiration of the term, at any time before the Secretary makes the appointment, if the organization complies with the reasonable request of the Secretary for the list.

(iv) If a list is not submitted to the Secretary as required under subparagraph (iii) of this paragraph, within 3 months after a request is made by the Secretary, the Secretary may appoint any professional individual who meets the requirements under subsection (b) of this section.

(4) The 4 nonvoting members shall be representatives of the Department, appointed by the Secretary.

(b) Each professional individual selected for the Advisory Council shall be knowledgeable in the diagnosis and treatment of hereditary and congenital disorders.

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

(2) The terms of the voting members are staggered as required by the terms provided for voting members of the Advisory Council on July 1, 1982. The terms of those members end as follows:

(i) 3 in 1983;

(ii) 3 in 1984;

(iii) 3 in 1985; and

(iv) 2 in 1986.

(3) At the end of a term, a voting member continues to serve until a successor is appointed and qualifies.

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

(5) A voting member who serves 2 consecutive full 4–year terms may not be reappointed for 4 years after completion of those terms.

(6) When a vacancy occurs, a successor shall be appointed promptly.

§13–105.

From among its voting members, the Advisory Council shall elect every 2 years a chairman and a vice chairman.

§13–106.

(a) A majority of the full authorized voting membership of the Advisory Council is a quorum to do business.

(b) The Advisory Council shall meet at least twice a year, at the times and places that it determines.

(c) A member of the Advisory Council:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) The Secretary shall designate the staff necessary to carry out this subtitle.

§13–107.

The Advisory Council may establish subcommittees.

§13–108.

To preserve and protect the health and welfare of the citizens of this State, the Advisory Council may:

(1) Gather and give out information to further the public's understanding of hereditary and congenital disorders;

(2) Reevaluate continually the need for and the effectiveness of State hereditary and congenital disorders programs;

(3) Make any necessary recommendation to end any unjustified discrimination that might result from identification of an individual as a carrier of a hereditary disorder, but this item does not affect any right of anyone to seek or have any other redress for this discrimination;

(4) Advise the Secretary as to the need for rules, regulations, and standards for the detection and management of hereditary and congenital disorders;

(5) Participate actively in the development of the rules and regulations adopted by the Department; and

(6) Assist the Department in prioritizing its efforts.

§13–109.

(a) Subject to the requirements of this section, the Department may adopt rules, regulations, and standards for the detection and management of hereditary and congenital disorders.

(b) (1) Before the Department adopts a rule, regulation, or standard, the Department shall consult:

(i) The public, especially communities and groups who particularly are affected by hereditary and congenital disorders programs;

(ii) Where appropriate, experts in the medical, psychological, ethical, social, and economic effects of programs for the detection and management of hereditary and congenital disorders; and

(iii) The Advisory Council.

(2) Before the Department adopts a rule, regulation, or standard, the Department shall consider:

(i) The incidence of each hereditary or congenital disorder; and

(ii) The cost of detection and management of each hereditary or congenital disorder.

(c) (1) The rules, regulations, and standards of the Department shall require the Department and each person who conducts a hereditary and congenital disorders program to keep in code and treat as a confidential medical record all information that is gathered in the program and identifies an individual. However, this requirement does not prevent the disclosure of information if the individual or, if the individual is a minor or disabled person, a parent or guardian of the person:

(i) Is informed of the scope of information to be released and the purpose of the release; and

(ii) Consents to the release.

(2) The rules, regulations, and standards of the Department shall provide that, subject to the restrictions on disclosure of confidential information, information on the operation of a hereditary and congenital disorders program shall be open and freely available to the public.

(d) The rules, regulations, and standards of the Department shall provide that procedures for a hereditary and congenital disorders program shall:

(1) Be accurate;

(2) Provide maximum information;

(3) Be set forth clearly; and

(4) Be reviewed regularly.

(e) The rules, regulations, and standards of the Department shall:

(1) Require that, before an individual participates in a hereditary and congenital disorders program, the person who conducts the program shall inform the individual or, if the individual is a minor or disabled person, a parent or guardian of the person of the requirement that participation in the program be wholly voluntary and of any risk that is involved in participation;

(2) Prohibit the testing of an individual for a hereditary or congenital disorder unless the individual or, if the individual is a minor or disabled person, a parent or guardian of the person:

(i) Is informed fully of the purpose of the test and the nature and consequences of being affected by a hereditary or congenital disorder or being a carrier of a hereditary disorder;

(ii) Is given a reasonable opportunity to object; and

(iii) Does not object to the test; and

(3) Require unambiguous diagnostic results to be made available through a physician or other source of health care to the individual or, if the individual is a minor or disabled person, to a parent or guardian of the person.

(f) The rules, regulations, and standards of the Department shall provide that a hereditary and congenital disorders program may not:

(1) Require participation in the program;

(2) Require restriction of childbearing; or

(3) Be prerequisite for eligibility for any service or other program.

(g) The rules, regulations, and standards of the Department shall provide that:

(1) Each participant in a hereditary and congenital disorders program shall be:

(i) Protected from undue physical or mental harm; and

(ii) Informed of the nature, cost, benefits, and risks of any therapy or maintenance program available for an individual affected by a hereditary or congenital disorder; and

(2) Each participant in a screening program for a hereditary or congenital disorder shall have available counseling services that:

(i) Are nondirective;

(ii) Emphasize informing the individual; and

(iii) Do not require restriction of childbearing.

(h) Only the Department may adopt rules, regulations, and standards under this subtitle.

§13–110.

The Secretary:

(1) Is responsible for the operation of hereditary and congenital disorders programs within the rules, regulations, and standards that the Department adopts;

(2) Shall disburse and collect any funds available to the Department;

(3) Shall enforce the rules, regulations, and standards that the Department adopts; and

(4) Shall keep the Advisory Council informed of:

(i) The progress of hereditary and congenital disorders programs; and

(ii) Any need for a change in the Department's rules, regulations, and standards.

§13–111.

(a) The Department shall establish a coordinated statewide system for screening all newborn infants in the State for certain hereditary and congenital disorders associated with severe problems of health or development, except when the parent or guardian of the newborn infant objects.

(b) Except as provided in § 13–112 of this subtitle, the Department's public health laboratory is the sole laboratory authorized to perform tests on specimens from newborn infants collected to screen for hereditary and congenital disorders as determined under subsection (d)(2) of this section.

(c) The system for newborn screening shall include:

(1) Laboratory testing and the reporting of test results; and

(2) Follow–up activities to facilitate the rapid identification and treatment of an affected child.

(d) In consultation with the State Advisory Council on Hereditary and Congenital Disorders, the Department shall:

(1) Establish protocols for a health care provider to obtain and deliver test specimens to the Department's public health laboratory;

(2) Determine the screening tests that the Department's public health laboratory is required to perform;

(3) Maintain a coordinated statewide system for newborn screening that carries out the purpose described in subsection (c) of this section that includes:

(i) Communicating the results of screening tests to the health care provider of the newborn infant;

(ii) Locating newborn infants with abnormal test results;

(iii) Sharing newborn screening information between hospitals, health care providers, treatment centers, and laboratory personnel;

(iv) Delivering needed clinical, diagnostic, and treatment information to health care providers, parents, and caregivers; and

(v) Notifying parents and guardians of newborn infants that laboratories other than the Department's public health laboratory are authorized to perform postscreening confirmatory or diagnostic tests on newborn infants for hereditary and congenital disorders; and

(4) Adopt regulations that set forth the standards and requirements for newborn screening for hereditary and congenital disorders that are required under this subtitle, including:

(i) Performing newborn screening tests;

(ii) Coordinating the reporting, follow–up, and treatment activities with parents, caregivers, and health care providers; and

(iii) Establishing fees for newborn screening that do not exceed an amount sufficient to cover the administrative, laboratory, and follow–up costs associated with the performance of screening tests under this subtitle.

(e) (1) (i) The Department shall screen for each core condition listed in the U.S. Department of Health and Human Services' Recommended Uniform Screening Panel.

(ii) Subject to subparagraph (iii) of this paragraph, the Department shall implement testing for a core condition within 1 year and 6 months after the core condition is added to the Recommended Uniform Screening Panel.

(iii) 1. If the Department is unable to implement testing within 1 year and 6 months after a core condition is added to the Recommended Uniform Screening Panel due to a delay in the procurement of equipment or supplies needed to implement the testing, the Department shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, within 1 year and 3 months after the addition of the core condition to the Recommended Uniform Screening Panel and every 3 months thereafter until the testing for the core condition is implemented.

2. A report required under subsubparagraph 1 of this subparagraph shall include the reason for the delay and the anticipated timeline for implementation.

(2) Notwithstanding any other provision of law, if the Secretary of Health and Human Services issues federal recommendations on critical congenital heart disease screening of newborns, the Department shall adopt the federal screening recommendations.

(3) The Department may screen for any condition recommended by the Advisory Council and approved by the Secretary.

(f) (1) The Secretary shall pay all fees collected under the provisions of this subtitle to the Comptroller.

(2) The Comptroller shall distribute the fees to the Newborn Screening Program Fund established under § 13–113 of this subtitle.

§13–112.

(a) The Secretary may contract or delegate the screening required under § 13–111 of this subtitle to another entity with the approval of the State Advisory Council on Hereditary and Congenital Disorders.

(b) Subject to subsection (c) of this section, a laboratory other than the Department's public health laboratory may perform postscreening confirmatory or diagnostic tests on newborn infants for hereditary and congenital disorders.

(c) Before offering or performing a postscreening test on a newborn infant for hereditary and congenital disorders under subsection (b) of this section, a laboratory shall:

(1) Obtain and maintain a license issued by the Secretary as required by Title 17 of this article; and

(2) Meet all the standards and requirements for a laboratory to perform tests on newborn infants for hereditary and congenital disorders that are established by the Secretary.

§13–113.

(a) In this section, "Fund" means the Newborn Screening Program Fund.

(b) There is a Newborn Screening Program Fund.

(c) The purpose of the Fund is to provide funding for the screening of newborn infants in the State for certain hereditary and congenital disorders.

(d) The Secretary shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Revenue distributed to the Fund under § 13–111(f) of this subtitle;

(2) Money appropriated in the State budget to the Fund;

(3) Interest earnings of the Fund; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used only to cover the administrative, laboratory, and follow–up costs associated with the performance of newborn screening tests conducted under this subtitle.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(i) Expenditures from the Fund may be made only in accordance with the State budget.

(j) The accounts and transactions of the Fund shall be subject to audit by the legislative auditor as provided in § 2–1220 of the State Government Article.

§13–201.

In this subtitle, "Advisory Council" means the State Advisory Council on Health and Wellness.

§13–202.

There is a State Advisory Council on Health and Wellness.

§13–203.

(a) The Advisory Council consists of voting members appointed by the Secretary.

(b) The following members shall serve without term limits:

(1) The Secretary, or the Secretary's designee;

(2) The State Superintendent of Schools, or the State Superintendent's designee;

(3) The Secretary of Aging, or the Secretary's designee;

(4) The Secretary of Disabilities, or the Secretary's designee;

(5) A representative of the Maryland Office of Minority Health and Health Disparities;

(6) A representative of the Maryland Association of County Health Officers; and

(7) The Executive Director of the Maryland Commission for Women, or the Executive Director's designee.

(c) The following members are subject to term limits:

(1) One representative of the American Heart Association Mid–Atlantic, Inc., nominated by the Executive Director of the Association;

(2) One representative of the Arthritis Foundation, Mid–Atlantic Region, Maryland, nominated by the Executive Director of the Foundation;

(3) One representative of the American Diabetes Association, Maryland Chapter, nominated by the Executive Director of the Association;

(4) One representative of Johns Hopkins Medicine, nominated by the Chief Executive Officer of Johns Hopkins Medicine;

(5) One representative of MedChi, the Maryland State Medical Society, nominated by the Executive Director of MedChi;

(6) One representative of the University of Maryland Medical Center and University of Maryland School of Medicine, nominated by the Chief Executive Officer of the Medical Center and the Dean of the School of Medicine;

(7) One representative of the Maryland Chapter of the American Academy of Pediatrics, nominated by the Executive Director of the Chapter;

(8) One representative of the Maryland Nurses Association, nominated by the Executive Director of the Association;

(9) One representative of the Maryland Academy of Nutrition and Dietetics, nominated by the President of the Academy;

(10) One representative of the Maryland Chapter of the American College of Emergency Physicians, nominated by the President of the Chapter;

(11) One representative with expertise in perimenopausal, menopausal, and postmenopausal evaluation and treatment; and

(12) Seventeen members of the public, who may include:

(i) Individuals with a chronic disease or family members of an individual with a chronic disease;

(ii) Licensed health care providers;

(iii) Individuals with a physical fitness background;

(iv) Employers or representatives of the business sector;

(v) Representatives of health insurers;

(vi) Representatives of community–based organizations; and

(vii) Individuals with expressed interest in health and wellness.

(d) (1) This subsection applies to members who are subject to term limits.

(2) The term of a member is 4 years.

(3) The terms of members are staggered as required by the terms provided for members of the Advisory Council on October 1, 2017.

(4) A member may serve two consecutive full terms.

(5) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(7) A member who serves two consecutive full 4–year terms may not be reappointed for 4 years after the completion of those terms.

(e) If a vacancy occurs, the Secretary promptly shall appoint a successor.

§13–204.

(a) A member of the Advisory Council:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(b) (1) The Advisory Council shall create committees as it determines to organize its work, including at a minimum the following four committees:

(i) Arthritis;

(ii) Diabetes;

(iii) Heart Disease and Stroke; and

(iv) Physical Fitness.

(2) Each Advisory Council member shall serve on at least one committee.

(c) The Secretary shall designate the staff necessary to carry out this subtitle.

§13–205.

The Advisory Council shall:

(1) Promote evidence–based programs for healthy lifestyles and the prevention, early detection, and treatment of chronic disease; and

(2) Make recommendations to the Department related to chronic disease prevention, health, and wellness.

§13–206.

The Secretary shall adopt regulations governing the role and operations of the Advisory Council.

§13–301.

The Kidney Disease Program is a program in the Department for the purpose of providing funding of kidney disease treatment for qualified individuals who elect to enroll in the Program and agree to pay fees which are described in this subtitle.

§13–302.

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

(b) "Commission" means the State Commission on Kidney Disease.

(c) "Department" means the department responsible for administering the Kidney Disease Program.

(d) (1) "Liquid assets" includes cash, bank accounts, and investments such as stocks and bonds that can be readily converted to cash.

(2) "Liquid assets" does not include an individual's:

(i) Principal residence; or

(ii) Principal car.

(e) "Program" means the Kidney Disease Program.

(f) "Recipient" means an individual with chronic kidney disease who has been certified to receive benefits under the Kidney Disease Program.

§13–303.

(a) The General Assembly finds that:

(1) One of the most serious and tragic problems facing the public health and welfare is the death of hundreds of people in this State each year from chronic kidney disease, when the present state of medical art and technology could return these individuals to a socially productive life;

(2) Advances and discoveries in the treatment of patients who have chronic kidney disease allow not mere survival, but rehabilitation to normal occupations and activities;

(3) Treatment for persons with kidney disease is very expensive and continues throughout a person's life;

(4) Private insurance coverage for kidney disease treatment is difficult to obtain; and

(5) Individuals who receive State benefits for kidney disease treatment should be responsible for bearing some of the cost of that care taking into account their ability to pay.

(b) (1) This State recognizes its responsibilities:

(i) To allow its citizens to keep their health without being made paupers; and

(ii) To use its resources and organization to aid in gathering and giving out information on the treatment of chronic kidney disease.

(2) The General Assembly seeks to meet these responsibilities by making the treatment of chronic kidney disease easily available through the education, treatment, and reimbursement programs under this subtitle, thus, lowering the cost of this treatment.

§13–304.

There is a State Commission on Kidney Disease.

§13–305.

(a) (1) The Commission consists of 12 members appointed by the Governor.

(2) Of the 12 Commission members:

(i) 1 shall be an individual from the Renal Administrators Association;

(ii) 3 shall be individuals who are laypersons to the field of medicine;

(iii) 3 shall be individuals appointed at the discretion of the Governor who:

1. Are medical specialists or other patient care providers in nephrology or kidney transplants; and

2. Do not have direct ownership of more than 30% in renal dialysis or kidney transplant centers that do business in the State;

(iv) 4 shall be individuals appointed as provided in paragraph (3) of this subsection; and

(v) 1 shall be a renal social worker nominated by the Maryland Chapter of the Council of Nephrology Social Workers or the National Capital Area Chapter of the Council of Nephrology Social Workers.

(3) (i) Except as provided in subparagraph (iv) of this paragraph, the Governor shall appoint 1 member from a list of individuals submitted to the Governor by each of the following organizations:

1. The Kidney Foundation of Maryland;

2. The faculty of the University of Maryland School of Medicine;

3. The faculty of the Johns Hopkins University School of Medicine; and

4. The Medical and Chirurgical Faculty of the State of Maryland.

(ii) The number of names on a list shall be at least 2.

(iii) An organization shall submit its list at least 3 months before the expiration of the term of the member who represents the organization.

(iv) If a list is not submitted to the Governor as required under subparagraph (iii) of this paragraph or if a vacancy occurs for a reason other than expiration of the term, the Governor may appoint any individual without the list.

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

(2) The terms of the members are staggered as required by the terms provided for members of the Commission on July 1, 1982. The terms of one fourth of those members end each year.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) A member who serves 2 consecutive full 4–year terms may not be reappointed for 4 years after completion of those terms.

(6) (i) If a vacancy occurs, the Governor promptly shall appoint a successor who will serve until the term expires.

(ii) The successor may be reappointed for a full term.

§13–306.

(a) The members present at a meeting are a quorum to do business.

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

(c) A member of the Commission:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) The Secretary shall designate the staff necessary to carry out this subtitle.

§13–307.

(a) The Commission:

(1) Shall institute and supervise education programs for health providers and the public on the prevention and treatment of chronic kidney disease; and

(2) May use existing programs and groups for this purpose.

(b) The Commission shall:

(1) Evaluate annually the Kidney Disease Program under this subtitle; and

(2) Submit an annual report of the evaluation to the Governor.

§13–308.

(a) Subject to the limitations provided in this section, the Commission may adopt rules and regulations to carry out the provisions of this subtitle.

(b) The Commission shall adopt physical and medical standards for the operation of dialysis and transplant centers.

(c) (1) The Commission shall adopt reasonable medical standards for acceptance of an individual for treatment.

(2) The Commission may not adopt any standard that prevents an individual from receiving federal medical or financial aid.

(d) The Commission may adopt rules and regulations for:

(1) Coverage of treatment that is given outside this State; and

(2) Approval or disapproval, for purposes of State payment under this subtitle, of a dialysis or transplant center that is outside this State.

(e) The Department, in consultation with the Commission, shall adopt rules and regulations under this subtitle governing:

(1) Nonmedical eligibility criteria for recipients; and

(2) Reimbursement of providers and recovery of Program expenditures from recipients and third parties.

§13–309.

The Secretary:

(1) Is responsible for the operation of the Kidney Disease Program under this subtitle within the rules, regulations, and standards that the Commission and the Department adopt;

(2) Shall disburse and collect any funds under this subtitle; and

(3) Shall keep the Commission informed of:

(i) The progress of the Kidney Disease Program; and

(ii) Any need for a change in its rules, regulations, or standards.

§13–310.

The Department shall certify a dialysis or transplant center that meets the standards that the Commission adopts under this subtitle.

§13–310.1.

(a) In this section, "Fund" means the Kidney Disease Fund.

(b) There is a Kidney Disease Fund.

(c) (1) Subject to the provisions of paragraphs (2) and (3) of this subsection, the Commission shall set by regulation reasonable fees to be paid by all certified kidney dialysis and transplant centers as an additional requirement for annual certification.

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

(i) State–owned facilities; or

(ii) Hospital services under the jurisdiction of the Health Services Cost Review Commission.

(3) The fee set by the Commission may not exceed $1500 per year.

(d) The Department shall collect the fee set by the Commission under subsection (c) of this section and transfer the fee into the Fund.

(e) (1) The Fund is a continuing, nonlapsing fund, not subject to § 7–302 of the State Finance and Procurement Article.

(2) (i) The Fund shall be used exclusively to offset and partially cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission as described in this subtitle.

(ii) The Department shall pay the indirect costs the Commission incurs in fulfilling the statutory and regulatory duties of the Commission as described in this subtitle.

(3) Any unspent portions of the Fund may not be transferred or revert to the General Fund of the State, but shall remain in the Fund to be used for the purposes specified in paragraph (2)(i) of this subsection.

(f) (1) The Chairman of the Commission or the designee of the Chairman shall administer the Fund.

(2) Money in the Fund may be expended only for the purposes specified in subsection (e)(2)(i) of this section.

(g) The Legislative Auditor shall audit the accounts and transactions of the Fund as provided in § 2–1220 of the State Government Article.

§13–311.

(a) The Department shall certify an individual as eligible for benefits under the Program if the Department determines that:

(1) The individual has chronic kidney disease as defined in the Commission's regulations; and

(2) The individual meets the residency, citizenship, and other nonmedical eligibility requirements established by the Department.

(b) (1) The certification of an individual under this section shall be for a period of 1 year.

(2) The certification is renewable after each 1-year period if the individual meets the requirements of subsection (a) of this section.

§13–312.

(a) Except as provided in subsection (b) of this section, the Department shall require Program recipients to apply for eligibility in the Maryland Medical Assistance Program, the Medicare Part B Program, and the Medicare Part D Program within 60 days of notification to do so by the Department.

(b) The Department may not require Program recipients to apply for eligibility in the Medicare Part B Program or the Medicare Part D Program if the Department determines the Program recipient has comparable insurance coverage.

§13–313.

(a) (1) Prior to receiving Program benefits, each recipient whose family income exceeds 175 percent of the federal poverty income guidelines shall be required to pay an annual fee equal to the sum of:

(i) 5 percent of the amount by which the sum of the recipient's adjusted gross income as defined in the Internal Revenue Code for federal income tax purposes plus Social Security benefits and tier 1 railroad retirement benefits not otherwise included in the recipient's gross income under § 86 of the Internal Revenue Code exceeds 175 percent of the federal poverty guidelines adjusted for family size; and

(ii) 5 percent of the value of the recipient's liquid assets above 200 percent of the federal poverty guidelines adjusted for family size.

(2) The annual fee required under paragraph (1) of this subsection shall be collected quarterly by the Department.

(b) A recipient is required to submit copies of the most recent tax returns of the recipient and of persons in the recipient's family.

(c) The Department shall provide recipients with a grace period after the deadline for a fee payment.

(d) A recipient who has not paid overdue fees by the end of the grace period shall be terminated from the Program.

(e) The Department shall extend the grace period in an appropriate hardship case.

§13–314.

(a) This State shall pay the incurred cost of all treatment related to kidney disease that a certified patient is given, for any cause, on or after the date of certification of that patient, if the treatment is given in:

(1) A certified dialysis or transplant center that is in this State;

(2) A dialysis or transplant center that is in a contiguous state and is approved by that contiguous state and the Commission; or

(3) A home dialysis program that is approved by the Commission.

(b) The State shall pay the incurred cost of all approved hospital services provided in any Maryland hospital, other than routine chronic maintenance dialysis, which a certified patient may require as a direct result of end stage renal disease.

(c) The State shall pay the incurred costs of all prescription drugs and other pharmaceutical products that are determined to be medically necessary by the recipient's physician for treatment related to kidney disease in accordance with rates established by the Department.

(d) The Secretary may not pay for any treatment that an individual receives at a facility or program that is not certified or otherwise approved.

(e) (1) Except for an invoice submitted to a Medicare intermediary or any other insurance provider, the Secretary may not make any payment for an invoice that the Secretary receives more than 6 months after the dates of the services given.

(2) An invoice shall be submitted to the Secretary within 3 months after payment or rejection by the Medicare intermediary or other insurance providers.

(3) A provider who fails to submit an invoice within the required time may not recover the amount later from either the patient or the Secretary.

§13–315.

(a) The Program shall be the payor of last resort. The Department is authorized to require providers to seek all available third party reimbursement prior to billing the Program.

(b) If it is determined to be in the Department's best interest, the Department may pay the health insurance premiums of recipients, including Part B premiums, to insurance carriers or employers under the Program.

§13–316.

The Department shall specifically request the Governor to appropriate and identify in a separate line item in the annual budget the money necessary to carry out this subtitle.

§13–401.

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

(b) "County advisory council" means an advisory council on physical fitness for a county.

(c) "State Advisory Council" means the State Advisory Council on Health and Wellness.

§13–402.

The purposes of this subtitle and of the advisory councils that it creates are to protect and improve physical fitness, including:

(1) Improvement of habits in recreation, exercise, sports, and the use of leisure time;

(2) Protection and improvement of physique and health; and

(3) Improvement of instruction for any of these purposes.

§13–403.

There may be an advisory council for physical fitness for each county and Baltimore City.

§13–404.

The county and Baltimore City advisory councils shall consult with the State Advisory Council on Health and Wellness.

§13–405.

If the federal government, any of its agencies or officers, or any other person offers to this State or to any county any services, equipment, supplies, materials, or funds by way of gift or grant for purposes of physical fitness, this State, acting in accordance with the requirements of law, may:

(1) Accept the offer; and

(2) Authorize any officer of this State or of a county to receive and use the aid and assistance.

§13–501.

The Arthritis Prevention and Control Program is a program in the Department for the purpose of raising public awareness, educating consumers, and educating and training health professionals, teachers, and providers about arthritis.

§13–502.

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

(b) "Advisory Council" means the State Advisory Council on Health and Wellness.

(c) "Program" means the Arthritis Prevention and Control Program.

§13–503.

The General Assembly finds that:

(1) Arthritis encompasses more than 100 diseases and conditions that affect joints, the surrounding tissues, and other connective tissues;

(2) As one of the most common family of diseases in the United States, arthritis affects nearly one of every six Americans and will impact an estimated 60,000,000 people by the year 2020;

(3) Arthritis is the leading cause of disability in the United States, limiting daily activities for more than 7,000,000 people;

(4) Although prevailing myths inaccurately portray arthritis as an old person's disease, arthritis is a multigenerational disease that has become one of the country's most pressing health problems;

(5) Arthritis has a significant impact on quality of life for the individual experiencing the painful symptoms and for the family members and caregivers providing for that individual;

(6) The economic and social costs associated with treating arthritis and the complications of arthritis are estimated at almost $80,000,000,000 annually;

(7) Currently, the challenge exists to ensure delivery of effective, but often underutilized, interventions that are necessary in the prevention or reduction of arthritis-related pain and disability;

(8) The large quantity of public information and programs about arthritis remain inadequately disseminated and are insufficient in addressing the needs of specific diverse populations and other underserved groups;

(9) The Arthritis Foundation, the Centers for Disease Control and Prevention, and the Association of State and Territorial Health Officials have led the development of a public health strategy, the National Arthritis Action Plan, to ensure the delivery of effective, but often underutilized interventions that are necessary in the prevention or reduction of arthritis-related pain and disability; and

(10) Educating the public and health care community throughout the State about arthritis is of paramount importance and is in every respect in the public interest and to the benefit of all residents of the State.

§13–504.

The purposes of this subtitle are to:

(1) Create and foster a statewide program that promotes public awareness and increases knowledge about the causes of arthritis, the importance of early diagnosis and appropriate management, effective prevention strategies, and pain prevention and management;

(2) Enhance understanding of arthritis by disseminating to patients, health professionals, and the public:

(i) Educational materials;

(ii) Information on research results;

(iii) Information on services provided; and

(iv) Strategies for prevention and control;

(3) Establish a solid scientific base of knowledge on the prevention of arthritis and related disability through surveillance, epidemiology, and prevention research;

(4) Utilize educational and training resources and services developed by organizations with appropriate expertise and knowledge of arthritis and use available technical assistance;

(5) Evaluate the need for improving the quality and accessibility of existing community-based arthritis services;

(6) Increase awareness about the prevention, detection, and treatment of arthritis among State and local health officials, providers, professionals, and policy makers;

(7) Implement and coordinate State and local programs and services to reduce the public health burden of arthritis; and

(8) Improve the quality of life and contain health care costs for individuals with arthritis and their families.

§13–505.

The Secretary shall:

(1) Provide sufficient staff to implement the Program;

(2) Provide appropriate training for staff of the Program;

(3) Identify the appropriate organizations to carry out the Program;

(4) Base the Program on the most current scientific information and findings;

(5) Work to increase and improve community–based services available to people with arthritis and their family members;

(6) Work with governmental offices, national voluntary health organizations and their local chapters, community and business leaders, community

organizations, and health care and human service providers to coordinate efforts and maximize State resources in the areas of prevention, education, detection, pain management, and treatment of arthritis; and

(7) Identify and, when appropriate, use evidence–based arthritis programs and obtain related materials and services from organizations with appropriate expertise and knowledge of arthritis.

§13–506.

The operation, management, and administration of the Program shall be funded as provided for in the State budget.

§13–507.

This subtitle may be cited as the "Maryland Arthritis Prevention and Control Act".

§13–601.

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

(b) "Hearing status" means the state of an individual's ability to perceive sound, based on audiological assessment.

(c) "Infant" means a child who is under the age of 1 year.

(d) "Newborn" means a child up to 29 days old who is born in the State.

(e) "Program" means the program that the Secretary establishes to provide for universal hearing screening of newborns and early identification and follow–up of newborns and infants who have, or are at risk for developing, a permanent hearing status that affects speech–language skills.

§13–602.

(a) The Secretary shall establish a program for the universal hearing screening of newborns and early identification and follow–up of newborns and infants who have, or who are at risk for developing, a permanent hearing status that affects speech–language skills.

(b) The program shall be based on the model system developed by the Department.

§13–603.

(a) There is an Early Hearing Detection and Intervention Advisory Council for the Program.

(b) (1) The Advisory Council consists of 12 members appointed by the Secretary.

(2) Of the 12 members:

(i) 1 shall be a physician with expertise in childhood hearing status that affects speech–language skills;

(ii) 3 shall be from the field of education:

1. 1 shall be from the Maryland State Department of Education;

2. 1 shall be from the Maryland School for the Deaf; and

3. 1 shall be an educator of the deaf from a local education agency;

(iii) 1 shall be from the Maryland Department of Health;

(iv) 1 shall be a mental health professional with expertise in the area of deafness;

(v) 2 shall be parents of children with a permanent hearing status that affects speech–language skills;

(vi) 1 shall be from the Maryland Association of the Deaf;

(vii) 1 shall be an audiologist with expertise in childhood hearing status that affects speech–language skills;

(viii) 1 shall be from the Alexander Graham Bell Association of Maryland; and

(ix) 1 shall be from the Governor's Office of the Deaf, Deafblind, and Hard of Hearing.

(c) (1) The term of a member is 3 years.

(2) The term of a member begins July 1.

(3) The terms of members are staggered as required by the terms provided for members of the Advisory Council on July 1, 2014.

(4) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(6) A member who serves 2 consecutive 3–year terms may not be reappointed for 3 years after completion of those terms.

(d) The Advisory Council shall elect a chairperson from among its members.

(e) The Advisory Council shall meet at least 4 times a year at the times and places that it determines.

(f) A member of the Advisory Council:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) The Advisory Council shall:

(1) Advise the Department on the implementation of the Program;

(2) Advise the Department on the development of protocols to assist hospitals, health care providers, and audiologists in conducting universal newborn hearing screening and follow–up hearing evaluations of infants;

(3) Provide consultation to the Department in the establishment of an educational program for families, professionals, and the public that can be integrated with existing State and local education agency programs; and

(4) Review any materials the Department may distribute to the public concerning the Program.

(h) In consultation with the Advisory Council, the Department shall develop guidelines for the operations of the Advisory Council.

§13–604.

(a) The Secretary may contract with any qualified person to administer the Program.

(b) The Secretary shall:

(1) Develop a system to gather and maintain data;

(2) Develop methods to:

(i) Contact parents or guardians of newborns and their identified primary care providers regarding the results of the newborn hearing screening;

(ii) Contact parents or guardians of newborns and infants who have, or are at risk for developing, a permanent hearing status that affects speech–language skills; and

(iii) Ensure families are referred to appropriate services;

(3) Establish a toll–free telephone line to communicate information about hearing status that affects speech–language skills and services for infants who have, or are at risk for developing, a permanent hearing status that affects speech–language skills;

(4) Appoint an Advisory Council for the Program;

(5) Meet annually with the Advisory Council; and

(6) In consultation with the Advisory Council, adopt rules and regulations necessary to implement the Program.

§13–605.

(a) As part of the supplemental information required to be submitted to the Department as part of the birth event, a hospital shall include the results of the hearing screening of the newborn.

(b) The Department may adopt regulations for results reporting procedures for hospitals, birthing sites, and audiologists.

§13–701.

The Emergency and Allergy Treatment Program is a program in the Department for the purpose of providing a means of authorizing certain individuals to administer life–saving treatment to individuals who have severe adverse reactions to allergens or insect stings when physician, physician assistant, registered nurse practitioner, or emergency medical services are not immediately available in a youth camp.

§13–702.

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

(b) "Agent" means an individual who:

(1) Is at least 18 years of age;

(2) Has successfully completed, at the expense of an applicant, an educational training program approved by the Department; and

(3) Is appointed by a certificate holder to administer emergency use epinephrine in accordance with the provisions of this subtitle.

(c) "Anaphylaxis" means a sudden, severe, and potentially life–threatening allergic reaction that occurs when an individual is exposed to an allergen.

(d) "Certificate" means a certificate or an endorsement on the operating certificate of a youth camp issued by the Department to an individual who operates a youth camp under Title 14, Subtitle 4 of this article to obtain, store, and administer emergency use epinephrine.

(e) "Certificate holder" means an individual who is authorized by the Department to obtain, store, and administer emergency use epinephrine to be used in an emergency situation.

(f) "Emergency use epinephrine" means a portable, disposable drug delivery device or product approved by the federal Food and Drug Administration that contains a premeasured single dose of epinephrine that is used to treat anaphylaxis in an emergency situation.

(g) "Program" means the Emergency and Allergy Treatment Program.

(h) "Registered nurse practitioner" has the meaning stated in § 8–101 of the Health Occupations Article.

(i) "Youth camp" has the meaning stated in § 14–401 of this article.

§13–703.

(a) The Department may:

(1) Adopt regulations for the administration of the Program;

(2) Collect fees necessary for the administration of the Program;

(3) Issue and renew a certificate to a person meeting the requirements of this subtitle; and

(4) Approve educational training programs, including programs conducted by other State agencies or private entities.

(b) A certificate issued by the Department shall be valid for up to 1 year.

§13–704.

(a) To qualify for a certificate, an individual shall meet the requirements of this section.

(b) The applicant shall operate a youth camp.

(c) The applicant shall be at least 18 years old.

(d) The applicant shall successfully complete, at the expense of the applicant, an educational training program approved by the Department.

(e) An applicant shall have a written policy that includes:

(1) Authorization for the certificate holder or agent to administer emergency use epinephrine, if available, to an individual who has been determined to be or is believed to be experiencing anaphylaxis, whether or not the individual:

(i) Has previously been known to have experienced anaphylaxis; or

(ii) Has a prescription for epinephrine prescribed by an authorized health care practitioner licensed under the Health Occupations Article;

(2) A requirement that youth camp personnel complete training on how to recognize the symptoms of anaphylaxis;

(3) Procedures for the emergency administration of emergency use epinephrine;

(4) Procedures for proper emergency follow–up;

(5) Authorization for a certificate holder to obtain and store emergency use epinephrine to be used in an emergency; and

(6) A requirement that each certificate holder implement a method for notifying the parent or guardian of a camper of the youth camp's policy under this section before the camper's attendance.

§13–705.

(a) (1) A registered nurse practitioner, physician assistant, or a physician licensed to practice in the State may prescribe emergency use epinephrine in the name of a certificate holder.

(2) A registered nurse practitioner, a pharmacist, a physician assistant, or a physician licensed to practice in the State may dispense emergency use epinephrine under a prescription issued to a certificate holder.

(b) A certificate holder may:

(1) On presentment of a certificate, receive from any registered nurse practitioner, physician assistant, or any physician licensed to practice in the State a prescription for emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine; and

(2) Possess and store prescribed emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine.

(c) In an emergency situation when registered nurse practitioner, physician, physician assistant, or emergency medical services are not immediately available, a certificate holder or agent may administer emergency use epinephrine to an individual who is experiencing or believed in good faith by the certificate holder or agent to be experiencing anaphylaxis.

§13–706.

(a) A certificate holder shall submit to the Department, on a form required by the Department, a report of each incident that occurs while the youth camp is in session that required the administration of emergency use epinephrine.

(b) The Department shall include in the report required under § 13–7A–03 of this title a summary of the information obtained from the reports submitted to the Department under subsection (a) of this section.

§13–707.

(a) A cause of action may not arise against a certificate holder or agent authorized under this subtitle for any act or omission when the certificate holder or agent is acting in good faith while administering emergency use epinephrine to an individual experiencing or believed by the certificate holder or agent to be experiencing anaphylaxis, except where the conduct of the certificate holder or agent amounts to gross negligence, willful or wanton misconduct, or intentionally tortious conduct.

(b) (1) A cause of action may not arise against any physician or physician assistant for any act or omission when the physician or physician assistant in good faith prescribes or dispenses emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine to a person certified by the Department under this subtitle.

(2) A cause of action may not arise against any pharmacist for any act or omission when the pharmacist in good faith dispenses emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine to a person certified by the Department under this subtitle.

(3) A cause of action may not arise against any nurse practitioner for any act or omission when the nurse practitioner in good faith prescribes or dispenses emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine to a person certified by the Department under this subtitle.

(c) This section does not affect, and may not be construed as affecting, any immunities from civil liability or defenses established by any other provision of the Code or by common law to which a volunteer, registered nurse practitioner, physician, physician assistant, or pharmacist may be entitled.

§13–708.

(a) This subtitle may not be construed to create a duty upon any individual to obtain a certificate under this subtitle, and an individual may not be held civilly liable for failing to obtain a certificate under this subtitle.

(b) An individual may not be held civilly liable in any action arising from or in connection with the administration of emergency use epinephrine by the individual solely because the individual did not possess a certificate issued under this subtitle.

§13–7A–01.

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

(b) "Agent" means an individual who:

(1) Is at least 18 years of age;

(2) Has successfully completed, at the expense of the participating facility, an educational training program approved by the Department under § 13–7A–03 of this subtitle; and

(3) Is designated by a certificate holder to administer emergency use epinephrine in accordance with the provisions of this subtitle.

(c) "Anaphylaxis" means a sudden, severe, and potentially life–threatening allergic reaction that occurs when an individual is exposed to an allergen.

(d) "Certificate" means a certificate issued by the Department to an individual to obtain, store, and administer emergency use epinephrine.

(e) "Certificate holder" means an individual who is authorized by the Department to obtain, store, and administer emergency use epinephrine to be used in an emergency situation.

(f) "Eligible institution" means an institution of higher education that has a food service facility or a recreation and wellness facility on the premises and that is authorized under this subtitle to obtain and store emergency use epinephrine.

(g) "Emergency use epinephrine" means a portable, disposable drug delivery device or product approved by the federal Food and Drug Administration that contains a premeasured single dose of epinephrine that is used to treat anaphylaxis in an emergency situation.

(h) "Food service facility" has the meaning indicated in § 21–301 of this article.

(i) "Participating facility" means a recreation or wellness facility at an eligible institution or a food service facility, including a food service facility at an eligible institution, in the State that voluntarily participates in the Program.

(j) "Program" means the Emergency Use Epinephrine Program established under § 13–7A–02 of this subtitle.

§13–7A–02.

(a) There is an Emergency Use Epinephrine Program.

(b) The purpose of the Program is to authorize individuals employed by a participating facility to obtain and store emergency use epinephrine and administer emergency use epinephrine to individuals who are experiencing or are believed to be experiencing anaphylaxis when a physician or emergency medical services are not immediately available.

(c) (1) Subject to paragraph (4) of this subsection, each participating facility may obtain:

(i) A prescription for a supply of emergency use epinephrine from a licensed physician as provided in § 13–7A–06 of this subtitle; and

(ii) A supply of emergency use epinephrine from a licensed pharmacist or a licensed physician as provided in § 13–7A–06 of this subtitle.

(2) Each participating facility shall store a supply of emergency use epinephrine obtained under paragraph (1)(ii) of this subsection:

(i) In accordance with the manufacturer's instructions; and

(ii) In a location that is readily accessible to employees or affiliated individuals in an emergency situation.

(3) Each participating facility shall designate the employees who are certificate holders or designated affiliated individuals who are certificate holders who will be responsible for the storage, maintenance, and control of the supply of emergency use epinephrine.

(4) A participating facility may not obtain or store emergency use epinephrine unless the participating facility has at least two employees or designated affiliated individuals who are certificate holders.

(5) Each participating facility shall maintain a copy of the certificate issued to an employee or a designated affiliated individual under § 13–7A–05 of this subtitle.

§13–7A–03.

(a) The Department shall:

(1) Adopt regulations for the administration of the Program;

(2) Collect fees necessary for the administration of the Program;

(3) Issue a certificate to, or renew the certificate of, an individual meeting the requirements of § 13–7A–04 of this subtitle;

(4) Approve educational training programs, including programs conducted by other State agencies or private entities;

(5) Develop a method by which certificate holders may submit a report to the Department about each incident that occurred on the premises of a participating facility that involved the administration of emergency use epinephrine by a certificate holder or an agent; and

(6) On or before January 31 each year, publish a report summarizing the information obtained from reports submitted to the Department under item (5) of this subsection.

(b) The Department may:

(1) Set an application fee for a certificate;

(2) Establish a fee for the renewal or replacement of a certificate; and

(3) Require applicants to apply to the Program in the manner the Department chooses.

(c) An educational training program approved by the Department under subsection (a)(4) of this section may be an online training program.

§13–7A–04.

(a) To qualify for a certificate, an applicant shall:

(1) Be employed by a participating facility;

(2) Successfully complete, at the expense of the participating facility, an educational training program approved by the Department under § 13–7A–03 of this subtitle;

(3) Submit an application to the Department in a manner required by the Department under § 13–7A–03 of this subtitle; and

(4) Subject to subsection (b) of this section, pay to the Department an application fee required under § 13–7A–03 of this subtitle.

(b) (1) A participating facility may pay the application fee on behalf of the applicant.

(2) If the participating facility is a food service facility that is part of an eligible institution, either entity may pay the application fee on behalf of the applicant.

§13–7A–05.

(a) The Department shall issue a certificate to any applicant who meets the requirements of § 13–7A–04 of this subtitle.

(b) Each certificate shall include:

(1) The full name of the certificate holder; and

(2) A serial number.

(c) A replacement certificate may be issued to replace a lost, destroyed, or mutilated certificate if the certificate holder pays a certificate replacement fee set by the Department.

(d) (1) A certificate shall be valid for a term of 1 year.

(2) To renew a certificate for an additional 1–year term, the renewal applicant shall successfully complete a refresher educational training program approved by the Department under § 13–7A–03 of this subtitle.

§13–7A–06.

(a) (1) A physician licensed to practice medicine in the State may prescribe emergency use epinephrine in the name of a certificate holder.

(2) A pharmacist licensed to practice pharmacy in the State or a physician may dispense emergency use epinephrine under a prescription issued to a certificate holder.

(b) A certificate holder may:

(1) On presentment of a certificate, receive from any physician licensed to practice medicine in the State a prescription for emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine; and

(2) Possess and store prescribed emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine.

(c) In an emergency situation when a physician or emergency medical services are not immediately available, a certificate holder or an agent may administer emergency use epinephrine to an individual who is experiencing or is believed in good faith by the certificate holder or agent to be experiencing anaphylaxis.

§13–7A–07.

(a) (1) Except as provided in paragraph (2) of this subsection, a cause of action may not arise against a certificate holder for any act or omission if the certificate holder or agent is acting in good faith while administering emergency use epinephrine to an individual who is experiencing or believed by the certificate holder or agent to be experiencing anaphylaxis except where the conduct of the certificate holder or agent amounts to gross negligence, willful or wanton misconduct, or intentionally tortious conduct.

(2) The provisions of paragraph (1) of this subsection do not apply if a certificate holder or participating facility that makes available, or a certificate holder who administers, emergency use epinephrine to an individual who is experiencing or is believed by the certificate holder or participating facility to be experiencing anaphylaxis:

(i) Fails to follow standards and procedures for storage and administration of emergency use epinephrine; or

(ii) Administers emergency use epinephrine that is beyond the manufacturer's expiration date.

(b) (1) A cause of action may not arise against any physician for any act or omission if the physician in good faith prescribes or dispenses emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine to a certificate holder or participating facility under this subtitle.

(2) A cause of action may not arise against any pharmacist for any act or omission if the pharmacist in good faith dispenses emergency use epinephrine and the necessary paraphernalia for the administration of emergency use epinephrine to a certificate holder or a participating facility under this subtitle.

(c) This section does not affect and may not be construed as affecting any immunities from civil liability or defenses established by any other provision of law or by common law to which a physician or pharmacist may be entitled.

§13–7A–08.

(a) This subtitle may not be construed to create a duty on any individual employed by a recreation or wellness facility at an eligible institution or food service facility to obtain a certificate under this subtitle, and an individual employed by a recreation or wellness facility at an eligible institution or food service facility may not be held civilly liable for failing to obtain a certificate under this subtitle.

(b) An individual may not be held civilly liable in any action arising from or in connection with the administration of emergency use epinephrine by the individual solely because the individual did not possess a certificate issued under this subtitle.

§13–7A–09.

A certificate holder shall submit to the Department, in the manner required under § 13–7A–03 of this subtitle, a report of each incident that occurred on the premises of a participating facility that involved the administration of emergency use epinephrine by a certificate holder or an agent.

§13–901. IN EFFECT

(a) (1) There is an Organ and Tissue Donation Awareness Fund.

(2) The Fund consists of:

(i) Money collected under § 16–111.2(f) of the Transportation Article; and

(ii) Funds appropriated in accordance with subsection (c) of this section.

(3) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(4) The State Treasurer shall separately hold and the State Comptroller shall account for the Fund.

(5) The Fund shall be invested and reinvested in the same manner as other State funds.

(6) Any investment earnings shall be retained to the credit of the Fund.

(b) (1) The Fund shall be managed and supervised by the Secretary or the Secretary's designee.

(2) (i) The Fund shall be used to promote public education and awareness about organ, tissue, and eye donations and to fund the establishment, operation, and maintenance of a donor registry as provided in § 4–516 of the Estates and Trusts Article.

(ii) 1. Beginning in fiscal year 2024, at least $500,000 shall be distributed annually from the Fund to the qualified nonprofit entity described in § 4–516 of the Estates and Trusts Article.

2. Any unused funds distributed to the qualified nonprofit entity under subsubparagraph 1 of this subparagraph shall revert to the Fund at the end of each fiscal year.

(3) The Fund shall be subject to audit by the Office of Legislative Audits under Title 2, Subtitle 12 of the State Government Article.

(c) For each of fiscal years 2024 through 2027, the Governor shall include in the annual budget bill an appropriation to the Fund in an amount equal to the difference between:

(1) The funds collected under § 16–111.2(f) of the Transportation Article in the second immediately preceding fiscal year; and

(2) $500,000.

§13–901. // EFFECTIVE SEPTEMBER 30, 2027 PER CHAPTERS 273 AND 274 OF 2022 //

(a) (1) There is an Organ and Tissue Donation Awareness Fund.

(2) The Fund consists of money collected under § 16–111.2(f) of the Transportation Article.

(3) The Fund is a special, continuing, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(4) The Treasurer shall separately hold and the Comptroller shall account for the Fund.

(5) The Fund shall be invested and reinvested in the same manner as other State funds.

(6) Any investment earnings shall be retained to the credit of the Fund.

(b) (1) The Fund shall be managed and supervised by the Secretary or the Secretary's designee.

(2) The Fund shall be used to promote public education and awareness about organ, tissue, and eye donations and to fund the establishment, operation, and maintenance of a donor registry as provided in § 4–516 of the Estates and Trusts Article.

(3) The Fund shall be subject to audit by the Office of Legislative Audits under Title 2, Subtitle 12 of the State Government Article.

§13–1001.

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

(b) "Administrative Component" means the component of the Program that is established under § 13-1014 of this subtitle.

(c) "Baseline Tobacco Study" means the study that is conducted under § 13-1003 of this subtitle.

(d) "Cigarette Restitution Fund" means the fund that is established under § 7-317 of the State Finance and Procurement Article.

(e) "Community Health Coalition" means a coalition established under § 13-1008(b)(1) of this subtitle.

(f) "Comprehensive Plan for Tobacco Use Prevention and Cessation" means a plan that is developed under § 13-1008(b)(2) of this subtitle.

(g) "Counter-Marketing and Media Component" means the component of the Program that is established under § 13-1013 of this subtitle.

(h) "County" includes Baltimore City.

(i) "Local health officer" means:

(1) The head of a county health department; or

(2) A person designated by the Department under § 13-1008(g) of this subtitle.

(j) "Local Public Health Component" means the component of the Program that is established under § 13-1006 of this subtitle.

(k) "Local Public Health Tobacco Grant" means a grant distributed by the Department to a county under §§ 13-1006 through 13-1012 of this subtitle.

(l) "Maryland Adolescent Survey" means the Maryland Adolescent Survey that is administered by the Maryland State Department of Education.

(m) "Master Settlement Agreement" means the Master Settlement Agreement executed by the State and participating tobacco manufacturers.

(n) "Minority individual" means a woman or an individual of African American, Hispanic, Native American, or Asian descent.

(o) "National Public Education Fund" means the National Public Education Fund that was established under the Master Settlement Agreement.

(p) "Program" means the Tobacco Use Prevention and Cessation Program established under § 13-1002 of this subtitle.

(q) "Statewide Public Health Component" means the component of the Program that is established under § 13-1005 of this subtitle.

(r) "Surveillance and Evaluation Component" means the component of the Program that is established under § 13-1003 of this subtitle.

(s) (1) "Targeted minority population" means a minority population to which the tobacco industry disproportionately marketed tobacco products.

(2) "Targeted minority population" includes:

(i) Women; and

(ii) Individuals of African American, Hispanic, Native American, and Asian descent.

(t) "Task Force Report" means the report entitled "Making Maryland the Tobacco Free State" that was issued in December 1999 by the Governor's Task Force to End Smoking in Maryland.

(u) (1) "Tobacco product" means any product that is:

(i) Intended for human inhalation, absorption, ingestion, smoking, heating, chewing, dissolving, or any other manner of consumption that is made of, derived from, or contains:

1. Tobacco; or

2. Nicotine; or

(ii) An accessory or component used in any manner of consumption of a product described in item (i) of this paragraph.

(2) "Tobacco product" includes:

(i) Cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, and snus;

(ii) Electronic smoking devices; and

(iii) Filters, rolling papers, pipes, and liquids used in electronic smoking devices regardless of nicotine content.

(3) "Tobacco product" does not include a drug, device, or combination product authorized for sale by the U.S. Food and Drug Administration under the Federal Food, Drug, and Cosmetic Act.

(v) "Uninsured individual" means an individual:

(1) For whom the appropriate treatment is not covered by private health insurance, Medicaid, Medicare, or the Maryland Children's Health Program; and

(2) Who the Department determines does not have the financial means to pay for appropriate treatment.

(w) "Youth Tobacco Survey" means the Youth Tobacco Survey developed by the Centers for Disease Control and Prevention and administered by the Department with the assistance of the Maryland State Department of Education.

§13–1002.

(a) There is a Tobacco Use Prevention and Cessation Program in the Department.

(b) The purpose of the Program is to coordinate the State's use of the Cigarette Restitution Fund to address issues relating to tobacco use prevention and cessation so as to create a lasting legacy of public health initiatives that result in a reduction of tobacco use in the State and otherwise benefit the health and welfare of the State's residents.

(c) The Program consists of:

(1) A Surveillance and Evaluation Component;

(2) A Statewide Public Health Component;

(3) A Counter–Marketing and Media Component;

(4) A Local Public Health Component; and

(5) An Administrative Component.

(d) (1) The Program shall be funded as provided in the State budget with money from the Cigarette Restitution Fund.

(2) The Legislative Auditor is authorized to audit the appropriations and expenditures made for the purpose of implementing the Program, including the use of any funds received by a person under any component of this Program.

(e) (1) The annual budget bill shall specify the amount of funding that is allocated to each component of the Program.

(2) Except as provided in paragraph (3) of this subsection, money that is allocated to a component of the Program in the State budget:

(i) May only be expended for the purpose for which it is appropriated; and

(ii) May not be transferred to any other component of the Program, any other program in the Department, or any other unit of State government.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, the Department may transfer a maximum of 10% of the total amount of money that is allocated to the Program in the State budget among components of the Program if the transfer is specifically authorized in the annual budget bill as enacted.

(ii) The Department may not transfer money to the Administrative Component from any other component of the Program.

(iii) If the Department transfers any money among the components of the Program as authorized under subparagraph (i) of this paragraph, the Department shall report the transfer to the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health Committee within 60 days of the transfer.

(iv) The Department may transfer money that is allocated to a component of the Program in the State budget to another program in the Department, or another unit of State government if the transfer is specifically authorized by:

1. A provision of this subtitle; or

2. A provision of the annual budget bill as enacted that relates specifically to the transfer of funds from that component.

(f) (1) Money that is allocated to a component of the Program in the State budget that remains unspent and unobligated at the end of the applicable fiscal year shall revert to the Cigarette Restitution Fund.

(2) Money that reverts to the Cigarette Restitution Fund under paragraph (1) of this subsection shall be used to fund the Program in the fiscal year to which the next annual budget bill relates.

(3) The Governor shall include in the next annual budget bill an appropriation for the Program that is at least equal to the amount of money that reverted to the Cigarette Restitution Fund under paragraph (1) of this subsection.

(g) No later than January 31 of each year, the Department shall report to the Governor and, subject to § 2–1257 of the State Government Article, the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health Committee:

(1) The amount of money that was allocated to each component of the Program during:

(i) The prior fiscal year that remained unspent and unobligated at the end of that year; and

(ii) The current fiscal year that remained unspent and unobligated as of December 31 of the preceding calendar year; and

(2) The amount of money that was distributed to a county as a Local Public Health Tobacco Grant during:

(i) The prior fiscal year that remained unspent and unobligated at the end of that year; and

(ii) The current fiscal year that remained unspent and unobligated as of December 31 of the preceding calendar year.

(h) The Department shall adopt regulations that establish the criteria that the Department will use to determine whether, for the purpose of qualifying as an uninsured individual under § 13–1001(v) of this subtitle, an individual has the financial means to pay for appropriate treatment.

§13–1003.

(a) There is a Surveillance and Evaluation Component in the Program.

(b) The purposes of the Surveillance and Evaluation Component are to:

(1) Collect, analyze, and monitor data relating to tobacco use and tobacco use prevention and cessation in the State;

(2) Measure and evaluate the results of the Program, including the results of each component of the Program;

(3) Conduct a Baseline Tobacco Study, as provided under subsections (c) through (e) of this section; and

(4) Conduct a Tobacco Study, as provided under § 13–1004 of this subtitle.

(c) (1) To initiate the Surveillance and Evaluation Component, the Department shall conduct a comprehensive statewide Baseline Tobacco Study as provided under this section.

(2) The Baseline Tobacco Study shall measure:

(i) The number and percentage of individuals attending middle school or high school who smoke or otherwise use tobacco products, both statewide and in each county;

(ii) The number and percentage of minority individuals attending middle school or high school who smoke or otherwise use tobacco products, both statewide and in each county;

(iii) The number and percentage of individuals who smoke or otherwise use tobacco products, both statewide and in each county;

(iv) The number and percentage of minority individuals who smoke or otherwise use tobacco products, both statewide and in each county;

(v) The number and percentage of pregnant women who smoke or otherwise use tobacco products, both statewide and in each county;

(vi) The number and percentage of households with individuals attending middle school or high school in which at least one household member who is at least 18 years old smokes tobacco products, both statewide and in each county;

(vii) The number and percentage of individuals who, within an established amount of time before the start of the Baseline Tobacco Study, started to smoke or otherwise use tobacco products;

(viii) The number and percentage of individuals who smoke or otherwise use tobacco on a regular basis and who, within an established amount of time before the start of the Baseline Tobacco Study, voluntarily stopped smoking or otherwise using tobacco products for a significant amount of time, as determined by the Department, both statewide and in each county; and

(ix) Any other factor that the Department determines to be important for measuring tobacco use or evaluating whether the Program meets its objectives.

(d) (1) In conducting the Baseline Tobacco Study, the Department may consider any data collected after March 1, 2000, through the administration of the Maryland Adolescent Survey or the Youth Tobacco Survey.

(2) The Maryland State Department of Education, county boards of education, and each school selected to participate in the Maryland Adolescent Survey

or the Youth Tobacco Survey shall cooperate with the Department in administering the surveys.

(3) (i) Subject to subparagraph (ii) of this paragraph, the Maryland State Department of Education may not discontinue administration of the Maryland Adolescent Survey until after it has submitted a report to the Governor and, subject to § 2–1257 of the State Government Article, the General Assembly that states the reason for discontinuing the survey.

(ii) If the Maryland State Department of Education submits a report as provided under subparagraph (i) of this paragraph, it may discontinue the Maryland Adolescent Survey in the first school year that begins after the report has been submitted.

(e) (1) Subject to paragraphs (2) through (4) of this subsection, the Department shall contract with a higher education institution or private entity to conduct the Baseline Tobacco Study.

(2) The Department shall issue a request for proposal to select the entity that will conduct the Baseline Tobacco Study.

(3) The request for proposal shall require that any methodology or model that is used by the entity to conduct the Baseline Tobacco Study, any data collected under the Study, and any electronic files, codes, and definitions relating to the Study be provided to the State for use in subsequent studies, regardless of whether the subsequent studies are conducted by the same entity.

(4) The Department may contract with an entity to conduct the Baseline Tobacco Study and one or more biennial tobacco studies as required under § 13–1004 of this subtitle.

(5) (i) The Department shall use the criteria established in subparagraph (ii) of this paragraph as a guide in administering the request for proposal process for the Baseline Tobacco Study.

(ii) The Department shall give preference to an entity that:

1. Is a Maryland–based vendor;

2. Has previous work experience relating to tobacco or health activities;

3. Has previous work experience relating to youth and adolescents;

4. Demonstrates a capability for innovative activities and use of state–of–the–art technologies;

5. Has demonstrated the ability to provide culturally–specific and effective services to targeted minority populations;

6. Has previous work experience with the public sector;

7. Demonstrates performance in the specific content area for at least 3 years;

8. Has previous work experience with rural or urban communities;

9. Will maximize the use of State funds through the use of preexisting materials, funding partnerships, and resource matching; and

10. Has no history of working for the tobacco industry.

§13–1004.

(a) Beginning in fiscal year 2007 and in every second year thereafter, the Department shall conduct a Tobacco Study which shall measure the same factors that are set forth in § 13–1003(c) of this subtitle and use the same methodology or model that was used for the Baseline Tobacco Study.

(b) To carry out the evaluation and surveillance functions of this subtitle, the Department may conduct any other tobacco study measuring the factors set forth in § 13–1003(c) of this subtitle and using a methodology or model that is consistent with but need not be identical to that used to conduct the Baseline Tobacco Study.

(c) (1) Subject to paragraphs (2) through (4) of this subsection, the Department shall contract with a higher education institution or private entity to conduct the Biennial Tobacco Study.

(2) The Department shall issue a request for proposal to select the entity that will conduct the Biennial Tobacco Study.

(3) The Department may contract with an entity to conduct one or more biennial tobacco studies.

(4) The Department shall use the criteria established in § 13–1003(e)(5) of this subtitle as a guide in administering the request for proposal process.

(d) On or before May 31 of each even–numbered fiscal year, beginning in fiscal year 2008, the Department shall submit a report to the Governor and, subject to § 2–1257 of the State Government Article, the General Assembly on:

(1) The results of the Biennial Tobacco Study; and

(2) Beginning in fiscal year 2024, a State– and county–level data summary and trends report on data collected under § 7–420 of the Education Article.

§13–1005.

(a) There is a Statewide Public Health Component in the Program.

(b) The purpose of the Statewide Public Health Component is to maximize the effectiveness of the anti-tobacco initiatives in the State by authorizing the Department to take steps to ensure that the Program is implemented in a coordinated and integrated manner throughout the State.

(c) Subject to subsections (d) and (e) of this section and as necessary to ensure a coordinated and integrated statewide effort to implement tobacco use prevention and cessation programs, the Department may develop and implement statewide anti-tobacco initiatives that are consistent with the findings and recommendations of the Task Force Report and the recommendations of the Centers for Disease Control and Prevention regarding best practices for comprehensive tobacco control programs as they relate to statewide programs, including programs that support the implementation of the Local Public Health Component.

(d) (1) To implement this section, the Department may issue a request for proposal, distribute a grant, or enter into a contract.

(2) The request for proposal, grant, or contract shall state with specificity the objectives and performance criteria that will be used to measure the success of the Program to which the request for proposal, grant, or contract relates.

(3) If the Department issues a request for proposal to select an entity to implement an initiative under this section, the Department shall use the criteria established in § 13-1003(e)(5) of this subtitle as a guide in administering the request for proposal process.

(e) (1) Except as provided under paragraph (2) of this subsection, the Department may not spend any of the money that is allocated to the Statewide Public Health Component in the State budget until after the Baseline Tobacco Study is completed.

(2) (i) Subject to subparagraph (ii) of this paragraph and before the Baseline Tobacco Study is completed, the Department may use money that is allocated to the Statewide Public Health Component in the State budget for fiscal year 2001 to distribute grants that will be used to provide outreach and start-up technical assistance to communities for the purpose of organizing participation in community health coalitions.

(ii) The Department shall use at least $750,000 of the money that is allocated to the Statewide Public Health Component in the State budget for fiscal year 2001 to provide outreach and start-up technical assistance to African American communities in the State for the purpose of organizing participation in community health coalitions that are formed under § 13-1008(b), § 13-1109(c), or § 13-1115(b) of this title.

§13–1006.

(a) There is a Local Public Health Component in the Program.

(b) The purpose of the Local Public Health Component is to maximize the effectiveness of anti-tobacco initiatives in the State by authorizing local health coalitions to develop and implement tobacco use prevention and cessation programs in coordination with the Department.

(c) Subject to §§ 13-1007 through 13-1012 of this subtitle, the Department may distribute grants to counties for tobacco use prevention and cessation programs, including:

(1) Community-based programs;

(2) School-based programs which may include tobacco use prevention and cessation components of school-based health care services and programs established under §§ 7-401 and 7-415 of the Education Article; and

(3) Programs relating to enforcement of tobacco control laws.

(d) (1) Except as provided under paragraph (2) of this subsection, the Department may not spend any funds that are allocated to the Local Public Health Component in the State budget until after the Baseline Tobacco Study has been completed.

(2) Before the Baseline Tobacco Study is completed, the Department may distribute a planning grant of not more than $10,000 to each local health department.

§13–1007.

(a) After the Baseline Tobacco Study has been completed and before soliciting applications for Local Public Health Tobacco Grants, the Department, in consultation with the local health departments, shall:

(1) Establish short–term and long–term tobacco use prevention and cessation goals for each county;

(2) Establish other requirements for each county that the Department determines to be necessary to meet the goals established under paragraph (1) of this subsection; and

(3) Provide for the distribution of Local Public Health Tobacco Grants to eligible counties based on the formula established under subsection (b) of this section.

(b) Subject to subsections (c) through (e) of this section and §§ 13–1008 through 13–1012 of this subtitle, the Department shall distribute a Local Public Health Tobacco Grant to each county that is equal to the sum of:

(1) A base amount of funding as determined by the Department for each county and Baltimore City;

(2) The product of:

(i) One–half of the amount remaining from the allocation to the Local Public Health Component in the State budget after the base amount under item (1) of this subsection is distributed to each county and Baltimore City; and

(ii) The number of individuals in the county attending middle school or high school who smoke or otherwise use tobacco products divided by the number of individuals in the State attending middle school or high school who smoke or otherwise use tobacco products; and

(3) The product of:

(i) One–half of the amount remaining from the allocation to the Local Public Health Component in the State budget after the base amount under item (1) of this subsection is distributed to each county and Baltimore City; and

(ii) The number of individuals in the county who smoke or otherwise use tobacco products divided by the number of individuals in the State who smoke or otherwise use tobacco products.

(c) Beginning in fiscal year 2005, the calculations of the numbers of individuals smoking or using tobacco products required in subsection (b)(2)(ii) and (3)(ii) of this section shall be based on the most recent data averaged over a multiyear period as determined by the Department.

(d) The allocation formula calculated in accordance with subsection (b) of this section for fiscal year 2005 shall remain in effect for the following 3 years and thereafter shall be recalculated every 4th year in accordance with the provisions of this section.

§13–1008.

(a) (1) Subject to the other provisions of this section, a local health officer may apply to the Department for a Local Public Health Tobacco Grant.

(2) The amount of the Local Public Health Tobacco Grant shall be determined by the Department using the formula established under § 13–1007 of this subtitle.

(b) Before applying for a Local Public Health Tobacco Grant, a local health officer shall:

(1) Establish a Community Health Coalition, as provided under § 13–1010 of this subtitle, or identify another coalition approved by the Department; and

(2) With the assistance of the coalition established or identified under item (1) of this subsection:

(i) Identify all existing tobacco use prevention and cessation programs in the county that are publicly funded;

(ii) Evaluate the effectiveness of the publicly funded programs identified under item (i) of this paragraph; and

(iii) Develop a Comprehensive Plan for Tobacco Use Prevention and Cessation that outlines a strategy for meeting the tobacco use prevention and cessation goals and requirements established for the county under § 13–1007 of this subtitle.

(c) A Comprehensive Plan for Tobacco Use Prevention and Cessation shall:

(1) Include a list of the members of the coalition established or identified under subsection (b)(1) of this section and their organizational affiliations;

(2) Include an evaluation of any county program funded with a Local Public Health Tobacco Grant in the prior year;

(3) Each year, after the first year of funding, demonstrate that progress has been made toward meeting the tobacco use prevention and cessation goals established for the county under § 13–1007 of this subtitle;

(4) Include a budget plan that provides specific levels of funding for each initiative described in the Plan and an explanation as to how each initiative is expected to help meet the tobacco use prevention and cessation goals and requirements established for the county under § 13–1007 of this subtitle;

(5) Demonstrate that the county has met the base–year funding requirement established under § 13–1011 of this subtitle;

(6) Each year, after the first year of funding, identify all persons who received money under a Local Public Health Tobacco Grant in the prior year and state the amount of money that was received by each person under the grant;

(7) Each year, after the first year of funding, state the amount of money that was received by a county under a Local Public Health Tobacco Grant in the prior fiscal year that remained unspent and unobligated at the end of that year;

(8) Describe how the Plan will help to reduce tobacco use among women, minority individuals, and individuals attending middle school or high school, with particular emphasis on how the Plan seeks to address the relevant findings and recommendations of the Task Force Report;

(9) Describe how the Plan will help to increase availability of and access to cessation programs for uninsured individuals and medically underserved populations, with particular emphasis on how the Plan seeks to address the relevant findings and recommendations of the Task Force Report;

(10) Allocate resources in a manner that is consistent with:

(i) The needs of different populations in the county, including targeted minority populations, as identified in the Baseline Tobacco Study and annual tobacco studies; and

(ii) The recommendations of the Centers for Disease Control and Prevention regarding best practices for a comprehensive tobacco control program; and

(11) Contain any data or other information required by the Department.

(d) If a Comprehensive Plan for Tobacco Use Prevention and Cessation does not allocate resources in a manner that is consistent with the recommendations of the Centers for Disease Control and Prevention regarding best practices for a comprehensive tobacco control program, the Plan shall:

(1) State the reason for not allocating resources in this manner; and

(2) Identify the extent to which other resources assist the county in meeting this requirement.

(e) A local health officer who seeks to obtain a Local Public Health Tobacco Grant shall apply to the Department by submitting a copy of the county's Comprehensive Plan for Tobacco Use Prevention and Cessation for approval.

(f) Each year, a local health officer, in consultation with the coalition established or identified under subsection (b)(1) of this section, shall update the Comprehensive Plan for Tobacco Use Prevention and Cessation.

(g) (1) The Department may designate a person other than the head of a county health department to coordinate a county's tobacco use prevention and cessation efforts if:

(i) The county health department is unwilling to coordinate these efforts;

(ii) The county health department has been unsuccessful in implementing tobacco use prevention and cessation initiatives that satisfy performance standards established by the Department; or

(iii) The county health department lacks sufficient staff or resources to coordinate these efforts.

(2) Subject to paragraph (3) of this subsection, the Department shall establish procedures for making a designation under this subsection.

(3) If the Department determines that it is necessary to designate a person other than the local health officer to coordinate a county's tobacco use

prevention and cessation efforts, the Department may designate the Department as the entity that will coordinate the county's efforts.

§13–1009.

(a) The local health officers of two or more counties may join together as a region to apply for a Local Public Health Tobacco Grant.

(b) The amount of the Local Public Health Tobacco Grant that is distributed to a region under subsection (a) of this section shall be equal to the sum of the Local Public Health Tobacco Grants that otherwise would have been distributed to each county under § 13–1007 of this subtitle.

(c) If the local health officers of two or more counties join together as a region to apply for a Local Public Health Tobacco Grant, the local health officers shall act jointly to:

(1) Develop a Comprehensive Plan for Tobacco Use Prevention and Cessation, as required under § 13–1008 of this subtitle;

(2) Establish a Community Health Coalition, as required under § 13–1008 of this subtitle, or identify another coalition approved by the Department;

(3) Demonstrate that the base–year funding requirement of § 13–1011 of this subtitle has been met; and

(4) Otherwise satisfy the requirements of §§ 13–1006 through 13–1012 of this subtitle.

§13–1010.

(a) The membership of a Community Health Coalition established under § 13-1008(b) of this subtitle shall:

(1) Reflect the demographics of the county; and

(2) Include representatives of community-based groups, including minority, rural, and medically underserved populations, that, taken together, are familiar with all of the different communities and cultures in the county.

(b) The membership of a Community Health Coalition established under § 13–1008(b) of this subtitle may include:

(1) Representatives of:

(i) A local management board established under Title 8, Subtitle 3 of the Human Services Article;

(ii) The local public school system;

(iii) Local hospitals, clinics, physicians, and other health care providers;

(iv) Local law enforcement;

(v) Local businesses;

(vi) Local religious organizations;

(vii) Local media;

(viii) Institutions of higher education; and

(ix) Hospitals and other entities located outside the county that could enhance the county's tobacco use prevention and cessation efforts; and

(2) Any other person that the local health officer believes would help the county meet the tobacco use prevention and cessation goals and requirements established for the county under § 13–1007 of this subtitle.

§13–1011.

(a) (1) Before receiving a Local Public Health Tobacco Grant, a local health officer shall submit to the Department an inventory of all publicly funded tobacco use prevention and cessation programs in the county that were identified under § 13-1008(b)(2) of this subtitle.

(2) The inventory shall specify the amount of county funds that are being spent on each of the programs included in the inventory.

(b) The level of funding specified under subsection (a)(2) of this section shall be the county's base-year funding for tobacco use prevention and cessation programs.

(c) A Local Public Health Tobacco Grant may not be used to supplant a county's base-year funding for tobacco use prevention and cessation programs.

(d) The Department may not distribute a Local Public Health Tobacco Grant to a county unless the Department determines that the county will spend, in

the applicable fiscal year, at least its base-year funding for tobacco use prevention and cessation programs.

§13–1012.

(a) The Department shall review a Comprehensive Plan for Tobacco Use Prevention and Cessation submitted under § 13-1008(d) of this subtitle and determine whether:

(1) The Plan addresses the goals and requirements established for the county under § 13-1007 of this subtitle;

(2) The Plan allocates resources in a manner that is consistent with the needs of the different populations in the county, including targeted minority populations, as identified in the Baseline Tobacco Study and biennial tobacco studies;

(3) The Plan allocates resources in a manner that is consistent with the recommendations of the Centers for Disease Control and Prevention regarding best practices for a comprehensive tobacco control program or states a reason for not meeting this requirement and identifies other resources that, taken together, meet this requirement; and

(4) The local health officer has complied with the other requirements of §§ 13-1007 through 13-1011 of this subtitle.

(b) The Department may not distribute a county's share of money for a Local Public Health Tobacco Grant, as provided under § 13-1007 of this subtitle, if the Department determines that the requirements of subsection (a) of this section have not been met.

§13–1013.

(a) There is a Counter–Marketing and Media Component in the Program.

(b) The purpose of the Counter–Marketing and Media Component is to coordinate a statewide counter–marketing and media campaign to counter tobacco advertisements and discourage the use of tobacco products.

(c) (1) Except as provided in paragraph (2) of this subsection, the Department may not spend any money that is allocated to the Counter–Marketing and Media Component in the State budget until after the Baseline Tobacco Study is completed.

(2) Before the Baseline Tobacco Study is completed, the Department may spend money that is allocated to the Counter–Marketing and Media Component in the State budget to conduct formative research relating to the Counter–Marketing and Media Component.

(d) (1) The Department may contract with a higher education institution or private entity to implement any part of the Counter–Marketing and Media Component.

(2) If the Department determines that any part of the Counter–Marketing and Media Component should be implemented by a higher education institution or private entity, the Department shall issue a request for proposal to select the entity that will implement that part of the Component.

(3) At a minimum, the request for proposal shall:

(i) State with specificity the goals of the Counter–Marketing and Media Component;

(ii) State with specificity the objectives and performance criteria that will be used to measure the success of the program to which the request for proposal relates; and

(iii) Require that the response to the request for proposal include a plan to reach the targeted audiences identified by the Department.

(4) If the Department issues a request for proposal to select an entity to implement any part of the Counter–Marketing and Media Component, the Department shall use the criteria established in § 13–1003(e)(5) of this subtitle as a guide in administering the request for proposal process.

(e) To the extent practicable, the Department shall take steps to maximize the cost effectiveness of the Counter–Marketing and Media Component, including:

(1) Using advertisements and other communications and public relations products and services that have been developed by and shown to be effective in other states;

(2) Subject to subsection (f) of this section, using money that is allocated to the Counter–Marketing and Media Component to obtain money from the federal government, the National Public Education Fund, or any other entity; and

(3) Coordinating the purchase of broadcast time with other states.

(f) The Department may not accept money from the federal government, the National Public Education Fund, or any other entity if the Department is required to accept, as a condition of receiving the money, restrictions on the content of advertisements, communications, or other public relations products or services that are funded with money from the Cigarette Restitution Fund if the restrictions are inconsistent with the purposes of this subtitle.

§13–1014.

(a) There is an Administrative Component in the Program.

(b) The purpose of the Administrative Component is to provide the necessary administrative structure in the Department for effective management of the Program.

(c) Funds that are allocated to the Administrative Component in the State budget shall be used to cover administrative costs incurred by the Department in administering the Program.

(d) Unless otherwise specified in the annual budget bill as enacted, the amount of funds that are allocated to the Administrative Component in the State budget may not exceed 7% of the total amount that is allocated to the Program in the State budget.

(e) A county that receives funds under a Local Public Health Tobacco Grant, a person who receives funds under a Local Public Health Tobacco Grant, and any other person who receives funds under any component of the Program may not use more than 7% of the funds to cover administrative costs.

§13–1015.

(a) For fiscal year 2011 and fiscal year 2012, the Governor shall include at least $6,000,000 in the annual budget in appropriations for activities aimed at reducing tobacco use in Maryland as recommended by the Centers for Disease Control and Prevention, including:

(1) Media campaigns aimed at reducing smoking initiation and encouraging smokers to quit smoking;

(2) Media campaigns educating the public about the dangers of secondhand smoke exposure;

(3) Enforcement of existing laws banning the sale or distribution of tobacco products to individuals under the age of 21 years;

(4) Promotion and implementation of smoking cessation programs; and

(5) Implementation of school–based tobacco education programs.

(b) (1) For fiscal years 2013 through 2021, the Governor shall include at least $10,000,000 in the annual budget in appropriations for the purposes described in subsection (a) of this section.

(2) For fiscal years 2022 through 2026, the Governor shall include at least $18,250,000 in the annual budget in appropriations for the purposes described in subsection (a) of this section.

(3) For fiscal year 2027 and each fiscal year thereafter, the Governor shall include at least $17,520,000 in the annual budget in appropriations for the purposes described in subsection (a) of this section.

§13–1101.

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

(b) "Administrative Component" means the component of the Program established under § 13–1119 of this subtitle.

(c) "Baseline Cancer Study" means the study conducted under § 13–1103 of this subtitle.

(d) "Cancer Research Plan" means a plan developed under § 13–1116 of this subtitle.

(e) "Cigarette Restitution Fund" means the fund that is established under § 7–317 of the State Finance and Procurement Article.

(f) "Community Health Coalition" means a coalition established under § 13–1109(c)(1) or § 13–1115(b)(1) of this subtitle.

(g) "Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment" means a plan developed under § 13–1109(c)(2) or § 13–1115(b)(2) of this subtitle.

(h) "County" includes Baltimore City.

(i) "Education" means information provided to the public regarding the purpose of, availability of, and access to screening programs.

(j) "Federally qualified health center" has the meaning stated in 42 U.S.C. § 254b.

(k) "Johns Hopkins Institutions" means the Johns Hopkins University and the Johns Hopkins Health System.

(l) "Local health officer" means:

(1) The head of a county health department; or

(2) A person designated by the Department under § 13–1109(g) or § 13–1115(f) of this subtitle.

(m) "Local Public Health Cancer Grant" means a grant distributed by the Department to a county under §§ 13–1107 through 13–1113 of this subtitle.

(n) "Local Public Health Component" means the component of the Program that is established under § 13–1107 of this subtitle.

(o) "Maryland Cancer Registry" means the computerized data system, operated by the Department with the assistance of the Maryland State Council on Cancer Control, that registers cases of cancer that are diagnosed and treated in the State.

(p) "Maryland Technology Development Corporation" means the entity that is established under Title 10, Subtitle 4 of the Economic Development Article.

(q) "Minority individual" means a woman or an individual of African American, Hispanic, Native American, or Asian descent.

(r) "Outreach efforts" means activities that are related to encouraging individuals to seek screening services.

(s) "Prevention" means activities relating to early detection, screening, and risk factor reduction.

(t) "Program" means the Cancer Prevention, Education, Screening, and Treatment Program that is established under § 13–1102 of this subtitle.

(u) "Screening" includes screening, early detection, identification, diagnosis, and outreach efforts associated with screening and early detection programs.

(v) "Statewide Academic Health Center" means the University of Maryland Medical Group or the Johns Hopkins Institutions.

(w) "Statewide Academic Health Center Cancer Research Grant" means a grant that is distributed under § 13–1116 of this subtitle.

(x) "Statewide Academic Health Center Component" means the component established under § 13–1114 of this subtitle.

(y) "Statewide Academic Health Center Public Health Grant" means a grant that is distributed under § 13–1115 of this subtitle.

(z) "Statewide Academic Health Center Tobacco–Related Diseases Research Grant" means a grant that is distributed under § 13–1017 of this title.

(aa) "Statewide Public Health Component" means the component of the Program that is established under § 13–1106 of this subtitle.

(bb) "Surveillance and Evaluation Component" means the component of the Program that is established under § 13–1103 of this subtitle.

(cc) "Targeted cancer" means a cancer that is identified by the Department under § 13–1102(d) of this subtitle.

(dd) "Task Force Report" means the report entitled "Report of the Governor's Task Force to Conquer Cancer" that was issued in December 1999.

(ee) "Tobacco–related diseases" means cardiovascular disease, chronic pulmonary disease, peripheral vascular disease, stroke, and infant mortality due to low birth weight.

(ff) "Treatment" includes appropriate access to:

(1) Local hospitals, community clinics, physicians, and other health care providers; and

(2) Clinical trials, transportation, case management, hospice care, and cancer support groups.

(gg) "Underinsured individual" means an individual:

(1) For whom the appropriate treatment is not adequately covered by private health insurance, Medicaid, Medicare, or the Maryland Children's Health Program due to out–of–pocket costs, including required copayments, coinsurance, or deductibles; and

(2) Who the Department determines does not have the financial means to pay for appropriate treatment.

(hh) "Uninsured individual" means an individual:

(1) For whom the appropriate treatment is not covered by private health insurance, Medicaid, Medicare, or the Maryland Children's Health Program; and

(2) Who the Department determines does not have the financial means to pay for appropriate treatment.

(ii) "University of Maryland Medical Group" means the University of Maryland Medical System Corporation, the University of Maryland Medical School, and the University of Maryland, Baltimore Campus.

§13–1102.

(a) There is a Cancer Prevention, Education, Screening, and Treatment Program in the Department.

(b) The purpose of the Program is to coordinate the State's use of the Cigarette Restitution Fund so as to create a lasting legacy of public health initiatives that reduce mortality and morbidity rates for cancer and tobacco–related diseases in the State and otherwise benefit the health and welfare of the State's residents.

(c) The Program consists of:

(1) A Surveillance and Evaluation Component;

(2) A Statewide Public Health Component;

(3) A Local Public Health Component;

(4) A Statewide Academic Health Center Component; and

(5) An Administrative Component.

(d) To initiate the Program, the Department shall identify the types of cancers that will be targeted under the Program.

(e) (1) The Program shall be funded as provided in the State budget with money from the Cigarette Restitution Fund.

(2) The Legislative Auditor is authorized to audit the appropriations and expenditures made for the purpose of implementing the Program, including the use of any funds received by a person under any component of the Program.

(f) (1) The annual budget bill shall specify the amount of funding that is allocated to each component of the Program.

(2) Except as provided in paragraph (3) of this subsection, money that is allocated to a component of the Program in the State budget:

(i) May only be expended for the purpose for which it is appropriated; and

(ii) May not be transferred to any other component in the Program, any other program in the Department, or any unit of State government.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, the Department may transfer a maximum of 10% of the total amount of money that is allocated to the Program among the components of the Program if the transfer is specifically authorized in the annual budget bill as enacted.

(ii) The Department may not transfer funds to the Statewide Academic Health Center Component or the Administrative Component from any other component of the Program.

(iii) If the Department transfers any money among the components of the Program as authorized under subparagraph (i) of this paragraph, the Department shall report the transfer to the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health Committee within 60 days after the transfer.

(iv) The Department may transfer money that is allocated to a component of the Program in the State budget to another program in the Department or another unit of State government if the transfer is specifically authorized by:

1. A provision of this subtitle; or

2. A provision of the annual budget bill as enacted that relates specifically to the transfer of funds from that component.

(g) (1) Money that is allocated to a component of the Program in the State budget that remains unspent and unobligated at the end of the applicable fiscal year shall revert to the Cigarette Restitution Fund.

(2) Money that reverts to the Cigarette Restitution Fund under paragraph (1) of this subsection shall be used to fund the Program in the fiscal year to which the next annual budget bill relates.

(3) The Governor shall include in the next annual budget bill an appropriation for the Program that is at least equal to the amount of money that reverted to the Cigarette Restitution Fund under paragraph (1) of this subsection.

(h) No later than January 31 of each year, the Department shall report to the Governor and, subject to § 2–1257 of the State Government Article, Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health Committee:

(1) The amount of money that was allocated to each component of the Program during:

(i) The prior fiscal year that remained unspent and unobligated at the end of that year; and

(ii) The current fiscal year that remained unspent and unobligated as of December 31 of the preceding calendar year; and

(2) The amount of money that was distributed to a county as a Local Public Health Cancer Grant during:

(i) The prior fiscal year that remained unspent and unobligated at the end of that year; and

(ii) The current fiscal year that remained unspent and unobligated as of December 31 of the preceding calendar year.

(i) The Department shall adopt regulations that establish the criteria that the Department will use to determine whether, for the purpose of qualifying as an uninsured individual under § 13–1101(hh) of this subtitle, an individual has the financial means to pay for appropriate treatment.

§13–1103.

(a) There is a Surveillance and Evaluation Component in the Program.

(b) The purpose of the Surveillance and Evaluation Component is to:

(1) Collect, analyze, and monitor data relating to:

(i) Targeted cancers;

(ii) As determined by the Department, nontargeted cancers; and

(iii) Cancer prevention, education, screening, and treatment programs in the State;

(2) Measure and evaluate the results of the Program, including the results of each component of the Program;

(3) Conduct the Baseline Cancer Study, as provided under subsections (c) and (d) of this section; and

(4) Conduct a Biennial Cancer Study, as provided under § 13-1104 of this subtitle.

(c) (1) To initiate the Surveillance and Evaluation Component, the Department shall conduct a comprehensive statewide Baseline Cancer Study as provided in this section.

(2) The Department may:

(i) Conduct the Baseline Cancer Study or any part of the Study; or

(ii) Contract with a higher education institution or private entity to conduct the Baseline Cancer Study or any part of the Study.

(d) The Baseline Cancer Study shall measure:

(1) The number and percentage of individuals who have each targeted cancer, both statewide and in each county;

(2) The number and percentage of individuals within each minority population who have each targeted cancer, both statewide and in each county;

(3) The mortality rate for each targeted cancer, both statewide and in each county;

(4) The mortality rate for different minority populations for each targeted cancer, both statewide and in each county;

(5) The number of identifiable cancers with a high incidence in the State for which there are effective methods of:

(i) Early detection; and

(ii) Prevention and treatment after detection;

(6) Any aspect of targeted and nontargeted cancers that the Department seeks to measure; and

(7) Any other factor that the Department determines to be important for measuring rates of cancers in the State or for evaluating whether the Program meets its objectives.

(e) In order to maximize the cost effectiveness of the Baseline Cancer Study, the Department may use data in the Maryland Cancer Registry or provided by other sources, to the extent that these sources provide reliable data relating to the factors listed in subsection (d) of this section.

(f) (1) If the Department chooses to have a higher education institution or private entity conduct the Baseline Cancer Study or any part of the Study, the Department shall issue a request for proposal to select the entity that will conduct the Study or the relevant part of the Study.

(2) The request for proposal shall require that any methodology or model that is used by the entity to conduct the Baseline Cancer Study or the relevant part of the Study, any data collected under the Study, and any electronic files, codes, and definitions relating to the Study be provided to the State for use in subsequent studies, regardless of whether the studies are conducted by the same entity.

(3) The Department may contract with an entity to conduct the Baseline Cancer Study and one or more biennial cancer studies as required under § 13-1104 of this subtitle.

§13–1104.

(a) Beginning in fiscal year 2004 and biennially thereafter, the Department shall conduct a Biennial Cancer Study.

(b) The Biennial Cancer Study shall:

(1) Measure the same factors that are set forth in § 13–1103(d) of this subtitle; and

(2) Use the same methodology or model that is used to conduct the Baseline Cancer Study.

(c) The Department may:

(1) Conduct the Biennial Cancer Study or any part of the Study; or

(2) Contract with a higher education institution or private entity to conduct the Biennial Cancer Study or any part of the Study.

(d) (1) If the Department chooses to have a higher education institution or private entity conduct the Biennial Cancer Study or any part of the Study, the Department shall issue a request for proposal to select the entity that will conduct the Study or the relevant part of the Study.

(2) The Department may contract with an entity to conduct one or more biennial cancer studies or a part of one or more biennial cancer studies.

(e) On or before December 31 of each odd numbered fiscal year, beginning in fiscal year 2005, the Department shall submit a report to the Governor and, subject to § 2–1257 of the State Government Article, the General Assembly, on the results of the Biennial Cancer Study.

§13–1105.

Before the Department distributes a Local Public Health Cancer Grant to any county under §§ 13-1107 through 13-1113 of this subtitle, the Department shall develop an inventory of publicly funded screening programs that includes information relating to:

(1) The number and types of publicly funded screening programs for each targeted cancer, both statewide and in each county, and the number of individuals screened each year in these programs; and

(2) The existence of mechanisms to ensure that uninsured individuals receive appropriate treatment for any cancer that is detected in the screening programs identified under item (1) of this section.

§13–1106.

(a) There is a Statewide Public Health Component in the Program.

(b) The purpose of the Statewide Public Health Component is to maximize the effectiveness of the anti-cancer initiatives in the State by authorizing the Department to take steps to ensure that the Program is implemented in a coordinated and integrated manner throughout the State.

(c) Subject to subsection (d) of this section and as necessary to ensure a coordinated and integrated statewide effort to implement cancer prevention, identification, and treatment programs for targeted cancers, the Department may develop and implement statewide anti-cancer initiatives that are consistent with the findings and recommendations of the Task Force Report, including programs that support the implementation of the Local Public Health Component of the Program.

(d) If the Department issues a request for proposal, distributes a grant, or enters into a contract as authorized under subsection (c) of this section, the request for proposal, grant, or contract shall state with specificity the objectives and performance criteria that will be used to measure the success of the program to which the request for proposal, grant, or contract relates.

(e) The Department may not spend any money that is allocated to the Statewide Public Health Component in the State budget until the Baseline Cancer Study has been completed.

§13–1107.

(a) There is a Local Public Health Component in the Program.

(b) The purpose of the Local Public Health Component is to maximize the effectiveness of anti–cancer initiatives in the State by empowering local health coalitions to develop and implement cancer prevention, education, screening, and treatment programs in coordination with the Department.

(c) Subject to §§ 13–1108 through 13–1113 of this subtitle, the Department may distribute grants to counties for cancer prevention, education, screening, and treatment programs.

(d) (1) Except as provided under paragraph (2) of this subsection, the Department may not spend any funds that are allocated to the Local Public Health Component in the State budget until after the Baseline Cancer Study has been completed.

(2) Before the Baseline Cancer Study is completed, the Department may distribute a planning grant of not more than $10,000 to each local health department other than the Baltimore City Health Department.

(e) Prior to each fiscal year, the Department shall determine the percentage of funds that shall be allocated to cancer screening, diagnosis, and treatment by a county or Statewide Academic Health Center that receives funds under a Local Public Health Cancer Grant.

§13–1108.

(a) After the Baseline Cancer Study has been completed and before soliciting applications for Local Public Health Cancer Grants, the Department, in consultation with local health departments, shall:

(1) Establish short-term and long-term cancer prevention, education, screening, and treatment goals for each county;

(2) Establish other requirements for each county that the Department determines to be necessary to meet the goals established under paragraph (1) of this subsection; and

(3) Provide for the distribution of Local Public Health Cancer Grants to eligible counties based on the formula established under subsection (b) of this section.

(b) Subject to subsections (c) through (e) of this section and §§ 13-1109 through 13-1113 of this subtitle, the Department shall distribute a Local Public Health Cancer Grant to each county that is equal to the sum of:

(1) A base amount of funding as determined by the Department for each county;

(2) The product of:

(i) One-half of the amount remaining from the allocation to the Local Public Health Component in the State budget after the base amount under item (1) of this subsection is distributed to each county; and

(ii) The number of individuals in the county who have any of the targeted cancers divided by the number of individuals in the State residing outside of Baltimore City who have any of the targeted cancers; and

(3) The product of:

(i) One-half of the amount remaining from the allocation to the Local Public Health Component in the State budget after the base amount under item (1) of this subsection is distributed to each county; and

(ii) The number of individuals in the county who died from any of the targeted cancers during the prior year divided by the number of individuals in the State residing outside of Baltimore City who died from any of the targeted cancers during the prior year.

(c) (1) Except as provided in this subsection, Baltimore City is not eligible to receive money from the Department based on the formula established under subsection (b) of this section.

(2) Each year, before calculating the amount of money that may be distributed to each county as a Local Public Health Cancer Grant under subsection (b) of this section, the Department shall calculate the amount of money that would have been distributed to each county if Baltimore City were included in the formula.

(3) For fiscal year 2007 or any subsequent fiscal year, if the amount of money that would have been distributed to Baltimore City using the formula established under subsection (b) of this section if Baltimore City were included in the formula exceeds 19%, the Department shall transfer the difference between that amount and 19% from the Local Public Health Component to the Statewide Academic Health Center Component.

(d) Beginning in fiscal year 2004, the calculations required in subsection (b)(2)(ii) and (3)(ii) of this section of the numbers of individuals having any of the targeted cancers or who died from any of the targeted cancers shall be based on the most recent data averaged over a multiyear period as determined by the Department.

(e) The allocation formula calculated in accordance with subsection (b) of this section for fiscal year 2004 shall remain in effect for the following 3 years and thereafter be recalculated every 4th year in accordance with the provisions of this section.

(f) The Department may reallocate projected unspent funds awarded to a county to another county as needed during the fiscal year in order to address any unmet county funding needs as determined under § 13–1107 of this subtitle.

§13–1109.

(a) Except as provided in § 13–1115(f) of this subtitle, this section does not apply to Baltimore City.

(b) (1) Subject to the other provisions of this section, a local health officer may apply to the Department for a Local Public Health Cancer Grant.

(2) The amount of a Local Public Health Cancer Grant shall be determined by the Department using the formula that is established under § 13–1108 of this subtitle.

(c) Before applying for a Local Public Health Cancer Grant, a local health officer shall:

(1) Establish a Community Health Coalition, as provided under § 13–1111 of this subtitle, or identify another coalition approved by the Department; and

(2) With the assistance of the coalition established or identified under item (1) of this subsection:

(i) Identify all existing cancer prevention, education, screening, and treatment programs that relate to targeted cancers in the county that are publicly funded;

(ii) Evaluate the effectiveness of the publicly funded programs identified under item (i) of this paragraph; and

(iii) Develop a Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment that outlines a strategy for meeting the cancer prevention, education, screening, and treatment goals and requirements established for the county under § 13–1108 of this subtitle.

(d) A Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment shall:

(1) Include a list of the members of the coalition established or identified under subsection (c)(1) of this section and their organizational affiliations;

(2) Include the evaluation of any program funded with a Local Public Health Cancer Grant in the prior year;

(3) Each year, after the first year of funding, demonstrate that progress has been made toward meeting the cancer prevention, education, screening, and treatment goals established for the county under § 13–1108 of this subtitle;

(4) Include a budget plan that provides specific levels of funding for each initiative described in the Plan and an explanation as to how each initiative is

expected to help meet the cancer prevention, education, screening, and treatment goals and requirements established for the county under § 13–1108 of this subtitle;

(5) Demonstrate that the county has met the base–year funding requirement established under § 13–1112 of this subtitle;

(6) Demonstrate that any early detection or screening program that is or will be funded under a Local Public Health Cancer Grant provides necessary treatment or linkages to necessary treatment for uninsured individuals who are diagnosed with a targeted or non–targeted cancer as a result of the screening process;

(7) Each year, after the first year of funding, identify all persons who received money under a Local Public Health Cancer Grant in the prior year and state the amount of money that was received by each person under the Grant;

(8) Each year, after the first year of funding, state the amount of money that was received by a county under a Local Public Health Cancer Grant in the prior fiscal year that remained unspent and unobligated at the end of that year;

(9) Describe how the Plan will help to eliminate the greater incidence of and higher morbidity rates for cancer in minority populations and rural areas, with particular emphasis on how the Plan seeks to address the relevant findings and recommendations of the Task Force Report;

(10) Describe how the Plan will help to increase availability of and access to health care services for uninsured and underinsured individuals and medically underserved populations, with particular emphasis on how the Plan seeks to address the relevant findings and recommendations of the Task Force Report;

(11) Demonstrate that priority consideration was given to persons, including federally qualified health centers, that have demonstrated a commitment to providing cancer prevention, education, screening, and treatment services to uninsured and underinsured individuals in the county and a proven ability to do so; and

(12) Contain any data or other information required by the Department.

(e) A local health officer who seeks to obtain a Local Public Health Cancer Grant shall apply to the Department by submitting a copy of the county's Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment for approval.

(f) Each year, a local health officer, in consultation with the coalition established or identified under subsection (c)(1) of this section, shall update the Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment.

(g) (1) The Department may designate a person other than the head of a county health department to coordinate a county's cancer prevention, education, screening, and treatment efforts if:

(i) The county health department is unwilling to coordinate these efforts;

(ii) The county health department has been unsuccessful in implementing cancer prevention, education, screening, and treatment initiatives that satisfy performance standards established by the Department; or

(iii) The county health department lacks sufficient staff or resources to coordinate these efforts.

(2) Subject to paragraph (3) of this subsection, the Department shall establish procedures for making a designation under this subsection.

(3) If the Department determines that it is necessary to designate a person other than the local health officer to coordinate a county's cancer prevention, education, screening, and treatment efforts, the Department may designate the Department as the entity that will coordinate the county's efforts.

§13–1110.

(a) The local health officers of two or more counties may join together as a region to apply for a Local Public Health Cancer Grant.

(b) The Department may require that two or more counties join together as a region to apply for a Local Public Health Cancer Grant if the Department determines that:

(1) It would be cost–effective to fund cancer prevention, education, screening, and treatment programs for targeted cancers on a regional basis; and

(2) It would serve the public health interests of the counties to fund cancer prevention, education, screening, and treatment programs for targeted cancers on a regional basis.

(c) The amount of a Local Public Health Cancer Grant that is distributed to a region under this section shall be equal to the sum of the Local Public Health

Cancer Grants that otherwise would have been distributed to each county under the formula established under § 13–1108 of this subtitle.

(d) If the local health officers of two or more counties choose to join together as a region to apply for a Local Public Health Cancer Grant or are required to do so by the Department, the local health officers shall act jointly to:

(1) Develop a Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment, as required under § 13–1109(c) of this subtitle;

(2) Establish a Community Health Coalition, as provided under § 13–1111 of this subtitle, or identify another coalition approved by the Department;

(3) Demonstrate that the base–year funding requirement established under § 13–1112 of this subtitle has been met; and

(4) Otherwise satisfy the requirements of §§ 13–1107 through 13–1113 of this subtitle.

§13–1111.

(a) (1) The membership of a Community Health Coalition established under § 13-1109(c) of this subtitle shall:

(i) Reflect the demographics of the county; and

(ii) Include representatives of community-based groups, including minority, rural, and medically underserved populations, that, taken together, are familiar with all of the different communities and cultures in the county.

(2) (i) In addition to the requirements of paragraph (1) of this subsection, in Baltimore City and in Baltimore, Montgomery, and Prince George's counties, the Community Health Coalition shall include representatives of the major community hospitals that treat county residents with targeted cancers.

(ii) In Baltimore, Montgomery, and Prince George's counties, the local health officer, in consultation with the Department, shall determine whether a hospital is a major community hospital based on the following factors:

1. The number of county residents with targeted cancers who are served by the hospital;

2. Whether the hospital has special expertise in treating targeted cancers;

3. Whether the hospital has demonstrated a commitment to treating uninsured individuals; and

4. The number of research activities conducted by the hospital that relate to targeted cancers and the amount of funding for these activities.

(iii) In Baltimore City, the University of Maryland Medical Group and the Johns Hopkins Institutions, acting jointly in collaboration with the Baltimore City Health Department, in consultation with the Department, shall determine whether a hospital is a major community hospital based on the factors listed under subparagraph (ii) of this paragraph.

(b) The membership of a Community Health Coalition established under § 13–1109(c) of this subtitle may include:

(1) Representatives of:

(i) A local management board established under Title 8, Subtitle 3 of the Human Services Article;

(ii) Local hospitals, clinics, physicians, and other health care providers;

(iii) Local religious organizations;

(iv) Institutions of higher education; and

(v) Hospitals and other entities located outside the county that could enhance the county's cancer prevention, education, screening, and treatment efforts; and

(2) Any other person that the local health officer believes would help the county meet the cancer prevention, education, screening, and treatment goals and requirements established for the county under § 13–1108 of this subtitle.

§13–1112.

(a) Except as provided in § 13-1115(f) of this subtitle, this section does not apply in Baltimore City.

(b) (1) Before receiving a Local Public Health Cancer Grant, a local health officer shall submit to the Department an inventory of all existing publicly funded cancer prevention, education, screening, and treatment programs that relate

to targeted cancers in the county that were identified under § 13-1109(c) of this subtitle.

(2) The inventory shall specify the amount of county funds that are being spent on each of the programs included in the inventory.

(c) The level of funding specified under subsection (b)(2) of this section shall be the county's base-year funding for cancer prevention, education, screening, and treatment programs that relate to targeted cancers.

(d) A Local Public Health Cancer Grant may not be used to supplant a county's base-year funding for cancer prevention, education, screening, and treatment programs that relate to targeted cancers.

(e) The Department may not distribute a Local Public Health Cancer Grant to a county unless the Department determines that the county will spend, in the applicable fiscal year, at least its base-year funding for cancer prevention, education, screening, and treatment programs that relate to targeted cancers.

§13–1113.

(a) The Department shall review a Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment submitted under § 13-1109(e) of this subtitle and determine whether:

(1) The Plan addresses the goals and requirements established for the county under § 13-1108 of this subtitle; and

(2) All other requirements of §§ 13-1107 through 13-1112 of this subtitle have been met.

(b) The Department may not distribute a county's share of money for a Local Public Health Cancer Grant, as provided under § 13-1108 of this subtitle, if the Department determines that the requirements of subsection (a) of this section have not been met.

§13–1114.

(a) There is a Statewide Academic Health Center Component in the Program.

(b) The purpose of the Statewide Academic Health Center Component is to maximize the effectiveness of the Program by involving the University of Maryland

Medical Group and the Johns Hopkins Institutions in the implementation of the Program.

(c) Subject to §§ 13–1115 and 13–1116 of this subtitle, the Department may implement the Statewide Academic Health Center Component by distributing:

(1) Statewide Academic Health Center Public Health Grants, as provided under § 13–1115 of this subtitle; and

(2) Statewide Academic Health Center Cancer Research Grants, as provided under § 13–1116 of this subtitle.

(d) The University of Maryland Medical Group and the Johns Hopkins Institutions shall coordinate their efforts with regard to initiatives that are funded with grants that are distributed under the Statewide Academic Health Center Component to maximize the benefits received from the use of these grant funds and to eliminate unnecessary duplication of efforts.

§13–1115.

(a) (1) Subject to the other provisions of this section, the University of Maryland Medical Group and the Johns Hopkins Institutions may each apply for a Statewide Academic Health Center Public Health Grant.

(2) For fiscal year 2007 and any subsequent fiscal year, the amount of each Statewide Academic Health Center Public Health Grant that is distributed to the University of Maryland Medical Group or the Johns Hopkins Institutions, respectively, shall be equal to the sum of:

(i) At least 9.5% of the total local public health component money distributed under § 13–1108(b) of this subtitle; and

(ii) One–half of any money that is transferred from the Local Public Health Component to the Statewide Academic Health Center Component under § 13–1108(c) of this subtitle.

(b) Before applying for a Statewide Academic Health Center Public Health Grant, the University of Maryland Medical Group and the Johns Hopkins Institutions, acting jointly in collaboration with the Baltimore City Health Department, shall:

(1) Establish a Baltimore City Community Health Coalition, as provided under § 13–1111 of this subtitle, or identify another coalition approved by the Department that reflects the demographics of Baltimore City and includes

representatives of community–based groups, including minority and medically underserved populations, that, taken together, are familiar with all of the different communities and cultures in Baltimore City; and

(2) With the assistance of the coalition established or identified under item (1) of this subsection:

(i) Identify all existing cancer prevention, education, screening, and treatment programs that relate to targeted cancers in Baltimore City that are publicly funded;

(ii) Evaluate the effectiveness of the publicly funded programs identified under item (i) of this paragraph; and

(iii) Develop a Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment that outlines a strategy for meeting the cancer prevention, education, screening, and treatment goals and requirements established for Baltimore City under § 13–1108 of this subtitle.

(c) The Baltimore City Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment shall:

(1) Include a list of the members of the coalition established or identified under subsection (b)(1) of this section and their organizational affiliations;

(2) Include the evaluation of any program funded with a Statewide Academic Health Center Public Health Grant in the prior year;

(3) Each year, after the first year of funding, demonstrate that progress has been made toward meeting the cancer prevention, education, screening, and treatment goals established for Baltimore City under § 13–1108 of this subtitle;

(4) Include a budget plan that provides specific levels of funding for each initiative described in the Plan and an explanation as to how each initiative is expected to help meet the cancer prevention, education, screening, and treatment goals and requirements established for Baltimore City under § 13–1108 of this subtitle;

(5) Demonstrate that Baltimore City has met the base–year funding requirement established under subsection (h) of this section;

(6) Demonstrate that any early detection or screening program that is or will be funded under a Statewide Academic Health Center Public Health Grant provides necessary treatment or linkages to necessary treatment for uninsured

individuals who are diagnosed with a targeted and non–targeted cancer as a result of the screening process;

(7) State that the Statewide Academic Health Center Public Health Grant will not be used to supplant any existing funding at the University of Maryland Medical Group or the Johns Hopkins Institutions for any cancer prevention, education, screening, or treatment programs that relate to targeted cancers;

(8) Each year, after the first year of funding, identify all persons who received money under the Statewide Academic Health Center Public Health Grant in the prior year and state the amount of money that was received by each person under the Grant;

(9) Each year, after the first year of funding, state the amount of money that was received by the University of Maryland Medical Group and the Johns Hopkins Institutions under a Statewide Academic Health Center Public Health Grant in the prior fiscal year that remained unspent and unobligated at the end of that year;

(10) Describe how the Plan will help to eliminate the greater incidence of and higher morbidity rates for cancer in minority populations, with particular emphasis on how the Plan seeks to address the relevant findings and recommendations of the Task Force Report;

(11) Describe how the Plan will help to increase availability of and access to health care services for uninsured and underinsured individuals and medically underserved populations, with particular emphasis on how the Plan seeks to address the relevant findings and recommendations of the Task Force Report;

(12) Demonstrate that priority consideration was given to persons, including federally qualified health centers, that have a demonstrated commitment to providing cancer prevention, education, screening, and treatment services to uninsured and underinsured individuals in the city and a proven ability to do so; and

(13) Contain any data or other information required by the Department.

(d) To apply for a Statewide Academic Health Center Public Health Grant, the University of Maryland Medical Group and the Johns Hopkins Institutions shall submit to the Department a copy of Baltimore City's Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment for approval.

(e) Each year, the University of Maryland Medical Group and the Johns Hopkins Institutions, acting jointly in collaboration with the Baltimore City Health

Department, in consultation with the coalition established or identified under subsection (b)(1) of this section, shall update the Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment.

(f) (1) Rather than distributing a Statewide Academic Health Center Public Health Grant to the University of Maryland Medical Group or the Johns Hopkins Institutions under this section, the Department may distribute to the Baltimore City Health Department or another person designated by the Department a Local Public Health Cancer Grant for the purpose of coordinating Baltimore City's cancer prevention, education, screening, and treatment efforts if:

(i) The University of Maryland Medical Group or the Johns Hopkins Institutions are unwilling to coordinate these efforts;

(ii) The University of Maryland Medical Group or the Johns Hopkins Institutions have been unsuccessful in implementing cancer prevention, education, screening, and treatment initiatives that satisfy performance standards established by the Department; or

(iii) The University of Maryland Medical Group or the Johns Hopkins Institutions lack sufficient staff or resources to coordinate these efforts.

(2) If the Department distributes a Local Public Health Cancer Grant to the Baltimore City Health Department or another person designated by the Department under this subsection rather than distributing a Statewide Academic Health Center Public Health Grant to the University of Maryland Medical Group, the amount of the Grant shall equal the sum of:

(i) $2,000,000; and

(ii) One–half of any money that is transferred from the Local Public Health Component to the Statewide Academic Health Center Component under § 13–1108(c) of this subtitle.

(3) If the Department distributes a Local Public Health Cancer Grant to the Baltimore City Health Department or another person designated by the Department under this subsection rather than distributing a Statewide Academic Health Center Public Health Grant to the Johns Hopkins Institutions, the amount of the Grant shall equal the sum of:

(i) $2,000,000; and

(ii) One–half of any money that is transferred from the Local Public Health Component to the Statewide Academic Health Center Component under § 13–1108(c) of this subtitle.

(4) The Department shall use money that is allocated to the Statewide Academic Health Center Component in the State budget or transferred to the Statewide Academic Health Center Component under § 13–1108(c) of this subtitle to fund a Local Public Health Cancer Grant that is distributed to the Baltimore City Health Department or another person designated by the Department under this subsection.

(5) If the Baltimore City Health Department or another person designated by the Department applies for a Local Public Health Cancer Grant as authorized under this subsection, the Baltimore City Health Department or other person shall comply with the requirements of §§ 13–1107 through 13–1113 of this subtitle.

(6) Subject to paragraph (7) of this subsection, the Department shall establish procedures for making a designation under this subsection.

(7) If the Department determines that it is necessary to designate a person other than the Baltimore City Health Department to coordinate the city's cancer prevention, education, screening, and treatment efforts as authorized under this subsection, the Department may designate the Department as the entity that will coordinate the city's efforts.

(g) (1) (i) Before the University of Maryland Medical Group or the Johns Hopkins Institutions may receive a Statewide Academic Health Center Public Health Grant, the Baltimore City Health Department shall submit to the Department an inventory of all existing publicly funded cancer prevention, education, screening, and treatment programs that relate to targeted cancers in Baltimore City that are identified under subsection (b) of this section.

(ii) The inventory prepared under subparagraph (i) of this paragraph shall specify the amount of funds that are being spent by Baltimore City on each of the programs included in the inventory.

(2) The level of funding specified under paragraph (1)(ii) of this subsection shall be Baltimore City's base–year funding for cancer prevention, education, screening, and treatment programs that relate to targeted cancers.

(3) A Statewide Academic Health Center Public Health Grant may not be used to supplant:

(i) Baltimore City's base–year funding for cancer prevention, education, screening, and treatment programs that relate to targeted cancers; or

(ii) Any existing funding at the University of Maryland Medical Group or the Johns Hopkins Institutions for cancer prevention, education, screening, and treatment programs that relate to targeted cancers.

(h) (1) Subject to paragraph (2) of this subsection, the Department may not distribute a Statewide Academic Health Center Public Health Grant under this section until after the Baseline Cancer Study has been completed.

(2) Before the Baseline Cancer Study is completed, the Department may use money that is allocated to the Statewide Academic Health Center Component in the State budget to fund a planning grant of not more than $10,000 that may be distributed to and used collectively by the University of Maryland Medical Group, the Johns Hopkins Institutions, and the Baltimore City Health Department.

(i) (1) The Department shall review a Comprehensive Plan for Cancer Prevention, Education, Screening, and Treatment submitted under this section and determine whether:

(i) The Plan addresses the goals and requirements established for Baltimore City under § 13–1108 of this subtitle; and

(ii) All other requirements of this section have been met.

(2) If the Department determines that the requirements of this section have not been met, the Department may not distribute:

(i) A Statewide Academic Health Center Public Health Grant to the University of Maryland Medical Group or the Johns Hopkins Institutions; or

(ii) A Local Public Health Cancer Grant to the Baltimore City Health Department or another person designated by the Department under subsection (f) of this section.

§13–1116.

(a) (1) (i) For each of fiscal years 2011 and 2012:

1. The Governor shall include at least $2,400,000 in the annual budget in appropriations for the Statewide Academic Health Center Cancer Research Grants under this section; and

2. The Grants shall be distributed between the Statewide Academic Health Centers as follows:

A. $2,007,300 to the University of Maryland Medical Group; and

B. $392,700 to the Johns Hopkins Institutions.

(ii) For fiscal year 2013 and each fiscal year thereafter:

1. The Governor shall include at least $13,000,000 in the annual budget in appropriations for the Statewide Academic Health Center Cancer Research Grants under this section; and

2. The Grants shall be distributed according to historical allocations between the Academic Health Centers.

(2) Subject to the other provisions of this section, the Department may distribute Statewide Academic Health Center Cancer Research Grants to the University of Maryland Medical Group and the Johns Hopkins Institutions for the purpose of enhancing cancer research activities that may lead to a cure for a targeted cancer and increasing the rate at which cancer research activities are translated into treatment protocols in the State.

(b) Before receiving a Statewide Academic Health Center Cancer Research Grant, an institution shall:

(1) Submit a Cancer Research Plan that:

(i) Provides a detailed plan as to how the Statewide Academic Health Center Cancer Research Grant will be spent and how it will be used to meet the goals established by the Department;

(ii) Provides a complete inventory of all cancer research activities relating to targeted cancers that are currently being conducted by the institution, including a breakdown of the types of cancer to which the research relates;

(iii) Specifies the source and amount of funding for all of the cancer research activities identified under item (ii) of this paragraph;

(iv) Certifies that the cancer research activities that will be funded by the Statewide Academic Health Center Cancer Research Grant have been

endorsed by an independent peer review group that is comprised of experts in the field from outside the institution who will not be involved in the research;

(v) Identifies the individuals who make up the independent peer review group; and

(vi) Includes any other information that is requested by the Department; and

(2) Enter into a memorandum of understanding with the Maryland Department of Health, the Department of Commerce, and the Maryland Technology Development Corporation that:

(i) Establishes the scope of the State's ownership or other financial interest in the commercialization and other benefits of the results, products, inventions, and discoveries of cancer research activities funded by a Statewide Academic Health Center Cancer Research Grant;

(ii) Establishes a plan for expediting the translation of cancer research activities into treatment protocols and clinical trials; and

(iii) To the extent consistent with federal and State law, reflects the intellectual property policies of the Statewide Academic Health Center.

(c) A memorandum of understanding established under subsection (b)(2) of this section may allow for the selection of a higher education institution or private entity to expedite the translation of cancer research activities into treatment protocols and clinical trials.

(d) The Department may not distribute a Statewide Academic Health Center Cancer Research Grant unless the Department first determines that:

(1) A Cancer Research Plan will help achieve the purpose of the Program;

(2) The institution that receives the Grant will not use any part of the Grant to supplant existing cancer research activities or any other type of current expenditure by the institution;

(3) The Grant will be used to fund cancer research activities that relate to targeted cancers;

(4) The institution has executed a memorandum of understanding as required by subsection (b)(2) of this section; and

(5) The institution satisfies any other requirement established by the Department as a condition of receiving the Grant.

§13–1119.

(a) There is an Administrative Component in the Program.

(b) The purpose of the Administrative Component is to provide the necessary administrative structure in the Department for effective management of the Program.

(c) Funds that are allocated to the Administrative Component in the State budget shall be used to cover administrative costs incurred by the Department in administering the Program.

(d) Unless otherwise specified in the annual budget bill as enacted, the amount of funds that are allocated to the Administrative Component in the State budget may not exceed 7% of the total amount that is allocated to the Program in the State budget.

(e) A county that receives funds under a Local Public Health Cancer Grant, a person who receives funds under a Local Public Health Cancer Grant, a Statewide Academic Health Center that receives money under any of the grants distributed under the Statewide Academic Health Component, and any other person who receives funds under the Program may not use more than 7% of the funds to cover administrative costs.

§13–11A–01.IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2031 PER CHAPTERS 812 AND 813 OF 2024 //

(a) The Department shall develop and implement a 3–year public education campaign on prostate, lung, and breast cancer prevention that targets communities disproportionately impacted by prostate, lung, and breast cancer.

(b) In developing the public education campaign, the Department shall work with:

(1) Health care providers, including licensed physicians, who treat individuals impacted by prostate, lung, and breast cancer;

(2) Hospitals; and

(3) Health care associations that focus on prostate, lung, and breast cancer.

(c) The public education campaign shall:

(1) Provide educational information on prostate, lung, and breast cancer, including information regarding:

(i) The risks and warning signs of prostate, lung, and breast cancer; and

(ii) Guidelines and best practices to prevent prostate, lung, and breast cancer;

(2) Promote screenings for prostate, lung, and breast cancer; and

(3) Provide information on legislation that reduces cost barriers to prevention services for prostate, lung, and breast cancer.

(d) To implement the public education campaign, the Department shall:

(1) Use communications tools and messaging;

(2) Post all materials on the Department's website in a conspicuous manner and an accessible format; and

(3) Develop partnerships with health agencies, nonprofit organizations, and private entities that work with communities disproportionately impacted by prostate, lung, and breast cancer.

(e) The Department shall:

(1) Develop the public education campaign on or before December 1, 2026;

(2) Implement the public education campaign on or before January 1, 2027; and

(3) Set measurable goals for the public education campaign.

(f) (1) For each of fiscal years 2026, 2027, 2028, 2029, and 2030, the Governor shall include in the annual budget bill an appropriation to the Department

for the public education campaign from the Cigarette Restitution Fund established under § 7–317 of the State Finance and Procurement Article.

(2) The total appropriation for fiscal years 2026 through 2030 shall be not more than $750,000.

§13–1201.

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

(b) "Data use agreement" means an agreement between the Department and a national, State, or local agency or program that establishes the terms and conditions for the confidential submission, collection, storage, analysis, reporting, aggregation, and dissemination of de–identified data obtained from the Maternal Mortality Review Program.

(c) "Local team" means the multidisciplinary and multiagency maternal mortality review team established for a county.

(d) "Maternal death" means the death of a woman during pregnancy or within 1 year after the woman ceases to be pregnant.

(e) "Maternal mortality review committee" means the maternal mortality review committee of MedChi that is a medical review committee, as defined under § 1–401 of the Health Occupations Article.

(f) "MedChi" means the Maryland State Medical Society.

§13–1202.

The General Assembly finds that:

(1) Maternal deaths are a serious public health concern and have a tremendous family and societal impact;

(2) Maternal deaths are significantly underestimated and inadequately documented, preventing efforts to identify and reduce or eliminate the causes of death;

(3) No processes exist in the State for the confidential identification, investigation, or dissemination of findings regarding maternal deaths; and

(4) There is a need to establish a Maternal Mortality Review Program to review maternal deaths and to develop strategies for the prevention of maternal deaths.

§13–1203.

The Secretary shall establish a Maternal Mortality Review Program to review maternal deaths and to develop strategies for the prevention of maternal deaths.

§13–1204.

(a) The Secretary may contract with MedChi to administer the Maternal Mortality Review Program.

(b) In consultation with the maternal mortality review committee of MedChi, the Secretary shall develop a system to:

(1) Identify maternal death cases;

(2) Review medical records and other relevant data;

(3) Contact family members and other affected or involved persons to collect additional relevant data;

(4) Consult with relevant experts to evaluate the records and data collected;

(5) Make determinations regarding the preventability of maternal deaths;

(6) Develop recommendations for the prevention of maternal deaths; and

(7) Disseminate findings and recommendations to policy makers, health care providers, health care facilities, and the general public.

(c) On the approval of the Secretary and with a signed data use agreement, the Department may release de–identified data and findings to the Centers for Disease Control and Prevention, local maternal mortality review teams, and other entities at the discretion of the Secretary.

(d) In accordance with § 4–221 of this article and notwithstanding § 4–224 of this article, the Secretary shall provide the Program with:

(1) Information on maternal death cases when the records become available, including a copy of the death certificate; and

(2) Medical information from the birth or fetal death record for any pregnancy that occurred within 1 year before the death of the woman, excluding Social Security numbers, addresses, and names of the infants.

(e) On the request of the Secretary, the Program shall be provided access, to the extent allowed by law, to all information and records maintained by a State or local government agency, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to a woman whose death is being reviewed by the Program.

(f) The Maternal Mortality Review Program, in consultation with the Office of Minority Health and Health Disparities, shall make recommendations to reduce any disparities in the maternal mortality rate including recommendations related to social determinants of health.

§13–1205.

(a) A health care provider or health care facility, as defined under Title 19, Subtitles 3, 3A, and 3B of this article, shall provide the Maternal Mortality Review Program reasonable access to all relevant medical records associated with a case under review by the Maternal Mortality Review Program.

(b) A health care provider or health care facility, as defined under Title 19, Subtitles 3, 3A, and 3B of this article, shall provide to the local team, on request of the chair, prompt access to all relevant medical records associated with a case under review by the Maternal Mortality Review Program without undue delay.

(c) The provisions of Title 4, Subtitle 3 of this article do not apply to a disclosure made to the Program or to a local team under this subtitle.

§13–1206.

(a) Notwithstanding the provisions of Title 4, Subtitle 3 of this article, if a patient of a health care provider or a health care facility dies of a maternal death and the health care provider or the health care facility has knowledge of the circumstances of the death, the health care provider or the health care facility shall report the death to the Maternal Mortality Review Program.

(b) Any health care provider and health care facility report required under this section shall be:

(1) Confidential;

(2) Not open to public inspection; and

(3) Except under a court order sealing the court record, not subject to subpoena or discovery in any criminal or civil proceeding.

(c) A health care provider or health care facility may not be held liable for civil damages or subject to any criminal or disciplinary action for good faith efforts made to comply with the provisions of this subtitle.

§13–1207.

(a) (1) Subject to paragraph (2) of this subsection, there may be a multidisciplinary and multiagency maternal mortality review team in each county.

(2) (i) Two or more counties may agree to establish a single multicounty local team.

(ii) A multicounty local team shall execute a memorandum of understanding on membership, staffing, and operation.

(b) If a local team is established in a county, the local team:

(1) Shall be convened by the local health officer; and

(2) May include representatives from other local agencies and local organizations, licensed health care providers with expertise in maternal child health, and other individuals necessary to the work of the local team, recommended by the local team, and designated by the local health officer.

(c) From among its members, each local team shall elect a chair by majority vote.

§13–1208.

(a) The purpose of a local team is to prevent maternal deaths by:

(1) Promoting cooperation and coordination among agencies involved in preventing and responding to maternal deaths or in providing services to surviving family members;

(2) Developing an understanding of the causes and incidence of maternal deaths in the county;

(3) Developing plans for and recommending changes within the community, local institutions, and agencies the members represent to prevent maternal deaths; and

(4) Advising the Maternal Mortality Review Program on changes to law, policy, or practice to prevent maternal deaths.

(b) To achieve its purpose, a local team shall:

(1) In consultation with the Maternal Mortality Review Program, establish and implement a protocol for the local team;

(2) Meet at least annually to review the status of maternal fatality cases, recommend actions to improve coordination of services in the community, and recommend actions within local institutions and member agencies to prevent maternal deaths;

(3) Enter into a data use agreement with the Department for the receipt of information from the Maternal Mortality Review Program necessary to carry out the local team's purpose and duties; and

(4) Provide reports to the Maternal Mortality Review Program, including:

(i) Information on, and local team discussions related to, individual cases;

(ii) Any racial disparities observed during case review;

(iii) Steps taken to improve coordination of services and investigations;

(iv) Steps taken to implement changes recommended by the local team within member agencies; and

(v) Recommendations on necessary changes to State and local law, policy, and practice to prevent maternal deaths.

§13–1209.

On request of the chair of the local team and as necessary to carry out the local team's purpose and duties, the local team shall be provided:

(1) Access to all relevant information and records in accordance with the local team's data use agreement with the Department; and

(2) Access, to the extent allowed by law, to all information and records maintained by any State or local government agency, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency that provided services to a woman whose death is being reviewed by the local team.

§13–1210.

(a) A meeting of a local team shall be closed to the public and not subject to Title 3 of the General Provisions Article when a local team is discussing individual cases of maternal deaths.

(b) Subject to subsection (c) of this section, a meeting of a local team shall be open to the public and subject to Title 3 of the General Provisions Article when the local team is not discussing individual cases of maternal deaths.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased woman; or

(ii) A family member, guardian, or caretaker of a deceased woman.

(2) During a public meeting, information may not be disclosed regarding the involvement of any agency with:

(i) A deceased woman; or

(ii) A family member, guardian, or caretaker of a deceased woman.

(d) This section does not prohibit a local team from requesting the attendance at a team meeting of an individual who has information relevant to the team's performance of its purpose and duties.

(e) A violation of this section is a misdemeanor and is punishable by a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§13–1211.

(a) Except as otherwise provided in this section, the proceedings, records, and files of a local team are confidential and privileged, and are not discoverable or admissible as evidence in any civil or criminal proceeding.

(b) Statistical compilations of data that do not contain any information that would cause the identification of any person to be ascertained are public records.

(c) Reports of a local team that do not contain any information that would cause the identification of any person to be ascertained are public information.

(d) A member of a team and an individual attending a team meeting may not disclose what transpired at a meeting that is not public under § 13–1210 of this subtitle or any information the disclosure of which is prohibited by this section.

(e) (1) Subject to paragraph (2) of this subsection, a member of a team, an individual attending a team meeting, and an individual who presents information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting.

(2) Paragraph (1) of this subsection does not prohibit an individual from testifying to information obtained independently of the team or that is public information.

§13–1212.

(a) On or before December 1 of each year, the Secretary shall submit a report on findings, recommendations, and Program actions to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly.

(b) The Secretary shall include in the report required under subsection (a) of this section:

(1) A summary of any stakeholder meetings held under § 13–1213 of this subtitle during the immediately preceding 12–month period that includes:

(i) Stakeholder responses to existing recommendations; and

(ii) Recommendations from stakeholders that address factors contributing to maternal mortality; and

(2) A section on racial disparities that includes:

(i) A comparison of the maternal mortality rates of non–Hispanic black and non–Hispanic white women;

(ii) Data on changes in the maternal mortality rate by race and ethnicity;

(iii) The number of live births by race;

(iv) The percentage of women who gave birth by race;

(v) The percentage of maternal deaths by race and ethnicity;

(vi) The maternal mortality rate by race;

(vii) A comparison of the leading causes of maternal death by race; and

(viii) Any other information that the Secretary determines necessary to carry out the purposes of this subtitle.

§13–1213.

(a) (1) Subject to paragraph (2) of this subsection, at least twice a year, the Secretary shall convene a meeting of stakeholders, including:

(i) Representatives of:

1. The Maryland Office of Minority Health and Health Disparities;

2. The Maryland Patient Safety Center;

3. The Maryland Healthy Start Program;

4. Women's health advocacy organizations;

5. Community organizations engaged in maternal health and family support issues;

6. Local health departments; and

7. Health care providers that provide maternal health services; and

(ii) 1. Families of women who have experienced a near maternal death, a high–risk pregnancy, other challenges during pregnancy, or a maternal death; or

2. Women who have experienced a near maternal death, a high–risk pregnancy, or other challenges during pregnancy.

(2) To the extent practicable, the stakeholders convened in accordance with paragraph (1) of this subsection shall reflect the racial and ethnic diversity of women most impacted by maternal deaths in the State.

(b) Of the two meetings required under subsection (a) of this section:

(1) One meeting shall be held within 90 days after submission of the report required under § 13–1212 of this subtitle to:

(i) Review the findings and recommendations in the report;

(ii) Examine issues resulting in disparities in maternal deaths;

(iii) Review the status of implementation of previous recommendations; and

(iv) Identify new recommendations with a focus on initiatives to address issues resulting in disparities in maternal deaths; and

(2) One meeting shall be held within 6 months after the meeting held under item (1) of this subsection to review the status of implementation of previous recommendations and consider any new information that may be relevant for the identification of additional recommendations.

§13–1301.

(a) There is a Governor's Wellmobile Program within the University of Maryland School of Nursing.

(b) The purpose of the Program is to:

(1) Deliver primary and preventive health care services to geographically underserved communities and uninsured individuals around the State; and

(2) Provide principal training sites for the University of Maryland School of Nursing that will expand student learning opportunities in the care of underserved populations.

(c) The Program shall be operated, managed, and administered by the University of Maryland School of Nursing.

(d) The operation, management, and administration of the Program shall be funded as provided for in the State budget.

§13–1302.

(a) (1) There is a Governor's Wellmobile Program Advisory Board.

(2) The purpose of the Advisory Board is to assist the University of Maryland School of Nursing in overseeing and raising funds for the Program.

(b) The Advisory Board consists of nine individuals, of whom:

(1) One shall be the Dean of the University of Maryland School of Nursing;

(2) One shall be a member of the House of Delegates appointed by the Speaker;

(3) One shall be a member of the Senate appointed by the President;

(4) Two shall have business expertise;

(5) Two shall have health expertise; and

(6) Two shall have media or marketing expertise.

(c) Except for the ex officio and legislative members, the members of the Advisory Board shall be appointed by the Governor with the advice and consent of the Senate.

(d) The Dean of the University of Maryland School of Nursing shall serve as the chairman of the Advisory Board.

(e) (1) Except for the ex officio and legislative members, the term of a member is 3 years.

(2) Except for the ex officio and legislative members, the terms of members are staggered as required by the terms provided for members of the Board on October 1, 2000.

(3) At the end of a term, a member continues to serve until a successor is appointed.

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

(f) The Board shall meet at least four times each year, at the times and places that it determines.

§13–1303.

(a) The University of Maryland School of Nursing and the Advisory Board shall ensure that the following geographic areas are served by the Program:

(1) Western Maryland;

(2) The Washington metropolitan area;

(3) The Baltimore metropolitan area;

(4) Southern/Central Maryland;

(5) The upper Eastern Shore; and

(6) The lower Eastern Shore.

(b) The University of Maryland School of Nursing and the Advisory Board shall:

(1) Develop partnerships with local health departments, hospitals, schools, community associations, businesses, and other entities that can facilitate the provision of primary and preventive health care services through the Program;

(2) Solicit public and private grants and donations on behalf of the Program; and

(3) Develop a mechanism for receiving third party reimbursement.

(c) The University of Maryland, Baltimore Campus may establish a nonprofit corporation to accept any public and private grants or donations made to the Program.

(d) The accounts and transactions of the Governor's Wellmobile Program shall be subject to audit by the Legislative Auditor in accordance with §§ 2–1220 through 2–1227 of the State Government Article.

§13–1501.

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

(b) "Advisory Council" means the Children's Environmental Health and Protection Advisory Council.

(c) "Environmental hazard" means one or a group of toxic chemical, biological, or physical agents in the environment, resulting from human activities or natural processes, that may impact the health of exposed children, including such pollutants as lead, pesticides, air pollutants, contaminated drinking water, polluted waters, toxic waste, polychlorinated biphenyls, secondhand tobacco smoke, and industrial and home chemicals.

§13–1502.

(a) The General Assembly finds that:

(1) Children in the State face an array of preventable exposures to environmental hazards in their schools, homes, and communities;

(2) In certain cases children are at greater risk than adults for exposure to and possible illness from environmental hazards because children:

(i) Have a decreased ability to detoxify certain substances;

(ii) Have a greater sensitivity to environmental hazards during the stages of development and growth as a result of their immature body organs and tissues and immature immune systems;

(iii) Have different exposure behavior patterns, such as hand-to-mouth behavior, spending a greater amount of time outdoors near hazards, and spending more time on the floor and on the ground where contaminants can concentrate; and

(iv) Take in a greater amount of contaminants due to their eating proportionately more food, breathing proportionately more air, and drinking proportionately more fluids than adults;

(3) Higher rates of poverty are one of the factors that place children of ethnic and minority communities at disproportionate risk for environmental exposures, due to inadequate housing, poor nutrition, and limited access to health care;

(4) Solutions to complex environmental health problems require the ongoing communication, collaboration, and cooperation of affected communities and many disciplines including science, medicine, public health, economics, planning, law, and policy; and

(5) As recommended by the Advisory Council on Environmental Justice in its report pursuant to Chapter 741 of the Acts of the General Assembly of 1997, as amended, it is necessary to assess the impacts of State policies, programs, and activities on affected communities and, in this instance, children are the affected community.

(b) (1) The General Assembly recognizes its responsibilities:

(i) To enable all children to grow up in a safe and healthy environment; and

(ii) To use its resources to ensure that every child is provided with an environmentally safe and healthy learning environment in which to grow, develop, and mature into a productive and healthy adult.

(2) The General Assembly seeks to meet these responsibilities by creating an Advisory Council to:

(i) Identify environmental hazards that may affect children's health; and

(ii) Recommend solutions to those hazards through interdisciplinary problem solving and coalition building.

§13–1503.

There is a State Children's Environmental Health and Protection Advisory Council.

§13–1504.

(a) (1) The Advisory Council shall be composed of 19 members as follows:

(i) One member of the Senate of Maryland, appointed by the President of the Senate;

(ii) One member of the House of Delegates, appointed by the Speaker of the House;

(iii) The Secretary of Health, or the Secretary's designee;

(iv) The Secretary of the Environment, or the Secretary's designee;

(v) The Secretary of Agriculture, or the Secretary's designee;

(vi) The Secretary of Education, or the Secretary's designee;

(vii) The Secretary of Human Services, or the Secretary's designee;

(viii) The Secretary of Housing and Community Development, or the Secretary's designee;

(ix) The Special Secretary of the Governor's Office for Children, or the Special Secretary's designee;

(x) Two licensed health care providers with expertise in the field of children's environmental health, appointed by the Governor;

(xi) One representative from an academic institution who has expertise in studying the impact of environmental exposures on childhood disease, appointed by the Governor;

(xii) One parent or guardian whose child has been clinically diagnosed as having been exposed to environmental health hazards including lead paint or pesticides, appointed by the Governor;

(xiii) One epidemiologist with expertise in children's environmental health, appointed by the Governor;

(xiv) One economist skilled in measuring the economic costs of illness and the benefits of prevention, appointed by the Governor;

(xv) One environmental toxicologist with expertise in issues of importance to children's environmental health, appointed by the Governor;

(xvi) One representative from the Maryland Association of Counties, appointed by the Governor;

(xvii) One individual from private industry representing the regulated community, appointed by the Governor; and

(xviii) One representative from the Maryland Commission on Environmental Justice and Sustainable Communities, appointed by the Governor.

(2) The Secretary of Health or the Secretary's designee shall serve as the chairman.

(3) The Secretary of the Environment or the Secretary's designee shall serve as the vice chairman.

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

(2) The terms of the members are staggered as required by the terms provided for members of the Advisory Council on October 1, 2000.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

§13–1505.

(a) A majority of the full authorized membership of the Advisory Council is a quorum.

(b) The Advisory Council shall meet at least six times a year, at the times and places that it determines.

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

(d) (1) The Maryland Department of Health shall coordinate with the Department of the Environment and other State agencies to provide for staffing of the Advisory Council.

(2) The Advisory Council may employ consultants subject to the State budget.

(e) (1) The Advisory Council may contract for an analysis of the current State organizational structure regarding children's environmental health and protection.

(2) An analysis under this subsection shall be performed in a manner consistent with the recommendation of the Advisory Council on Environmental Justice contained in the Council's report dated November 1999.

§13–1506.

The Advisory Council shall:

(1) Review and comment on existing rules, regulations, and standards to ensure that the rules, regulations, and standards adequately protect the health of children from environmental hazards by taking into account the special vulnerability of children because of their developing physiology, and because their exposures, behaviors, and diets can differ greatly from those of adults;

(2) (i) Review proposed regulations submitted to the Advisory Council in accordance with § 10–110 of the State Government Article to determine if the proposed regulation:

1. Adequately protects the health of children from environmental hazards by taking into account the special vulnerability of children because of their developing physiology, and because their exposures, behaviors, and diets can differ greatly from those of adults; and

2. Is consistent and uniform with the children's environmental health policies, rules, regulations, and standards of other State agencies; and

(ii) Recommend to the promulgating unit measures that would avoid or minimize any negative impact that the proposed regulation may have on the health of children;

(3) Comment on any proposed regulations that may be submitted by any other principal department of the Executive Branch, as enumerated in § 8–201 of the State Government Article, during the public comment period required under § 10–112(a)(3)(v) of the State Government Article if the Advisory Council determines that the proposed regulation will have an adverse impact on children's health;

(4) Gather and disseminate information to the public, including the research and medical communities, community–based organizations, schools, and State agencies, on how to reduce, treat, and eliminate children's exposures to environmental hazards to further the public's understanding of the environmental hazards that may potentially affect children;

(5) Recommend uniform guidelines for State agencies to follow to help reduce and eliminate children's exposure to environmental hazards, especially in areas reasonably accessible to children;

(6) Create and promote education programs, in partnership with health and environmental professionals, for parents, guardians, and caregivers of children that include information on:

(i) The potential health effects of environmental hazards;

(ii) Practical suggestions on how to reduce children's exposure to environmental hazards; and

(iii) Any other relevant information to assist parents, guardians, and caregivers in protecting children from environmental hazards;

(7) Provide input to the General Assembly on legislation that may impact environmental hazards that affect the health of children; and

(8) Report to the Governor and, in accordance with § 2–1257 of the State Government Article, to the General Assembly on or before December 1, 2001 and each December 1 thereafter describing the activities of the Children's Environmental Health and Protection Advisory Council.

§13–1601.

There is a State Advisory Council on Serious Illness Care.

§13–1602.

(a) The Advisory Council consists of the following 23 members:

(1) The Attorney General or the Attorney General's designee;

(2) One member of the Senate of Maryland, appointed by the President of the Senate of Maryland;

(3) One member of the House of Delegates, appointed by the Speaker of the House;

(4) The Secretary of Aging or the Secretary's designee;

(5) The Secretary of Health or the Secretary's designee;

(6) The Secretary of Disabilities or the Secretary's designee; and

(7) 17 members appointed by the Governor:

(i) One physician with experience in end–of–life care;

(ii) One nurse with experience in end–of–life care;

(iii) One pharmacist with experience in end–of–life care;

(iv) One physician with experience managing long–term care;

(v) One nurse with experience managing long–term care;

(vi) One representative of the health insurance industry;

(vii) One representative from a managed care organization;

(viii) One representative of the legal community;

(ix) One representative from the hospice care community;

(x) Two representatives from advocacy groups for end–of–life care;

(xi) Two representatives from religious groups;

(xii) Two representatives of the general public with experience with end–of–life or long–term care issues;

(xiii) One representative of the hospital industry; and

(xiv) One representative of the nursing home industry.

(b) (1) The term of a member appointed by the Governor is 4 years.

(2) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(4) A member who serves two consecutive 4–year terms may not be reappointed for 4 years after the completion of those terms.

(5) If a vacancy occurs among the members appointed by the Governor, the Governor shall promptly appoint a successor.

§13–1603.

(a) The Governor shall appoint the chair of the Advisory Council.

(b) The members present at a meeting are a quorum to do business.

(c) The Advisory Council shall meet at least twice a year, at the times and places that it determines.

(d) A member of the Advisory Council may not receive compensation but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) The Department of Aging and the Office of the Attorney General shall jointly provide staff support and technical assistance for the Advisory Council.

§13–1604.

The Advisory Council shall:

(1) Monitor trends in the provision of care to Marylanders with life–limiting illnesses;

(2) Study the impact of State statutes, regulations, policies, and other aspects of public policy on the provision of care at the end of life;

(3) Provide recommendations to the Office of the Attorney General, the Department, the Department of Aging, and other agencies of State government with respect to their activities affecting the provision of care at the end of life;

(4) Advise the General Assembly on legislative proposals affecting the provision of care at the end of life;

(5) Participate in or otherwise promote public and professional educational efforts concerning care at the end of life; and

(6) Carry out other duties as may be requested by the Governor or the General Assembly.

§13–1701.

In this subtitle, "Program" means the Asthma Control Program.

§13–1702.

There is an Asthma Control Program in the Department.

§13–1703.

(a) The Secretary shall appoint a director for the Program.

(b) The director may establish advisory councils, task forces, committees, and work groups to the extent necessary to implement the Program.

§13–1704.

(a) The director shall:

(1) Establish a statewide asthma coalition composed of individuals and organizations with an interest in asthma;

(2) Develop and finalize a comprehensive statewide asthma plan;

(3) After finalization of the development of the statewide asthma plan, implement a statewide asthma intervention program;

(4) Develop and organize collaborative relationships with asthma control and stakeholders within other State and local agencies and in the private sector;

(5) Develop and implement an asthma surveillance system;

(6) Upon completion of the asthma surveillance system in paragraph (5) of this subsection, identify mechanisms for the utilization of surveillance data in identifying interventions to control asthma;

(7) Identify and promote educational programs for providers, parents, guardians, caregivers, and asthma patients that include information on identifying symptoms of asthma, effective treatment for asthma, and methods of preventing asthma; and

(8) Identify sources of grant funding for the Asthma Control Program.

(b) The Program may:

(1) Provide funding for local asthma intervention initiatives; and

(2) Provide training for school personnel, or other appropriate personnel, on asthma education in conjunction with the Department of Education and local health departments.

§13–1705.

(a) The Program shall be funded as provided in the State budget.

(b) The funding provided in the State budget for the Program is intended to complement funding received:

(1) By the Department from the Centers for Disease Control and Prevention for the Program for enhancing the State's capacity to address asthma from a public health perspective; and

(2) From any other lawful source.

§13–1706.

The Secretary shall, in consultation with the director, adopt rules and regulations necessary to implement the Program.

§13–17A–01.

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

(2) "Eligible household" means a household located in East Baltimore City that:

(i) Has a household income of not more than 150% of the federal poverty level; and

(ii) Includes an individual who is under the age of 14 years.

(3) "Pilot Program" means the Breathe Easy East Baltimore Pilot Program.

(b) (1) There is a Breathe Easy East Baltimore Pilot Program in the Baltimore City Health Department.

(2) The purpose of the Pilot Program is to provide and study the effects of asthma remediation services on eligible households.

(3) Asthma remediation services provided by the Pilot Program may include cleaning, education, structural interventions, and any other services the Baltimore City Health Department, in consultation with the Green and Healthy Homes Initiative, determines to be necessary.

(c) The Baltimore City Health Department, in consultation with the Green and Healthy Homes Initiative, shall:

(1) On or before July 1, 2020, select eligible households to participate in the Pilot Program;

(2) Provide participating eligible households with asthma remediation services; and

(3) Study the effect that asthma remediation services have on the well–being of members of participating eligible households by measuring, relative to individuals who do not receive asthma remediation services:

(i) Health outcomes;

(ii) Economic outcomes; and

(iii) Educational outcomes for children.

(d) In addition to the items listed in subsection (c) of this section, the Baltimore City Health Department may include in the Pilot Program, at the discretion of the Baltimore City Health Department:

(1) Implementation of policies and procedures to encourage participation in the Pilot Program; and

(2) Development of a referral process or integrated partnerships with other local or State agencies through which eligible households may access programs and services that target improved health.

(e) In addition to any other funds available for the Pilot Program, the Baltimore City Health Department shall attempt to access any federal funds related to asthma remediation services for households.

(f) (1) On or before December 1, 2024, the Baltimore City Health Department shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the Pilot Program.

(2) The report required under paragraph (1) of this subsection shall include:

(i) The number of eligible households participating in the Pilot Program;

(ii) Information regarding how the Pilot Program has affected the health, economic, and educational well–being of the members of participating eligible households; and

(iii) A recommendation on whether the Pilot Program should be extended or expanded.

§13–2001.

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

(b) "Federal regulations on the protection of human subjects" means:

(1) Title 45, Part 46 of the Code of Federal Regulations, and any subsequent revision of those regulations; and

(2) With respect to research that is subject to the jurisdiction of the federal Food and Drug Administration, Title 21, Parts 50 and 56 of the Code of Federal Regulations, and any subsequent revision of those regulations.

(c) "Human subject" has the meaning stated in the federal regulations on the protection of human subjects.

(d) "Institutional review board" has the meaning stated in the federal regulations on the protection of human subjects.

(e) "Research" has the meaning stated in the federal regulations on the protection of human subjects.

§13–2002.

(a) A person may not conduct research using a human subject unless the person conducts the research in accordance with the federal regulations on the protection of human subjects.

(b) Notwithstanding any provision in the federal regulations on the protection of human subjects that limits the applicability of the federal regulations to certain research, subsection (a) of this section applies to all research using a human subject.

§13–2003.

(a) An institutional review board shall make the final minutes of a meeting available for inspection within 30 days of receipt of a request for the minutes from any person.

(b) Prior to making the minutes of a meeting available for inspection under subsection (a) of this section, an institutional review board may redact confidential or privileged information.

(c) The minutes of a meeting of an institutional review board are not public records under Title 4 of the General Provisions Article.

§13–2004.

(a) The Office of the Attorney General may seek appropriate injunctive or other relief to prevent the conduct of human subject research in violation of the federal regulations on the protection of human subjects or this subtitle.

(b) In exercising the authority granted under subsection (a) of this section, the Office of the Attorney General may not:

(1) Duplicate the investigatory, compliance, or enforcement action undertaken by an agency of the federal government; or

(2) Bring an action under subsection (a) of this section if an agency of the federal government has determined that an investigation is not warranted.

§13–2101.

In this subtitle, "Advisory Board" means the State Traumatic Brain Injury Advisory Board.

§13–2102.

There is a State Traumatic Brain Injury Advisory Board.

§13–2103.

The Advisory Board consists of the following 36 voting members:

(1) The following two members, who shall serve ex officio:

(i) One member of the Senate, to be appointed by the President of the Senate; and

(ii) One member of the House of Delegates, to be appointed by the Speaker of the House;

(2) The Secretary of Disabilities, or the Secretary's designee;

(3) The Secretary of Health, or the Secretary's designee;

(4) The Secretary of Education, or the Secretary's designee;

(5) One representative of the State Department of Education, Division of Rehabilitation Services, appointed by the Director of the Division;

(6) One representative of the Maryland Department of Health, Developmental Disabilities Administration, appointed by the Director of the Administration;

(7) One representative of the Maryland Department of Health, Behavioral Health Administration, appointed by the Director of the Administration;

(8) One representative of the Maryland Department of Health, Prevention and Health Promotion Administration, Center for Chronic Disease Prevention and Control, appointed by the Director of the Center;

(9) One representative of the Maryland Department of Health, Prevention and Health Promotion Administration, Office for Genetics and People with Special Health Care Needs, appointed by the Director of the Office;

(10) One representative of the Maryland Institute of Emergency Medical Services Systems, appointed by the Director of the Institute;

(11) One representative of the Maryland Department of Health, Office of Health Services, appointed by the Director of the Office;

(12) One representative of the Maryland Department of Health, Alcohol and Drug Abuse Administration, appointed by the Director of the Administration;

(13) Four representatives of the Brain Injury Association of Maryland, appointed by the Executive Director of the Association;

(14) One representative of the Maryland Statewide Independent Living Council, appointed by the Executive Director of the Council;

(15) One representative of the Maryland Disability Law Center, Maryland's Protection Advocacy System, appointed by the Director of the Office;

(16) One representative of the National Institutes of Health, appointed by the Director of the Institutes; and

(17) The following 16 members, appointed by the Governor:

(i) One representative of State or local law enforcement;

(ii) Six Maryland citizens who have experienced a traumatic brain injury;

(iii) Five Maryland citizens who are currently caring for, or are family members of, individuals who have experienced a traumatic brain injury; and

(iv) Four professionals with specialized experience in providing services to individuals with traumatic brain injuries or traumatic brain injury prevention activities.

§13–2104.

(a) (1) The term of a member is 3 years.

(2) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(3) A member appointed to fill a vacancy in an unexpired term serves only for the remainder of the term and until a successor is appointed and qualifies.

(4) A member of the Advisory Board may not serve more than two consecutive terms.

(5) The terms of the members of the Advisory Board are staggered as required by the terms provided for members on October 1, 2005.

(b) The members of the Advisory Board shall elect a chair of the Advisory Board each year.

(c) A majority of the members present at a meeting shall constitute a quorum for transacting business or performing any duties.

(d) The Advisory Board shall meet at least once every other month.

(e) A member of the Advisory Board:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Maryland Department of Health and the Department of Disabilities shall jointly provide staff support and technical assistance for the Advisory Board.

§13–2105.

The Advisory Board shall:

(1) Investigate the needs of citizens with traumatic brain injuries;

(2) Identify gaps in services to citizens with traumatic brain injuries;

(3) Facilitate collaboration among State agencies that provide services to individuals with traumatic brain injuries;

(4) Facilitate collaboration among organizations and entities that provide services to individuals with traumatic brain injuries;

(5) Encourage and facilitate community participation in program implementation;

(6) Issue an annual report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on or before November 30, 2005, and each November 30 thereafter:

(i) Summarizing the actions of the Advisory Board and containing recommendations for:

1. Providing oversight in acquiring and utilizing State and federal funding dedicated to services for individuals with traumatic brain injuries;

2. Building provider–capacity and provider–training that address the needs of individuals with traumatic brain injuries; and

3. Improving the coordination of services for individuals with traumatic brain injuries; and

(ii) Including information concerning the number of individuals served and the services provided in the preceding fiscal year to individuals with traumatic brain injury; and

(7) Disseminate copies of the annual report to the President of the Senate, Speaker of the House, and the secretary of each department represented on the Advisory Board.

§13–21A–01.

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

(b) "Fund" means the State Brain Injury Trust Fund.

(c) "Secretary" means the Secretary of Health.

(d) "Traumatic brain injury" has the meaning established in the policies and procedures adopted by the State Traumatic Brain Injury Advisory Board under § 13–2105 of this title.

§13–21A–02.

(a) There is a State Brain Injury Trust Fund.

(b) (1) The purpose of the Fund is to assist in the provision of the following services to eligible individuals who have sustained brain injuries:

(i) Individual case management services; and

(ii) Neuropsychological evaluation.

(2) The Fund may be used to support:

(i) Prevention, education, and awareness programs;

(ii) Rehabilitation services;

(iii) Medical services;

(iv) Durable medical equipment;

(v) Assistive technology assessment and equipment;

(vi) Services to assist in the return to driving;

(vii) Evaluation and training related to the brain injury;

(viii) Neurobehavioral health services;

(ix) Nursing home transition services;

(x) Community reentry services;

(xi) Educational needs;

(xii) Housing and residential services; and

(xiii) Transportation services.

(c) The Secretary or the Secretary's designee shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund;

(2) Investment earnings of the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only to provide funding for the purpose described in subsection (b) of this section.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(h) Money expended from the Fund to support services to individuals with brain injuries is supplemental to and is not intended to take the place of funding that would otherwise be appropriated for those services.

§13–21A–03.

(a) To be eligible for assistance from the Fund, an individual shall:

(1) Be a United States citizen and a resident of the State at the time of the brain injury;

(2) Have a brain injury that has been documented in the medical records of the individual;

(3) Have income at or below 300% of the federal poverty level; and

(4) Have exhausted all other health, rehabilitation, and disability benefit funding sources that cover the services provided by the Fund.

(b) An individual may not receive services from the Fund costing more than:

(1) The annual amount established by policies and procedures adopted by the Secretary or the Secretary's designee; and

(2) The lifetime of the individual amount established by policies and procedures adopted by the Secretary or the Secretary's designee.

§13–2201.

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

(b) "Child Abuse Medical Providers (Maryland CHAMP)" means a network of Maryland health care professionals with the expertise to address the prevention, diagnosis and treatment of child abuse and neglect while working closely with other disciplines and organizations addressing these issues, including child advocacy centers.

(c) "Child Abuse Medical Providers (Maryland CHAMP) faculty" means a core group of clinical experts, as designated by the Department, who provide training, consultation, and support for the diagnosis and treatment of child abuse and neglect to health care professionals.

(d) "Child advocacy center" means a child–focused entity within or outside a health care facility that investigates, diagnoses, and treats children who may have been abused or neglected that:

(1) Includes local law enforcement officers, local criminal prosecutors, and the local department of social services; and

(2) May include child mental health service providers and other children and family service providers.

(e) "Initiative" means the Child Abuse Medical Providers (Maryland CHAMP) Initiative.

(f) "Multidisciplinary team" means a group of professionals with expertise in various health care and social service professional disciplines who provide consultation, treatment, and planning in cases of child abuse and neglect.

§13–2202.

(a) There is a Child Abuse Medical Providers (Maryland CHAMP) Initiative in the Department.

(b) The purposes of the Initiative are:

(1) To improve the protection of children in the State;

(2) To recruit local physicians to gain clinical expertise in the diagnosis and treatment of child abuse and neglect;

(3) To develop and guide the practice of local or regional multidisciplinary teams to improve the medical assessment and treatment of children

who are the subject of a child abuse or neglect investigation or a child in need of assistance;

(4) To facilitate the appropriate prosecution of criminal child abuse and neglect; and

(5) To provide expert consultation and training to local or regional multidisciplinary teams in the diagnosis and treatment of physical child abuse and neglect and sexual abuse through teleconferencing and on–site services.

§13–2203.

The Child Abuse Medical Providers (Maryland CHAMP) faculty shall:

(1) Assist local and regional jurisdictions to develop standards and protocols for the composition and operation of local or regional Child Abuse Medical Providers (Maryland CHAMP);

(2) Provide training and consultation to local or regional Child Abuse Medical Providers (Maryland CHAMP) in the diagnosis and treatment of child abuse and neglect;

(3) Provide financial support to part–time local and regional expert clinic staff for the diagnosis and treatment of child abuse and neglect;

(4) Collaborate with local or regional child advocacy centers and forensic nurse examiner programs; and

(5) Help assure that medical professionals have access to information on how to cooperate with local departments of social services, child advocacy centers, and local law enforcement officers to:

(i) Protect children from trauma during the process of child abuse and neglect investigations and prosecution;

(ii) Minimize the number of times each child is interviewed and examined; and

(iii) Minimize the potential for influencing a child's statement.

§13–2204.

A Child Abuse Medical Provider (Maryland CHAMP) may receive information from the Department and may consult with the Department on any case:

(1) Referred from the Children in Need of Assistance program;

(2) Concerning a child committed to the Department or a local department of social services; or

(3) Concerning a child who is the subject of a child abuse or neglect investigation.

§13–2206.

(a) In fiscal year 2007, the Governor shall include in the State budget an appropriation in the amount of $225,000 for the Child Abuse Medical Providers (Maryland CHAMP) Initiative.

(b) In each fiscal year beginning with fiscal 2008, the Governor shall include in the annual budget bill submitted to the General Assembly a General Fund appropriation for the Child Abuse Medical Providers (Maryland CHAMP) Initiative in an amount not less than the amount of the General Fund appropriation for the Initiative as approved in the State budget as enacted by the General Assembly for the prior fiscal year, increased by not less than the percentage by which the projected total General Fund revenues for the upcoming fiscal year exceed the revised estimate of total General Fund revenues for the current fiscal year, as contained in the report of the estimated State revenues submitted by the Board of Revenue Estimates to the Governor under § 6–106(b) of the State Finance and Procurement Article.

(c) The accounts and transactions of the Child Abuse Medical Providers (Maryland CHAMP) Initiative shall be subject to audit by the Legislative Auditor in accordance with §§ 2–1220 through 2–1227 of the State Government Article.

§13–2207.

(a) In this section, "Fund" means the Children's Trust Fund.

(b) There is a Children's Trust Fund.

(c) The purpose of the Fund is to provide funding for the Child Abuse Medical Providers (Maryland CHAMP) Initiative.

(d) The Department shall administer the Fund.

(e) The Fund is a special, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.

(f) The Fund consists of:

(1) Fees distributed to the Fund from the issuance of commemorative birth certificates under § 4-217(a)(3) of this article;

(2) Money appropriated in the State budget to the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(g) The Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(h) The Treasurer shall invest and reinvest the money of the Fund in the same manner as other State money may be invested.

(i) (1) The Comptroller shall pay out money from the Fund as directed by the Secretary.

(2) No part of the Fund may revert or be credited to:

(i) The General Fund of the State; or

(ii) Any other special fund of the State.

(j) Expenditures from the Fund may be made only in accordance with the State budget.

§13–2301.

In this subtitle, "women of childbearing age" means women between the ages of 15 and 45 years old who have family incomes at or below 185% of the federal poverty level.

§13–2302.

(a) The Department shall establish a program to distribute a folic acid supplement to women of childbearing age.

(b) The purpose of the program is to reduce the number of cases of neural tube defects in the State.

(c) The program shall provide the following to women of childbearing age as appropriate, based on an assessment of their individual need:

(1) An appropriate folic acid supplement that contains the recommended level of folic acid for women of childbearing age;

(2) Counseling and written information regarding the proper use of the supplement; and

(3) Any other health information that the Department determines necessary to carry out the purposes of this subtitle.

§13–2303.

Subject to the availability of funding, the program shall be funded as provided in the State budget.

§13–2501.

(a) In this subtitle, "Program" means the Oral Health Safety Net Program.

(b) There is an Oral Health Safety Net Program in the Office of Oral Health in the Department.

(c) The purpose of the Program is to provide start–up funding to expand oral health capacity for underserved low–income and disabled individuals, including individuals enrolled in the Maryland Medical Assistance Program and in the Maryland Children's Health Program.

§13–2502.

(a) The Office of Oral Health shall solicit proposals from local health departments, federally qualified health centers, and entities providing dental services within State facilities, for the purpose of issuing grants to support collaborative and innovative ways to increase dental provider capacity for the underserved.

(b) Subject to the limitations of the State budget, the Office of Oral Health shall:

(1) Award grants; and

(2) Oversee the operation of the Program.

(c) The Office of Oral Health shall place priority on awarding grants to proposals that:

(1) Are targeted to regions of the State where oral health services are most scarce for low–income, disabled, and Medicaid populations; and

(2) Outline how the potential grantee will maximize limited resources, including:

(i) Sharing of resources with other persons;

(ii) Case management to eliminate barriers to dental services;

(iii) Public–private purchasing agreements;

(iv) Obtaining matching funds to increase resources;

(v) Incentives to increase provider participation;

(vi) Quantifiable outcome measures of success;

(vii) School–based screenings; and

(viii) Plans to ensure sustainability of services after termination of grants awarded under this subtitle.

§13–2503.

Subject to the limitations of the State budget, the Office of Oral Health shall:

(1) Contract with a licensed dentist to provide expertise in dental public health issues for the Office; and

(2) Provide for appropriate continuing education courses for providers that offer oral health treatment to underserved populations.

§13–2504.

(a) (1) The Office of Oral Health shall conduct an annual evaluation of the Program.

(2) The evaluation required under this subsection shall include:

(i) Data on any progress resulting from each grant awarded under this subtitle;

(ii) Data on any progress of the overall Program;

(iii) Data demonstrating any increase in the use of restorative dental care among underserved populations; and

(iv) Data from any statewide survey conducted by the Department that demonstrates any progress of the Program.

(b) The Department, in conjunction with the Office of Oral Health, shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on or before November 1 of each year on:

(1) The results of the Program;

(2) Findings and recommendations for the Oral Health Program and any other oral health programs established under Title 18, Subtitle 8 of this article;

(3) The availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance Program;

(4) The outcomes that managed care organizations and dental managed care organizations under the Maryland Medical Assistance Program achieve concerning the utilization of targets required by the Five Year Oral Health Care Plan, including:

(i) Loss ratios that the managed care organizations and dental managed care organizations experience for providing dental services; and

(ii) Corrective action by managed care organizations and dental managed care organizations to achieve the utilization targets; and

(5) The allocation and use of funds authorized for dental services under the Maryland Medical Assistance Program.

§13–2505.

It is the intent of the General Assembly:

(1) That grants shall be awarded through the Program from July 1, 2008 through June 30, 2009, for fiscal year 2009; and

(2) That full funding for grants shall continue in the subsequent two fiscal years unless the Office of Oral Health determines that a grantee is not fulfilling the conditions of the award.

§13–2506.

The Department shall conduct a statewide follow–up survey on or before June 1, 2011, concerning the oral health status of school children in the State.

§13–2701.

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

(b) "Behavioral health services" means mental health services or alcohol and substance abuse services.

(c) (1) "Crisis services" means temporary services designed to address and stabilize a severe behavioral health problem and to avoid an emergency situation.

(2) "Crisis services" includes hotlines, in–home support, and residential crisis services.

(d) "Eligible veteran" means a veteran who is a Maryland resident.

(e) "Maryland Defense Force" means the military force established under § 13–501 of the Public Safety Article.

(f) "Maryland National Guard" means the Maryland Army National Guard and Maryland Air National Guard.

(g) "Service coordination" means a service designed to coordinate and provide assistance in obtaining access to behavioral health services.

(h) "Web–based resource program" means an interactive web–based communication medium that:

(1) Allows individuals to access comprehensive information, advocacy, and other resources regarding public and private behavioral health services, crisis and emergency services, and early intervention and prevention programs; and

(2) Enables the public and private health care communities to work together to address the problems related to providing and obtaining access to behavioral health services.

§13–2702.

(a) Subject to the limitations of its budget, the Department:

(1) In collaboration with the United States Department of Veterans Affairs, the Maryland Department of Veterans and Military Families, the Maryland National Guard, and the Maryland Defense Force, shall provide behavioral health service coordination for eligible veterans in all geographic regions of the State to connect them to behavioral health services, including mental health first aid described under § 13–2703(b) of this subtitle, which may be available through the United States Department of Veterans Affairs;

(2) (i) Where behavioral health services are not yet available or accessible through the United States Department of Veterans Affairs, shall provide service coordination for eligible veterans in all geographic regions of the State to connect them to behavioral health services, including mental health first aid described under § 13–2703(b) of this subtitle, which may be available through the Behavioral Health Administration, until such federal services can be accessed and obtained; and

(ii) Shall provide behavioral health services through the Behavioral Health Administration based on eligibility and medical necessity criteria established by these administrations; and

(3) Shall provide eligible veterans up–to–date information about behavioral health services and resources through a web–based resource program.

(b) Subject to the limitations of its budget and in addition to the service coordination provided under subsection (a) of this section, the Department shall provide or fund certain behavioral health services for eligible veterans who:

(1) Meet the eligibility and medical necessity criteria of the Behavioral Health Administration; and

(2) Cannot obtain immediate access to behavioral health services through the United States Department of Veterans Affairs.

(c) (1) The behavioral health services provided under subsection (b) of this section may include:

(i) Crisis services in all geographic regions of the State; and

(ii) Short–term behavioral health services, where existing federal and State behavioral health services are determined by the Department to be inadequate or inaccessible.

(2) The short–term behavioral health services provided under paragraph (1)(ii) of this subsection:

(i) Shall be available only until an eligible veteran is able to access and obtain adequate behavioral health services through the United States Department of Veterans Affairs; and

(ii) May include:

1. Screening assessments;

2. Individual, family, and group therapy;

3. Substance abuse early intervention and detoxification services; and

4. Substance abuse medication–assisted treatment.

(3) The Department shall seek reimbursement from the United States Department of Veterans Affairs or other responsible public or private payer for any behavioral health services provided under subsection (b) of this section.

(d) The Department shall account separately for funds used to provide behavioral health services to eligible veterans under subsection (b) of this section.

§13–2703.

(a) The behavioral health services for which the Department provides service coordination for eligible veterans under this subtitle shall include mental health first aid.

(b) Mental health first aid shall consist of training for eligible veterans and the immediate family members of eligible veterans on how to identify and respond to signs of mental illness and substance use disorders.

(c) Each entity teaching a mental health first aid course shall report to the Department:

(1) The number of eligible veterans who took the mental health first aid course; and

(2) The number of family members of eligible veterans who took the mental health first aid course.

(d) On or before June 1 each year, beginning in 2023, if the Department received a report under subsection (c) of this section in the immediately preceding year, the Department shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly the following information for the immediately preceding year:

(1) The total number of eligible veterans in the State who took a mental health first aid course;

(2) The total number of family members of eligible veterans in the State who took a mental health first aid course; and

(3) The total number of mental health first aid courses taught in the State, reported by the entity that taught the mental health first aid course.

§13–3001.

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

(b) "Cord blood transplant center" means a medical facility that uses cells obtained from a human umbilical cord or placenta to treat pediatric or adult patients afflicted with a disease or injury.

(c) "Fund" means the Cord Blood Transplant Center Support Fund.

(d) "Qualified medical institution" means a medical institution accredited by the Joint Commission on Accreditation of Health Care Organizations that:

(1) Is located in the State; and

(2) Has an established hematologic malignancies research program.

§13–3002.

(a) There is a Cord Blood Transplant Program in the Department.

(b) The purpose of the Cord Blood Transplant Program is to provide funding, subject to the limitations of the State budget, to qualified medical institutions to establish or maintain a cord blood transplant center.

§13–3003.

(a) There is a Cord Blood Transplant Center Support Fund.

(b) The purpose of the Fund is to promote economic development by supporting cord blood transplant centers at qualified medical institutions with a goal of being recognized as a regional center of excellence in the area of cord blood transplantation.

(c) The Department shall administer the Fund.

(d) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(e) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Beginning in 2013, any money appropriated in the State budget to the Fund; and

(2) Any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used only for the establishment of or support for a cord blood transplant center at a qualified medical institution.

(h) (1) The State Treasurer shall invest and reinvest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be paid into the Fund.

(i) (1) The Comptroller shall pay out money from the Fund as directed by the Secretary.

(2) No part of the Fund may revert or be credited to:

(i) The General Fund of the State; or

(ii) Any other special fund of the State.

(j) Expenditures from the Fund may be made only in accordance with the State budget.

§13–3004.

(a) A qualified medical institution may apply for a grant from the Fund each year.

(b) The Department shall adopt regulations to administer the Fund in accordance with the purposes of this subtitle.

§13–3101.

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

(b) "Pharmacist" has the meaning stated in § 12–101 of the Health Occupations Article.

(c) "Private or public entity" means a health care provider, local health department, community–based organization, substance abuse treatment organization, or other person that addresses medical or social issues related to drug addiction.

(d) "Program" means the Overdose Response Program.

(e) "Standing order" means a written instruction for the prescribing and dispensing of an opioid overdose reversal drug approved by the federal Food and Drug Administration in accordance with § 13–3106 of this subtitle.

§13–3102.

The Overdose Response Program is a program administered by the Department for the purpose of providing a means of authorizing certain individuals to administer an opioid overdose reversal drug approved by the federal Food and Drug Administration to an individual experiencing, or believed to be experiencing, opioid overdose to help prevent a fatality when medical services are not immediately available.

§13–3103.

(a) The Department shall adopt regulations necessary for the administration of the Program.

(b) The Department may:

(1) Collect fees necessary for the administration of the Program;

(2) Authorize private or public entities to conduct education and training on opioid overdose recognition and response that include:

(i) Education on recognizing the signs and symptoms of an opioid overdose;

(ii) Training on responding to an opioid overdose, including the administration of opioid overdose reversal drugs approved by the federal Food and Drug Administration, emphasizing the restoration of breathing, avoiding withdrawal, and compassionate postoverdose support and care; and

(iii) Access to opioid overdose reversal drugs approved by the federal Food and Drug Administration and the necessary supplies for the administration of the opioid overdose reversal drugs;

(3) Develop guidance regarding the content of educational training programs conducted by private or public entities; and

(4) Collect and report data on the operation and results of the programs.

(c) An individual is not required to obtain training and education on opioid overdose recognition and response from a private or public entity under subsection (b) of this section in order for a pharmacist to dispense an opioid overdose reversal drug approved by the federal Food and Drug Administration to the individual.

(d) (1) Subject to the limitations of the State budget, the Department shall purchase and provide opioid overdose reversal drugs approved by the federal Food and Drug Administration, at no cost, to the providers who are required to offer opioid overdose reversal drugs approved by the federal Food and Drug Administration under § 8–408 or § 19–310.3 of this article.

(2) An entity required to offer an opioid overdose reversal drug approved by the federal Food and Drug Administration under § 8–408 or § 19–310.3 of this article may provide an opioid overdose reversal drug approved by the federal Food and Drug Administration only if the opioid overdose reversal drug approved by the federal Food and Drug Administration is provided by the Department.

(3) The Department shall, subject to the limitations of the State budget, allow an entity that is provided with opioid overdose reversal drugs by the Department under this subsection to choose the formulation or dosage of opioid overdose reversal drugs approved by the federal Food and Drug Administration with which the entity is to be provided.

§13–3104.

An authorized private or public entity shall enter into a written agreement with a licensed health care provider with prescribing authority to establish protocols for the prescribing and dispensing of an opioid overdose reversal drug approved by the federal Food and Drug Administration to any individual in accordance with this subtitle.

§13–3105.

(a) An individual may receive from any licensed health care provider with prescribing authority a prescription for an opioid overdose reversal drug approved by the federal Food and Drug Administration and the necessary supplies for the administration of the opioid overdose reversal drug.

(b) An individual for whom an opioid overdose reversal drug approved by the federal Food and Drug Administration is prescribed and dispensed in accordance with this subtitle may:

(1) Possess the prescribed opioid overdose reversal drug and the necessary supplies for the administration of the opioid overdose reversal drug; and

(2) In an emergency situation when medical services are not immediately available, administer the opioid overdose reversal drug to an individual experiencing or believed by the individual to be experiencing an opioid overdose.

§13–3106.

(a) A licensed health care provider with prescribing authority may prescribe and dispense an opioid overdose reversal drug approved by the federal Food and Drug Administration to an individual who:

(1) Is believed by the licensed health care provider to be at risk of experiencing an opioid overdose; or

(2) Is in a position to assist an individual at risk of experiencing an opioid overdose.

(b) (1) A licensed health care provider with prescribing authority may prescribe and dispense opioid overdose reversal drugs approved by the federal Food and Drug Administration by issuing a standing order if the licensed health care provider:

(i) Is employed by the Department or a local health department; or

(ii) Has a written agreement with an authorized private or public entity under § 13–3104 of this subtitle.

(2) A licensed health care provider with prescribing authority who issues a standing order under paragraph (1) of this subsection may delegate the dispensing of opioid overdose reversal drugs approved by the federal Food and Drug Administration to an employee or a volunteer of an authorized private or public entity in accordance with a written agreement under § 13–3104 of this subtitle.

(3) Any licensed health care provider who has dispensing authority also may dispense an opioid overdose reversal drug approved by the federal Food and Drug Administration to any individual in accordance with a standing order issued by a licensed health care provider with prescribing authority in accordance with this subsection.

(c) A pharmacist may dispense opioid overdose reversal drugs approved by the federal Food and Drug Administration in accordance with a therapy management contract under Title 12, Subtitle 6A of the Health Occupations Article.

§13–3107.

(a) An individual who, in accordance with this subtitle, is administering an opioid overdose reversal drug approved by the federal Food and Drug Administration to an individual experiencing or believed by the individual to be experiencing an opioid overdose may not be considered to be practicing:

(1) Medicine for the purposes of Title 14 of the Health Occupations Article; or

(2) Registered nursing for the purposes of Title 8 of the Health Occupations Article.

(b) An employee or volunteer of a private or public entity who, in accordance with this subtitle, provides an opioid overdose reversal drug approved by the federal Food and Drug Administration to an individual who has received education and training in opioid overdose recognition and response in accordance with a standing order may not be considered to be practicing:

(1) Medicine for the purposes of Title 14 of the Health Occupations Article;

(2) Registered nursing for the purposes of Title 8 of the Health Occupations Article; or

(3) Pharmacy for the purposes of Title 12 of the Health Occupations Article.

(c) A licensed health care provider who prescribes or dispenses opioid overdose reversal drugs approved by the federal Food and Drug Administration in accordance with this subtitle may not be subject to any disciplinary action by the appropriate licensing health occupations board under the Health Occupations Article solely for the act of prescribing or dispensing opioid overdose reversal drugs approved by the federal Food and Drug Administration.

§13–3108.

(a) An individual who administers an opioid overdose reversal drug approved by the federal Food and Drug Administration to an individual who is or in good faith is believed to be experiencing an opioid overdose shall have immunity from liability under §§ 5–603 and 5–629 of the Courts Article.

(b) A cause of action may not arise against any licensed health care provider with prescribing authority or pharmacist for any act or omission when the health care provider with prescribing authority or pharmacist in good faith prescribes or dispenses an opioid overdose reversal drug approved by the federal Food and Drug Administration and the necessary paraphernalia for the administration of the opioid overdose reversal drug approved by the federal Food and Drug Administration to an individual under § 13–3106 of this subtitle.

(c) A cause of action may not arise against any business or business owner for any act or omission when the business or business owner in good faith makes opioid overdose reversal drugs approved by the federal Food and Drug Administration available to the employees or patrons of the business along with the necessary paraphernalia for administration of the opioid overdose reversal drugs approved by the federal Food and Drug Administration to an individual under § 13–3104 or § 13–3106 of this subtitle.

(d) This subtitle may not be construed to create a duty on any individual to:

(1) Obtain education and training from an authorized private or public entity under this subtitle, and an individual may not be held civilly liable for failing to obtain education and training from an authorized private or public entity under this subtitle; or

(2) Administer opioid overdose reversal drugs approved by the federal Food and Drug Administration to an individual who is experiencing or believed by the individual to be experiencing an opioid overdose.

§13–3109.

A person who dispenses an opioid overdose reversal drug approved by the federal Food and Drug Administration in accordance with this subtitle is exempt from any laws that require a person to maintain a permit to dispense prescription drugs.

§13–3201.

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

(b) "Council" means the Virginia I. Jones Alzheimer's Disease and Related Dementias Council.

(c) "Director" means the Director of Dementia Services and Brain Health established under Subtitle 32A of this title.

§13–3202.

There is a Virginia I. Jones Alzheimer's Disease and Related Dementias Council.

§13–3203.

(a) The Council consists of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary of Health, or the Secretary's designee;

(4) The Secretary of Aging, or the Secretary's designee;

(5) The Executive Director of the Alzheimer's Association, Greater Maryland Chapter, or the Executive Director's designee;

(6) The President of the Alzheimer's Association, National Capital Area Chapter, or the President's designee; and

(7) The following members, appointed by the Governor:

(i) Seven health care professionals with relevant professional experience;

(ii) Three human service professionals with relevant professional experience;

(iii) One elder law attorney with relevant professional experience;

(iv) Two research professionals with relevant professional experience;

(v) Two family caregivers of individuals with Alzheimer's disease or a related disorder; and

(vi) At the recommendation of the Council, any other member necessary to fulfill the duties of the Council.

(b) To the extent practicable, the members appointed to the Council shall reflect the geographic, racial, ethnic, cultural, and gender diversity of the State.

§13–3204.

(a) The members of the Council shall select the chair of the Council.

(b) A member of the Council:

(1) May not receive compensation as a member of the Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(c) (1) The term of an appointed member of the Council is 3 years.

(2) The terms of the appointed members of the Council are staggered as required by the terms provided for the appointed members of the Council on October 1, 2022.

(3) At the end of a term, an appointed member continues to serve until a successor is appointed and qualifies.

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

§13–3205.

(a) The Dementia Services and Brain Health Program, with assistance from the Department of Aging, shall provide staff support for the Council.

(b) The Director may request staffing assistance from public health entities with an interest in the duties of the Council.

§13–3206.

The Council shall:

(1) Update the State Plan on Alzheimer's Disease and Related Dementias and advocate for the State Plan;

(2) (i) Examine the needs of individuals with Alzheimer's disease and related dementias and their caregivers; and

(ii) Identify methods through which the State can most effectively and efficiently assist in meeting those needs;

(3) (i) Examine the readiness and capacity of health care providers to deliver care to individuals with or at risk for Alzheimer's disease and related dementias; and

(ii) Identify methods through which the State can assist health care providers in delivering care to individuals with or at risk for Alzheimer's disease and related dementias in the most effective and efficient manner;

(4) Advise the Governor and the General Assembly on policy, funding, regulatory, and other issues related to individuals with Alzheimer's disease and related dementias and their caregivers; and

(5) Develop and promote strategies to encourage brain health and reduce cognitive decline.

§13–3207.

On or before September 1, 2022, and on or before September 1 every 5 years thereafter, the Council shall issue and publish an update to the State Plan on Alzheimer's Disease and Related Dementias.

§13–32A–01.

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

(b) "Council" means the Virginia I. Jones Alzheimer's Disease and Related Dementias Council.

(c) "Director" means the Director of Dementia Services and Brain Health.

(d) "Program" means the Dementia Services and Brain Health Program.

§13–32A–02.

There is a Director of Dementia Services and Brain Health in the Department.

§13–32A–03.

The position of Director shall be a full–time and permanent position.

§13–32A–04.

(a) There is a Dementia Services and Brain Health Program in the Department.

(b) The Director shall administer the Program.

(c) The purpose of the Program is to lead the State's public health efforts relating to brain health and dementia.

(d) The Program shall:

(1) Coordinate the Department's approach to addressing Alzheimer's disease and other forms of dementia and brain health, including through public awareness, prevention, and early detection and diagnosis;

(2) Staff the Council and update the Council each quarter on the Program's activities;

(3) Oversee implementation of the State Plan on Alzheimer's Disease and Related Dementias;

(4) Assess, analyze, and conduct outreach to share cognitive health and dementia–related data;

(5) Develop and monitor implementation milestones and measurable outcomes to assess progress in achieving the goals laid out in the State Plan on Alzheimer's Disease and Related Dementias;

(6) Identify efficiencies across State agencies that aid individuals with dementia and their caregivers, and coordinate public and private stakeholder partnerships;

(7) Support and promote the delivery of dementia–capable care across health care settings through various methods, including:

(i) Establishing and maintaining a provider resource toolkit for dementia care, as defined in § 13–32A–07 of this subtitle, to support health care providers in delivering evidence–based, person–centered care;

(ii) Coordinating with academic institutions, health occupations boards, and continuing education providers to promote participation in dementia–specific education, training, and certification for health care professionals; and

(iii) Collaborating with State–led care transformation initiatives to identify opportunities to incorporate dementia–capable care practices into health care models;

(8) Apply for grants to enable the implementation of the State Plan on Alzheimer's Disease and Related Dementias goals to reduce the risk of dementia, and to improve the quality of care for individuals with dementia and their caregivers; and

(9) Carry out other duties relevant to the support of individuals with dementia as may be assigned by the Department.

§13–32A–05.

On or before September 1, 2023, and on or before September 1 every 5 years thereafter, the Director shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee on the activities and recommendations of the Program.

§13–32A–06.

The Governor shall include in the annual budget bill an appropriation to fund the position of Director and the Council, as follows:

(1) For fiscal year 2023, at least $71,400;

(2) For fiscal year 2024, at least $83,000;

(3) For fiscal year 2025, at least $85,300;

(4) For fiscal year 2026, at least $87,600; and

(5) For fiscal year 2027 and each fiscal year thereafter, at least $89,900.

§13–32A–07.

(a) In this section, "toolkit" means the provider resource toolkit for dementia care for health care providers developed under subsection (b) of this section.

(b) On or before October 1, 2027, the Department, in partnership with the Department of Aging, the Council, and other public or private organizations with expertise in Alzheimer's disease or related dementias shall establish and maintain a provider resource toolkit for dementia care for health care providers.

(c) The purpose of the toolkit is to provide a centralized, up–to–date resource to support health care providers in caring for patients who are at risk for or who may have dementia.

(d) The toolkit developed under subsection (b) of this section shall:

(1) Be composed of materials that can be developed using existing resources and expertise within the Department or obtained through partnerships with public or private entities as determined necessary by the Department; and

(2) Include information on:

(i) Risk factors for Alzheimer's disease and related dementias, including chronic diseases and the co–occurrence of Down syndrome (Trisomy–21);

(ii) Risk reduction strategies, including information on lifestyle interventions to reduce dementia risk;

(iii) The importance of early detection and diagnosis of Alzheimer's disease and related dementias;

(iv) Validated assessment tools for the detection and diagnosis of cognitive impairment;

(v) The racial and ethnic disparities in detecting, diagnosing, and accessing treatment and services;

(vi) Person–centered care delivery and relevant sources of clinical practice guidelines and tools;

(vii) Effective care planning tools, including:

1. Available reimbursement tools, including relevant billing codes, for individuals with cognitive impairment;

2. Referral pathways to community–based services and care planning resources; and

3. Information on treatment options and relevant sources for guidelines; and

(viii) Continuing education opportunities related to dementia care best practices.

(e) The Department shall promote the use of the toolkit across health care sectors, including:

(1) Managed care programs;

(2) Academic research institutions;

(3) Hospitals and health systems;

(4) Federally qualified health centers;

(5) Hospital and health system associations;

(6) Physician and medical student organizations;

(7) Organizations representing the advancement of nurses, health care professionals, and health care organizations; and

(8) Any other public or private organization, entity, or part of an organization or entity the Department deems necessary.

(f) On or before January 1 each year, beginning in 2028, the Department shall review and update the information in the toolkit to reflect the most recent and accurate available information.

§13–3401.

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

(b) "Family planning providers" means providers of services:

(1) Funded under Title X of the federal Public Health Service Act as of December 31, 2024; and

(2) That lost eligibility for Title X funding as a result of the termination of federal funding for providers because of:

(i) The scope of services offered by the providers; or

(ii) The scope of services for which the providers offer referrals.

(c) "Family planning services" means services provided under Title X of the federal Public Health Service Act as of December 31, 2024.

(d) "Program" means the Family Planning Program established under § 13–3402 of this subtitle.

§13–3402.

(a) There is a Family Planning Program in the Department.

(b) The purpose of the Program is to ensure the continuity of family planning services in the State.

(c) The Program shall provide family planning services to individuals who are eligible for family planning services through family planning providers that meet Program requirements.

(d) The Department may adopt regulations to implement this subtitle, including regulations establishing a sliding scale fee for services provided under the Program.

(e) Funding used to support family planning services under the Program shall be in addition to any funding applied by the Department before December 31,

2024, to the maintenance of effort requirement for federal funding under Title X of the federal Public Health Service Act.

(f) (1) The Department may not accept any federal funding under Title X of the federal Public Health Service Act if the Title X program:

(i) Excludes family planning providers; and

(ii) Does not require family planning providers to provide a broad range of acceptable and effective medically approved family planning methods and services.

(2) If the Department does not accept Title X program funds in accordance with paragraph (1) of this subsection, the Governor shall fund the Program with State funds at the same level of total funds provided to the Program in the immediately preceding fiscal year.

§13–3501.

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

(b) "Co–prescribing" means, with respect to an opioid overdose reversal drug, the practice of prescribing the drug in conjunction with an opioid prescription for a patient at an elevated risk of overdose.

(c) "Opioid overdose reversal drug" means naloxone or a similarly acting and equally safe drug that is approved by the federal Food and Drug Administration for the treatment of a known or suspected opioid overdose.

§13–3502.

(a) The Secretary shall establish guidelines for the co–prescribing of opioid overdose reversal drugs that are applicable to all licensed health care providers in the State who are authorized by law to prescribe a monitored prescription drug, as defined in § 21–2A–01 of this article.

(b) The guidelines established under subsection (a) of this section shall address the co–prescribing of opioid overdose reversal drugs for patients who are:

(1) At an elevated risk of overdose; and

(2) (i) Receiving opioid therapy for chronic pain;

(ii) Receiving a prescription for benzodiazepines; or

(iii) Being treated for opioid use disorders.

§13–3601.

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

(b) "Emergency medical services provider" has the meaning stated in § 13–516 of the Education Article.

(c) "Law enforcement officer" has the meaning stated in § 1–101 of the Public Safety Article.

(d) "Overdose" means a condition, including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death, resulting from the consumption or use of any controlled dangerous substance that requires medical attention, assistance, or treatment, and clinical suspicion for drug overdose, including respiratory depression, unconsciousness, or altered mental state, without other conditions to explain the clinical condition.

§13–3602.

(a) An emergency medical services provider or a law enforcement officer who treats and releases or transports to a medical facility an individual experiencing a suspected or an actual overdose may report the incident using an appropriate information technology platform with secure access, including the Washington/Baltimore High Intensity Drug Trafficking Area overdose detection mapping application program, or any other program operated by the federal government or a unit of State or local government.

(b) A report of an overdose made under this section shall include:

(1) The date and time of the overdose;

(2) The approximate address where the overdose victim was initially encountered or where the overdose occurred;

(3) Whether an opioid overdose reversal drug was administered; and

(4) Whether the overdose was fatal or nonfatal.

(c) If an emergency medical services provider or a law enforcement officer reports an overdose under this section, the emergency medical services provider or

law enforcement officer making the report shall make best efforts to make the report within 24 hours after responding to the incident.

(d) On receipt of a patient care report that indicates an overdose, the Maryland Institute for Emergency Medical Services Systems shall report the information listed under subsection (b) of this section to an appropriate information technology platform with secure access, including the Washington/Baltimore High Intensity Drug Trafficking Area overdose detection mapping application, or any other program operated by the federal government or a unit of State or local government.

(e) Overdose information reported by an emergency medical services provider under subsection (a) of this section or by the Maryland Institute for Emergency Medical Services Systems under subsection (d) of this section may not be:

(1) Used for a criminal investigation or prosecution; or

(2) Obtained by a law enforcement officer as part of a criminal investigation or prosecution.

(f) An emergency medical services provider or a law enforcement officer who in good faith makes a report under this section shall be immune from criminal liability for making the report.

§13–3603.

A law enforcement agency may not publicly publish the exact address of an overdose location unless there is a valid public safety concern.

§13–3701.

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

(b) "Advisory Committee" means the State Community Health Worker Advisory Committee.

(c) "Community health worker" means a frontline public health worker who:

(1) Is a trusted member of, or has an unusually close understanding of, the community being served;

(2) Serves as a liaison to, link to, or intermediary between health and social services and the community to:

(i) Facilitate access to services; and

(ii) Improve the quality and cultural competence of service delivery; and

(3) Builds individual and community capacity by increasing health knowledge and self–sufficiency through a range of activities, including:

(i) Outreach;

(ii) Community education;

(iii) The provision of information to support individuals in the community;

(iv) Social support; and

(v) Advocacy.

(d) "Fund" means the State Community Health Workers Fund established under § 13–3707 of this subtitle.

§13–3702.

(a) There is a State Community Health Worker Advisory Committee.

(b) The Advisory Committee consists of the following members:

(1) The Secretary of Health, or the Secretary's designee; and

(2) The following members appointed by the Governor, with the advice and consent of the Senate:

(i) Nine community health workers;

(ii) One registered nurse with experience in community health;

(iii) One licensed social worker with experience in community health;

(iv) One representative of a community health worker training organization;

(v) One representative of the Maryland Public Health Association;

(vi) One representative of a community–based employer of community health workers;

(vii) One member of the public who is familiar with the services of community health workers;

(viii) One representative of the Maryland Association of County Health Officers;

(ix) One representative of the Maryland Hospital Association; and

(x) One representative of the Community Behavioral Health Association of Maryland.

(c) Each Advisory Committee member must be a resident of the State.

(d) (1) The term of an appointed member is 4 years.

(2) The terms of the appointed members are staggered as required by the terms provided for the appointed members of the Advisory Committee on October 1, 2018.

(3) At the end of a term, an appointed member continues to serve until a successor is appointed and qualifies.

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

(5) An appointed member may not serve more than two consecutive full terms.

(6) To the extent practicable, the Governor shall fill any vacancy on the Advisory Committee within 60 days after the date of the vacancy.

(e) (1) The Governor may remove an appointed member for incompetence, misconduct, incapacity, or neglect of duty.

(2) On the recommendation of the Secretary, the Governor may remove an appointed member whom the Secretary finds to have been absent from two successive Advisory Committee meetings without adequate reason.

§13–3703.

(a) (1) The Secretary of Health, or the Secretary's designee, shall serve as the chair of the Advisory Committee.

(2) (i) From among its appointed members, the Advisory Committee annually shall elect a vice chair and a secretary.

(ii) The Advisory Committee shall determine:

1. The manner of election of the vice chair and the secretary; and

2. The duties of each officer.

(b) A majority of the members then serving on the Advisory Committee is a quorum.

(c) The Advisory Committee shall meet at least two times each year, at the times and places that the Advisory Committee determines, to make recommendations regarding the items listed under § 13–3704 of this subtitle.

(d) A member of the Advisory Committee is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) The Department shall provide staff support and technical assistance for the Advisory Committee.

(f) Written materials used to conduct the business of the Advisory Committee shall be provided in the preferred language of the Advisory Committee members, as necessary.

(g) Training or educational opportunities shall be made available to Advisory Committee members on the formal and informal processes that will be used to conduct the business of the Advisory Committee.

§13–3704.

After seeking input from the Maryland Department of Labor, the Maryland Higher Education Commission, the Maryland Rural Health Association, the Maryland Academy of Nutrition and Dietetics, the Maryland State Dental Association, community and hospital employers of community health workers, and

institutions of postsecondary education with programs in nursing, social work, and dietetics, the Advisory Committee shall advise the Department on:

(1) Community health worker training programs, including tiers of training;

(2) Fees for the issuance and renewal of certificates and other services;

(3) Grandfathering provisions;

(4) Criteria for the denial of a certification application, reprimand of a certificate holder, placing a certificate holder on probation, or suspension or revocation of a certificate;

(5) Hearing procedures before the Department takes any disciplinary action listed under item (4) of this section;

(6) Appeal procedures for a person aggrieved by a decision of the Department;

(7) Criteria for the reinstatement of a suspended or revoked certificate;

(8) Penalties for violations of this subtitle; and

(9) The appropriate term of a certificate and renewal procedures.

§13–3705.

(a) (1) (i) Subject to subparagraph (ii) of this paragraph, a certified community health worker training program must be accredited by the Department before operating in the State.

(ii) A certified community health worker training program in operation on October 1, 2018, may continue to operate until the deadline established by the Department under paragraph (3)(i)2 of this subsection.

(iii) An apprenticeship program registered with the Maryland Department of Labor may be accredited by the Department as a certified community health worker training program.

(2) The Department, working in collaboration with the Advisory Committee, shall adopt regulations establishing a procedure for accrediting community health worker training programs.

(3) (i) The regulations adopted under this subsection shall include:

1. A deadline before which certified community health worker training programs in operation on October 1, 2018, must apply for accreditation; and

2. A deadline before which the Department will make a decision regarding accreditation applications.

(ii) The Department shall consult with community health worker training programs in establishing the time frames required under this paragraph.

(4) The regulations adopted under this subsection shall include:

(i) A procedure for reviewing a certified community health worker training program's application;

(ii) Curriculum requirements;

(iii) A process through which an individual working as a community health worker on October 1, 2018, and who already possesses the knowledge taught in a community health worker training program accredited by the Department under this section, may be exempted from the training required under § 13–3706(b)(1) of this subtitle;

(iv) Requirements for periodic review of an accredited certified community health worker training program;

(v) A process by which the Department shall notify a certified community health worker training program in operation on October 1, 2018, of any changes needed to comply with the Department's accreditation requirements;

(vi) A reasonable deadline before which a certified community health worker training program in operation on October 1, 2018, is required to comply with the Department's accreditation requirements; and

(vii) A process by which the Department may revoke a certified community health worker training program's accreditation that allows for an adequate hearing and chance for appeal.

(b) The Department, working in collaboration with the Advisory Committee, shall:

(1) Adopt initial regulations for the certification of community health workers that establish:

(i) That any individual who completes a community health worker training program accredited by the Department under subsection (a) of this section is a qualified community health worker applicant; and

(ii) An initial fee for the certification of community health workers, not to exceed $75, which shall be adjusted as advised by the Advisory Committee;

(2) Keep a current record of all certified community health workers;

(3) Collect and account for fees provided for under this subtitle;

(4) Pay all necessary expenses associated with certifying community health workers in accordance with the State budget;

(5) Keep a complete record of proceedings relating to certified community health workers; and

(6) Maintain a list of certified community health workers on its website to allow employers and consumers to verify the certification status of community health workers.

(c) The Department may adopt regulations on the procedures for:

(1) Denying a certification application;

(2) Suspending and revoking certificates;

(3) Renewing certificates; and

(4) Otherwise regulating the certification of community health workers.

(d) The Department may adopt any additional regulations recommended by the Advisory Committee for the certification of community health workers.

§13–3706.

(a) The Department may certify an individual to practice as a community health worker in the State.

(b) To qualify for certification, an applicant shall:

(1) (i) Have completed a community health worker training program accredited by the Department under § 13–3705 of this subtitle; or

(ii) Be exempted by the Department from the training required under item (i) of this item; and

(2) Meet any other requirements established by the Department.

(c) To apply for certification as a community health worker, an applicant shall:

(1) Submit an application to the Department on the form that the Department requires; and

(2) Pay any fee and submit any additional materials required by the Department.

(d) The Department shall issue a certificate to any applicant who meets the requirements of subsection (b) of this section.

(e) The Department shall include on each certificate that the Department issues:

(1) The full name of the certificate holder;

(2) The dates of issuance and expiration;

(3) A serial number; and

(4) The signature of the Department's representative.

(f) (1) The Department shall establish a deadline after which an individual must be certified under this subtitle to make representations to the public that the individual is a certified community health worker.

(2) On or after the date set under paragraph (1) of this subsection, unless certified as a community health worker under this subtitle, an individual may not represent to the public by title that the individual is certified as a community health worker.

(3) An individual who violates paragraph (2) of this subsection is subject to a penalty determined and collected by the Department.

§13–3707.

(a) There is a State Community Health Workers Fund.

(b) (1) The Department may set fees as advised by the Advisory Committee.

(2) Funds to cover the expenses of the Department relating to the certification of community health workers shall be generated by fees set under this subtitle.

(c) (1) The Department shall remit all fees collected under this subtitle to the Comptroller.

(2) The Comptroller shall distribute the fees to the Fund.

(d) (1) The Fund shall be used to cover the actual documented direct and indirect costs of fulfilling the statutory and regulatory duties of the Department as provided under this subtitle.

(2) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) Any unspent portion of the Fund may not be transferred or revert to the General Fund but shall remain in the Fund to be used for the purposes specified in this subtitle.

(4) No other State money may be used to support the Fund.

(e) (1) A designee of the Department shall administer the Fund.

(2) Money in the Fund may be expended only for any lawful purpose authorized under this subtitle.

§13–3708.

A person shall have the immunity from liability described in § 5–702 of the Courts Article for giving information to the Department or the Advisory Committee or otherwise participating in activities of the Department or the Advisory Committee relating to community health workers.

§13–3709.

This subtitle may be cited as the Maryland Community Health Workers Act.

§13–3901. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2029 PER CHAPTER 35 OF 2019 //

(a) The Department shall develop a comprehensive action plan to increase access to and availability of professional veteran health services to prevent veteran suicides that includes:

(1) Short–term initiatives and reforms and a plan for State implementation beginning on or before July 1, 2021; and

(2) Long–term initiatives and reforms and a plan for State implementation beginning on or before July 1, 2023.

(b) The action plan developed under subsection (a) of this section shall:

(1) Identify opportunities for raising awareness of and providing resources for veteran suicide prevention;

(2) Identify opportunities to increase access to veteran mental health services;

(3) Identify funding resources to provide accessible and affordable veteran mental health services;

(4) Provide measures to expand public–private partnerships to ensure access to quality and timely mental health services;

(5) Provide for proactive outreach measures to reach veterans needing care;

(6) Provide for peer–to–peer service coordination, including training, certification, recertification, and continuing education for peer coordinators; and

(7) Address suicide prevention awareness, measures, and training regarding veterans who are involved in the justice system.

(c) The Department shall collaborate with interested parties in developing the plan required under subsection (a) of this section, including:

(1) The Maryland Department of Veterans and Military Families;

(2) The United States Department of Veterans Affairs;

(3) The Service Members, Veterans, and their Families Technical Assistance Center Implementation Academy of the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services;

(4) Veteran advocacy groups;

(5) Medical providers; and

(6) Any other interested party the Department considers appropriate.

(d) (1) The Department shall implement the short–term initiatives and reforms in the plan developed under subsection (a)(1) of this section on or before June 30, 2023.

(2) The Department shall implement the long–term initiatives and reforms in the plan required under subsection (a)(2) of this section on or before June 30, 2029.

§13–39A–01.

(a) In this subtitle, "guide" means the youth suicide prevention and firearm safe storage guide developed under subsection (b) of this section.

(b) On or before January 1, 2024, the Deputy Secretary for Public Health Services shall develop a youth suicide prevention and firearm safe storage guide.

(c) The guide developed under subsection (b) of this section shall:

(1) Provide a description of the firearm and ammunition requirements for safely storing firearms under State law;

(2) Identify the risks associated with unsafe firearm storage for minors, including:

(i) Suicide;

(ii) Death or serious bodily injury from accidental discharge; and

(iii) Shooting incidents involving minors; and

(3) Incorporate best practices for firearm and ammunition safe storage.

(d) The Department shall:

(1) Post the guide on its website;

(2) Make an electronic version of the guide available to families, health and social services providers, and any other entities that have an interest in youth suicide prevention or firearms storage, including:

(i) Behavioral health programs;

(ii) The Department of Juvenile Services;

(iii) Firearms dealers licensed by the federal government;

(iv) Local health departments;

(v) Local school systems;

(vi) The Maryland Association of Nonpublic Special Education Facilities;

(vii) The Maryland Association of Youth Service Bureaus;

(viii) State and local law enforcement agencies;

(ix) The State Department of Education; and

(x) Instructors who have been licensed or certified by the Department of State Police to teach firearm safety training courses; and

(3) Provide grants to local school systems, local health departments, and nonprofit agencies to support the education of families on the safe storage practices recommended in the guide.

§13–4001.

In this subtitle, "Program" means the Professional and Volunteer Firefighter Innovative Cancer Screening Technologies Program.

§13–4002.

(a) There is a Professional and Volunteer Firefighter Innovative Cancer Screening Technologies Program in the Department.

(b) The Department shall administer the Program.

(c) The Department may adopt regulations to implement this subtitle.

§13–4003.

(a) The purpose of the Program is to provide grants to local fire departments and volunteer fire companies and departments to procure innovative cancer screening tests that are not otherwise conducted during routine physical examinations or covered by insurance to professional firefighters employed by a local fire department and volunteer firefighters who serve in a volunteer fire company or department.

(b) The goal of the Program is to reduce cancer mortality among professional and volunteer firefighters while advancing the adoption of novel technologies that may also benefit the health of Marylanders and the economy of the State.

§13–4004.

(a) (1) A local fire department or a volunteer fire company or department may apply to the Department for a grant under the Program.

(2) The county in which a volunteer fire company or department is located shall assist volunteer fire companies or departments in filing applications under paragraph (1) of this subsection.

(b) Each year, the Department shall issue a request for applications from local fire departments and volunteer fire companies or departments for grants offered under the Program.

(c) An application submitted in accordance with subsection (b) of this section shall include, at minimum:

(1) The names and qualifications of competent health care providers that are advising the applicant on the selection and administration of cancer screening tests;

(2) The number of firefighters proposed to be screened and the criteria for selecting those firefighters that the applicant has determined to be at the highest cancer risk based on the latest scientific and medical research reports; and

(3) A description of each test proposed to be procured by the applicant, including:

(i) The claimed accuracy and reliability of the test;

(ii) The scientific and clinical evidence supporting the claimed accuracy and reliability;

(iii) Whether the test employs innovative or novel technologies, such as DNA sequencing, genomics, proteomics, metabolomics, machine learning, artificial intelligence, big data analytics, or other state–of–the–art technology;

(iv) Whether the test has the ability to simultaneously screen for two or more cancer types for which firefighters have a higher incidence or death rate;

(v) The cost of the test; and

(vi) Whether the test is developed, manufactured, or commercialized by a business entity located in the State.

§13–4005.

(a) The Department shall develop a weighting formula by which to rate each application received under § 13–4004 of this subtitle.

(b) Subject to subsection (c) of this section, the Department shall prioritize awarding grants to applicants based on the quality of the application and the degree to which the tests proposed to be procured by the applicant meet the following criteria:

(1) The scientific and clinical evidence supporting the claimed accuracy and reliability of the test;

(2) Whether the test employs innovative or novel technologies;

(3) The ability of the test to simultaneously screen for two or more cancer types;

(4) The cost–effectiveness of the test; and

(5) Whether the test is developed, manufactured, or commercialized by a business entity located in the State.

(c) If the Department receives applications for grants totaling more than the amount of funds appropriated for the Program for a fiscal year, the Department shall award the grants on a pro rata basis.

§13–4006. IN EFFECT

(a) (1) For fiscal years 2021 through 2024, the Governor shall include at least $100,000 in the annual budget for the Program.

(2) For fiscal year 2025 and each fiscal year thereafter, the Governor may include at least $1,000,000 in the annual budget for the Program.

(b) Appropriations and expenditures made for the purpose of implementing the Program, including the use of any funds received by a person under any component of the Program, are subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

(c) The Secretary may use up to 20% of Program funds to support research centers, including the University of Maryland Institute for Health Computing, in the collection, analysis, and processing of Program outcome data for the purposes of assessing, maximizing, and improving the effectiveness and clinical utility of the cancer screening funded by the Program.

§13–4006. // EFFECTIVE JUNE 30, 2030 PER CHAPTERS 639 AND 640 OF 2025 //

(a) (1) For fiscal years 2021 through 2024, the Governor shall include at least $100,000 in the annual budget for the Program.

(2) For fiscal year 2025 and each fiscal year thereafter, the Governor may include at least $500,000 in the annual budget for the Program.

(b) Appropriations and expenditures made for the purpose of implementing the Program, including the use of any funds received by a person under any component of the Program, are subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

§13–4007.

On or before December 1, 2020, and each December 1 thereafter, the Department shall report, in accordance with § 2–1257 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on:

(1) The number of individuals who have been screened through the Program;

(2) The types of tests used to screen those individuals;

(3) The costs of the tests; and

(4) The types of cancers detected by the tests.

§13–4101.

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

(b) "Direct threat" has the meaning stated in the federal Americans with Disabilities Act.

(c) "Eligible child" means a child who has a history of trauma, has been diagnosed with post–traumatic stress disorder, or has been diagnosed with a developmental disability and special health care need under Title V of the Social Security Act.

(d) "Fund" means the Maryland Children's Service Animal Program Fund established under § 13–4105 of this subtitle.

(e) "Nonprofit training entity" means a corporation, a foundation, or any other legal entity that:

(1) Is qualified under § 501(c)(3) of the Internal Revenue Code;

(2) (i) Engages in the training of service dogs or support dogs for use by children; or

(ii) Uses trained therapy horses for interaction with children; and

(3) Has been selected by the Department to provide services under this subtitle.

(f) "Program" means the Maryland Children's Service Animal Program established under § 13–4102 of this subtitle.

(g) "Program participant" means an eligible child who participates in the Program.

(h) "Successful Program participant" means a Program participant who successfully completes the training or therapy protocol specified by a nonprofit training entity.

§13–4102.

(a) There is a Maryland Children's Service Animal Program in the Department.

(b) The purposes of the Program are to:

(1) Refer eligible children who may benefit from participation in the Program to one or more nonprofit training entities;

(2) Provide additional funding mechanisms to assist children participating in the Program; and

(3) Expand treatment of children with a history of trauma or post–traumatic stress disorder or with a developmental disability and special health care need under Title V of the Social Security Act.

§13–4103.

(a) The Department shall select at least one nonprofit training entity to:

(1) Implement a training or therapy protocol for the purposes of the Program that will teach each Program participant methodologies, strategies, and techniques for:

(i) Partnering with a service dog or support dog; or

(ii) Interacting with therapy horses;

(2) Select qualified Program participants from those eligible children referred to the nonprofit entity under the Program;

(3) Select an appropriate service dog, support dog, or therapy horse, as applicable, for each Program participant;

(4) Facilitate each Program participant's training or therapy using the nonprofit training entity's training or therapy protocol; and

(5) Unless the nonprofit training entity uses trained therapy horses, partner each successful Program participant with the service dog or support dog on the Program participant's successful completion of the nonprofit training entity's training protocol.

(b) To be eligible for selection under subsection (a) of this section, a nonprofit entity must:

(1) Be based in the State;

(2) Serve the needs of children with a history of trauma or post–traumatic stress disorder or with a developmental disability and special health care need under Title V of the Social Security Act; and

(3) Generate its own revenue and reinvest the proceeds of that revenue in the growth and development of its programs.

§13–4104.

(a) A nonprofit training entity may disqualify a Program participant from participation in the Program if the nonprofit training entity determines that the Program participant's involvement in the Program:

(1) Presents a danger to the Program participant's mental or physical well–being;

(2) Presents a direct threat to others;

(3) Presents a direct threat to the mental or physical well–being of the service dog, support dog, or therapy horse; or

(4) Does not meet the training requirements of the nonprofit training entity.

(b) A Program participant may discontinue involvement in the Program for any reason.

§13–4105.

(a) There is a Maryland Children's Service Animal Program Fund.

(b) The Department shall use revenue from the Fund to pay a nonprofit training entity.

(c) Revenue from the Fund may be used only to pay:

(1) A nonprofit training entity; and

(2) Administrative costs of the Program.

(d) The Secretary shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Revenue collected by the Department in the form of donations to the Program;

(2) Money appropriated in the State budget to the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(g) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(h) Any interest earnings of the Fund shall be credited to the General Fund of the State.

(i) Money expended from the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated for the Program.

§13–4106.

The Department shall adopt regulations to carry out this subtitle.

§13–4201.

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

(b) "Center" means the Maryland Behavioral Health and Public Safety Center of Excellence established under § 13–4202 of this subtitle.

(c) "Maryland HBCU" means the following historically black colleges and universities:

(1) Bowie State University;

(2) Coppin State University;

(3) Morgan State University; and

(4) University of Maryland Eastern Shore.

(d) "Racial impact analysis" means a systematic examination of how racial minorities are or will be impacted by existing or proposed models, plans, policies, strategies, programs, processes, or recommendations.

(e) "Racial minority" means:

(1) Black or African American;

(2) Hispanic or Latino;

(3) Indigenous, American Indian, or Alaska Native;

(4) Asian; or

(5) Native Hawaiian or Pacific Islander.

(f) "Sequential Intercept Model" means a systems–level framework for criminal justice and behavioral health stakeholders to prevent entrance into the criminal justice system, minimize penetration into the criminal justice system, and engage individuals with behavioral health services and recovery supports as they transition into the community from the criminal justice system.

§13–4202.

(a) There is a Maryland Behavioral Health and Public Safety Center of Excellence in the Governor's Office of Crime Prevention and Policy.

(b) The purposes of the Center are to:

(1) Act as the statewide information repository for behavioral health treatment and diversion programs related to the criminal justice system;

(2) Lead the development of a strategic plan to increase treatment and reduce the detention of individuals with behavioral health disorders involved in the criminal justice system;

(3) Provide technical assistance to local governments for developing effective behavioral health systems of care that prevent and minimize involvement with the criminal justice system for individuals with behavioral health disorders;

(4) Facilitate local or regional planning workshops using the Sequential Intercept Model;

(5) Coordinate with the Department and the Behavioral Health Administration to implement and track the progress of creating an effective behavioral health system of care in the State relating to individuals involved in the criminal justice system; and

(6) Identify and inform any relevant stakeholders of any federal funding available to the Center to carry out the mission of the Center, including through the provision of grants, scholarships, and other funding to recipients engaged in training, the provision of services, or the study of matters relating to behavioral health, public safety, and criminal justice.

(c) In carrying out its duties, the Center shall continuously monitor and analyze its models, plans, policies, strategies, programs, technical assistance, and training for their validity and for opportunities to reduce and eliminate disparities in the criminalization of racial minorities with behavioral health disorders and increase access to culturally competent care.

(d) (1) The Governor's Office of Crime Prevention and Policy shall appoint the following individuals to jointly oversee the Center:

(i) A crisis intervention law enforcement coordinator;

(ii) A mental health coordinator; and

(iii) Any other individuals determined necessary by the Office.

(2) The individuals appointed under paragraph (1) of this subsection may be associated with the Crisis Intervention Team Center of Excellence within the Governor's Office of Crime Prevention and Policy.

(e) The Center may designate points of contact throughout the State who specialize in behavioral health treatment within the criminal justice system to brief the Center on the progress of statewide implementation of diversion programs.

(f) The Center may coordinate with the Justice Reinvestment Oversight Board and other State entities working to reduce State and local detention facility populations and recidivism.

(g) (1) The Center may enter into contracts with the University of Maryland System, Maryland HBCUs, or other entities or organizations for the purposes of carrying out its mission.

(2) For fiscal year 2024 and each fiscal year thereafter, the Governor shall include in the annual budget bill an appropriation of $500,000 for the Center to enter into contracts for the purposes of carrying out its mission, including:

(i) Facilitating the gathering of information from all counties in the State;

(ii) Supporting local or regional planning workshops; and

(iii) Supporting the purposes of the Center established under subsection (b) of this section.

(h) The operation of the Center is subject to the limitations of the State budget.

§13–4203.

(a) The activities of the Center shall include:

(1) Strategic planning;

(2) Technical assistance;

(3) State and local government coordination; and

(4) Facilitating the provision of train–the–trainer courses for the Sequential Intercept Model for completion in 2021 in partnership with the federal Substance Abuse and Mental Health Services Administration, with the goal of training 50 individuals in the State as facilitators.

(b) The Center shall provide technical assistance to local governments for the purposes of:

(1) Sharing best practices across jurisdictions;

(2) Applying for grants to support work related to behavioral health, public safety, or criminal justice;

(3) Facilitating the distribution of resources, technical assistance, and training in best practices related to behavioral health, public safety, or criminal justice; and

(4) Facilitating local and regional Sequential Intercept Model Summits.

(c) The Center shall develop the following:

(1) A statewide model for law enforcement–assisted diversion;

(2) Recommendations for pretrial services;

(3) Procedures for sharing deflection and diversion statistics between relevant State agencies;

(4) Recommendations for statewide implementation of law enforcement–assisted diversion programs; and

(5) A statewide model for community crisis intervention services other than law enforcement.

(d) (1) The Center shall host one State Sequential Intercept Model Summit each year for the purpose of sharing best practices across jurisdictions and tracking the progression of Maryland's community health and public safety system.

(2) It is the intent of the General Assembly that the Center apply to the federal Substance Abuse and Mental Health Services Administration for grant funding to hold subsequent State Sequential Intercept Model Summits annually.

(e) The Center shall support county or regional Sequential Intercept Model mapping workshops and summarize results in reports that inform cross–agency planning and program development.

(f) The Center shall implement systems and policies that establish a regional approach to community health and public safety, including by:

(1) Facilitating multijurisdictional applications for federal behavioral health and criminal justice grants;

(2) Coordinating and connecting similar programs across multiple jurisdictions; and

(3) Assisting localities in broadening and formalizing county–level collaboration in behavioral health, public safety, and criminal justice.

§13–4204.

(a) On or before December 1 each year, beginning in 2022, the Center shall produce and update a multiyear strategic plan to implement the recommendations of the report of the annual State Sequential Intercept Model Summit.

(b) The strategic plan shall include:

(1) A plan for formal, consistent, appropriate, and coordinated behavioral health screening processes that are properly applied at jail booking, including expanded behavioral health screening for veterans;

(2) Recommendations for the coordination of behavioral health and criminal justice initiatives with related State health initiatives;

(3) Recommendations for investment in preventive services systems including:

(i) Assertive community treatment;

(ii) Crisis response services;

(iii) Harm reduction strategies; and

(iv) Other preventive services for individuals with behavioral health disorders;

(4) An expansion of the use of technology and data analysis across the behavioral health, public safety, and criminal justice systems in accordance with the purposes of the Center;

(5) A plan for expanding the use of peer support services across intercepts; and

(6) A racial impact analysis.

(c) In developing the strategic plan, the Center shall consider:

(1) Opportunities for the provision of pre–crisis–to–recovery services to individuals with behavioral health disorders who are involved in the criminal justice system;

(2) The availability of housing options for individuals with behavioral health disorders who are involved with the criminal justice system; and

(3) The availability of transportation for individuals with behavioral health disorders who are involved with the criminal justice system.

§13–4205.

(a) Each local jurisdiction in the State shall develop a 2–year community health and public safety plan in collaboration with:

(1) The Center;

(2) The local health department;

(3) The local department of human services;

(4) Behavioral health coordinators for the local school system;

(5) The local health improvement council;

(6) Community–based behavioral health providers;

(7) A representative of the NAACP;

(8) A representative of public defenders; and

(9) Other key stakeholders.

(b) The plan shall include:

(1) An assessment of the capacity of the local behavioral system;

(2) Recommendations for the enhancement of the local crisis response system;

(3) Recommendations for the enhancement of the local behavioral health care system, including culturally competent care;

(4) An analysis of available federal grant funds available to the county or jurisdiction; and

(5) A racial impact analysis.

(c) A local jurisdiction is encouraged to use an existing local planning and coordinating committee or local management board to satisfy the requirements of this section.

§13–4206.

It is the intent of the General Assembly that the Center, to the extent practicable, identify opportunities to fund:

(1) Behavioral health crisis grants;

(2) Training for 9–1–1 operators;

(3) Peer support services;

(4) Behavioral health screenings;

(5) Scholarships for students who attend a Maryland HBCU to study behavioral health–, public safety–, or criminal justice–related issues; and

(6) Behavioral health initiatives in rural communities.

§13–4301.

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

(b) "Commission" means the Maryland Commission on Health Equity.

(c) "Health equity framework" means a public health framework through which policymakers and stakeholders in the public and private sectors use a collaborative approach to improve health outcomes and reduce health inequities in the State by incorporating health considerations into decision making across sectors and policy areas.

(d) "Statewide health equity plan" means the equity plan required under a cooperative grant funding agreement with the Center for Medicare and Medicaid Innovation.

§13–4302.

There is a Maryland Commission on Health Equity.

§13–4303.

(a) The Commission consists of the following members:

(1) One member of the Senate, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary, or the Secretary's designee;

(4) The Secretary of Aging, or the Secretary's designee;

(5) The Secretary of Budget and Management, or the Secretary's designee;

(6) The Secretary of Disabilities, or the Secretary's designee;

(7) The State Superintendent of Schools, or the State Superintendent's designee;

(8) The Secretary of Housing and Community Development, or the Secretary's designee;

(9) The Secretary of Human Services, or the Secretary's designee;

(10) The Secretary of Planning, or the Secretary's designee;

(11) The Deputy Secretary for Behavioral Health, or the Deputy Secretary's designee;

(12) The Deputy Secretary for Public Health Services, or the Deputy Secretary's designee;

(13) The Deputy Secretary for Health Care Financing, or the Deputy Secretary's designee;

(14) The Maryland Insurance Commissioner, or the Insurance Commissioner's designee;

(15) The Executive Director of the Health Services Cost Review Commission, or the Executive Director's designee;

(16) The Executive Director of the Office of Minority Health and Health Disparities, or the Executive Director's designee;

(17) The Executive Director of the Maryland Health Care Commission, or the Executive Director's designee;

(18) The Executive Director of the Maryland Community Health Resources Commission, or the Executive Director's designee;

(19) One representative of a local health department, designated by the Maryland Association of County Health Officers; and

(20) The following members, appointed by the Secretary with the advice of the Health Services Cost Review Commission:

(i) At least one representative of hospitals in the State;

(ii) At least two individuals with experience in hospital–based population health;

(iii) At least one representative of a federally qualified health center in the State;

(iv) At least two representatives of community–based organizations;

(v) At least two patients from underserved communities;

(vi) At least one representative of a managed care organization;

(vii) At least one representative of a commercial health insurer;

(viii) At least two representatives of clinicians and providers who are not affiliated with a hospital or a federally qualified health center;

(ix) At least one representative from the State Rural Health Office; and

(x) At least one representative of a tribal community in the State.

(b) To the extent practicable, the members appointed to the Commission shall reflect the geographic, racial, ethnic, cultural, and gender diversity of the State.

(c) A majority of the members present at a meeting shall constitute a quorum.

(d) (1) Subject to paragraph (2) of this subsection, the Commission shall determine the times, places, and frequency of its meetings.

(2) The Commission shall meet at least four times each year.

§13–4304.

(a) The Secretary, or the Secretary's designee, and the Executive Director of the Health Services Cost Review Commission, or the Executive Director's designee, shall cochair the Commission.

(b) A member of the Commission:

(1) May not receive compensation as a member of the Commission; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(c) The Department shall provide staff support for the Commission.

§13–4305.

(a) The purpose of the Commission is to:

(1) Employ a health equity framework to:

(i) Develop a statewide health equity plan; and

(ii) Examine:

1. The health of residents of the State to the extent necessary to carry out the requirements of this section;

2. Ways for units of State and local government to collaborate to implement policies that will positively impact the health of residents of the State; and

3. The impact of the following factors on the health of residents of the State:

A. Access to safe and affordable housing;

B. Educational attainment;

C. Opportunities for employment;

D. Economic stability;

E. Environmental factors;

F. Public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individuals who are in prison or released from prison; and

G. Food insecurity;

(2) Provide direct advice to the Secretary and the State's independent health regulatory commissions, and indirect advice to the Department's senior administrators and planners through the Secretary, regarding issues of racial, ethnic, cultural, or socioeconomic health disparities;

(3) Facilitate coordination of the expertise and experience of the State's health and human services, housing, transportation, education, environment, community development, and labor systems in developing a comprehensive health equity plan addressing the social determinants of health; and

(4) Set goals for health equity and prepare a plan for the State to achieve health equity in alignment with any other statewide planning activities.

(b) The Commission, using a health equity framework, shall:

(1) Examine and make recommendations regarding:

(i) Health considerations that may be incorporated into the decision–making processes of government agencies and private sector stakeholders who interact with government agencies;

(ii) Requirements for implicit bias training for clinicians engaged in patient care and whether the State should provide the training;

(iii) Training for health care providers on consistent and proper collection of patient self–identified race, ethnicity, and language data to identify disparities accurately; and

(iv) Requirements to comply with, and for enforcement of, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards);

(2) Foster collaboration between units of the State and local government and develop policies to improve health and reduce health inequities;

(3) Identify measures for monitoring and advancing health equity in the State;

(4) Establish a State plan for achieving health equity in alignment with other statewide planning activities in coordination with the State's health and human services, housing, transportation, education, environment, community development, and labor systems;

(5) Make recommendations and provide advice, including direct advice to the Secretary, on implementing laws and policies to improve health and reduce health inequities; and

(6) Develop and monitor a statewide health equity plan as required by the Center for Medicare and Medicaid Innovation under any agreement entered into between the State and the Centers for Medicare and Medicaid Services.

(c) (1) The Commission may establish advisory committees to assist the Commission in the performance of its duties under this section.

(2) An advisory committee established under this subsection may include individuals who are not members of the Commission.

§13–4306.

(a) (1) The Commission shall, in coordination with the Department, the Health Services Cost Review Commission, and the State designated health information exchange, establish an advisory committee to make recommendations on data collection, needs, quality, reporting, evaluation, and visualization for the Commission to carry out the purposes of this subtitle.

(2) The advisory committee shall include representatives from the State designated health information exchange.

(3) The advisory committee shall define the parameters of a health equity data set to be maintained by the State designated health information exchange, including indicators for:

(i) Social and economic conditions;

(ii) Environmental conditions;

(iii) Health status;

(iv) Behaviors;

(v) Health care; and

(vi) Priority health outcomes for monitoring health equity for racial and ethnic minority populations in the State.

(4) The data set for which parameters are defined under paragraph (3) of this subsection shall include data from:

(i) Health care facilities that report to the Health Services Cost Review Commission;

(ii) Health care payers that report to the Maryland Health Care Commission; and

(iii) Any other data source the advisory committee determines necessary.

(5) Data shall be reported in the aggregate if it is reported:

(i) To the public; or

(ii) From the State designated health information exchange to the Commission.

(6) If the advisory committee makes a recommendation that data be made available to the public, the recommendation shall comply with applicable federal and State privacy law.

(b) (1) The Commission may request data consistent with the recommendations of the advisory committee.

(2) Data requested by the Commission under paragraph (1) of this subsection shall be provided, to the extent authorized by federal and State privacy law, to:

(i) The Commission; or

(ii) The State designated exchange.

(c) The Commission may publish or provide to the public any data collected under this section consistent with the recommendations of the advisory committee established under subsection (a) of this section.

§13–4307.

On or before December 1 each year, the Commission shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the activities of the Commission.

§13–4401.

(a) The Natalie M. LaPrade Medical Cannabis Commission, in consultation with the Department, the Behavioral Health Administration, the Governor's Office of Crime Prevention and Policy, the Maryland Poison Center, the State's designated Health Information Exchange, and the Maryland Hospital Association, shall conduct, or contract with an institution of higher education or a private research entity to conduct, a comprehensive baseline study of cannabis use in the State that includes a survey of:

(1) Patterns of use, including frequency of use and dosing, methods of consumption, and general perceptions of cannabis among:

(i) Individuals under the age of 18 years;

(ii) Individuals at least 18 years old and under the age of 21 years;

(iii) Individuals at least 21 years old and under the age of 55 years;

(iv) Individuals at least 55 years old;

(v) Pregnant women; and

(vi) Breastfeeding women;

(2) Incidents of impaired driving, including arrests, accidents, and fatalities, related to cannabis use;

(3) Hospitalizations related to cannabis use;

(4) Calls to poison control centers related to cannabis use, including data on calls related to individuals under the age of 21 years; and

(5) Diagnoses of cannabis use disorder and problem cannabis use.

(b) On or before March 1, 2023, the Natalie M. LaPrade Medical Cannabis Commission shall submit a report of the findings of the baseline study conducted under subsection (a) of this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee, the Senate Judicial Proceedings Committee, the House Judiciary Committee, and the House Health and Government Operations Committee.

(c) On or before March 1, 2025, and every other year thereafter, the Natalie M. LaPrade Medical Cannabis Commission shall:

(1) Survey the same factors that are set forth in subsection (a) of this section;

(2) Use the same methodology or model that is used to conduct the survey required under subsection (a) of this section; and

(3) Submit a report of the findings of the survey required under this subsection to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee, the Senate Judicial Proceedings Committee, the House Judiciary Committee, and the House Health and Government Operations Committee.

§13–4501.

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

(b) "Advisory Council" means the Cannabis Public Health Advisory Council.

(c) "Fund" means the Cannabis Public Health Fund.

§13–4502.

(a) There is a Cannabis Public Health Advisory Council.

(b) The Advisory Council consists of the following members:

(1) One member from the Senate of Maryland, appointed by the President of the Senate;

(2) One member from the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary, or the Secretary's designee;

(4) The Deputy Secretary for Behavioral Health, or the Deputy Secretary's designee;

(5) The Director of the Maryland Cannabis Administration, or the Director's designee;

(6) The State Superintendent of Schools, or the State Superintendent's designee;

(7) The Executive Director of the Governor's Office of Crime Prevention and Policy, or the Executive Director's designee;

(8) The Administrator of the Motor Vehicle Administration, or the Administrator's designee;

(9) The Executive Director of the Office of Social Equity in the Department of Social and Economic Mobility, or the Executive Director's designee; and

(10) The following members appointed by the Governor:

(i) One representative from a historically black college or university;

(ii) One health care provider with experience in cannabis;

(iii) One pharmacist licensed in the State;

(iv) One health care provider with expertise in substance use disorder treatment and recovery;

(v) One individual with expertise in cannabis use disorder;

(vi) One academic researcher with expertise in cannabis law and policy;

(vii) One individual with at least 5 years of experience in health or social equity;

(viii) One public health professional with cannabis experience; and

(ix) One representative of a laboratory that tests cannabis.

(c) (1) To the extent practicable and consistent with federal and State law, the membership of the Advisory Council shall reflect the gender, ethnic, and racial diversity of the State.

(2) The membership of the Advisory Council shall include residents of rural and urban regions of the State.

(d) A member of the Advisory Council shall file a financial disclosure statement with the State Ethics Commission in accordance with Title 5, Subtitle 6 of the General Provisions Article.

(e) (1) The term of an appointed member is 4 years.

(2) The terms of the appointed members are staggered as required by the terms provided for the appointed members of the Advisory Council on January 1, 2023.

(3) At the end of a term, an appointed member continues to serve until a successor is appointed and qualifies.

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

(5) An appointed member may not serve more than two consecutive full terms.

§13–4503.

(a) The chair of the Advisory Council shall be elected by the members of the Advisory Council.

(b) A majority of the members then serving on the Advisory Council is a quorum.

(c) The Advisory Council shall meet at least four times each year, at the times and places that the Advisory Council determines.

(d) The Advisory Council may form workgroups to assist in the work of the Advisory Council.

(e) A member of the Advisory Council:

(1) May not receive compensation as a member of the Advisory Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Department shall provide staff support and technical assistance for the Advisory Council.

§13–4504.

(a) The Advisory Council shall study and make recommendations regarding:

(1) The promotion of public health and mitigation of youth use of, misuse of, and addiction to cannabis;

(2) Data collection and reporting of data that measures the impact of cannabis consumption and legalization;

(3) The impact of cannabis legalization on the education, behavioral health, and somatic health of individuals under the age of 21 years;

(4) Initiatives to prevent cannabis use by individuals under the age of 21 years, including educational programs for use in schools;

(5) Public health campaigns on cannabis;

(6) Advertising, labeling, product testing, and quality control requirements;

(7) Training for health care providers related to cannabis use;

(8) Best practices regarding requirements to reduce the appeal of cannabis to minors, including advertising, potency, packaging, and labeling standards; and

(9) Any other issues that advance public health related to cannabis use and legalization.

(b) To the extent practicable, the Advisory Council shall consider any data collected by the State related to cannabis use when making recommendations, including data collected under § 13–4401 of this title.

§13–4505.

(a) There is a Cannabis Public Health Fund.

(b) The purpose of the Fund is to provide funding to address the health effects associated with the legalization of adult–use cannabis.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Revenue distributed to the Fund based on revenues from adult–use cannabis;

(2) Money appropriated in the State budget to the Fund;

(3) Revenue distributed to the Fund in accordance with § 2–1302.2 of the Tax – General Article; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only for:

(1) Supporting the Advisory Council in performing its duties;

(2) Supporting data collection and research on the effects of cannabis legalization in the State;

(3) Providing funding for education and public awareness campaigns related to cannabis use, including funding for educational programs to be used in schools;

(4) Supporting substance use disorder counseling and treatment for individuals;

(5) Training and equipment for law enforcement to recognize impairments due to cannabis; and

(6) Purchasing technology proven to be effective at measuring cannabis levels in drivers.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

§13–4506.

On or before December 1 each year, the Advisory Council shall report its findings and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

§13–4701.

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

(b) "Fund" means the Abortion Care Clinical Training Program Fund.

(c) "Program" means the Abortion Care Clinical Training Program.

§13–4702.

There is an Abortion Care Clinical Training Program in the Department.

§13–4703.

The purpose of the Program is to protect access to abortion care by ensuring that there are a sufficient number of health professionals to provide abortion care.

§13–4704.

(a) (1) The Department shall contract with a coordinating organization to administer the Program.

(2) The Department shall use funds appropriated in the budget for the Program to contract with the coordinating organization under paragraph (1) of this subsection.

(b) The coordinating organization shall:

(1) Have demonstrated experience in coordinating abortion care training programs at community–based and hospital–based provider sites;

(2) Be a nonprofit entity;

(3) Be in good standing in any state or jurisdiction in which the organization is registered or incorporated;

(4) Submit an annual report to the Department on the performance of the Program;

(5) Meet any other requirements established by the Department if the requirements are not inconsistent with Title 20, Subtitle 2 of this article; and

(6) Perform the following functions:

(i) Administer grants to develop and sustain abortion care training programs at a minimum of two community–based provider sites;

(ii) Administer grants if funding is available to:

1. Other community–based sites;

2. Hospital–based provider sites;

3. Continuing education programs for qualified providers through professional associations or other clinical education programs; and

4. Establish training program requirements that:

A. Are consistent with evidence–based training standards;

B. Comply with any applicable State law and regulations; and

C. Focus on the provision of culturally congruent care and include implicit bias training;

(iii) Support abortion care clinical training to qualified providers as defined in § 20–103 of this article and to the clinical care teams of the qualified providers to:

1. Expand the number of health care professionals with abortion care training; and

2. Increase the racial and ethnic diversity among health care professionals with abortion care training; and

(iv) Support the identification, screening, and placement of qualified providers at training sites.

(c) (1) The Department shall release the name of the coordinating organization that the Department contracts with under subsection (a) of this section and any entity receiving funds through the coordinating organization.

(2) The Department may not release the name of any individual or person administering services through or participating in the Program.

§13–4705.

For each fiscal year, the Governor shall include in the annual budget bill an appropriation of $3,500,000 to the Program.

§13–4706.

(a) There is an Abortion Care Clinical Training Program Fund.

(b) The purpose of the Fund is to support the Program.

(c) The Department shall administer the Fund.

(d) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(e) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Any money appropriated in the State budget to the Fund;

(2) Interest earnings; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used only for the Program.

(h) (1) The State Treasurer shall invest and reinvest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be paid into the Fund.

(i) The Comptroller shall pay out money from the Fund as directed by the Secretary.

(j) No part of the Fund may revert or be credited to:

(1) The General Fund of the State; or

(2) Any other special fund of the State.

(k) Expenditures from the Fund may be made only in accordance with the State budget.

§13–4707.

On or before July 1 each year, the Department shall submit an annual report on the Program to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

§13–4801. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

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

(b) "Behavioral health" includes substance–related disorders, addictive disorders, mental disorders, life stressors and crises, and stress–related physical symptoms.

(c) "Commission" means the Commission on Behavioral Health Care Treatment and Access.

§13–4802. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

There is a Commission on Behavioral Health Care Treatment and Access, which shall meet jointly with the Behavioral Health Advisory Council.

§13–4803. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

(a) The Commission consists of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) One representative of Maryland's Congressional Delegation;

(4) The Secretary of Health, or the Secretary's designee;

(5) The Secretary of Human Services, or the Secretary's designee;

(6) The Secretary of Juvenile Services, or the Secretary's designee;

(7) The Deputy Secretary for Behavioral Health, or the Deputy Secretary's designee;

(8) The Maryland Insurance Commissioner, or the Commissioner's designee;

(9) The Executive Director of the Health Services Cost Review Commission, or the Executive Director's designee;

(10) The Executive Director of the Maryland Health Care Commission, or the Executive Director's designee;

(11) The Executive Director of the Maryland Community Health Resources Commission, or the Executive Director's designee;

(12) The Executive Director of the State–designated health information exchange, or the Executive Director's designee;

(13) The Executive Director of the Governor's Office of Crime Prevention and Policy, or the Executive Director's designee;

(14) The Secretary of the Maryland Department of Disabilities, or the Secretary's designee;

(15) The Secretary of the Department of Public Safety and Correctional Services, or the Secretary's designee;

(16) The Special Secretary of the Governor's Office for Children, or the Special Secretary's designee;

(17) The Special Secretary of Opioid Response, or the Special Secretary's designee;

(18) The Secretary of Aging, or the Secretary's designee; and

(19) The following members appointed by the Governor:

(i) One representative of the Mental Health Association of Maryland;

(ii) One representative of the National Alliance on Mental Illness;

(iii) One representative of the Community Behavioral Health Association of Maryland;

(iv) One representative of a provider of residential behavioral health services;

(v) One representative of an acute care hospital;

(vi) One representative of an inpatient psychiatric hospital;

(vii) One individual with experience as a consumer of behavioral health services;

(viii) One family member of an individual with experience as a consumer of behavioral health services;

(ix) One representative of a provider of substance use treatment services;

(x) One representative of a school–based health center;

(xi) One individual with expertise in social determinants of health;

(xii) One individual with expertise in health economics;

(xiii) One representative of a health insurance carrier;

(xiv) One representative of a managed care organization;

(xv) One representative from the Office of the Public Defender;

(xvi) One representative of the Developmental Disability Coalition;

(xvii) One representative of the Maryland Chapter of the National Council on Alcoholism and Drug Dependence;

(xviii) One representative of the Maryland Psychological Association;

(xix) One representative of Disability Rights Maryland;

(xx) One representative of a Federally Qualified Health Center;

(xxi) One representative of a local behavioral health authority;

(xxii) One individual with an intellectual disability who uses self–directed behavioral health services; and

(xxiii) One representative of the Maryland State's Attorneys' Association.

(b) To the extent practicable, the membership of the Commission shall reflect the geographic and ethnic diversity of the State.

(c) The Governor, the President of the Senate, and the Speaker of the House jointly shall designate the chair of the Commission.

(d) The Department shall provide staff for the Commission.

(e) A member of the Commission:

(1) May not receive compensation as a member of the Commission; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Commission shall meet at least three times per year at the times and places determined jointly by the Commission and the Behavioral Health Advisory Council.

§13–4804. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

The purpose of the Commission is to make recommendations to provide appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the State across the behavioral health continuum.

§13–4805. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

The Commission shall:

(1) Conduct an assessment of behavioral health services in the State to identify needs and gaps in services across the continuum, including community–based outpatient and support services, crisis response, and inpatient care;

(2) Examine the methods for reimbursing behavioral health care services in the State and make recommendations on the most effective forms of reimbursement to maximize service delivery;

(3) Compile findings of State–specific needs assessments related to behavioral health care services;

(4) Review recommendations and reports of State commissions, workgroups, or task forces related to behavioral health care services;

(5) Conduct a needs assessment on the State's behavioral health care workforce to identify gaps and make recommendations to ensure an adequate, culturally competent, and diverse workforce across the behavioral health care continuum;

(6) Review trends and best practices from other states regarding policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care;

(7) Examine and make recommendations related to the behavioral health of the geriatric and youth populations in the State;

(8) Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with developmental disabilities and complex behavioral health needs, specifically youth;

(9) Assess the health infrastructure, facilities, personnel, and services available for the State's forensic population and identify deficiencies in resources and policies needed to prioritize health outcomes, increase public safety, and reduce recidivism;

(10) Make recommendations on expanding behavioral health treatment access for the State's court–ordered population;

(11) Make recommendations on action plans regarding the behavioral health care system's capacity to prepare for and respond to future challenges affecting the entire State or particular regions or populations in the State, including pandemics and extreme weather events;

(12) Make recommendations to ensure that behavioral health treatment is provided in the appropriate setting, including methods to divert behavioral health patients from emergency departments by using the Maryland Mental Health and Substance Use Disorder Registry and Referral System established under § 7.5–802 of this article and 2–1–1;

(13) Examine and review the use of harm reduction strategies to facilitate access to care;

(14) Examine methods to assist consumers in accessing behavioral health services; and

(15) Make, in coordination with the Behavioral Health Advisory Council, recommendations regarding the continuation of the State's behavioral health carve–out and the financing structure and quality oversight necessary to integrate somatic and behavioral health services and ensure compliance with the Mental Health Parity and Addiction Equity Act in the Maryland Medical Assistance Program.

§13–4806. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

(a) The Commission shall establish the following workgroups:

(1) Geriatric behavioral health;

(2) Youth behavioral health, individuals with developmental disabilities, and individuals with complex behavioral health needs;

(3) Criminal justice–involved behavioral health;

(4) Behavioral health workforce development, infrastructure, coordination, and financing; and

(5) Improvement of health, social, and economic outcomes related to substance use.

(b) The workgroup required under subsection (a)(5) of this section shall:

(1) Evaluate and review:

(i) The availability, affordability, and accessibility of treatment for substance use disorder and recovery support services, including housing and employment services, in the State;

(ii) The number and percentage of individuals who are directed to services described in item (i) of this item by the criminal justice system of the State;

(iii) The health outcomes after receiving services described in item (i) of this item disaggregated by whether the services were sought voluntarily or mandated by the criminal justice system of the State;

(iv) The impact of current criminal justice involvement related to substance use in the State on the health and well–being of individuals, families, and communities;

(v) The cost to the State and local governments resulting from current criminal justice involvement related to substance use in the State;

(vi) The equitable application of current criminal justice involvement related to substance use in the State;

(vii) The current research on the efficacy of voluntary treatment for substance use disorder compared to treatment mandated by criminal justice systems, including criminal justice systems outside the State; and

(viii) The availability and accessibility of data on the issues enumerated in this item;

(2) Evaluate and review the Department's regulations on the standards for the discharge of patients from substance use treatment programs to assess whether the standards adequately consider the patient's mental health or substance use disorder diagnosis and the impact of the discharge standards on the patient; and

(3) (i) Make recommendations on changes to State laws, policies, and practices needed to mitigate the harms related to the criminalization of substance use with the goal of improving the public health and safety of residents of the State; and

(ii) Make recommendations on changes to State laws, policies, and practices related to the discharge of patients from substance use treatment programs to consider the patient's mental health or substance use disorder diagnosis in making an appropriate placement.

(c) The workgroups established under subsection (a) of this section shall meet at least two times per year at the times and places determined by the workgroup.

(d) The workgroups established under subsection (a) of this section shall include members of the Commission and may include individuals invited by the Commission or the Behavioral Health Advisory Council to serve on the workgroup.

(e) On or before July 1 each year, beginning in 2024, the workgroups established under subsection (a) of this section shall report and make recommendations to the Commission and the Behavioral Health Advisory Council.

§13–4807. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTERS 290 AND 291 OF 2023 //

(a) (1) On or before January 1 each year, beginning in 2024, the Commission, in coordination with the Behavioral Health Advisory Council, shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the Commission's findings and recommendations, including funding and legislative recommendations, that are consistent with providing appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the State across the behavioral health continuum.

(2) Any legislative recommendations included in the report required under paragraph (1) of this subsection that require funding shall include an estimate of the funding required to implement the recommendation and information that supports the funding estimate.

(b) The report required on or before January 1, 2024, shall include the findings of the needs assessments required under § 13–4805 of this subtitle.

(c) On or before July 1, 2025, the Commission, in coordination with the Behavioral Health Advisory Council, shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the Commission's findings and recommendations regarding the continuation of the State's behavioral health carve–out and the financing structure and quality oversight

necessary to integrate somatic and behavioral health care services in the Maryland Medical Assistance Program.

§13–4901. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

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

(b) "Behavioral health care coordination" means a person–centered, team–based activity designed to:

(1) Assess and meet the needs of an individual with a behavioral health condition; and

(2) Help the individual navigate the health care system effectively and efficiently.

(c) "Pilot Program" means the Behavioral Health Care Coordination Value–Based Purchasing Pilot Program.

(d) "Value–based purchasing" means financially incentivizing providers to meet specified outcome measures.

§13–4902. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

There is a Behavioral Health Care Coordination Value–Based Purchasing Pilot Program in the Department.

§13–4903. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

The purpose of the Pilot Program is to establish and implement an intensive care coordination model using value–based purchasing in the specialty behavioral health system.

§13–4904. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

(a) The Department shall administer the Pilot Program.

(b) The Department shall identify at least 500 adults whose behavioral health condition or functioning places them at risk of hospital emergency department utilization or inpatient psychiatric hospital admission.

(c) The Pilot Program shall be operational for a 3–year period.

(d) A provider or network of providers selected to participate in the Pilot Program shall:

(1) Be licensed and in good standing with the Maryland Medical Assistance Program;

(2) Have experience in providing community–based care coordination to specialty behavioral health program recipients;

(3) Use an electronic medical record for documenting care coordination activities and outcomes collection; and

(4) Have an automated data exchange with the State–designated health information exchange.

(e) The Department shall:

(1) Provide reimbursement on a per member per month basis for the behavioral health care coordination activities that are not otherwise covered by the Maryland Medical Assistance Program;

(2) Collect outcomes data on recipients of health care services under the Pilot Program; and

(3) Evaluate the effectiveness of the value–based purchasing model by analyzing the following outcome measures:

(i) A comparison of the following data elements before and after enrollment of recipients of health care services under the Pilot Program:

1. Emergency department utilization for both behavioral and somatic health purposes;

2. Inpatient hospitalization for both behavioral and somatic health purposes; and

3. Total health care expenditures;

(ii) Outcomes for recipients with and without primary care services coordinated by a behavioral health provider; and

(iii) Recognized clinical quality metrics which may include patient experience measures.

§13–4905. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

If necessary to implement the Pilot Program, the Department shall apply to the Centers for Medicare and Medicaid Services for an amendment to the State's § 1115 HealthChoice Demonstration.

§13–4906. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

(a) For each of fiscal years 2025 through 2027, the Governor may include in the annual budget bill an appropriation of $600,000 for the Pilot Program.

(b) Beginning in fiscal year 2026, the Department may allocate a percentage of the annual appropriation required under subsection (a) of this section to reimbursement paid based on the achievement of the outcome measures described in § 13–4904(e)(3) of this subtitle.

(c) In fiscal year 2027, the Department may increase the percentage of the annual appropriation required under subsection (a) of this section allocated to reimbursement paid in accordance with subsection (b) of this section over the percentage allocated in fiscal year 2026.

§13–4907. IN EFFECT

// EFFECTIVE UNTIL NOVEMBER 30, 2027 PER CHAPTERS 290, 291, AND 369 OF 2023 //

On or before November 1, 2027, the Department shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the Department's findings and recommendations from the Pilot Program.

§13–5001.

There is a Rare Disease Advisory Council.

§13–5002.

(a) The Council consists of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary, or the Secretary's designee;

(4) The chair of the State Advisory Council on Hereditary and Congenital Disorders, or the chair's designee;

(5) One representative of the Office of Minority Health and Health Disparities, designated by the Director of the Office;

(6) One representative of the Maryland Medical Assistance Program, designated by the Secretary;

(7) One representative of the Maryland Insurance Administration, designated by the Maryland Insurance Commissioner; and

(8) The following members, appointed by the Governor:

(i) One representative of an academic research institution that receives grant funding for rare disease research;

(ii) One geneticist licensed and practicing in the State;

(iii) One registered nurse or advanced practice registered nurse licensed and practicing in the State with experience treating rare diseases;

(iv) One physician licensed in the State with experience treating rare diseases;

(v) One hospital administrator, or the designee of a hospital administrator, from a hospital in the State that provides care to individuals diagnosed with a rare disease;

(vi) One pharmacist licensed in the State with experience dispensing drugs used to treat rare diseases;

(vii) Two individuals who have been diagnosed with a rare disease;

(viii) One caregiver of an individual with a rare disease;

(ix) One representative of a rare disease patient organization that operates in the State;

(x) One representative of the biopharmaceutical industry;

(xi) One representative of a health insurance carrier providing health insurance coverage in the State;

(xii) One member of the scientific community who is engaged in rare disease research; and

(xiii) One representative of an organization that provides care management for individuals enrolled in the State's Rare and Expensive Case Management Program.

(b) For the appointed members of the Council, the appointment process shall be conducted in a transparent manner to provide interested individuals an opportunity to apply.

(c) All members of the Council must be full–time residents of the State.

(d) (1) The term of an appointed member is 3 years.

(2) If a vacancy occurs on the Council, the members of the Council shall appoint an individual to fill the vacancy by majority vote.

(e) (1) The Governor shall designate the initial chair of the Council to serve a term of 3 years.

(2) The initial chair designated by the Governor may not hold a position within State government.

(3) At the end of the term of the initial chair, the members of the Council shall designate a new chair by majority vote.

(4) Except as provided in paragraph (1) of this subsection, the term of a chair of the Council is 2 years.

(f) The Department shall provide staff for the Council.

(g) A member of the Council:

(1) May not receive compensation as a member of the Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(h) (1) The initial meeting of the Council shall occur on or before December 30, 2024.

(2) On or before October 1, 2025, the Council shall meet at least once per month in person or through an online meeting platform at a time designated by the chair.

(3) After October 1, 2025, the Council shall meet at least once per quarter in person or through an online meeting platform at a time designated by the chair.

§13–5003.

(a) The Council shall:

(1) Convene public hearings, make inquiries, and solicit comments from the public to assist the Council with a first–year survey of the needs of rare disease patients, caregivers, and health care providers in the State;

(2) Consult with experts on rare diseases to develop policy recommendations to improve patient access to and the quality of rare disease specialists, affordable and comprehensive health care coverage, relevant diagnostics, timely treatment, and other needed services;

(3) Research and make recommendations to State agencies and insurers that provide services to individuals with a rare disease on the impact of prior

authorization, cost–sharing, tiering, or other utilization management procedures on the provision of treatment and care for patients;

(4) Establish best practices and protocols to include in State planning related to natural disasters and public health emergencies or other emergency declarations to enable continuity of care for rare disease patients and ensure that safeguards against discrimination for rare disease patients are in place;

(5) Evaluate and make recommendations regarding coverage of prescription drugs for rare disease patients, including patients with private health insurance coverage and patients enrolled in the Maryland Medical Assistance Program, to improve coverage of diagnostics, and to facilitate access to necessary health care providers with expertise in the treatment of rare diseases;

(6) Publish a list of existing and publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases on the Council's webpage;

(7) Identify areas of unmet needs for research that can inform future studies and reports by the Council;

(8) Identify and distribute educational resources for health care providers to foster recognition and optimize treatment of rare diseases in the State; and

(9) Research and identify best practices to ensure continuity of care for rare disease patients transitioning from pediatric to adult care.

(b) The Council shall provide opportunities for the public to hear updates and provide input on the Council's activities.

(c) The Council shall maintain a webpage for the purposes of:

(1) Posting meeting minutes and notices of upcoming meetings;

(2) Allowing the public to submit comments to the Council; and

(3) Posting a list of resources as required under subsection (a)(7) of this section.

(d) (1) The Council may solicit funds on its behalf, including by applying for available federal or State grants.

(2) The Council shall set up a method to securely hold and distribute funds to support the duties of the Council.

§13–5004.

(a) On or before December 1 each year, beginning in 2024, the Council shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(b) The report required under subsection (a) of this section shall:

(1) Describe the activities of the Council under § 13–5003(a) of this subtitle;

(2) Describe the funding sources of the Council, including grants that were applied for and accepted and the remaining balances of any current grants; and

(3) Provide recommendations on the ways to address the needs of individuals living with rare diseases in the State.

§13–5101. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

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

(b) "Commission" means the Commission on Public Health.

(c) "Foundational public health services" includes:

(1) The following foundational areas:

(i) Communicable disease control;

(ii) Chronic disease and injury prevention;

(iii) Environmental public health;

(iv) Maternal, child, and family health; and

(v) Access to and linkage with clinical care; and

(2) The following foundational capabilities:

(i) Assessment and surveillance;

(ii) Community partnership development;

(iii) Equity;

(iv) Organizational competencies;

(v) Policy development and support;

(vi) Accountability and performance management;

(vii) Emergency preparedness and response; and

(viii) Communications.

§13–5102. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

There is a Commission on Public Health.

§13–5103. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

(a) The Commission consists of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) The Secretary of Budget and Management, or the Secretary's designee;

(4) The Secretary of Information Technology, or the Secretary's designee;

(5) The Deputy Secretary for Public Health, or the Deputy Secretary's designee;

(6) The Deputy Secretary for Operations, or the Deputy Secretary's designee;

(7) The Chief Executive Officer of the Chesapeake Regional Information System for Our Patients (CRISP), or the Chief Executive Officer's designee; and

(8) The following members, appointed by the Governor:

(i) Three local health officers of whom:

1. One shall be from a rural jurisdiction;

2. One shall be from a suburban jurisdiction; and

3. One shall be from an urban jurisdiction;

(ii) Two representatives from State academic institutions with expertise in public health systems; and

(iii) A faculty member from a public health program at a historically Black college or university.

(b) The Governor may appoint not more than two members of the public with experience in public health as additional members of the Commission.

(c) (1) The Commission may establish workgroups at the discretion of the Commission.

(2) The chair of the Commission may appoint members of the public to a workgroup.

(d) To the extent practicable and consistent with federal and State law, the membership of the Commission and workgroups established under this section shall reflect the racial, ethnic, and gender diversity of the State.

(e) (1) Subject to paragraph (2) of this subsection and except as provided in paragraph (3) of this subsection, the Commission shall select a chair and a vice chair from among its members.

(2) To qualify to serve as chair of the Commission, the member must agree to provide staff for the Commission on selection as chair.

(3) The members of the Commission may not select as chair a member listed in subsection (a)(3), (4), (5), or (6) of this section.

(f) A member of the Commission:

(1) May not receive compensation as a member of the Commission; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§13–5104. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

(a) The chair of the Commission shall provide staff support for the Commission.

(b) If the chair fails to provide staffing for the Commission, the members shall select a new chair in accordance with § 13–5103(e) of this subtitle.

§13–5105. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

(a) The purpose of the Commission is to make recommendations to improve the delivery of foundational public health services in the State.

(b) The Commission shall provide guidance for implementation of the Commission's recommendations.

(c) The Department shall provide an update regarding the implementation of the Commission's recommendations to the Commission each quarter.

§13–5106. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

(a) The Commission shall assess the foundational public health capabilities of the Department and local health departments in the State.

(b) (1) In conducting the assessment required under subsection (a) of this section, the Commission shall:

(i) Explain the impact of the foundational public health capabilities on the State's ability to address foundational public health areas, including as the foundational public health areas relate to behavioral health;

(ii) Explain the impact of the foundational public health capabilities on the State's ability to respond to COVID–19, overdoses, maternal and infant mortality, and other major public health challenges as appropriate; and

(iii) Provide public outreach to hold at least three public meetings in different areas of the State that include an opportunity for public comment.

(2) In conducting the assessment required under subsection (a) of this section, the Commission may:

(i) Request deidentified and publicly available data from the Department, local health departments, and the State–designated health data utility; and

(ii) Request interviews with State and local health officials.

(c) (1) Based on the assessment conducted under subsection (a) of this section, the Commission shall make recommendations for reform in the following areas:

(i) Organization of State and local public health departments;

(ii) Information technology, information exchange, and data and analytics;

(iii) Workforce, including human resources and use of the Maryland Medical Reserve Corps established under Title 2, Subtitle 11 of this article;

(iv) Procurement, including oversight of contractors;

(v) Funding;

(vi) Communication and public engagement; and

(vii) Any other area considered appropriate by the Commission.

(2) The recommendations made under paragraph (1) of this subsection shall include the funding or legislation required to implement the recommendation, if any.

(3) The Commission shall justify each recommendation made under paragraph (1) of this subsection based on how the recommendation contributes to the provision of foundational public health services.

(4) (i) The Commission shall make a draft of its recommendations available for public comment for 30 days.

(ii) The final report of the Commission shall include a response to any substantive public comment received on the draft recommendations.

(5) (i) The Commission shall use best efforts to reach consensus on its recommendations.

(ii) If the Commission cannot reach consensus on its recommendations, the Commission shall include the opportunity for dissenting comments in the Commission's final report.

§13–5107. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 190 OF 2026 //

On or before January 1 each year, the Commission shall submit a report on the implementation of its recommendations and barriers to implementation to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Budget and Taxation Committee, the Senate Finance Committee, the House Appropriations Committee, and the House Health Committee.

§13–5201.

In this subtitle, "Center" means the Center for Firearm Violence Prevention and Intervention.

§13–5202.

(a) There is a Center for Firearm Violence Prevention and Intervention in the Department.

(b) The purpose of the Center is to reduce firearm violence, harm from firearm violence, and misuse of firearms in the State by partnering with federal, State, and local agencies and affected communities to implement a public health approach to firearm violence reduction.

§13–5203.

(a) The Secretary shall appoint the executive director of the Center.

(b) The executive director shall appoint and remove all staff in accordance with the provisions of the State Personnel and Pensions Article.

(c) The executive director shall coordinate and direct any planning related to the Center initiated by the Department.

(d) The Center may apply for, receive, and spend federal grants–in–aid or any other federal funds made available to the Department for use in carrying out the powers and duties of the Secretary or the Department.

§13–5204.

(a) The Center shall:

(1) Work in consultation with the Governor's Office of Crime Prevention and Policy or any successor agency, the Maryland State Police, and any other relevant State or local agency to ensure a multidepartmental approach to reducing firearm violence;

(2) Solicit and consider recommendations from:

(i) Communities disproportionately impacted by firearm violence;

(ii) Public health experts;

(iii) Individuals or organizations with expertise in firearm safety and training; and

(iv) Any other experts, groups, or organizations as the executive director determines appropriate and necessary; and

(3) (i) On or before May 1, 2025, submit a preliminary State Plan for a Public Health Approach to Reducing Firearm Violence to guide the work of the Center to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly; and

(ii) On or before May 1, 2029, and every 4 years thereafter, submit a State Strategic Plan for Firearm Violence Reduction Using Public Health Strategies to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(b) The Center may:

(1) Offer training and technical assistance to State and local agencies, health care professionals, and community and faith–based organizations to increase capacity to implement evidence–based firearm violence prevention and intervention strategies;

(2) Issue best practice guidance and model processes in consultation with affected communities regarding implementation of evidence–based firearm violence prevention and intervention strategies;

(3) In consultation with the Governor's Office of Crime Prevention and Policy or any successor agency, facilitate cross–jurisdictional data and information sharing;

(4) Conduct public awareness campaigns;

(5) Share data and collaborate with higher education and research institutions regarding the prevention of firearm violence;

(6) Promote the development of evidence–based firearm violence prevention initiatives in affected communities throughout the State; and

(7) Engage in any other activity consistent with the Center's mission.

§13–5205.

For fiscal year 2026 and each fiscal year thereafter, the Governor may include in the annual budget bill an appropriation sufficient to fund the Center.

§13–5301.

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

(b) "Board" means the State Board of Pharmacy.

(c) "CDC Guidelines" means the "Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV – United States 2016" or any subsequent guidelines published by the Centers for Disease Control and Prevention.

(d) "Nonoccupational postexposure prophylaxis" or "nPEP" means medication used in accordance with the most recent CDC Guidelines to reduce the chances of a patient developing HIV after potential exposure to the disease.

(e) "Pharmacist" means a pharmacist licensed in the State under Title 12 of the Health Occupations Article.

(f) "Program" means the Nonoccupational Postexposure Prophylaxis (nPEP) Standing Order Program.

(g) "Standing order" means a directive authorizing pharmacists to dispense the nPEP regimens listed in the order without a prescription.

§13–5302.

(a) There is a Nonoccupational Postexposure Prophylaxis (nPEP) Standing Order Program.

(b) The Program shall:

(1) Authorize a pharmacist who is registered with the Program to dispense nPEP through a standing order in accordance with § 13–5203 of this subtitle; and

(2) Operate in accordance with the procedures approved by the Department with the advice and approval of the Board.

(c) The Department shall adopt regulations:

(1) Necessary for the administration of the Program; and

(2) That address the needs of specific populations including victims of sexual assault and pediatric patients.

(d) The Department may:

(1) Collect fees necessary for the administration of the Program, unless the patient qualifies for nPEP through the Program for Preventing HIV Infection for Rape Victims established under § 11–1008 of the Criminal Procedure Article;

(2) Administer the Program and establish a standardized set of guidelines for pharmacists participating in the Program to use in developing and conducting patient education and training on nPEP that includes:

(i) Avoiding exposure to HIV;

(ii) Responding to exposure to HIV with the appropriate use of nPEP;

(iii) Access to nPEP and the appropriate follow–up after the administration of nPEP; and

(iv) Engagement in additional care including:

1. Access to pre–exposure prophylaxis (PrEP); and

2. Harm reduction programs for patients with continuing risk of exposures; and

(3) Collect and report data on the operation and results of the Program.

§13–5303.

(a) At the time of dispensing nPEP, a pharmacist registered with the Program shall:

(1) Screen the patient to determine that HIV exposure occurred within 72 hours before the dispensing;

(2) Determine whether the patient meets clinical criteria consistent with the most recent CDC Guidelines, including:

(i) The identification of any contraindicated medications; and

(ii) If applicable, exposure as the result of an alleged rape or sexual offense or alleged child sexual abuse;

(3) Subject to subsection (b) of this section, determine whether an available standing order is appropriate for the patient and dispense nPEP in accordance with the most recent CDC Guidelines;

(4) Refer the patient to a disease intervention specialist within the Department for ongoing treatment; and

(5) Determine whether the patient has a primary care provider and:

(i) If the patient has a primary care provider, notify the provider that the patient was dispensed nPEP; or

(ii) If the patient does not have a primary care provider, provide the patient with a list of local primary care providers and clinics provided by the Department.

(b) If an available standing order is not appropriate for the patient, the pharmacist shall refer the patient to a primary care provider.

(c) A pharmacist may dispense nPEP in accordance with a therapy management contract under Title 12, Subtitle 6A of the Health Occupations Article.

§13–5401.

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

(2) "Program" means the Reproductive Health Care Clinic Security Grant Program.

(3) "Reproductive health care clinic" means a health care provider, as defined in § 4–301(h)(1)(ii) of this article, that provides legally protected health care, as defined in § 4–301(j) of this article.

(b) There is a Reproductive Health Care Clinic Security Grant Program in the Department.

(c) The Secretary shall administer the Program.

(d) The purpose of the Program is to assist reproductive health care clinics in the State with the costs associated with security improvements, including interior and exterior facility hardening, perimeter lighting, fencing and other barriers, door locks and access control systems, security cameras, alarms, panic buttons, lockdown systems, and public address systems.

(e) The Secretary shall establish procedures for:

(1) The application and award processes; and

(2) The criteria a reproductive health care clinic must meet to qualify for a grant under the Program.

(f) The Department may not release, publish, or otherwise disclose:

(1) The personal information of an individual applying for, participating in, or administering a grant under the Program; or

(2) Information regarding a grant awarded under the Program if the disclosure would compromise the safety of the grant recipient.

(g) (1) For fiscal year 2026, the Governor may include in the annual budget bill an appropriation of $500,000 to the Program.

(2) Up to 5% of the money appropriated to the Program may be used for administrative expenses.

§13–5601. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2030 PER CHAPTER 615 OF 2025 //

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

(b) "AHEAD Model" means the States Advancing All–Payer Health Equity Approaches and Development Model administered by the Center for Medicare and Medicaid Innovation.

(c) "Fund" means the Population Health Improvement Fund.

(d) "Statewide health equity plan" means the equity plan required under the AHEAD Model State Agreement with the Centers for Medicare and Medicaid Services.

§13–5602. IN EFFECT

(a) There is a Population Health Improvement Fund.

(b) The purpose of the Fund is to invest in population health improvements to support the statewide population health targets under the AHEAD Model and any successor models.

(c) The Department and the Health Services Cost Review Commission jointly shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) The revenues from the uniform, broad–based assessment made under subsection (l) of this section;

(2) Money appropriated in the State budget to the Fund;

(3) Interest earnings; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(f) (1) Subject to paragraphs (2), (3), and (4) of this subsection and except as provided under paragraph (3) of this subsection, the Fund may be used only for expenses associated with statewide population health improvement initiatives in alignment with the statewide health equity plan as directed by the Secretary.

(2) Except as provided under paragraph (3) of this subsection, activities paid for by the Fund must support the goal of meeting the statewide population health targets outlined in the AHEAD Model State Agreement with the Centers for Medicare and Medicaid Services and have at least one of the following functions:

(i) Reducing rates of common preventable health conditions;

(ii) Addressing health–related social needs; or

(iii) Reducing or eliminating health disparities.

(3) In calendar year 2026 only, up to $14,000,000 in the Fund may be used to fund expenses of the Medical Care Programs Administration within the Department if the Health Services Cost Review Commission increases hospital rates to provide financial assistance to Medicare Advantage Plans.

(4) The Department and the Health Services Cost Review Commission may, in a manner consistent with the AHEAD Model State Agreement, transfer money from the Fund to the Public Health Workforce Development Fund established under § 24–2802 of this article.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund is supplemental to and is not intended to take the place of funding that would otherwise be appropriated for the Maryland Medical Assistance Program.

(j) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

(k) (1) On or before July 1 each year, beginning in 2026, the Department shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article.

(2) The report required under paragraph (1) of this subsection shall:

(i) Reflect the required elements of the annual progress report as outlined in the State agreement and shall include:

1. Measures of effectiveness for funded programs and targeted populations;

2. Any impact on health outcomes and health disparities; and

3. Relevant components from hospital required reporting to the Health Services Cost Review Commission on population health improvement efforts; and

(ii) Include:

1. An accounting of all sources of funding accepted for the benefit of the Fund and the amount of funding from each source; and

2. A summary of the extent to which public comments informed the work of the Department and the Commission.

(3) The Department shall make a draft of its report available for public comment for 30 days.

(l) (1) Subject to paragraph (2) of this subsection, each year of the Total Cost of Care Model, the AHEAD Model, or any successor model, the Health Services

Cost Review Commission may assess a uniform, broad–based, and reasonable amount in hospital rates to be credited to the Fund.

(2) The Health Services Cost Review Commission shall include the full amount of the assessment authorized under paragraph (1) of this subsection in the hospital rates.

(3) Any funds generated from the assessment authorized under paragraph (1) of this subsection may be used only for the expenses described in subsection (f) of this section.

§13–5602. // EFFECTIVE DECEMBER 31, 2027 PER CHAPTER 615 OF 2025 //

// EFFECTIVE UNTIL DECEMBER 31, 2030 PER CHAPTER 615 OF 2025 //

(a) There is a Population Health Improvement Fund.

(b) The purpose of the Fund is to invest in population health improvements to support the statewide population health targets under the AHEAD Model and any successor models.

(c) The Department and the Health Services Cost Review Commission jointly shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund;

(2) Interest earnings; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(f) (1) Subject to paragraphs (2), (3), and (4) of this subsection and except as provided under paragraph (3) of this subsection, the Fund may be used only for expenses associated with statewide population health improvement initiatives in alignment with the statewide health equity plan as directed by the Secretary.

(2) Except as provided under paragraph (3) of this subsection, activities paid for by the Fund must support the goal of meeting the statewide population health targets outlined in the AHEAD Model State Agreement with the Centers for Medicare and Medicaid Services and have at least one of the following functions:

(i) Reducing rates of common preventable health conditions;

(ii) Addressing health–related social needs; or

(iii) Reducing or eliminating health disparities.

(3) In calendar year 2026 only, up to $14,000,000 in the Fund may be used to fund expenses of the Medical Care Programs Administration within the Department if the Health Services Cost Review Commission increases hospital rates to provide financial assistance to Medicare Advantage Plans.

(4) The Department and the Health Services Cost Review Commission may, in a manner consistent with the AHEAD Model State Agreement, transfer money from the Fund to the Public Health Workforce Development Fund established under § 24–2802 of this article.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund is supplemental to and is not intended to take the place of funding that would otherwise be appropriated for the Maryland Medical Assistance Program.

(j) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

(k) (1) On or before July 1 each year, beginning in 2026, the Department shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article.

(2) The report required under paragraph (1) of this subsection shall:

(i) Reflect the required elements of the annual progress report as outlined in the State agreement and shall include:

1. Measures of effectiveness for funded programs and targeted populations;

2. Any impact on health outcomes and health disparities; and

3. Relevant components from hospital required reporting to the Health Services Cost Review Commission on population health improvement efforts; and

(ii) Include:

1. An accounting of all sources of funding accepted for the benefit of the Fund and the amount of funding from each source; and

2. A summary of the extent to which public comments informed the work of the Department and the Commission.

(3) The Department shall make a draft of its report available for public comment for 30 days.

§13–5701.

(a) (1) The Department, in collaboration with the Commission on Health Equity, shall develop a clear and easy–to–understand graphic data dashboard that includes age–adjusted health disparity data disaggregated by race, ethnicity, and gender.

(2) The data dashboard shall include information regarding the following health indicators:

(i) Health insurance access;

(ii) Cardiovascular disease;

(iii) Chronic disease;

(iv) Mental health and substance use;

(v) Cancer;

(vi) HIV/AIDS;

(vii) Sexually transmitted infection;

(viii) Body mass index; and

(ix) Any other health indicators determined relevant by the Department.

(b) The Department shall:

(1) Update the data dashboard developed under subsection (a) of this section on a quarterly basis, as determined by data availability; and

(2) Post the most recent updated data dashboard prominently on its website.

§13–5801. IN EFFECT

// EFFECTIVE UNTIL SEPTEMBER 30, 2030 PER CHAPTER 759 OF 2025 //

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

(b) "Paramedic" has the meaning stated in § 13–516 of the Education Article.

(c) "Program" means the Buprenorphine Training Grant Program.

§13–5802. IN EFFECT

// EFFECTIVE UNTIL SEPTEMBER 30, 2030 PER CHAPTER 759 OF 2025 //

(a) (1) There is a Buprenorphine Training Grant Program in the Department.

(2) The purpose of the Program is to assist a county with offsetting the cost of training paramedics to administer buprenorphine.

(b) A county may apply to the Department for a grant from the Program.

(c) A county may use a grant awarded under the Program only for training paramedics to administer buprenorphine.

(d) The Governor shall include in the annual budget bill an appropriation of at least $50,000 from the Opioid Restitution Fund for the Program.

§13–5901. NOT IN EFFECT

** TAKES EFFECT OCTOBER 1, 2027 PER CHAPTER 237 OF 2026 **

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

(b) "Authorized agent" means an individual who is not counsel for the committed person and who is selected by the committed person to represent the interests of the committed person in all community monitoring board matters.

(c) "Committed person" has the meaning stated in § 3–101 of the Criminal Procedure Article.

(d) "Mental health team" means the committed person's inpatient behavioral health providers and outpatient community behavioral health providers.

(e) "Program" means the Community Forensic Aftercare Program.

(f) "Program monitor" means a licensed social worker employed by the Program to:

(1) Collect and review information pertaining to a committed person's compliance with a conditional release order; and

(2) Make behavioral health recommendations to the committed person's behavioral health providers and the court.

§13–5902. NOT IN EFFECT

** TAKES EFFECT OCTOBER 1, 2027 PER CHAPTER 237 OF 2026 **

(a) There is a Community Forensic Aftercare Program in the Department.

(b) The purpose of the Program is to monitor:

(1) Committed persons on conditional release; and

(2) Individuals with mental illness or intellectual disability who are required to be monitored under Title 3 of the Criminal Procedure Article.

(c) (1) The Program shall:

(i) Monitor committed persons on conditional release in accordance with the order of the court under Title 3 of the Criminal Procedure Article and the recommendations of the committed person's mental health team;

(ii) Monitor individuals who have been:

1. Found incompetent to stand trial but not a danger to self or the person or property of others under § 3–106 of the Criminal Procedure Article; and

2. Released from confinement in a Department facility in accordance with a court order for conditional release that requires community forensic aftercare monitoring;

(iii) Receive and report violations of a condition of conditional release under § 3–121 of the Criminal Procedure Article; and

(iv) Review applications for change in conditional release on behalf of the Department under § 3–122 of the Criminal Procedure Article.

(2) The Program:

(i) May not make clinical decisions regarding the treatment of committed persons; but

(ii) May make monitoring decisions and recommendations regarding the treatment of the committed person.

(3) A health care practitioner–patient relationship may not be determined to exist between a committed person and an individual who monitors individuals or provides other services under the Program.

(d) (1) Subject to paragraph (2) of this subsection, at least three times within the 6–month period immediately following the date the committed person was initially released from a facility, a program monitor shall hold a meeting with:

(i) Each committed person monitored by the Program; and

(ii) The mental health team of the committed person.

(2) Beginning 6 months after the date the committed person was released from a facility, meetings shall be held as determined necessary by:

(i) The mental health team of the committed person; or

(ii) At the request of the Program.

(3) A committed person may appoint an advocate, including a designee of counsel of the committed person, to attend a meeting held under paragraphs (1) and (2) of this subsection.

(4) If a meeting under paragraph (1) or (2) of this subsection concerns the committed person's compliance with a conditional release, the Program shall notify the advocate of the committed person and, if applicable, the counsel of the committed person of the meeting.

(5) If a meeting under paragraph (1) or (2) of this subsection is held due to an emergency involving the committed person, the Program shall notify the advocate of the committed person and, if the committed person has retained counsel, the counsel of the committed person of the content of the meeting as soon as practicable.

(e) If the Program receives a report alleging that a committed person has violated conditional release, the Program shall:

(1) Make the notifications required under § 3–121(b)(2)(i) of the Criminal Procedure Article;

(2) Provide the State's Attorney with the information required under § 3–121(b)(2)(ii) of the Criminal Procedure Article; and

(3) If applicable, provide to the counsel of record for the committed person the information provided under item (2) of this subsection.

(f) (1) Subject to paragraph (2) of this subsection, if the Program receives a request for records for an individual who has violated a condition of conditional release and a hearing under § 3–121(f) of the Criminal Procedure Article has been scheduled within 10 days, the Program shall provide the records within 5 business days after the request is received unless the Program is prohibited under applicable federal or State law from disclosing the records to the requesting person.

(2) In accordance with § 4–307(l) of this article, the Program and any health care provider involved in the treatment of the individual shall disclose any records without the authorization of the individual who is the subject of the record to a public defender who states in writing that the Office of the Public Defender represents the individual.

§13–5903. NOT IN EFFECT

** TAKES EFFECT OCTOBER 1, 2027 PER CHAPTER 237 OF 2026 **

(a) The Program shall establish a community monitoring board to make:

(1) Recommendations relating to the early termination of conditional release;

(2) Recommendations relating to modification of the conditions of release;

(3) Recommendations relating to the extension of conditional release;

(4) Recommendations relating to the eligibility of a committed person to remain on conditional release; and

(5) Decisions relating to any out–of–state travel request.

(b) (1) Each voting member of the community monitoring board shall be a health care provider licensed under the Health Occupations Article.

(2) Decisions of the community monitoring board shall be determined by a majority vote.

(3) The community monitoring board shall have an odd number of members.

(4) Each member of the community monitoring board shall have one vote.

(5) A community monitoring board may not issue a recommendation or render a decision under subsection (a) of this section unless a quorum is present.

(6) A majority of the members of the community monitoring board is a quorum.

(c) (1) A committed person may appoint an authorized agent to attend the entirety of a community monitoring board meeting concerning the committed person, except for the final voting portion of a meeting.

(2) An authorized agent may be a social worker or an investigator employed by the counsel representing the committed person.

(3) An authorized agent may only give and hear arguments.

(4) An authorized agent may attend a community monitoring board meeting virtually.

(d) (1) The community monitoring board shall maintain a written record containing its findings, recommendations, and decisions.

(2) The written record shall be included in the medical record of the committed person.

(3) The findings shall include the reasons for the community monitoring board's recommendation or decision.

(e) (1) When making a recommendation or decision under this section, the community monitoring board shall consider a written statement, if any, offered by the committed person to the community monitoring board.

(2) The community monitoring board shall provide notice to a committed person and the counsel of record for the committed person as soon as practicable but no later than 10 days before the community monitoring board holds a meeting concerning the committed person.

(3) A copy of this notice shall be maintained in the Program's records.

(f) The Office of the Attorney General may provide legal counsel to the Department at the Program's community monitoring board meetings.

(g) A copy of a document or record produced by the community monitoring board under this section shall, on request, be provided to:

(1) The committed person;

(2) Counsel for the committed person;

(3) The court;

(4) The State's Attorney; or

(5) The Department.

§13–5904. NOT IN EFFECT

** TAKES EFFECT OCTOBER 1, 2027 PER CHAPTER 237 OF 2026 **

The Department shall adopt regulations to carry out this subtitle.

§14–201.

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

(b) "Day care center for the elderly" means a place that:

(1) Is operated to provide, with or without charge, care for elderly individuals; and

(2) Either is:

(i) Designated for group care for at least 4 elderly individuals; or

(ii) A family home that provides care for 2 or 3 elderly individuals.

(c) "Elderly individual" means an individual who:

(1) Is 55 years old or older;

(2) Lives alone or with a spouse, family relative, or friend;

(3) Needs temporary supervision and care during a part of a day in a protective group setting; and

(4) Has a disability that is:

(i) A reasonably static physical impairment that prevents:

1. Gainful employment; or

2. The accomplishment of the routine of normal daily activities without assistance; or

(ii) A permanent or recurrent mental impairment.

§14–202.

(a) The purposes of this subtitle are:

(1) To provide for the establishment of day care centers for the elderly and services that will give many elderly individuals the chance to stay with their families or in their communities instead of being placed in a nursing home or State institution;

(2) To allow children and other relatives to keep elderly individuals instead of placing them in impersonal institutions; and

(3) To allow this State to deal more effectively and economically with the needs of its elderly individuals.

(b) The General Assembly intends that day care centers for the elderly and services be used:

(1) To avoid, as much as possible, unnecessary commitment of an elderly individual to a nursing home, State institution, or other long term care facility;

(2) To provide opportunities for elderly individuals to be discharged from nursing homes, State institutions, or general and special hospitals; and

(3) To serve only those elderly individuals who otherwise would be eligible under State or federal law for care in a nursing home, State institution, or other long term care facility.

§14–203.

This subtitle does not affect a relative who cares for an elderly individual or a neighbor or friend who cares for an elderly individual by mutual agreement.

§14–204.

The Maryland Department of Health:

(1) Has the primary responsibility, in conjunction with the Department of Human Services and the Department of Aging, to provide the guidance and means for establishing day care centers for the elderly in accordance with this subtitle; and

(2) Shall recruit and encourage the establishment of day care centers for the elderly and provide for their licensing.

§14–205.

(a) The Maryland Department of Health may use funds appropriated for the day care for the elderly to:

(1) Assist in start–up costs of establishing a day care center for the elderly; and

(2) Subsidize day care services for financially eligible elderly individuals.

(b) The services that are provided by the day care center for the elderly under this section shall include:

(1) Therapeutic arts and crafts;

(2) Community excursions, if appropriate;

(3) Hobby cultivation;

(4) Health services;

(5) Counseling services for elderly individuals and their families;

(6) Group dynamics; and

(7) Other services that enhance social functioning and develop activities in daily living and personal independence.

§14–206.

(a) The Department shall adopt rules and regulations that set the standards necessary for the welfare and safety of elderly individuals who receive care in day care centers for the elderly.

(b) Before the Department adopts a proposed plan, rule, or regulation under this subtitle, the Department shall submit the plan, rule, or regulation to the Department of Aging for its recommendations.

§14–2A–01. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2025 PER CHAPTER 437 OF 2022 //

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

(b) "Elderly individual" has the meaning stated in § 14–201 of this title.

(c) "Integrator" means an entity that:

(1) Organizes a voluntary association of licensed medical adult day care providers, home health care providers, and other providers and entities to coordinate to provide integrated services under the pilot program; and

(2) Is licensed in the State to provide at least one of the services included in the pilot program.

(d) "Pilot program" means the Howard County and Montgomery County Adult Day Health Care Services Pilot Program.

(e) "Task Force" means the Task Force on the Howard County and Montgomery County Adult Day Health Care Services Pilot Program.

§14–2A–02. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2025 PER CHAPTER 437 OF 2022 //

(a) This section applies only in Howard County and Montgomery County.

(b) (1) There is a Howard County and Montgomery County Adult Day Health Care Services Pilot Program.

(2) The purpose of the pilot program is to integrate the provision of medical adult day care services, home health care services, and medical services provided under the Maryland Medical Assistance Program.

(c) Participation in the pilot program is limited to elderly individuals who are:

(1) Residents of Howard County or Montgomery County; and

(2) Receiving medical adult day care services, home health care services, or medical services provided under the Maryland Medical Assistance Program, including medical services that are offered by a managed care organization.

(d) Services provided under the pilot program shall include, when applicable:

(1) An evaluation and assessment of each pilot program participant by a licensed nurse to complete an interdisciplinary care plan for the participant;

(2) The provision of remote services to the participant, using an electronic device with video conferencing capability issued to the participant to facilitate communication with providers;

(3) The creation of a medication strategy for the participant in order to provide appropriate evaluation and monitoring of the administration of medications;

(4) A program of activities and social engagement to assist participants in reducing loneliness and depression and to develop a sense of community with other participants;

(5) Coordination of medical care and other services ordered by a physician for the purpose of allowing participants to live safely in their home environment;

(6) The provision of basic housekeeping services to assist participants in daily activities that may be challenging; and

(7) The provision of transportation and delivery of meals.

(e) (1) Howard County and Montgomery County jointly may designate and authorize the operation of one or more entities to serve as an integrator in Howard County and Montgomery County.

(2) An integrator shall be licensed in the State to provide at least one of the services to be included in the pilot program.

(f) In consultation with Howard County and Montgomery County, an integrator shall coordinate all services provided under the pilot program.

§14–2A–03. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2025 PER CHAPTER 437 OF 2022 //

(a) There is a Task Force on the Howard County and Montgomery County Adult Day Health Care Services Pilot Program.

(b) The Task Force consists of the following members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate;

(2) One member of the House of Delegates, appointed by the Speaker of the House;

(3) One representative of the Howard County government, designated by the Howard County Executive;

(4) One representative of the Montgomery County government, designated by the Montgomery County Executive;

(5) The Secretary of Aging, or the Secretary's designee;

(6) The Secretary, or the Secretary's designee; and

(7) The following members, appointed by the Governor:

(i) Two representatives of the Maryland Association of Adult Day Services;

(ii) One representative of the home health care industry;

(iii) One representative of the Maryland Managed Care Organization Association; and

(iv) One representative of the Greater Maryland and the National Capital Area chapters of the Alzheimer's Association.

(c) The Governor shall designate the chair of the Task Force.

(d) Howard County and Montgomery County jointly shall provide staff for the Task Force.

(e) A member of the Task Force:

(1) May not receive compensation as a member of the Task Force; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Task Force shall:

(1) Examine the status of medical adult day care in the State, including the provision of home health care and medical services to enrollees in medical adult day care programs;

(2) Review and evaluate the list of required services provided under § 14–2A–02(d) of this subtitle;

(3) Review and evaluate the efficacy of providing services using an integrator;

(4) Identify and measure any enhanced continuity of care, using the integrator model, that would allow enrollees to remain in their homes and the community, defer treatment in higher levels of care such as nursing homes, and reduce the incidence of treatment in acute care settings;

(5) Identify and measure any reduction in unnecessary utilization of emergency medical services by enrollees;

(6) Identify and compare differences and similarities between the pilot program, using the integrator model, and the features of the Program for All–Inclusive Care of the Elderly (PACE), including differences and similarities in the populations served;

(7) Identify and measure other potential benefits of the integrator model, such as greater social interaction, additional transportation options, avoidance of food insecurity, and monitoring the administration of medications; and

(8) Make recommendations regarding the implementation of the pilot program on a statewide basis.

(g) On or before October 1 each year, the Task Force shall report its findings and any recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

§14–301.

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

(b) "Day care center for adults" means a place that:

(1) Is operated to provide, with or without charge, care for medically handicapped adults; and

(2) Either is:

(i) Designated for group day care for 4 or more medically handicapped adults; or

(ii) A family home that provides day care for 2 or 3 medically handicapped adults.

(c) "Medically handicapped adult" means an individual who:

(1) Is 16 years old or older;

(2) Lives alone or with a spouse, relative, or friend; and

(3) Has a disability that is:

(i) A reasonably static physical impairment that prevents gainful employment or the accomplishment of the routine of normal daily activities outside of an institutional or sheltered environment; or

(ii) A permanent or recurrent mental impairment that requires domiciliary or institutional care in a sheltered environment.

§14–302.

(a) The purposes of this subtitle are:

(1) To provide for the establishment of day care centers for adults and services that will give medically handicapped adults the chance to stay with their families or in their communities instead of being placed in a nursing home or State institution; and

(2) To allow this State to deal more effectively and economically with the needs of its medically handicapped adults.

(b) The General Assembly intends that day care centers for adults and services be used:

(1) To avoid, as much as possible, unnecessary commitment of a medically handicapped adult to a nursing home, State institution, or other long term care facility;

(2) To provide opportunities for medically handicapped adults to be discharged from nursing homes, State institutions, or general or special hospitals; and

(3) To serve only those medically handicapped adults who otherwise would be eligible under State or federal law for care in a nursing home, State institution, or other long term care facility.

§14–303.

This subtitle does not affect a relative who cares for a medically handicapped adult or a neighbor or friend who cares for a medically handicapped adult by mutual choice and agreement.

§14–304.

(a) The Department of Human Services shall cooperate with and assist the Maryland Department of Health in carrying out the purposes of this subtitle.

(b) The Maryland Department of Health shall:

(1) Provide the guidance and means for establishing day care centers for adults in accordance with this subtitle;

(2) Recruit and encourage the establishment of day care centers for adults;

(3) Provide for licensing of day care centers for adults; and

(4) Adopt and enforce rules and regulations that set the standards necessary for the welfare and safety of medically handicapped adults who receive care in these day care centers for adults.

(c) (1) The Maryland Department of Health shall buy from any public or private agency the day care services for medically handicapped adults that are necessary and essential to enhance their well–being.

(2) These services shall include:

(i) Therapeutic arts and crafts;

(ii) Community excursions, if appropriate;

(iii) Hobby cultivation;

(iv) Health services;

(v) Counseling services for medically handicapped adults and their families;

(vi) Group dynamics; and

(vii) Other services that enhance social functioning and develop activities in daily living and personal independence.

§14–401.

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

(b) "Alternative accreditation" means a national camping standard that is acceptable to the Secretary as providing adequate health and safety protection for the campers, such as the American Camping Association standards for camp programs and services and the Boy Scouts of America standards, which includes an annual monitoring process to verify compliance with the standard.

(c) "Camper" means any child under 18 years of age who is attending a youth camp.

(d) "Certificate" means a single certificate issued by the Department to a youth camp under this subtitle.

(e) "Council" means the Youth Camp Safety Advisory Council.

(f) "Day" means all or part of a 24-hour period.

(g) "Day camp" means a youth camp that:

(1) Is operated for all or part of the day but less than 24 hours a day;

(2) Is conducted for at least 7 days during a 3–week period; and

(3) Provides 3 or more recreational activities or any 1 specialized activity including:

(i) Aquatic programs;

(ii) Horseback riding;

(iii) Firearms control;

(iv) Riflery;

(v) Archery;

(vi) Adventure camps;

(vii) Artistic gymnastics;

(viii) Hang gliding;

(ix) Road cycling;

(x) Skiing;

(xi) Rock climbing;

(xii) Spelunking;

(xiii) Motorized vehicle activities;

(xiv) Rappelling; and

(xv) High ropes.

(h) "Occasional use" means periodic involvement in a program where there is no expectation of regular attendance.

(i) "Operate" means to supervise, control, conduct, or manage a youth camp as:

(1) An owner;

(2) An agent of the owner;

(3) A lessee of the owner;

(4) A director; or

(5) An independent contractor.

(j) "Residential camp" means a youth camp operating at a facility or campsite at which a camper either lives apart or intends to live apart from the camper's relatives, parents, or legal guardians for at least 5 consecutive days.

(k) "Routine activity" means any type of activity other than a specialized activity as set forth in subsection (g)(3) of this section that is conducted for children by a youth camp.

(l) "Travel camp" means a residential camp that:

(1) Operates for at least 5 consecutive days; and

(2) Provides for campers to use motorized transportation to move as a group to or among sites for experiences in different environments.

(m) "Trip camp" means a residential camp:

(1) That operates for at least 5 consecutive days; and

(2) In which a group of individuals move from 1 site to another under their own power or by transportation which permits individual guidance of a vehicle or animal.

(n) "Unit" means a board, department, agency, or other component of a county or a municipal corporation.

(o) "Youth camp" or "camp" means any day camp, residential camp, travel camp, or trip camp that:

(1) Accommodates 7 or more campers who are unrelated to the person operating the camp;

(2) Provides primarily recreational activities or has a substantial outdoor recreational component;

(3) Has permanent buildings, temporary buildings, or no buildings; and

(4) Operates on:

(i) Owned private property;

(ii) Owned private facilities;

(iii) Leased private property;

(iv) Leased private facilities;

(v) Public property; or

(vi) Public facilities.

(p) "Youth overnight program" means an activity sponsored by a religious or a community organization at a facility or site at which an individual less than 18 years old either lives apart or intends to live apart from the individual's relatives, parent, or legal guardians for fewer than 5 consecutive days.

§14–402.

(a) This subtitle and the regulations issued under this subtitle do not apply to:

(1) Purely social activities of a family or the guests of a family;

(2) Subject to subsection (b) of this section, programs or activities directed or operated by a board of recreation, recreation department, or similar public unit of a county, a municipality, as defined by § 1–101 of the Local Government Article, or the Maryland–National Capital Park and Planning Commission, that involve use of neighborhood facilities, including:

(i) Schools;

(ii) Playgrounds;

(iii) Parks; or

(iv) Recreation centers;

(3) Subject to subsection (c) of this section, programs or activities directed or operated by an agency of the State that involve occasional use of public facilities including:

(i) Schools;

(ii) Playgrounds;

(iii) Parks; or

(iv) Recreation centers; or

(4) Youth overnight programs sponsored by religious or community organizations operating or conducted for not more than 5 consecutive days during any 1 calendar year, such as a vacation bible school, youth bike trip, and similar activities.

(b) (1) Subject to the provisions of paragraph (2) of this subsection, each local government shall adopt health and safety standards pertaining to the operation of youth camps.

(2) Each unit of local government, or the Maryland–National Capital Park and Planning Commission, that directs or operates a program or activity under subsection (a)(2) of this section shall certify in writing on or before April 1 of each year to the Maryland Department of Health that all of those programs and activities operated by the unit comply with the applicable health and safety standards of the local jurisdiction in which the program or activity is located and any State law the enforcement of which has been delegated to local government. However, a unit may annually elect to comply with this subtitle and the regulations adopted under it.

(c) Each agency of the State that directs or operates a program or activity that is not exempt under subsection (a)(3) of this section shall annually certify in writing to the Maryland Department of Health that each program or activity operated by the agency complies with this subtitle and the regulations adopted under it.

(d) The Department shall:

(1) Conduct inspections of:

(i) A random 5 percent sample of programs or activities described under subsection (b) or (c) of this section to ensure that each program or activity is in compliance with all applicable health and safety laws and standards; and

(ii) Any program or activity about which a complaint has been filed; and

(2) Advise the unit or agency of any significant violation of State regulations that would adversely impact the health or safety of children participating in a program or activity.

§14–403.

(a) (1) In addition to the powers set forth elsewhere in this article and subject to the provisions of Title 10 of the State Government Article, on or before October 1, 1987, the Secretary shall adopt regulations for certifying youth camps and for issuing letters of compliance.

(2) (i) An applicant for a certificate shall submit an application to the Department on the form that the Secretary requires.

(ii) An application for a certificate or for a letter of compliance shall include:

1. The name and permanent mailing address of the applicant;

2. The proposed location of the youth camp; and

3. Any other information and fee that the Department requires.

(iii) For a unit or agency subject to the provisions of this subtitle, the Secretary shall require the unit or agency to complete only one application for certification for all youth camps directed or operated by that unit or agency.

(3) (i) The Department shall be solely responsible for implementing and enforcing the provisions of this subtitle.

(ii) Except as provided in subparagraph (iii) of this paragraph, the Secretary may impose a fee for the purpose of inspecting, monitoring, and regulating youth camps in accordance with § 2-104 of this article.

(iii) A camp accredited or certified in accordance with the provisions of subsection (b)(9) of this section may not be charged a fee under the provisions of this article.

(4) (i) The operator of a youth camp directed or operated by a bona fide religious organization shall:

1. Submit an application for certification;

2. Submit an application for a letter of compliance and have the youth camp inspected by the Department; or

3. Submit an application for a letter of compliance and proof of an alternative form of accreditation acceptable to the Secretary under subsection (b)(9) of this section.

(ii) When a youth camp is operating under subparagraph (i) of this paragraph, and an inspection reveals health or safety violations of the regulations adopted under this subtitle, the Secretary may issue an order to abate the violation or to cease operation.

(b) With due consideration for conditions existing in nature and for the importance of outdoor adventure experiences, the regulations shall include:

(1) Safety procedures for:

(i) Aquatic programs;

(ii) Horseback riding;

(iii) Firearms control;

(iv) Riflery;

(v) Archery;

(vi) Adventure camps;

(vii) Artistic gymnastics;

(viii) Hang gliding;

(ix) Road cycling;

(x) Skiing;

(xi) Rock climbing;

(xii) Spelunking;

(xiii) Motorized vehicle activities;

(xiv) Rappelling; or

(xv) High ropes;

(2) Except for outdoor cookouts, sanitation regulations pertaining to the facilities and personnel for the storage, preparation, and serving of food products;

(3) Personal health, first aid, and medical services, health supervision, and the maintenance of health records for campers;

(4) Water supplies, sewage disposal systems, and refuse collection and disposal procedures;

(5) Fire and safety standards relating to the buildings and the occupants of buildings;

(6) Systems for the routine reporting of fatalities and serious illnesses or accidents;

(7) Any personnel screening procedures that are required for operators and employees of group day care centers;

(8) Procedures for conducting inspection, monitoring compliance, and verifying information;

(9) Alternate accreditation which has been approved by the Secretary; and

(10) Minimum standards for the supervision of campers during routine activities.

(c) The Secretary may not adopt regulations that set ratios for camper to medical staff personnel except for:

(1) Camp health supervisors at a camp where 50% or more of the campers have identified medical problems;

(2) Personnel required to meet emergency safety standards, for example the number of persons that require certification in cardiopulmonary resuscitation (CPR) and first aid; and

(3) Camp health supervisors, or their designees, trained to administer medicine to campers.

(d) The Secretary shall cooperate with other departments or agencies to facilitate the activities of the departments or agencies in carrying out responsibilities for enforcing the laws and regulations relating to youth camps.

§14–403.1.

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

(2) "Applicant" means an individual who is seeking to become a youth camp owner, operator, employee, or volunteer who will have access to a camper.

(3) "Central Repository" means the Criminal Justice Information System Central Repository of the Department of Public Safety and Correctional Services.

(b) The Department shall apply to the Central Repository for an applicant's:

(1) State criminal history records check; and

(2) National criminal history records check.

(c) As part of the application for a criminal history records check, the Department shall submit to the Central Repository:

(1) A complete set of the applicant's legible fingerprints taken in a format approved by the Director of the Central Repository and the Director of the Federal Bureau of Investigation;

(2) The fee authorized under § 10–221(b)(7) of the Criminal Procedure Article for access to Maryland criminal history records; and

(3) The mandatory processing fee required by the Federal Bureau of Investigation for a national criminal history records check.

(d) In accordance with §§ 10–201 through 10–229 of the Criminal Procedure Article, the Central Repository shall forward to the applicant and the Department the applicant's criminal history record information.

(e) Information obtained from the Central Repository under this section:

(1) Is confidential;

(2) May not be redisseminated; and

(3) May be used only for the personnel screening procedures authorized by this subtitle.

(f) The subject of a criminal history records check under this section may contest the contents of the printed statement issued by the Central Repository as provided in § 10–223 of the Criminal Procedure Article.

(g) If criminal history record information is reported to the Central Repository after the date of the initial criminal history records check, the Central Repository shall provide to the Department revised criminal history record information for the applicant.

§14–404.

(a) There is a Youth Camp Safety Advisory Council in the Department.

(b) The Council shall advise and assist the Department in developing and reviewing the regulations required under § 14-403 of this subtitle.

(c) The Council shall report annually to the Secretary on:

(1) The number of youth camps;

(2) The number of facilities in each county;

(3) The number of campers; and

(4) Any other pertinent information.

§14–405.

(a) (1) The Council consists of 11 members.

(2) Of the 11 Council members:

(i) 1 shall be a representative of the Department;

(ii) 1 shall be a camping leader with professional experience, but who is not a youth camp owner or manager;

(iii) 1 shall be actively engaged in the ownership or management of a youth camp operating for profit;

(iv) 1 shall be actively engaged in the ownership or management of a nonprofit youth camp;

(v) 1 shall be actively engaged in the ownership or management of an American Camping Association accredited youth camp;

(vi) 1 shall be actively engaged in the ownership or management of a youth camp that is not accredited by the American Camping Association;

(vii) 1 shall be a member of the public;

(viii) 2 shall be selected from the local health departments from 2 counties; and

(ix) 2 shall be selected from nationwide organizations involved in camping such as scouting and 4-H.

(3) The Governor shall appoint the Council members with the advice of the Secretary and the advice and consent of the Senate.

(b) (1) The term of a member is 3 years.

(2) The terms of members are staggered as required by the terms provided for members of the Council on July 1, 1986.

(3) At the end of a term, a member continues to serve until a successor is appointed.

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

(5) Members of the Council:

(i) Are eligible for reappointment; but

(ii) May not serve more than 2 full consecutive terms.

(c) The Governor may remove a member for incompetence or misconduct.

§14–406.

A certificate issued under this subtitle is not transferable.

§14–407.

(a) The Department shall:

(1) Investigate complaints received regarding a youth camp; and

(2) Require appropriate training, including knowledge of outdoor camping, for a camp inspector.

(b) (1) Before a youth camp makes a formal offer of employment to a job applicant, the operator of the youth camp may request from the Department a

determination as to whether the results of a national or State criminal history records check would be the basis for prohibiting the hiring of the applicant.

(2) Within 3 business days after receipt of a request from the operator of a youth camp under paragraph (1) of this subsection, the Department shall issue a written determination to the youth camp as to whether the results of a national or State criminal history records check would be the basis for prohibiting the hiring of the applicant.

(3) A determination issued by the Department under paragraph (2) of this subsection is binding on the Department and the youth camp unless the applicant:

(i) Has subsequently been convicted of a crime;

(ii) Has pending criminal charges; or

(iii) Had previously undisclosed criminal convictions.

(4) The Department may set a reasonable fee to cover the cost of a criminal history records check required under this subsection.

§14–408.

Subject to the hearing provisions of § 14-409 of this subtitle, the Department may deny a certificate to any applicant, or suspend or revoke a certificate, if the applicant or certificate holder:

(1) Fraudulently or deceptively obtains or attempts to obtain a certificate for the applicant or certificate holder or for another;

(2) Fraudulently or deceptively uses a certificate;

(3) Violates this subtitle; or

(4) Violates any regulation adopted by the Department under this subtitle.

§14–409.

Except as otherwise provided in § 10-226(c) of the State Government Article, before the Department takes any action under § 14-408 of this subtitle, the Department shall give the person against whom the action is contemplated an opportunity for a hearing before the Department.

§14–410.

The Department or an official acting under authority granted under this subtitle may not restrict, determine, or influence the curriculum or ministry of a youth camp in the State.

§14–411.

This subtitle may be cited as the "Maryland Youth Camp Act".

§14–501.

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

(2) "Concussion" means a traumatic injury to the brain causing an immediate and, usually, short–lived change in mental status or an alteration of normal consciousness resulting from:

(i) A fall;

(ii) A violent blow to the head or body; or

(iii) The shaking or spinning of the head or body.

(3) "Sudden cardiac arrest" means a condition in which the heart suddenly and unexpectedly stops beating.

(4) "Youth athlete" means an individual who participates in an athletic activity in association with a youth sports program conducted:

(i) At a public school facility; or

(ii) By a recreational athletic organization.

(5) "Youth sports program" means a program organized for recreational athletic competition or instruction for participants who are under the age of 19 years.

(b) (1) A youth sports program shall make available information on concussions, head injuries, and sudden cardiac arrest developed by the State Department of Education under §§ 7–433 and 7–436 of the Education Article to coaches, youth athletes, and the parents or guardians of youth athletes.

(2) A coach of a youth sports program shall review the information provided in paragraph (1) of this subsection.

(c) (1) A youth athlete who is suspected of sustaining a concussion or other head injury in a practice or game shall be removed from play at that time.

(2) A youth athlete who has been removed from play may not return to play until the youth athlete has obtained written clearance from a licensed health care provider trained in the evaluation and management of concussions.

(d) Before a youth sports program may use a facility owned or operated by a local government, the local government shall provide notice to the youth sports program of the requirements of this section.

§15–101.

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

(a–1) "Dental managed care organization" means a pre–paid dental plan that receives fees to manage dental services.

(a–2) "Dental services" means diagnostic, emergency, preventive, and therapeutic services for oral diseases.

(b) "Enrollee" means a program recipient who is enrolled in a managed care organization.

(b–1) "Expedited eligibility" means a streamlined eligibility process, conducted by the local health departments, for medical assistance for children and pregnant women under which an eligibility determination is made promptly, but not later than 10 working days after the date of application.

(c) "Facility" means a hospital or nursing facility including an intermediate care facility, skilled nursing facility, comprehensive care facility, or extended care facility.

(d) "Former foster care adolescent" means an individual:

(1) Who is under 26 years of age; and

(2) Who, on the individual's 18th birthday, was in foster care under the responsibility of the State, any other state, or the District of Columbia.

(d–1) (1) "Historic provider" means a health care provider, as defined in § 19–132 of this article, or a residential service agency licensed under Title 19, Subtitle 4A of this article, that, on or before June 30, 1995, had a demonstrated history of providing services to program recipients, as defined by the Department in regulations.

(2) "Historic provider", to the extent the provider meets the requirements in paragraph (1) of this subsection, shall include:

(i) A federal or State qualified community health center;

(ii) A provider with a program for the training of health care professionals, including an academic medical center;

(iii) A hospital outpatient program, physician, or advanced practice nurse that is a Maryland Access to Care (MAC) provider;

(iv) A local health department;

(v) A hospice, as defined in Title 19, Subtitle 9 of this article;

(vi) A pharmacy; and

(vii) Any other historic provider designated in accordance with regulations adopted by the Department.

(e) "Managed care organization" means:

(1) A certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; or

(2) A corporation that:

(i) Is a managed care system that is authorized to receive medical assistance prepaid capitation payments;

(ii) Enrolls only program recipients or individuals or families served under the Maryland Children's Health Program; and

(iii) Is subject to the requirements of § 15–102.4 of this subtitle.

(f) "Ombudsman program" means a program that assists enrollees in resolving disputes with managed care organizations in a timely manner and that is responsible, at a minimum, for the following functions:

(1) Investigating disputes between enrollees and managed care organizations referred by the enrollee hotline;

(2) Reporting to the Department:

(i) The resolution of all disputes;

(ii) A managed care organization's failure to meet the Department's requirements; and

(iii) Any other information specified by the Department;

(3) Educating enrollees about:

(i) The services provided by the enrollee's managed care organization; and

(ii) The enrollee's rights and responsibilities in receiving services from the managed care organization; and

(4) Advocating on behalf of the enrollee before the managed care organization, including assisting the enrollee in using the managed care organization's grievance process.

(g) "Primary mental health services" means the clinical evaluation and assessment of services needed by an individual and the provision of services or referral for additional services as deemed medically appropriate by a primary care provider.

(h) "Program" means the Maryland Medical Assistance Program.

(i) "Program recipient" means an individual who receives benefits under the Program.

(j) "Self–measured blood pressure monitoring" means the regular measurement of blood pressure by the patient outside the clinical setting, either at home or elsewhere, requiring the use of a home blood pressure measurement device by the patient.

(k) "Special pediatric hospital" means a facility in the State that provides nonacute medical, rehabilitation, therapy, and palliative services to individuals:

(1) Under the age of 22 years; or

(2) Who are at least 2 years old and under the age of 23 years and have co–occurring physical and behavioral health conditions.

(l) "Specialty mental health services" means any mental health services other than primary mental health services.

(m) "Validated home blood pressure monitor" means a blood pressure measurement device that has been validated for accuracy and is listed in the U.S. Blood Pressure Validated Device Listing.

§15–101.1.

(a) Except as otherwise provided in this subtitle, a managed care organization is not subject to the insurance laws of the State or to the provisions of Title 19 of this article.

(b) A managed care organization may not be required to offer a qualified plan, as defined in § 31–101 of the Insurance Article, in the Maryland Health Benefit Exchange.

§15–102.

(a) Subject to the limitations of the State budget, the Department shall provide preventive and home care services for indigent and medically indigent individuals.

(b) (1) The Program shall promote educational opportunities for recipients on:

(i) Preventive health care;

(ii) Good health habits; and

(iii) The value of developing ongoing relationships with primary care and lower cost providers.

(2) In educating Program recipients in accordance with the provisions of paragraph (1) of this subsection, the Program shall work with appropriate groups to assist in the education of Program recipients.

§15–102.1.

(a) The General Assembly finds that it is a goal of this State to promote the development of a health care system that provides adequate and appropriate health care services to indigent and medically indigent individuals.

(b) The Department shall, to the extent permitted, subject to the limitations of the State budget:

(1) Provide a comprehensive system of quality health care services with an emphasis on prevention, education, individualized care, and appropriate case management;

(2) Develop a prenatal care program for Program recipients and encourage its utilization;

(3) Allocate State resources for the Program to provide a balanced system of health care services to the population served by the Program;

(4) Seek to coordinate the Program activities with other State programs and initiatives that are necessary to address the health care needs of the population served by the Program;

(5) Promote Program policies that facilitate access to and continuity of care by encouraging:

(i) Provider availability throughout the State;

(ii) Consumer education;

(iii) The development of ongoing relationships between Program recipients and primary health care providers; and

(iv) The regular review of the Program's regulations to determine whether the administrative requirements of those regulations are unnecessarily burdensome on Program providers;

(6) Ensure access to and the continuity of services provided by family planning providers that were family planning providers in the Program as of December 31, 2024, and were discontinued as recipients of federal funding under federal law or regulation because of the scope of services offered by the provider or the scope of services for which the provider offered referrals, by:

(i) Reimbursing for the Program services provided; and

(ii) Establishing Program requirements for the family planning providers that:

1. Are similar to the requirements for other providers of the same services;

2. Do not prohibit a provider from offering a service if the service is within the scope of practice of the provider as established under the Health Occupations Article; and

3. Do not limit the scope of services for which a provider may offer referrals;

(7) Strongly urge health care providers to participate in the Program and thereby address the needs of Program recipients;

(8) Require health care providers who participate in the Program to provide access to Program recipients on a nondiscriminatory basis in accordance with State and federal law;

(9) Seek to provide appropriate levels of reimbursement for providers to encourage greater participation by providers in the Program;

(10) Promote individual responsibility for maintaining good health habits;

(11) Encourage the Program and Maryland's health care regulatory system to work to cooperatively promote the development of an appropriate mix of health care providers, limit cost increases for the delivery of health care to Program recipients, and ensure the delivery of quality health care to Program recipients;

(12) Encourage the development and utilization of cost–effective and preventive alternatives to the delivery of health care services to appropriate Program recipients in inpatient institutional settings;

(13) Encourage the appropriate executive agencies to coordinate the eligibility determination, policy, operations, and compliance components of the Program;

(14) Work with representatives of inpatient institutions, third party payors, and the appropriate State agencies to contain Program costs;

(15) Identify and seek to develop an optimal mix of State, federal, and privately financed health care services for Program recipients, within available resources through cooperative interagency efforts;

(16) Develop joint Legislative and Executive Branch strategies to persuade the federal government to reconsider those policies that discourage the delivery of cost–effective health care services to Program recipients;

(17) Evaluate departmental recommendations as to those persons whose financial need or health care needs are most acute;

(18) Establish mechanisms for aggressively pursuing recoveries against third parties permitted under current law and exploring additional methods for seeking to recover other money expended by the Program;

(19) Take appropriate measures to assure the quality of health care services provided by managed care organizations; and

(20) Develop a process for providing information about the availability of the State's earned income tax credit established under § 10–704 of the Tax – General Article to each Program enrollee or potential Program enrollee when providing information about the Program.

(c) (1) The Department shall collaborate with the Office of the Comptroller or the Office of the State Treasurer to:

(i) Form a one–sentence statement advising that individuals who cannot afford health insurance may be eligible to enroll in a medical assistance program; and

(ii) Print the statement formed under item (i) of this paragraph:

1. On each State–issued tax refund check stub;

2. Once each pay quarter, on each State–issued employee paycheck stub; and

3. On each State–issued child support payment check stub.

(2) The statement shall include a telephone number or other contact information that an individual may use to receive more information on eligibility for medical assistance programs.

(3) The statement may be altered by the Department in collaboration with the Office of the Comptroller or the Office of the State Treasurer to:

(i) Provide the most current information;

(ii) Fit within the space constraints of the different types of checks listed in paragraph (1)(ii) of this subsection; or

(iii) Combine it with the statement required under § 15–304(c) of this title, if appropriate.

§15–102.2.

(a) Except as otherwise provided in this section, the provisions of § 19-706.1 of this article (Rehabilitation and liquidation) shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

(b) (1) A health care provider may not assert a claim of subrogation against an enrollee of a managed care organization or the State.

(2) Notwithstanding paragraph (1) of this subsection, a health care provider may assert any claim it may have against the receiver of the insolvent managed care organization.

§15–102.3.

(a) The provisions of § 15–112(b)(1)(ii) and (2), (f) through (m), (r), (s), and (u) through (w) of the Insurance Article (Provider panels) shall apply to managed care organizations in the same manner they apply to carriers.

(b) The provisions of § 15–1005 of the Insurance Article shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

(c) The provisions of §§ 4–311, 15–604, and 15–605 of the Insurance Article shall apply to managed care organizations in the same manner they apply to carriers.

(d) (1) The provisions of §§ 19–712(b), (c), and (d), 19–713.2, and 19–713.3 of this article apply to managed care organizations in the same manner they apply to health maintenance organizations.

(2) The Insurance Commissioner shall consult with the Secretary before taking any action against a managed care organization under this subsection.

(e) The provisions of § 15–112.1 of the Insurance Article apply to managed care organizations in the same manner they apply to carriers.

(f) The Insurance Commissioner or an agent of the Commissioner shall examine the financial affairs and status of each managed care organization at least once every 5 years.

(g) The provisions of § 15–1628.3 of the Insurance Article apply to pharmacy benefits managers that contract with managed care organizations in the same manner as they apply to pharmacy benefits managers that contract with carriers.

(h) (1) The provisions of § 6–102.1 of the Insurance Article apply to managed care organizations.

(2) For each calendar year that the Insurance Commissioner assesses a health insurance provider fee under § 6–102.1 of the Insurance Article, a managed care organization shall pay the fee on a quarterly basis in accordance with a schedule adopted by the Insurance Commissioner.

(i) The provisions of §§ 15–130 and 15–130.1 of the Insurance Article apply to managed care organizations and pharmacy benefits managers that contract with managed care organizations.

(j) The provisions of § 33–105(f) of the Insurance Article apply to managed care organizations.

(k) (1) To the extent authorized under federal law and subject to paragraph (2) of this subsection, the provisions of § 15–1008(a), (b), (c)(1) and (2)(i), (d), (e), and (f) of the Insurance Article shall apply to managed care organizations in the same manner they apply to carriers.

(2) If a retroactive denial of reimbursement is the result of coordination of benefits, a written statement provided by a managed care organization to a health care provider in accordance with § 15–1008(c)(2)(i) of the Insurance Article shall include the name and address of the entity identified by the managed care organization as responsible for payment of the claim.

(l) Beginning July 1, 2025, the provisions of § 15–859 of the Insurance Article apply to managed care organizations in the same manner they apply to carriers.

(m) Beginning January 1, 2026, the provisions of § 15–862 of the Insurance Article apply to managed care organizations in the same manner that they apply to carriers.

(n) The provisions of § 15–863 of the Insurance Article apply to managed care organizations in the same manner they apply to carriers.

§15–102.4.

(a) (1) Each managed care organization shall be actuarially sound.

(2) (i) Except as otherwise provided in this section, the surplus that a managed care organization is required to have shall be paid in full.

(ii) A managed care organization shall have an initial surplus that exceeds the liabilities of the managed care organization by at least $1,500,000.

(b) (1) In consultation with the Secretary, the Insurance Commissioner may adjust the initial surplus requirement for a managed care organization that is not licensed as a health maintenance organization. In determining whether to make an adjustment under this paragraph, the Commissioner shall consider:

(i) The proposed capitation level that would be received by the managed care organization under a contract with the Department under this subtitle;

(ii) The proposed range of benefits to be provided under a contract with the Department under this subtitle;

(iii) The existence of any commitment by the Secretary to designate funds over and above the proposed capitation where the designated funds:

1. Are equivalent to the difference between the requirements of § 19–710 of this article and any lower requirements determined by the Commissioner under this subparagraph; and

2. Would be available in case of the impairment or insolvency of the managed care organization; and

(iv) The availability of the money held in trust by the Secretary to pay claims in case of impairment or insolvency of the managed care organization.

(2) Notwithstanding subsection (a)(2)(ii) of this section, a managed care organization shall have an initial surplus that exceeds liabilities by at least $1,250,000. If a managed care organization has an initial surplus that is at least

$1,250,000 but less than $1,500,000, prior to approval, the Department shall designate funds under paragraph (1)(iii) of this subsection sufficient to provide an initial surplus of at least $1,500,000.

(c) (1) (i) Each managed care organization shall maintain a surplus that exceeds the liabilities of the managed care organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the managed care organization with the Commissioner.

(ii) No managed care organization shall be required to maintain a surplus in excess of a value of $3,000,000.

(2) (i) For the protection of the managed care organization's enrollees and creditors, the applicant shall deposit and maintain in trust with the State Treasurer $100,000 in cash or government securities of the type described in § 5–701(b) of the Insurance Article.

(ii) 1. The deposits shall be accepted and held in trust by the State Treasurer in accordance with the provisions of Title 5, Subtitle 7 of the Insurance Article.

2. For the purpose of applying this subparagraph, a managed care organization shall be treated as an insurer.

(d) Each managed care organization shall comply with risk based capital standards in accordance with regulations adopted by the Insurance Commissioner under § 4–311 of the Insurance Article.

§15–102.5.

(a) Subject to § 15–103.1(dd) of this subtitle, a health maintenance organization that requires its panel providers to participate in a managed care organization shall establish a mechanism, subject to review by the Secretary, which provides for equitable distribution of enrollees and which ensures that a provider will not be assigned a disproportionate number of enrollees.

(b) Nothing in this section may be interpreted as prohibiting a provider from voluntarily accepting additional enrollees.

§15–102.6.

(a) (1) Subject to paragraph (2) of this subsection, the provisions of Title 7 of the Insurance Article apply to managed care organizations.

(2) Before approving a transaction under § 7–306 of the Insurance Article, the Insurance Commissioner shall consult with the Secretary.

(3) The Insurance Commissioner:

(i) Shall adopt regulations establishing a reporting materiality threshold; and

(ii) May adopt regulations necessary to implement the provisions of this subsection.

(4) The provisions of this subsection may not apply to any transaction preempted by federal law.

(b) The provisions of Title 4, Subtitle 5 of the Insurance Article apply to managed care organizations.

§15–102.7.

The premium tax imposed under § 6-102 of the Insurance Article applies to managed care organizations.

§15–102.8.

(a) The Department may impose a claims processing charge on all Medicaid claims processed, approved, and paid by the Department to hospitals located in the District of Columbia for the provision of inpatient and outpatient hospital services.

(b) The amount to be paid under subsection (a) of this section may not exceed 6% of the amount of claims paid.

(c) The Department shall adopt regulations to implement this section.

§15–103. IN EFFECT

(a) The Secretary shall administer the Maryland Medical Assistance Program.

(b) The Program:

(1) Subject to the limitations of the State budget, shall provide medical and other health care services for indigent individuals or medically indigent individuals or both;

(2) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical, dental, and other health care services, including services provided in accordance with § 15–141.5 of this subtitle, for all eligible pregnant women whose family income is at or below 250% of the poverty level for the duration of the pregnancy and for 1 year immediately following the end of the woman's pregnancy;

(3) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical and other health care services for all eligible children currently under the age of 1 year whose family income falls below 185% of the poverty level;

(4) Beginning on January 1, 2012, shall provide, subject to the limitations of the State budget and as permitted by federal law, family planning services to all women whose family income is at or below 200% of the poverty level;

(5) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical and other health care services for all children who are at least 1 year old and under the age of 5 years whose family income falls below 133% of the poverty level;

(6) Beginning on January 1, 2014, shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical care and other health care services for all children who are at least 6 years old and under the age of 19 years whose family income falls below 133% of the poverty level;

(7) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical care and other health care services for all legal immigrants who meet Program eligibility standards and who arrived in the United States before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

(8) Shall provide, subject to the limitations of the State budget and any other requirements imposed by the State, comprehensive medical care and other health care services for all legal immigrant children under the age of 18 years and pregnant women who meet Program eligibility standards and who arrived in the United States on or after August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

(9) Beginning on January 1, 2014, shall provide, subject to the limitations of the State budget, and as permitted by federal law, medical care and

other health care services for adults whose annual household income is at or below 133% of the poverty level;

(10) Subject to the limitations of the State budget, and as permitted by federal law:

(i) Shall provide comprehensive medical care, dental care, and other health care services for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of the State and are not otherwise eligible for Program benefits; and

(ii) May provide comprehensive medical care, dental care, and other health care services for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of any other state or the District of Columbia;

(11) May include bedside nursing care for eligible Program recipients;

(12) Shall provide services in accordance with funding restrictions included in the annual State budget bill;

(13) Beginning on January 1, 2023, shall provide, subject to the limitations of the State budget, and as permitted by federal law, dental services for adults, including diagnostic, preventive, restorative, and periodontal services, whose annual household income is at or below 133 percent of the federal poverty level;

(14) Shall provide, subject to the limitations of the State budget, medically appropriate drugs that are approved by the United States Food and Drug Administration for the treatment of hepatitis C, regardless of the fibrosis score, and that are determined to be medically necessary;

(15) Shall provide, subject to the limitations of the State budget, health care services appropriately delivered through telehealth to a patient in accordance with § 15–141.2 of this subtitle;

(16) Beginning on January 1, 2021, shall provide, subject to the limitations of the State budget and § 15–855(b)(2) of the Insurance Article, and as permitted by federal law, services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy, for eligible Program recipients, if pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome are coded for billing and diagnosis purposes in accordance with § 15–855(d) of the Insurance Article;

(17) Beginning on January 1, 2022, may not include, subject to federal approval and limitations of the State budget, a frequency limitation on covered dental prophylaxis care or oral health exams that requires the dental prophylaxis care or oral health exams to be provided at an interval greater than 120 days within a plan year;

(18) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services to noncitizen pregnant women who would be eligible for the Program but for their immigration status and to their children up to the age of 1 year;

(19) Shall provide coverage of abortion care services to Program recipients in the manner described in § 15–857(b)(1)(ii) and (2) of the Insurance Article;

(20) Beginning on July 1, 2023, shall provide, subject to federal approval and limitations of the State budget, community violence prevention services in accordance with § 15–141.3 of this subtitle;

(21) Beginning on January 1, 2023, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for self–measured blood pressure monitoring for all Program recipients diagnosed with uncontrolled high blood pressure, including:

(i) The provision of validated home blood pressure monitors; and

(ii) Reimbursement of health care provider and other staff time used for patient training, transmission of blood pressure data, interpretation of blood pressure readings and reporting, and the delivery of co–interventions, including educational materials or classes, behavioral change management, and medication management;

(22) Beginning on January 1, 2024, shall provide gender–affirming treatment in accordance with § 15–151 of this subtitle;

(23) Beginning on July 1, 2025, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for biomarker testing in accordance with § 15–859 of the Insurance Article;

(24) Beginning on January 1, 2025, shall provide coverage for prostheses in accordance with § 15–844 of the Insurance Article;

(25) Beginning on January 1, 2026, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for self–measured blood pressure monitoring for eligible Program recipients in accordance with § 15–141.6 of this subtitle;

(26) Beginning on January 1, 2026, shall provide coverage for a transfer to a special pediatric hospital in accordance with § 15–158 of the Insurance Article;

(27) Beginning on January 1, 2026, if providing coverage for the delivery of anesthesia, shall provide coverage for the delivery of anesthesia in accordance with § 15–862 of the Insurance Article;

(28) Beginning on January 1, 2026, shall provide calcium score testing in accordance with § 15–863 of the Insurance Article; and

(29) Beginning on January 1, 2027, may provide comprehensive coverage for the treatment of obesity under § 15–160 of this subtitle.

(c) Subject to restrictions in federal law or waivers, the Department may:

(1) Impose cost–sharing on Program recipients; and

(2) For adults who do not meet requirements for a federal category of eligibility for Medicaid:

(i) Cap enrollment; and

(ii) Limit the benefit package.

(d) Subject to the limitations of the State budget, the Department shall implement the provisions of Title II of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, to include:

(1) Parents and caretaker relatives who have a dependent child living in the parents' or caretaker relatives' home; and

(2) Adults who do not meet requirements, such as age, disability, or parent or caretaker relative of a dependent child, for a federal category of eligibility for Medicaid and who are not enrolled in the federal Medicare program, as enacted by Title XVII of the Social Security Act.

(e) (1) On or before January 1, 2025, subject to the limitations of the State budget, and as permitted by federal law, the Department:

(i) Shall establish an Express Lane Eligibility Program to enroll individuals in the Program and Maryland Children's Health Program based on eligibility findings by the Supplemental Nutrition Assistance Program;

(ii) May not consider any other income or eligibility requirements;

(iii) To the extent that a waiver is needed to maximize the number of State residents who may qualify for the Express Lane Eligibility Program, shall apply to the Centers for Medicare and Medicaid Services for one or more waivers under § 1115 of the federal Social Security Act to implement the Express Lane Eligibility Program; and

(iv) Subject to paragraph (2) of this subsection, shall make all reasonable efforts to expedite enrollment of eligible individuals in the Express Lane Eligibility Program.

(2) The Department may propose or implement the use of Express Lane Eligibility for renewals before proposing or implementing the use of Express Lane Eligibility for initial enrollment.

(f) (1) The Department shall ensure that payments for services provided by a hospital located in a contiguous state or in the District of Columbia to an enrollee under the Program shall be reduced by 20% if the hospital fails to submit discharge data on all Maryland patients receiving care in the hospital to the Health Services Cost Review Commission in a form and manner the Commission specifies.

(2) Paragraph (1) of this subsection does not apply to a hospital that presently provides discharge data to the public in a form the Health Services Cost Review Commission determines is satisfactory.

(g) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Certified nurse practitioner" means a registered nurse who is licensed in this State, has completed a nurse practitioner program approved by the State Board of Nursing, and has passed an examination approved by that Board.

(iii) "Nurse anesthetist" means a registered nurse who is:

1. Certified under the Health Occupations Article to practice nurse anesthesia; and

2. Certified by the Council on Certification or the Council on Recertification of Nurse Anesthetists.

(iv) "Nurse midwife" means a registered nurse who is licensed in this State and has been certified by the American College of Nurse–Midwives as a nurse midwife.

(v) "Optometrist" has the meaning stated in § 11–101 of the Health Occupations Article.

(2) The Secretary may contract for the provision of care under the Program to eligible Program recipients.

(3) The Secretary may contract with insurance companies or nonprofit health service plans or with individuals, associations, partnerships, incorporated or unincorporated groups of physicians, chiropractors, dentists, podiatrists, optometrists, pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse midwives and certified nurse practitioners, opticians, and other health practitioners who are licensed or certified in this State and perform services on the prescription or referral of a physician.

(4) For the purposes of this section, the nurse midwife need not be under the supervision of a physician.

(5) Except as otherwise provided by law, a contract that the Secretary makes under this subsection shall continue unless terminated under the terms of the contract by the Program or by the provider.

(h) As permitted by federal law or waiver, the Secretary may administer the Medicare Option Prescription Drug Program, established under § 15–124.3 of this subtitle, as part of the Maryland Medical Assistance Program.

(i) By regulation, the Department shall adopt a methodology to ensure that federally qualified health centers are paid reasonable cost–based reimbursement that is consistent with federal law.

§15–103. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 628, 629, 636, AND 637 OF 2026 **

(a) The Secretary shall administer the Maryland Medical Assistance Program.

(b) The Program:

(1) Subject to the limitations of the State budget, shall provide medical and other health care services for indigent individuals or medically indigent individuals or both;

(2) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical, dental, and other health care services, including services provided in accordance with § 15–141.5 of this subtitle, for all eligible pregnant women whose family income is at or below 250% of the poverty level for the duration of the pregnancy and for 1 year immediately following the end of the woman's pregnancy;

(3) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical and other health care services for all eligible children currently under the age of 1 year whose family income falls below 185% of the poverty level;

(4) Beginning on January 1, 2012, shall provide, subject to the limitations of the State budget and as permitted by federal law, family planning services to all women whose family income is at or below 200% of the poverty level;

(5) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical and other health care services for all children who are at least 1 year old and under the age of 5 years whose family income falls below 133% of the poverty level;

(6) Beginning on January 1, 2014, shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical care and other health care services for all children who are at least 6 years old and under the age of 19 years whose family income falls below 133% of the poverty level;

(7) Shall provide, subject to the limitations of the State budget and as permitted by federal law, comprehensive medical care and other health care services for all legal immigrants who meet Program eligibility standards and who arrived in the United States before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

(8) Shall provide, subject to the limitations of the State budget and any other requirements imposed by the State, comprehensive medical care and other health care services for all legal immigrant children under the age of 18 years and pregnant women who meet Program eligibility standards and who arrived in the

United States on or after August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

(9) Beginning on January 1, 2014, shall provide, subject to the limitations of the State budget, and as permitted by federal law, medical care and other health care services for adults whose annual household income is at or below 133% of the poverty level;

(10) Subject to the limitations of the State budget, and as permitted by federal law:

(i) Shall provide comprehensive medical care, dental care, and other health care services for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of the State and are not otherwise eligible for Program benefits; and

(ii) May provide comprehensive medical care, dental care, and other health care services for former foster care adolescents who, on their 18th birthday, were in foster care under the responsibility of any other state or the District of Columbia;

(11) May include bedside nursing care for eligible Program recipients;

(12) Shall provide services in accordance with funding restrictions included in the annual State budget bill;

(13) Beginning on January 1, 2023, shall provide, subject to the limitations of the State budget, and as permitted by federal law, dental services for adults, including diagnostic, preventive, restorative, and periodontal services, whose annual household income is at or below 133 percent of the federal poverty level;

(14) Shall provide, subject to the limitations of the State budget, medically appropriate drugs that are approved by the United States Food and Drug Administration for the treatment of hepatitis C, regardless of the fibrosis score, and that are determined to be medically necessary;

(15) Shall provide, subject to the limitations of the State budget, health care services appropriately delivered through telehealth to a patient in accordance with § 15–141.2 of this subtitle;

(16) Beginning on January 1, 2021, shall provide, subject to the limitations of the State budget and § 15–855(b)(2) of the Insurance Article, and as permitted by federal law, services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset

neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy, for eligible Program recipients, if pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome are coded for billing and diagnosis purposes in accordance with § 15–855(d) of the Insurance Article;

(17) Beginning on January 1, 2022, may not include, subject to federal approval and limitations of the State budget, a frequency limitation on covered dental prophylaxis care or oral health exams that requires the dental prophylaxis care or oral health exams to be provided at an interval greater than 120 days within a plan year;

(18) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services to noncitizen pregnant women who would be eligible for the Program but for their immigration status and to their children up to the age of 1 year;

(19) Shall provide coverage of abortion care services to Program recipients in the manner described in § 15–857(b)(1)(ii) and (2) of the Insurance Article;

(20) Beginning on July 1, 2023, shall provide, subject to federal approval and limitations of the State budget, community violence prevention services in accordance with § 15–141.3 of this subtitle;

(21) Beginning on January 1, 2023, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for self–measured blood pressure monitoring for all Program recipients diagnosed with uncontrolled high blood pressure, including:

(i) The provision of validated home blood pressure monitors; and

(ii) Reimbursement of health care provider and other staff time used for patient training, transmission of blood pressure data, interpretation of blood pressure readings and reporting, and the delivery of co–interventions, including educational materials or classes, behavioral change management, and medication management;

(22) Beginning on January 1, 2024, shall provide gender–affirming treatment in accordance with § 15–151 of this subtitle;

(23) Beginning on July 1, 2025, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for biomarker testing in accordance with § 15–859 of the Insurance Article;

(24) Beginning on January 1, 2025, shall provide coverage for prostheses in accordance with § 15–844 of the Insurance Article;

(25) Beginning on January 1, 2026, shall provide, subject to the limitations of the State budget, and as permitted by federal law, coverage for self–measured blood pressure monitoring for eligible Program recipients in accordance with § 15–141.6 of this subtitle;

(26) Beginning on January 1, 2026, shall provide coverage for a transfer to a special pediatric hospital in accordance with § 15–158 of this subtitle;

(27) Beginning on January 1, 2026, if providing coverage for the delivery of anesthesia, shall provide coverage for the delivery of anesthesia in accordance with § 15–862 of the Insurance Article;

(28) Beginning on January 1, 2026, shall provide calcium score testing in accordance with § 15–863 of the Insurance Article;

(29) Beginning on January 1, 2027, may provide comprehensive coverage for the treatment of obesity under § 15–160 of this subtitle;

(30) Beginning on January 1, 2027, shall provide coverage for orthoses in accordance with § 15–820 of the Insurance Article; and

(31) Beginning on January 1, 2027, shall provide coverage for screening for perinatal behavioral health conditions at well visits within the first year of the child's life, as determined appropriate by the treating health care provider.

(c) Subject to restrictions in federal law or waivers, the Department may:

(1) Impose cost–sharing on Program recipients; and

(2) For adults who do not meet requirements for a federal category of eligibility for Medicaid:

(i) Cap enrollment; and

(ii) Limit the benefit package.

(d) Subject to the limitations of the State budget, the Department shall implement the provisions of Title II of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, to include:

(1) Parents and caretaker relatives who have a dependent child living in the parents' or caretaker relatives' home; and

(2) Adults who do not meet requirements, such as age, disability, or parent or caretaker relative of a dependent child, for a federal category of eligibility for Medicaid and who are not enrolled in the federal Medicare program, as enacted by Title XVII of the Social Security Act.

(e) (1) On or before January 1, 2025, subject to the limitations of the State budget, and as permitted by federal law, the Department:

(i) Shall establish an Express Lane Eligibility Program to enroll individuals in the Program and Maryland Children's Health Program based on eligibility findings by the Supplemental Nutrition Assistance Program;

(ii) May not consider any other income or eligibility requirements;

(iii) To the extent that a waiver is needed to maximize the number of State residents who may qualify for the Express Lane Eligibility Program, shall apply to the Centers for Medicare and Medicaid Services for one or more waivers under § 1115 of the federal Social Security Act to implement the Express Lane Eligibility Program; and

(iv) Subject to paragraph (2) of this subsection, shall make all reasonable efforts to expedite enrollment of eligible individuals in the Express Lane Eligibility Program.

(2) The Department may propose or implement the use of Express Lane Eligibility for renewals before proposing or implementing the use of Express Lane Eligibility for initial enrollment.

(f) (1) The Department shall ensure that payments for services provided by a hospital located in a contiguous state or in the District of Columbia to an enrollee under the Program shall be reduced by 20% if the hospital fails to submit discharge data on all Maryland patients receiving care in the hospital to the Health Services Cost Review Commission in a form and manner the Commission specifies.

(2) Paragraph (1) of this subsection does not apply to a hospital that presently provides discharge data to the public in a form the Health Services Cost Review Commission determines is satisfactory.

(g) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Certified nurse practitioner" means a registered nurse who is licensed in this State, has completed a nurse practitioner program approved by the State Board of Nursing, and has passed an examination approved by that Board.

(iii) "Nurse anesthetist" means a registered nurse who is:

1. Certified under the Health Occupations Article to practice nurse anesthesia; and

2. Certified by the Council on Certification or the Council on Recertification of Nurse Anesthetists.

(iv) "Nurse midwife" means a registered nurse who is licensed in this State and has been certified by the American College of Nurse–Midwives as a nurse midwife.

(v) "Optometrist" has the meaning stated in § 11–101 of the Health Occupations Article.

(2) The Secretary may contract for the provision of care under the Program to eligible Program recipients.

(3) The Secretary may contract with insurance companies or nonprofit health service plans or with individuals, associations, partnerships, incorporated or unincorporated groups of physicians, chiropractors, dentists, podiatrists, optometrists, pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse midwives and certified nurse practitioners, opticians, and other health practitioners who are licensed or certified in this State and perform services on the prescription or referral of a physician.

(4) For the purposes of this section, the nurse midwife need not be under the supervision of a physician.

(5) Except as otherwise provided by law, a contract that the Secretary makes under this subsection shall continue unless terminated under the terms of the contract by the Program or by the provider.

(h) As permitted by federal law or waiver, the Secretary may administer the Medicare Option Prescription Drug Program, established under § 15–124.3 of this subtitle, as part of the Maryland Medical Assistance Program.

(i) By regulation, the Department shall adopt a methodology to ensure that federally qualified health centers are paid reasonable cost–based reimbursement that is consistent with federal law.

§15–103.1.

(a) As permitted by federal law or waiver, the Secretary may establish a program under which Program recipients are required to enroll in managed care organizations.

(b) (1) The benefits required by the program developed under subsection (a) of this section shall be:

(i) Adopted by regulation; and

(ii) At least equivalent to the benefit level required by the Program on January 1, 1996.

(2) Subject to the limitations of the State budget and as permitted by federal law or waiver, the Department shall provide reimbursement for medically necessary and appropriate inpatient, intermediate care, and halfway house substance use disorder treatment services for enrollees at least 21 years old with substance use disorders who are recipients of temporary cash assistance under the Family Investment Program.

(3) Each managed care organization participating in the program developed under subsection (a) of this section shall provide or arrange for the provision of the benefits described in paragraph (2) of this subsection.

(4) This subsection may not be construed to prohibit a managed care organization from offering additional benefits if the managed care organization is not receiving capitation payments based on the provision of the additional benefits.

(5) Notwithstanding paragraph (1) of this subsection, the benefits required by the program developed under subsection (a) of this section shall include dental services for pregnant women.

(c) Subject to the limitations of the State budget and as permitted by federal law or waiver, the program developed under subsection (a) of this section may provide

guaranteed eligibility for each enrollee for up to 6 months unless an enrollee obtains health insurance through another source.

(d) (1) The Secretary may exclude specific populations or services from the program developed under subsection (a) of this section.

(2) For any populations or services excluded under this subsection, the Secretary may authorize a managed care organization to provide the services or provide for the population, including authorization of a separate dental managed care organization or a managed care organization to provide services to Program recipients with special needs.

(e) (1) Except for a service excluded by the Secretary under subsection (d) of this section, each managed care organization shall provide all the benefits required by regulations adopted under subsection (b) of this section.

(2) For a population or service excluded by the Secretary under subsection (d) of this section, the Secretary may authorize a managed care organization to provide only for that population or provide only that service.

(3) A managed care organization may subcontract specified required services to a health care provider that is licensed or authorized to provide those services.

(f) Except for the Program of All–Inclusive Care for the Elderly ("PACE") Program, the Secretary may not include the long–term care population or long–term care services in the program developed under subsection (a) of this section.

(g) The program developed under subsection (a) of this section shall ensure that enrollees have access to a pharmacy that:

(1) Is licensed in the State; and

(2) Is within a reasonable distance from the enrollee's residence.

(h) For cause, the Department may disenroll enrollees from a managed care organization and enroll them in another managed care organization.

(i) (1) Each managed care organization shall:

(i) Have a quality assurance program in effect that is subject to the approval of the Department and that, at a minimum:

1. Complies with any health care quality improvement system developed by the Centers for Medicare and Medicaid Services;

2. Complies with the quality requirements of applicable State licensure laws and regulations;

3. Complies with practice guidelines and protocols specified by the Department;

4. Provides for an enrollee grievance system, including an enrollee hotline;

5. Provides for a provider grievance system;

6. Provides for enrollee and provider satisfaction surveys, to be taken at least annually;

7. Provides for a consumer advisory board to receive regular input from enrollees;

8. Provides for an annual consumer advisory board report to be submitted to the Secretary; and

9. Complies with specific quality, access, data, and performance measurements adopted by the Department for treating enrollees with special needs;

(ii) Submit to the Department:

1. Service–specific data by service type in a format established by the Department;

2. Utilization and outcome reports, such as the Health Plan Employer Data and Information Set (HEDIS), as directed by the Department; and

3. At least semiannually, aggregate data that includes:

A. The number of enrollees provided with substance use disorder treatment services; and

B. The amount of money spent on substance use disorder treatment;

(iii) Promote timely access to and continuity of health care services for enrollees;

(iv) Demonstrate organizational capacity to provide special programs, including outreach, case management, and home visiting, tailored to meet the individual needs of all enrollees;

(v) Provide assistance to enrollees in securing necessary health care services;

(vi) Provide or ensure substance use disorder treatment for pregnant women with substance use disorders and all other enrollees of the managed care organization who require these services;

(vii) Educate enrollees on health care prevention and good health habits;

(viii) Ensure necessary provider capacity in all geographic areas under contract;

(ix) Be accountable and hold its subcontractors accountable for standards established by the Department and, on failure to meet those standards, be subject to one or more of the following penalties:

1. Fines;

2. Suspension of further enrollments;

3. Withholding of all or part of the capitation payment;

4. Termination of the contract;

5. Disqualification from future participation in the Program; and

6. Any other penalties that may be imposed by the Department;

(x) Subject to applicable federal and State law, include incentives for enrollees to comply with provisions of the managed care organization;

(xi) Provide or arrange to provide primary mental health services;

(xii) Provide or arrange to provide all Medicaid–covered services required to comply with State statutes and regulations mandating health and mental health services for children in State–supervised care:

1. According to standards set by the Department; and

2. Locally, to the extent the services are available locally;

(xiii) Submit to the Department aggregate information from the quality assurance program, including complaints and resolutions from the enrollee and provider grievance systems, the enrollee hotline, and enrollee satisfaction surveys;

(xiv) Maintain as part of the enrollee's medical record the following information:

1. The basic health risk assessment conducted on enrollment;

2. Any information the managed care organization receives that results from an assessment of the enrollee conducted for the purpose of any early intervention, evaluation, planning, or case management program;

3. Information from the local department of social services regarding any other service or benefit the enrollee receives, including assistance or benefits from a program administered by the Department of Human Services under the Human Services Article; and

4. Any information the managed care organization receives from a school–based clinic, a core services agency, a local health department, or any other person that has provided health services to the enrollee;

(xv) On provision of information specified by the Department under subsection (r)(3) of this section, pay school–based clinics for services provided to the managed care organization's enrollees;

(xvi) In coordination with participating dentists, enrollees, and families of enrollees, develop a process to arrange to provide dental therapeutic treatment to individuals under the age of 21 years that requires:

1. A participating dentist to notify a managed care organization when an enrollee is in need of therapeutic treatment and the dentist is unable to provide the treatment;

2. The managed care organization to provide the enrollee or the family of the enrollee with a list of participating providers who offer therapeutic dental services; and

3. The managed care organization to notify the enrollee or the family of the enrollee that the managed care organization will provide further assistance if the enrollee has difficulty obtaining an appointment with a provider of therapeutic dental services;

(xvii) Provide the advance directive information sheet developed under § 5–615 of this article:

1. To all enrollees at the time of initial enrollment and in the managed care organization's enrollee publications;

2. If the managed care organization maintains a website, on the managed care organization's website; and

3. At the request of an enrollee; and

(xviii) If the managed care organization maintains a website, provide a link to the webpage that is accessed through the tab on the State–designated health information exchange website required under § 19–145.1(b)(2)(iv) of this article.

(2) Paragraph (1)(xvii) of this subsection may not be construed to require a managed care organization to:

(i) Assist an enrollee in drafting an electronic advance care planning document;

(ii) Store electronic advance care planning documents; or

(iii) Access advance care planning documents.

(3) (i) Each managed care organization shall notify each enrollee when the enrollee should obtain an immunization, examination, or other wellness service.

(ii) Each managed care organization shall:

1. Maintain evidence of compliance with paragraph (1) of this subsection; and

2. On initial application to provide health care services to enrollees and on an annual basis thereafter, provide to the Department evidence of compliance with paragraph (1) of this subsection including submission of a written plan.

(iii) A managed care organization that does not comply with paragraph (1) of this subsection for at least 90% of its new enrollees:

1. Within 90 days of their enrollment may not receive more than 80% of its capitation payments;

2. Within 180 days of their enrollment may not receive more than 70% of its capitation payments; and

3. Within 270 days of their enrollment may not receive more than 50% of its capitation payments.

(iv) If a managed care organization does not comply with the requirements of paragraph (1) of this subsection, the Department may contract with any community–based health organization that the Department determines is willing and able to perform comprehensive outreach services to enrollees.

(v) In addition to the provisions of subparagraph (iv) of this paragraph, if a managed care organization does not comply with the requirements of paragraph (1) of this subsection or fails to provide evidence of compliance to the Department under subparagraph (ii) of this paragraph, the Department may:

1. Impose a fine on the managed care organization;

2. Suspend further enrollment into the managed care organization;

3. Withhold all or part of the capitation rate from the managed care organization;

4. Terminate the provider agreement; or

5. Disqualify the managed care organization from future participation in the program established under subsection (a) of this section.

(vi) The Department shall deposit fines imposed under subparagraph (v)1 of this paragraph in the HealthChoice Performance Incentive Fund established under § 15–103.5 of this subtitle.

(j) The Department shall adopt regulations that ensure that managed care organizations employ appropriate personnel to:

(1) Ensure that individuals with special needs obtain needed services; and

(2) Coordinate those services.

(k) (1) A managed care organization shall reimburse a hospital emergency facility and provider for:

(i) Health care services that meet the definition of emergency services in § 19–701 of this article;

(ii) Medical screening services rendered to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act;

(iii) Medically necessary services if the managed care organization authorized, referred, or otherwise allowed the enrollee to use the emergency facility and the medically necessary services are related to the condition for which the enrollee was allowed to use the emergency facility; and

(iv) Medically necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to the enrollee if the managed care organization fails to provide 24–hour access to a physician as required by the Department.

(2) A provider may not be required to obtain prior authorization or approval for payment from a managed care organization in order to obtain reimbursement under this subsection.

(l) The Department shall:

(1) Establish and maintain an ombudsman program and a locally accessible enrollee hotline;

(2) Perform focused medical reviews of managed care organizations that include reviews of how the managed care organizations are providing health care services to special populations;

(3) Provide timely feedback to each managed care organization on its compliance with the Department's quality and access system;

(4) Establish and maintain within the Department a process for handling provider complaints about managed care organizations; and

(5) Adopt regulations relating to appeals by managed care organizations of penalties imposed by the Department, including regulations providing for an appeal to the Office of Administrative Hearings.

(m) (1) Subject to paragraph (3) of this subsection, the Department shall delegate responsibility for maintaining the ombudsman program for a county to that county's local health department on the request of the local health department.

(2) A local health department may not subcontract the ombudsman program.

(3) Before the Department delegates responsibility to a local health department to maintain the ombudsman program for a county, a local health department that is also a Medicaid provider must receive the approval of the Secretary and the local governing body.

(n) A managed care organization may not:

(1) Without authorization by the Department, enroll an individual who at the time is a Program recipient; or

(2) Have face–to–face or telephone contact with, or otherwise solicit, an individual who at the time is a Program recipient before the Program recipient enrolls in the managed care organization unless:

(i) Authorized by the Department; or

(ii) The Program recipient initiates contact.

(o) (1) The Department shall be responsible for enrolling Program recipients into managed care organizations.

(2) The Department may contract with an entity to perform the enrollment function.

(3) The Department or its enrollment contractor shall administer a health risk assessment developed by the Department to ensure that individuals who need special or immediate health care services will receive the services on a timely basis.

(4) The Department or its enrollment contractor:

(i) May administer the health risk assessment only after the Program recipient has chosen a managed care organization; and

(ii) Shall forward the results of the health risk assessment to the managed care organization chosen by the Program recipient within 5 business days.

(p) For a managed care organization with which the Secretary contracts to provide services to Program recipients under this section, the Secretary shall establish a mechanism to initially ensure that each historic provider that meets the Department's quality standards has the opportunity to continue to serve Program recipients as a subcontractor of at least one managed care organization.

(q) (1) The Department shall make capitation payments to each managed care organization as provided in this subsection.

(2) In consultation with the Insurance Commissioner, the Secretary shall:

(i) Set capitation payments at a level that is actuarially adjusted to the benefits provided; and

(ii) Actuarially adjust the capitation payments to reflect the relative risk assumed by the managed care organization.

(3) In actuarially adjusting capitation payments under paragraph (2)(ii) of this subsection, the Secretary, in consultation with the Insurance Commissioner, shall take into account, to the extent allowed under federal law, the expenses incurred by the managed care organization applicable to the business of providing care to enrolled individuals.

(r) (1) School–based clinics and managed care organizations shall collaborate to provide continuity of care to enrollees.

(2) School–based clinics shall be defined by the Department in consultation with the State Department of Education.

(3) Each managed care organization shall require a school–based clinic to provide to the managed care organization information, as specified by the Department, about an encounter with an enrollee of the managed care organization before paying the school–based clinic.

(4) On receipt of information specified by the Department, the managed care organization shall pay, at Medicaid–established rates, school–based clinics for covered services provided to enrollees of the managed care organization.

(5) The Department shall work with managed care organizations and school–based clinics to develop collaboration standards, guidelines, and a process to ensure that the services provided are covered and medically appropriate and that the process provides for timely notification among the parties.

(6) Each managed care organization shall maintain records of all health care services:

(i) Provided to its enrollees by school–based clinics; and

(ii) For which the managed care organization has been billed.

(s) The Department shall establish standards for the timely delivery of services to enrollees.

(t) (1) The Department shall establish a delivery system for specialty mental health services for enrollees of managed care organizations.

(2) The Behavioral Health Administration shall:

(i) Design and monitor the delivery system;

(ii) Establish performance standards for providers in the delivery system; and

(iii) Establish procedures to ensure appropriate and timely referrals from managed care organizations to the delivery system that include:

1. Specification of the diagnoses and conditions eligible for referral to the delivery system;

2. Training and clinical guidance in appropriate use of the delivery system for managed care organization primary care providers;

3. Preauthorization by the utilization review agent of the delivery system; and

4. Penalties for a pattern of improper referrals.

(3) The Department shall collaborate with managed care organizations to develop standards and guidelines for the provision of specialty mental health services.

(4) The delivery system shall:

(i) Provide all specialty mental health services needed by enrollees;

(ii) For enrollees who are dually diagnosed, coordinate the provision of substance use disorder treatment services provided by the managed care organizations of the enrollees;

(iii) Consist of a network of qualified mental health professionals from all core disciplines;

(iv) Include linkages with other public service systems; and

(v) Comply with quality assurance, enrollee input, data collection, and other requirements specified by the Department in regulation.

(5) The Department may contract with a managed care organization for delivery of specialty mental health services if the managed care organization meets the performance standards adopted by the Department in regulations.

(6) The provisions of § 15–1005 of the Insurance Article apply to the delivery system for specialty mental health services established under this subsection and administered by an administrative services organization.

(7) The Department and the Behavioral Health Administration shall ensure that the delivery system has an adequate network of providers available to provide substance use disorder treatment for children under the age of 18 years.

(u) The Department shall include a definition of medical necessity in its quality and access standards.

(v) (1) The Department shall adopt regulations relating to enrollment, disenrollment, and enrollee appeals.

(2) Program recipients shall have the right to choose:

(i) The managed care organization with which they are enrolled; and

(ii) The primary care provider to whom they are assigned within the managed care organization.

(3) If a recipient is disenrolled and reenrolls within 120 days after the recipient's disenrollment, the Department shall:

(i) Assign the recipient to the managed care organization in which the recipient previously was enrolled; and

(ii) Require the managed care organization to assign the recipient to the primary care provider of record at the time of the recipient's disenrollment.

(4) Whenever a recipient has to select a new managed care organization because the recipient's managed care organization has departed from the program established under subsection (a) of this section, the departing managed care organization:

(i) Shall provide a written notice to the recipient 60 days before departing from the program established under subsection (a) of this section;

(ii) Shall include in the notice the name and provider number of the primary care provider assigned to the recipient and the telephone number of the enrollment broker; and

(iii) Within 30 days after departing from the program, shall provide the Department with a list of enrollees and the name of each enrollee's primary care provider.

(5) On receiving the list provided by the managed care organization, the Department shall provide the list to:

(i) The enrollment broker to assist and provide outreach to recipients in selecting a managed care organization; and

(ii) The remaining managed care organizations for the purpose of linking recipients with a primary care provider in accordance with federal law and regulation.

(6) Subject to subsection (dd)(4) and (5) of this section, an enrollee may disenroll from a managed care organization:

(i) Without cause in the month following the anniversary date of the enrollee's enrollment; and

(ii) For cause, at any time as determined by the Secretary.

(w) The Department or its subcontractor, to the extent feasible in its marketing or enrollment programs, shall hire individuals receiving assistance under the program of Aid to Families with Dependent Children established under Title IV, Part A of the Social Security Act, or the successor to the program.

(x) The Department shall disenroll an enrollee who is a child in State–supervised care if the child is transferred to an area outside the territory of the managed care organization.

(y) The Secretary shall adopt regulations to carry out this section.

(z) A managed care organization shall provide coverage for hearing loss screenings of newborns provided by a hospital before discharge.

(aa) (1) The Department shall provide enrollees and health care providers with an accurate directory or other listing of all available providers:

(i) In written form, made available on request; and

(ii) On an Internet database.

(2) The Department shall update the Internet database at least every 30 days.

(3) The written directory shall include a conspicuous reference to the Internet database.

(bb) A managed care organization may not apply a prior authorization requirement for a prescription drug used as postexposure prophylaxis for the prevention of HIV if the prescription drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines.

(cc) The Secretary shall adopt regulations for pharmacy benefits managers that contract with managed care organizations that establish requirements for conducting audits of pharmacies or pharmacists that are:

(1) To the extent practicable, substantively similar to the audit provisions under § 15–1629 of the Insurance Article; and

(2) Consistent with federal law.

(dd) (1) The Department shall establish mechanisms for:

(i) Identifying a Program recipient's primary care provider at the time of enrollment into a managed care program; and

(ii) Maintaining continuity of care with the primary care provider if:

1. The provider has a contract with a managed care organization or a contracted medical group of a managed care organization to provide primary care services; and

2. The recipient desires to continue care with the provider.

(2) If a Program recipient enrolls in a managed care organization and requests assignment to a particular primary care provider who has a contract with the managed care organization or a contracted group of the managed care organization, the managed care organization shall assign the recipient to the primary care provider.

(3) (i) A Program recipient may request a change of primary care providers within the same managed care organization at any time.

(ii) If the primary care provider has a contract with the managed care organization or a contracted group of the managed care organization, the managed care organization shall honor a request made under subparagraph (i) of this paragraph.

(4) In accordance with the federal Health Care Financing Administration's guidelines, a Program recipient may elect to disenroll from a managed care organization if the managed care organization terminates its contract with the Department.

(5) A Program recipient may disenroll from a managed care organization to maintain continuity of care with a primary care provider if:

(i) The contract between the primary care provider and the managed care organization or contracted group of the managed care organization terminates because:

1. The managed care organization or contracted group of the managed care organization terminates the provider's contract for a reason

other than quality of care or the provider's failure to comply with contractual requirements related to quality assurance activities;

2. A. The managed care organization or contracted group of the managed care organization reduces the primary care provider's capitated or applicable fee for services rates;

B. The reduction in rates is greater than the actual change in rates or capitation paid to the managed care organization by the Department; and

C. The provider and the managed care organization or contracted group of the managed care organization are unable to negotiate a mutually acceptable rate; or

3. The provider contract between the provider and the managed care organization is terminated because the managed care organization is acquired by another entity; and

(ii) 1. The Program recipient desires to continue to receive care from the primary care provider;

2. The provider contracts with at least one other managed care organization or contracted group of a managed care organization; and

3. The enrollee notifies the Department or the Department's designee of the enrollee's intention within 90 days after the contract termination.

(6) The Department shall provide timely notification to the affected managed care organization of an enrollee's intention to disenroll under the provisions of paragraph (5) of this subsection.

§15–103.2.

(a) In this section, "Committee" means the Maryland Medicaid Advisory Committee.

(b) The Department shall establish the Maryland Medicaid Advisory Committee.

(c) (1) The Committee shall be composed of not more than 25 members.

(2) The majority of the members of the Committee shall be enrollees or enrollee advocates.

(3) At least five members of the Committee shall be enrollees representative of the entire Medicaid population.

(4) The Committee members shall include:

(i) At least five current or former enrollees or the parents or guardians of current or former enrollees;

(ii) Providers who are familiar with the medical needs of low–income population groups, including board–certified physicians;

(iii) Hospital representatives;

(iv) At least five but not more than 10 advocates for the Medicaid population, including representatives of special needs populations, such as:

1. Children with special needs;

2. Individuals with physical disabilities;

3. Individuals with developmental disabilities;

4. Individuals with mental illness;

5. Individuals with brain injuries;

6. Medicaid and Medicare dual eligibles;

7. Individuals who are homeless or have experienced homelessness;

8. Individuals enrolled in home– and community–based services waivers;

9. Elderly individuals;

10. Low–income individuals and individuals receiving benefits through the Temporary Assistance for Needy Families Program; and

11. Individuals receiving substance use treatment services;

(v) Two members of the Senate Finance Committee, appointed by the President of the Senate; and

(vi) Three members of the House of Delegates, appointed by the Speaker of the House.

(5) A designee of each of the following shall serve as an ex officio member of the Committee:

(i) The Secretary of Human Services;

(ii) The Executive Director of the Maryland Health Care Commission; and

(iii) The Maryland Association of County Health Officers.

(6) The Secretary shall appoint nonvoting members from managed care organizations who may participate in Committee meetings, unless the Committee meets in closed session as provided in § 3–305 of the General Provisions Article.

(7) (i) Except as specified in paragraphs (4)(v) and (vi) and (5) of this subsection, the members of the Committee shall be appointed by the Secretary and serve for a 4–year term.

(ii) In making appointments to the Committee, the Secretary shall provide for continuity and rotation.

(iii) In appointing consumer members to the Committee, the Secretary shall seek recommendations from:

1. The State Protection and Advocacy System Organization;

2. The Statewide Independent Living Council;

3. The Developmental Disabilities Council;

4. The Department of Disabilities;

5. The Department of Aging;

6. Consumer advocacy organizations; and

7. The public.

(d) (1) Except as provided in paragraph (2) of this subsection, a member of the Committee:

(i) May not receive compensation; but

(ii) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(2) A member of the Committee who is an enrollee is entitled to reimbursement for:

(i) Expenses for personal and dependent care incurred during the meeting and during travel time to and from the meeting;

(ii) Expenses for cognitive supports related to the meeting; and

(iii) Appropriate transportation to and from the meeting.

(3) On request, the Department shall provide for a dedicated Department staff person:

(i) To review meeting materials with enrollee members in advance of a meeting by telephone or in person; and

(ii) To provide referrals to advocacy organizations.

(e) (1) The Secretary shall appoint the chair of the Committee.

(2) The Department shall provide staff for the Committee.

(3) The Committee shall determine the times and places of its meetings.

(4) (i) The chair of the Committee and the staff for the Committee shall provide the agenda, minutes, and any written materials to be presented or discussed at a meeting to the members of the Committee at least 5 days before the meeting.

(ii) The agenda, minutes, and written materials shall be provided to members of the Committee in a manner and format that reasonably accommodates the specific needs of the member.

(f) In addition to any duties imposed by federal law and regulation, the Committee shall:

(1) Advise the Secretary on the implementation, operation, and evaluation of managed care programs under this section;

(2) Review and make recommendations on the regulations developed to implement managed care programs under § 15–103.1 of this subtitle;

(3) Review and make recommendations on the standards used in contracts between the Department and managed care organizations;

(4) Review and make recommendations on the Department's oversight of quality assurance standards;

(5) Review data collected by the Department from managed care organizations participating in the Program and data collected by the Maryland Health Care Commission;

(6) Promote the dissemination of managed care organization performance information, including loss ratios, to enrollees in a manner that facilitates quality comparisons and uses layman's language;

(7) Assist the Department in evaluating the enrollment process; and

(8) Review reports of the ombudsmen.

§15–103.3.

The Program shall use its leverage as a high volume purchaser to promote the cost effectiveness of Maryland's health care system.

§15–103.4.

(a) The Department shall issue a request for proposals for the administration of dental services for Program recipients for the purpose of comparing and evaluating the performance and cost of dental services provided by a managed care organization and the performance and cost of dental services provided by a dental managed care organization that is separate from a managed care organization.

(b) The Department shall provide access to Program recipients for dental services to increase utilization of dental services in accordance with utilization targets that the Department by regulation establishes in an oral health care plan.

(c) The access required under subsection (b) of this section may be through a managed care organization or a dental managed care organization that is separate from a managed care organization.

§15–103.5.

(a) There is a HealthChoice Performance Incentive Fund established in the Department.

(b) (1) The Department shall pay all fines collected under § 15–103.1(i)(3)(v) of this subtitle and penalties collected under § 15–103.9(e)(2)(iv) of this subtitle to the Comptroller of the State.

(2) The Comptroller shall distribute the fines to the Fund.

(c) (1) The Fund shall be used exclusively for the provider reimbursement budget under the HealthChoice Program, including providing financial incentives designed to improve the quality of care to managed care organizations that exceed performance targets.

(2) The Fund is a continuing nonlapsing fund not subject to § 7–302 of the State Finance and Procurement Article.

(3) Except as provided in paragraph (4) of this subsection, any unspent portions of the Fund may not be transferred or revert to the General Fund of the State, but shall remain in the Fund to be used for the purposes specified in this section.

(4) At the end of each fiscal year, any amount in excess of $5 million shall revert to the General Fund.

(d) (1) The Secretary or the Secretary's designee shall administer the Fund.

(2) The Secretary shall adopt regulations to carry out the provisions of this section, including the distribution of money from the Fund to managed care organizations.

(e) The Legislative Auditor shall audit the accounts and transactions of the Fund as provided in § 2–1220 of the State Government Article.

§15–103.6.

(a) A managed care organization may deem a health care provider credentialed for a period of not more than 6 months from the date of receipt of a completed application if:

(1) The health care provider:

(i) Has been credentialed by another entity in the State that is required to credential health care providers; and

(ii) Has submitted an application to participate in the managed care organization's provider panel; and

(2) The managed care organization verifies that the health care provider was credentialed and remains in good standing with at least one entity that credentialed the health care provider.

(b) An entity that has credentialed a health care provider may not refuse a request by a managed care organization to verify that the health care provider is credentialed and in good standing.

(c) Nothing in this section may be construed to relieve the managed care organization from fully credentialing its health care providers.

§15–103.7.

(a) For the calendar year prior to the report date under subsection (b) of this section, the Department shall review the rates paid to providers under the federal Medicare fee schedule and compare the rates under the Medicare fee schedule to the fee–for–service rates paid to similar providers for the same services under the Maryland Medical Assistance Program and the rates paid to managed care organization providers for the same services under the Maryland Medical Assistance Program.

(b) On or before January 1, 2010, and each January 1 thereafter, the Department shall report, in accordance with § 2–1257 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on:

(1) The review and comparison under subsection (a) of this section;

(2) Whether the fee–for–service rates and managed care organization provider rates will exceed the rates paid under the Medicare fee schedule for the period covered by the review required under subsection (a) of this section;

(3) An analysis of the fee–for–service reimbursement rates paid in other states and how those rates compare with those in the State;

(4) A schedule for bringing the State's fee–for–service reimbursement rates to a level that assures that all health care providers are reimbursed adequately to provide access to care; and

(5) An analysis of the estimated costs of implementing the schedule and any proposed changes to the fee–for–service reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program.

§15–103.8.

(a) (1) Subject to paragraph (2) of this subsection, on or before June 30, 2017, the Department shall adopt regulations necessary to ensure that the Program is in compliance with the federal Mental Health Parity and Addiction Equity Act and the federal Patient Protection and Affordable Care Act.

(2) Except as provided in § 15–103.10 of this subtitle, the Department is not required to adopt regulations under paragraph (1) of this subsection for any change that may be made through a process other than the regulatory process.

(b) The regulations adopted under subsection (a) of this section shall include standards regarding treatment limitations for specialty mental health and substance use disorder services that comply with the federal Mental Health Parity and Addiction Equity Act and the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and relate to:

(1) The scope of benefits for:

(i) Telehealth services; and

(ii) Residential treatment programs that are not institutions for mental disease;

(2) Service notification and authorization requirements;

(3) Licensed specialty mental health or substance use disorder program billing for:

(i) Services provided by physicians, advanced practice nurses, and physician assistants;

(ii) Services provided by a licensed specialty mental health or substance use disorder program at a location that is not the primary location at which the program is licensed; and

(iii) Separate levels of service provided within a single day or week; and

(4) Reimbursement rates.

(c) The treatment limitations for specialty mental health and substance use disorder services comply with the federal Mental Health Parity and Addiction Equity Act and the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, if the operable processes, strategies, evidentiary standards, or other factors used in applying a treatment limitation to specialty mental health or substance use disorder services, as written and applied, are comparable to and no more restrictive than, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the treatment limitation to medical and surgical services.

§15–103.9.

(a) In this section, "Program" means the program established by the Department under subsection (b) of this section.

(b) (1) The Department shall establish a value–based purchasing program that awards financial incentives to and assesses penalties on managed care organizations based on the organization's performance on health measures established by the Department.

(2) The Department shall, in accordance with this section, establish criteria to implement the Program, including the establishment of performance targets, award of incentives, and collection of penalties.

(c) Not more than 1% of the amount of capitated payments received by a managed care organization each year shall be subject to the collection of penalties under the Program.

(d) For each measurement year, beginning January 1, 2021, the Department may not in any calendar year pay a total amount of incentives to managed care organizations under the Program in an amount that exceeds:

(1) The total amount of penalties the Department collects from managed care organizations under the Program; and

(2) Any additional funds allocated by the Department to support the Program.

(e) (1) For each measurement year, beginning January 1, 2021, the Department shall base the initial distribution of funding awarded under the Program to a managed care organization in each calendar year on the number of performance targets that the managed care organization meets or exceeds.

(2) For each measurement year, beginning January 1, 2021, if the total amount of penalties that the Department collects under the Program exceeds the total amount of incentive funding awarded in the initial distribution of funds in a calendar year under the Program, the remaining funds shall be allocated as follows:

(i) 40% to managed care organizations that have met or exceeded more performance targets than the managed care organization has not met;

(ii) 25% to managed care organizations that the Department determines have demonstrated performance improvement in the measurement year, if the managed care organizations use the funding to target performance improvement in areas identified by the Department;

(iii) 25% for health improvement programs under the Maryland Medicaid Managed Care Program, with the funding used to fund enhancements in:

1. Areas where the Maryland Medicaid Managed Care Program as a whole underperforms as compared to equivalent programs in other states; or

2. Areas determined by the Department to be a State health priority;

(iv) Except as provided in item (v) of this paragraph, 10% to establish a reserve in the HealthChoice Performance Incentive Fund to be used in any calendar year in which the amount of penalties the Department collects under the Program are insufficient to pay incentives earned by managed care organizations; and

(v) If the Department may not allocate funds, in whole or in part, in accordance with item (iv) of this paragraph because of the limitation in paragraph (3) of this subsection, the Department shall equally allocate the remaining funds for use under items (i), (ii), and (iii) of this paragraph.

(3) The Department may not allocate funds under paragraph (2)(iv) of this subsection in a manner that causes the balance in the HealthChoice Performance Incentive Fund to exceed $5 million.

(f) Subject to the provisions of this section, the Department may modify the Program if the Department:

(1) Adopts by regulation any changes to the core set of performance measures and the methodology for penalties, rewards, disincentives, or incentives under subsection (e)(1) and (2)(i) of this section before the calendar year for which the managed care organizations will be held accountable for the standard compliance with the performance measures; and

(2) Notifies each managed care organization of the core set of performance measures and targets under subsection (e)(1) and (2)(i) of this section at least 3 months before the calendar year for which the managed care organization will be held accountable to the standard for compliance with the performance measures.

(g) Any penalty or capitation adjustment imposed under this section on a managed care organization may not be accomplished or implemented by withholding a capitation payment.

(h) The Department shall adopt regulations to carry out this section.

§15–103.10.

(a) Notwithstanding any other provision of law, the Department may not limit or restrict a Program recipient's admission for inpatient care at a special psychiatric hospital or an acute general care hospital with separately identified inpatient psychiatric service unless the Department:

(1) Bases the limit or restriction on the medical necessity of the admission; and

(2) Establishes the limit or restriction through regulation.

(b) On or before July 1 each year, beginning in 2024, the Department shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on, for the immediately preceding fiscal year:

(1) The average length of stay for Program recipients for Serious Mental Illness Institute of Mental Disease services and for Substance Use Disorder

Institute of Mental Disease services as reported to the Centers for Medicare and Medicaid Services;

(2) Any corrective action plans and any limits on days of stay required by the Centers for Medicare and Medicaid Services;

(3) Any federal funding withheld and any additional State funding required due to subsection (a) of this section;

(4) Data on the effect of subsection (a) of this section on the length of emergency department stays among Program recipients; and

(5) Data on whether Program recipients receiving Institute of Mental Disease services were transferred to another facility and the type of facility to which they were transferred.

§15–103.11. IN EFFECT

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

(2) "Ex parte redetermination" means a process by which the Department determines a Program recipient's eligibility to continue to receive services using existing data, without requiring the Program recipient to submit additional information.

(3) "Home– and community–based services" means services authorized under a Medicaid State Plan option or waiver under § 1115 or § 1915(c), (i), or (k) of the federal Social Security Act.

(4) "Procedural disenrollment" means the termination of a Program recipient's eligibility to receive services based on reasons related to the renewal process and not on a determination of ineligibility.

(b) The Department shall comply with the requirements of 42 C.F.R. § 435.912 related to the timely determination and redetermination of Program eligibility, including processing an application:

(1) If a determination of disability is not required, within 45 days after the receipt of the application; and

(2) If a determination of disability is required, within 90 days after the receipt of the application.

(c) The Department shall conduct ex parte redeterminations and use all procedures authorized under 42 C.F.R. § 435.916 to prevent procedural disenrollment of individuals receiving home– and community–based services.

(d) In accordance with 42 C.F.R. § 435.905 and subject to subsection (e) of this section, the Department shall provide, in electronic and paper formats, and orally as an accommodation, the following information to all applicants and other individuals on request:

(1) Requirements for Program eligibility;

(2) Available Program services; and

(3) The rights and responsibilities of applicants and Program recipients.

(e) (1) The Department shall provide the information required under subsection (d) of this section in plain language and in a manner that is timely and accessible to individuals who are:

(i) Limited English proficient through the provision of language services, including oral interpretation and written translations, at no cost to the individual; or

(ii) Living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the federal Americans with Disabilities Act and § 504 of the federal Rehabilitation Act of 1973.

(2) The Department shall provide taglines in non–English languages to inform individuals of:

(i) The availability of the accessible information and language services under this section; and

(ii) How to access the information and services.

(f) (1) If a Program recipient is procedurally disenrolled from home– and community–based services due to a failure by the Department to redetermine eligibility in a timely manner after the recipient has timely returned information required under 42 C.F.R. § 435.916(b)(2)(i)(B) and 42 C.F.R. § 435.952(c), the Department shall reinstate the Program recipient's eligibility and the provision of home– and community–based services and authorize enrollment retroactively to the date of disenrollment pending the Department's completion of the redetermination process.

(2) This subsection may not be construed to limit the Department's authority or diminish the Department's responsibility to reinstate the eligibility of and the provision of home– and community–based services to a Program recipient who has been disenrolled for a reason other than a failure by the Department to redetermine eligibility in a timely manner.

(g) Subject to federal approval, the Department shall reserve capacity in home– and community–based services waivers for services needed by Program recipients with developmental disabilities who:

(1) Were disenrolled from the Maryland Medicaid Home and Community–Based Services waiver program on or after January 1, 2024;

(2) Have had Program eligibility reinstated; and

(3) Have requested the reinstatement of waiver services.

(h) (1) The Department may not procedurally disenroll an individual from the Program or home– and community–based services solely based on missing documentation, a missing signature, or incomplete information unless the Department has:

(i) Exhausted all ex parte verification processes required under 42 C.F.R. § 435.916;

(ii) Provided a clear, specific, and accessible written notice identifying the exact information required; and

(iii) Provided the Program recipient with a reasonable opportunity to supply the information.

(2) If the Department violates paragraph (1) of this subsection, a Program recipient's home– and community–based services shall continue without interruption.

(i) If the Department disenrolls a Program recipient in violation of this section, the Department shall:

(1) Automatically reinstate Program and home– and community–based services retroactive to the date of disenrollment; and

(2) Treat the Program recipient as continuously enrolled.

(j) (1) On or before January 1, 2027, and quarterly thereafter, the Department shall:

(i) Submit to the General Assembly, in accordance with § 2–1257 of the State Government Article, a report regarding Program recipients who receive home– and community–based services; and

(ii) Post each report submitted under item (i) of this paragraph on the Department's website.

(2) The reports required under paragraph (1) of this subsection shall include:

(i) The total number of Program recipients for whom a redetermination of eligibility was initiated;

(ii) The total number of Program recipients for whom Program coverage is renewed;

(iii) Of the Program recipients whose eligibility is renewed, the total number whose coverage was renewed based on an ex parte redetermination;

(iv) The total number of Program recipients whose eligibility was reinstated in accordance with subsection (f) of this section;

(v) The total number of Program recipients whose eligibility was terminated;

(vi) The total number of Program recipients whose eligibility was terminated for procedural reasons;

(vii) The total number of Program recipients whose eligibility was terminated due to a failure by the Department to redetermine eligibility in a timely manner; and

(viii) The mean and median processing times for redeterminations of eligibility.

§15–103.11. // EFFECTIVE SEPTEMBER 30, 2029 PER CHAPTER 175 OF 2026 //

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

(2) "Ex parte redetermination" means a process by which the Department determines a Program recipient's eligibility to continue to receive

services using existing data, without requiring the Program recipient to submit additional information.

(3) "Home– and community–based services" means services authorized under a Medicaid State Plan option or waiver under § 1115 or § 1915(c), (i), or (k) of the federal Social Security Act.

(4) "Procedural disenrollment" means the termination of a Program recipient's eligibility to receive services based on reasons related to the renewal process and not on a determination of ineligibility.

(b) The Department shall comply with the requirements of 42 C.F.R. § 435.912 related to the timely determination and redetermination of Program eligibility, including processing an application:

(1) If a determination of disability is not required, within 45 days after the receipt of the application; and

(2) If a determination of disability is required, within 90 days after the receipt of the application.

(c) The Department shall conduct ex parte redeterminations and use all procedures authorized under 42 C.F.R. § 435.916 to prevent procedural disenrollment of individuals receiving home– and community–based services.

(d) In accordance with 42 C.F.R. § 435.905 and subject to subsection (e) of this section, the Department shall provide, in electronic and paper formats, and orally as an accommodation, the following information to all applicants and other individuals on request:

(1) Requirements for Program eligibility;

(2) Available Program services; and

(3) The rights and responsibilities of applicants and Program recipients.

(e) (1) The Department shall provide the information required under subsection (d) of this section in plain language and in a manner that is timely and accessible to individuals who are:

(i) Limited English proficient through the provision of language services, including oral interpretation and written translations, at no cost to the individual; or

(ii) Living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the federal Americans with Disabilities Act and § 504 of the federal Rehabilitation Act of 1973.

(2) The Department shall provide taglines in non–English languages to inform individuals of:

(i) The availability of the accessible information and language services under this section; and

(ii) How to access the information and services.

(f) (1) If a Program recipient is procedurally disenrolled from home– and community–based services due to a failure by the Department to redetermine eligibility in a timely manner after the recipient has timely returned information required under 42 C.F.R. § 435.916(b)(2)(i)(B) and 42 C.F.R. § 435.952(c), the Department shall reinstate the Program recipient's eligibility and the provision of home– and community–based services and authorize enrollment retroactively to the date of disenrollment pending the Department's completion of the redetermination process.

(2) This subsection may not be construed to limit the Department's authority or diminish the Department's responsibility to reinstate the eligibility of and the provision of home– and community–based services to a Program recipient who has been disenrolled for a reason other than a failure by the Department to redetermine eligibility in a timely manner.

(g) Subject to federal approval, the Department shall reserve capacity in home– and community–based services waivers for services needed by Program recipients with developmental disabilities who:

(1) Were disenrolled from the Maryland Medicaid Home and Community–Based Services waiver program on or after January 1, 2024;

(2) Have had Program eligibility reinstated; and

(3) Have requested the reinstatement of waiver services.

(h) (1) The Department may not procedurally disenroll an individual from the Program or home– and community–based services solely based on missing documentation, a missing signature, or incomplete information unless the Department has:

(i) Exhausted all ex parte verification processes required under 42 C.F.R. § 435.916;

(ii) Provided a clear, specific, and accessible written notice identifying the exact information required; and

(iii) Provided the Program recipient with a reasonable opportunity to supply the information.

(2) If the Department violates paragraph (1) of this subsection, a Program recipient's home– and community–based services shall continue without interruption.

(i) If the Department disenrolls a Program recipient in violation of this section, the Department shall:

(1) Automatically reinstate Program and home– and community–based services retroactive to the date of disenrollment; and

(2) Treat the Program recipient as continuously enrolled.

§15–104.

The Secretary may contract with the Department of Human Services to provide medical services to those individuals for whom:

(1) Funds are appropriated to the Department of Human Services; and

(2) The Department of Human Services is responsible under the appropriation.

§15–105.

(a) In this section, "dual eligibility" means simultaneous eligibility for health insurance coverage under both the Program and Medicare and for which the Department may obtain federal matching funds.

(b) The Department shall adopt rules and regulations for the reimbursement of providers under the Program. However, except for an invoice that must be submitted to a Medicare intermediary or Medicare carrier for an individual with dual eligibility, payment may not be made for an invoice that is received more than 1 year after the dates of the services given.

(c) A provider who fails to submit an invoice within the required time may not recover the amount later from the Program recipient.

(d) (1) The Department shall adopt regulations for the reimbursement of specialty outpatient treatment and diagnostic services rendered to Program recipients at a freestanding clinic owned and operated by a hospital that is under a capitation agreement approved by the Health Services Cost Review Commission.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, the reimbursement rate under paragraph (1) of this subsection shall be set according to Medicare standards and principles for retrospective cost reimbursement as described in 42 C.F.R. Part 413 or on the basis of charges, whichever is less.

(ii) The reimbursement rate for hospital outpatient oncology, diagnostic, and rehabilitative services that the hospital transferred to an off–site facility prior to January 1, 1999, shall be set according to the rates approved by the Health Services Cost Review Commission if:

1. The transfer of services was due to zoning restrictions at the hospital campus;

2. The off–site facility is surveyed as part of the hospital for purposes of accreditation by the Joint Commission; and

3. The hospital notifies the Health Services Cost Review Commission in writing by June 1, 2013, that the hospital would like the services provided at the off–site facility to be subject to Title 19, Subtitle 2 of this article.

(e) (1) In this subsection, "provider" means a community–based program or an individual health care practitioner providing outpatient mental health treatment.

(2) For an individual with dual eligibility, the Program shall reimburse a provider the entire amount of the Program fee for outpatient mental health treatment, including any amount ordinarily withheld as a psychiatric exclusion and any copayment not covered under Medicare.

(f) This section has no effect if its operation would cause this State to lose any federal funds.

(g) The Program shall pay the rates set by the Health Services Cost Review Commission for hospital services, as defined in § 19–201 of this article, provided at:

(1) A freestanding medical facility pilot project authorized under § 19–3A–07 of this article prior to January 1, 2008; and

(2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015.

§15–105.1.

(a) This section does not apply to a person providing pharmacy benefit manager services.

(b) If a pharmacy is required to submit a request for payment electronically to the Department under § 15-105(b) of this subtitle, then the pharmacy may choose to be reimbursed electronically, and in that event, the Department shall reimburse the pharmacy electronically under the Program.

§15–105.2.

The Program shall reimburse health care providers in accordance with the requirements of Title 19, Subtitle 1, Part IV of this article.

§15–106.

(a) (1) In cooperation with the professional organizations whose members provide health care under the Program, the Secretary shall establish a system of review for all health care that is provided.

(2) The review shall include a study of the quality of care and the proper use of the services by the Program recipient or the provider.

(b) A member of an appointed committee of any of these professional organizations or an appointed member of a committee of a medical staff of a licensed hospital shall have the immunity from liability described under § 5-628 of the Courts and Judicial Proceedings Article.

§15–107.

(a) The Department may require facilities that participate in the Program to submit cost reports, as defined by the Department, within the time set by the Department.

(b) If a report is not submitted within that time, the Department shall withhold from the facility up to 10 percent of current interim payments for the

calendar month in which the report is due and any later calendar months until the report is submitted.

§15–107.1.

(a) Beginning in 2026, the Department shall conduct the in–State cost–of–dispensing survey at least once every 3 years.

(b) On or before December 1 each year in which the survey required under this section is conducted, the Department shall report the results of the survey to the General Assembly, in accordance with § 2–1257 of the State Government Article.

§15–108.

(a) In this section, "board" means an appeal board established under this section.

(b) (1) The Secretary may:

(i) Establish one or more boards for purposes of this section; and

(ii) Designate the jurisdiction of a board.

(2) A board shall consist of 3 members.

(3) Of the 3 board members:

(i) 2 shall be appointed by the Secretary; and

(ii) 1 shall be chosen by the appointed members.

(4) Of the 2 appointed members of a board:

(i) 1 shall be a representative of the industry affected who is an individual knowledgeable in Medicare and Medicaid reimbursement principles; and

(ii) 1 shall be an individual who is employed by this State and knowledgeable in Medicare and Medicaid reimbursement principles and who does not participate directly in the field verifications.

(c) (1) If the Department or an agent of the Department does a field verification of the costs and allowable charges of a facility that participates in the

Program, the Department or agent shall notify the facility of the results of the field verification.

(2) Within 60 days after the facility receives the notification required under paragraph (1) of this subsection, the Department shall pay the facility the amount the Department has determined is due the facility by the Department regardless of whether or not the facility files an appeal.

(d) (1) A facility may appeal the results of a field verification by filing written notice with the appropriate board within 30 days after the facility receives the notice from the Department or its agent.

(2) (i) Within 30 days after the filing of an appeal to the board by a facility that the Department has determined owes money to the State, the Department shall recalculate the amount that is due to the State based on the field verification, exclusive of the amount in controversy which is subject to the appeal, and shall notify the facility of that amount.

(ii) Subject to the provisions of subparagraphs (iii) and (iv) of this paragraph, payment for the amount due the State, if any, after the recalculation shall be made within 60 days after the facility receives notification of the recalculation.

(iii) If a facility requests a longer payment schedule within 60 days after the facility receives notification of the recalculation, the Department may establish, after consultation with the facility, a longer payment schedule.

(iv) The Department shall establish a longer payment schedule if, in the Department's reasonable judgment, failure to grant a longer payment schedule would:

1. Result in financial hardship to the facility; or

2. Have an adverse effect on the quality of patient care furnished by the facility.

(3) (i) If a facility files an appeal, the portion of the amount in controversy that is actually paid shall be subject to an award of interest that is:

1. Calculated from the date the appeal was filed through the date of payment; and

2. Determined in accordance with a rate of interest established by regulation.

(ii) Interest paid by a facility under subparagraph (i) of this paragraph is not an allowable cost.

(iii) Interest paid to a facility under subparagraph (i) of this paragraph is not subject to any offset or other reduction against otherwise allowable costs.

(4) If a facility other than a hospital, or if the Department is aggrieved by a final decision of the board under this section, the facility or the Department shall place any money due from the facility or from the Department in an interest bearing escrow account. The money shall remain in escrow until a final decision has been rendered.

(5) Upon a final determination of the dispute, the appropriate person administering the escrow account shall distribute the money in that account, including any interest accrued, in conformity with the final determination.

(e) (1) After the Department receives the findings of a board, the Department shall determine the amount that is due either to this State or to the facility and notify the facility of that amount.

(2) If the facility has accepted the determination made under paragraph (1) of this subsection, within 60 days after the facility receives the notification under paragraph (1) of this subsection the Department shall pay the amount the Department has determined is due the facility, if any.

(3) Subject to the provisions of paragraphs (4) and (5) of this subsection, within 60 days after the facility receives notification, the facility shall pay the amount due the Department, if any.

(4) If a facility requests a longer payment schedule within 30 days after the facility receives notification of the amount due the Department, the Department may establish, after consultation with the facility, a longer payment schedule.

(5) The Department shall establish a longer payment schedule if, in the Department's reasonable judgment, failure to grant a longer payment schedule would:

(i) Result in financial hardship to the facility; or

(ii) Have an adverse effect on the quality of patient care furnished by the facility.

(f) (1) The Department or any facility aggrieved by a reimbursement decision of the board under this section may take a direct judicial appeal.

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

§15–109.

(a) An individual is not ineligible under the Program solely because Social Security benefits received by the individual are increased, unless:

(1) The individual is considered ineligible because of the increase under applicable rules or regulations of the United States Department of Health and Human Services; and

(2) As to that individual, federal matching funds for the State Program are not available.

(b) Except as provided in § 15–103(b)(2) of this subtitle, to determine eligibility under the Program, the Department annually shall set the allowable yearly income levels in amounts at least equal to the following:

(1) Family of 1 – $2,500.

(2) Family of 2 – $3,000.

(3) Family of 3 – $3,500.

(4) Family of 4 – $4,000.

(5) Family of 5 or more – $4,500 plus an increase of $500 for each family member in excess of 5.

(c) This section is effective only to the extent that its provisions do not conflict with federal requirements for the administration of the Program in this State.

(d) As a condition of eligibility for medical assistance, a recipient is deemed to have assigned to the Secretary of Health or the Secretary's designee any rights to payment for medical care services from any third party who has the legal liability to make payments for those services, to the extent of any payments made by the Department on behalf of the recipient.

(e) (1) Each resident of a nursing home who is a recipient of medical assistance shall receive a personal needs allowance.

(2) After a determination of income eligibility is made for a nursing home resident under the Program, the personal needs allowance shall be deducted from the total income of the resident.

(3) The personal needs allowance for each resident of a nursing home who is a recipient of medical assistance shall be:

(i) If on or before June 30, 2002, the federal Centers for Medicare and Medicaid Services approve the Department's application for an amendment to the State's existing § 1115 demonstration waiver necessary to implement the Maryland Pharmacy Discount Program established under § 15–124.1 of this subtitle:

1. Beginning April 1, 2003, $50 per month;

2. Beginning July 1, 2004, $60 per month; and

3. Beginning July 1, 2005, adjusted annually by an amount not exceeding 5% to reflect the percentage by which benefits under Title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased by the federal government to reflect changes in the cost of living, as that percentage change is reported in the Federal Register in accordance with 42 U.S.C. 415(a)(1)(D); or

(ii) If on or before June 30, 2002, the federal Centers for Medicare and Medicaid Services do not approve the Department's application for an amendment to the State's existing § 1115 demonstration waiver necessary to implement the Maryland Pharmacy Discount Program established under § 15–124.1 of this subtitle:

1. Beginning July 1, 2003, $50 per month;

2. Beginning July 1, 2004, $60 per month; and

3. Beginning July 1, 2005, adjusted annually by an amount not exceeding 5% to reflect the percentage by which benefits under Title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased by the federal government to reflect changes in the cost of living, as that percentage change is reported in the Federal Register in accordance with 42 U.S.C. 415(a)(1)(D).

(4) The Secretary shall adopt regulations to implement this subsection.

(f) Subject to the confidentiality requirements of State and federal law, the courts of this State shall admit a certified copy of a 206N form, also known as a long–term care transaction form, into evidence.

§15–109.1.

(a) The Department, in consultation with the Office of the Attorney General, shall:

(1) Develop and implement a plan for making the advance directive information sheet developed under § 5–615 of this article widely available; and

(2) Make the information sheet described in item (1) of this subsection available in a conspicuous location in each local health department, in each local department of social services, and in community health centers.

(b) The Department shall implement the plan on or before January 1, 2017.

(c) During the development of the plan under subsection (a) of this section and the information sheet under § 5–615 of this article, the Office of the Attorney General shall consult with any interested party including the State Advisory Council on Serious Illness Care.

(d) The Department shall offer:

(1) The information sheet developed under § 5–615 of this article as part of the monthly enrollment packet mailed to a recipient by the enrollment broker; and

(2) The use of electronic advance directives to a recipient through an advance directives service that:

(i) Is approved by the Maryland Health Care Commission and the Department; and

(ii) Meets the technology, security, and privacy standards established by the Maryland Health Care Commission.

§15–109.2.

To the extent authorized by federal law or regulation, if a Program recipient who is at least 21 years old but is under the age of 65 years is incarcerated or is admitted to an institution for the treatment of mental disease, the Department:

(1) Shall suspend Program benefits for that individual while the individual is incarcerated or is in the institution; and

(2) May not terminate Program benefits for that individual based on the incarceration of the individual or on the admission of the individual to the institution.

§15–110.

The Department shall reimburse acute general and chronic care hospitals that participate in the Program for care provided to Program recipients in accordance with rates that the Health Services Cost Review Commission approves under Title 19, Subtitle 2 of this article, if the United States Department of Health and Human Services approves this method of reimbursement.

§15–111.

(a) The Department may authorize reimbursement of a licensed day care center for the elderly or medically handicapped adults for medical care that the center provides to a Program recipient who is certified as requiring nursing home care.

(b) (1) Reimbursement under this section is subject to the availability of federal funds.

(2) The reimbursement rate for medical day care:

(i) May not exceed a maximum per diem rate established by regulation of the Department; and

(ii) Shall cover the following:

1. Administrative overhead;

2. Drugs, supplies, and equipment;

3. Food;

4. Medical services;

5. Staff; and

6. Transportation.

§15–112.

After consultation with the State Board of Pharmacy, the Secretary may authorize reimbursement of a physician for the dispensing of drugs to Program recipients, on the same basis as a licensed pharmacist if:

(1) The physician dispenses drugs on a regular basis in the physician's office; and

(2) There is no pharmacy within 10 miles of that office.

§15–113.

(a) In this section, "incarcerated individual of a public institution" has the meaning stated in Title 42, § 435.1009 of the Code of Federal Regulations (1978 edition).

(b) (1) If an incarcerated individual of a public institution is eligible for federally funded Medicaid benefits, the Department shall pay the custodial authority for any medical care that is provided to the incarcerated individual during the month when the individual became an incarcerated individual.

(2) Payments under this subsection shall be made in accordance with applicable rules and regulations for the Program.

(c) The Department shall be reimbursed for the nonfederal cost of medical care by either the State or local authority that is responsible for the incarcerated individual of a public institution.

§15–114.

(a) In this section, "related institution" includes any of the following facilities, as classified from time to time by law, rule, or regulation:

(1) A comprehensive care facility;

(2) An extended care facility;

(3) An intermediate care facility; and

(4) A skilled nursing facility.

(b) This section applies only to the extent that federal funds are available for reimbursement under this section.

(c) Except as provided in subsection (f) of this section, and in accordance with subsection (e) of this section, the Department shall reimburse each hospital–based related institution that:

(1) Is a distinct part of an acute or chronic hospital; and

(2) On and after July 1, 1980, is licensed as a related institution.

(d) (1) The Health Services Cost Review Commission shall determine rates for fiscal years 1986, 1987, 1988, and 1989 for purposes of the reimbursement formula established under subsection (e) of this section and shall inform the Department of the reimbursement rates prior to the beginning of the respective fiscal year.

(2) The rates determined by the Health Services Cost Review Commission under this section shall be the rates that would have been in effect during the respective fiscal year if the hospital–based related institution had remained under the full rate jurisdiction of the Health Services Cost Review Commission.

(e) The reimbursement required by this section shall be in accordance with the following formula:

(1) For the period from July 1, 1985 through June 30, 1986, a per diem rate calculated as the sum of:

(i) 80% of the rate determined by the Health Services Cost Review Commission under subsection (d) of this section; and

(ii) 20% of the per diem rate of the hospital–based related institution determined under the Program regulations applicable to skilled and intermediate care nursing facilities.

(2) For the period from July 1, 1986 through June 30, 1987, a per diem rate calculated as the sum of:

(i) 60% of the rate determined by the Health Services Cost Review Commission under subsection (d) of this section; and

(ii) 40% of the per diem rate of the hospital–based related institution determined under the Program regulations applicable to skilled and intermediate care nursing facilities.

(3) For the period from July 1, 1987 through June 30, 1988, a per diem rate calculated as the sum of:

(i) 40% of the rate determined by the Health Services Cost Review Commission under subsection (d) of this section; and

(ii) 60% of the per diem rate of the hospital–based related institution determined under the Program regulations applicable to skilled and intermediate care nursing facilities.

(4) For the period from July 1, 1988 through June 30, 1989, a per diem rate calculated as the sum of:

(i) 20% of the rate determined by the Health Services Cost Review Commission under subsection (d) of this section; and

(ii) 80% of the per diem rate of the hospital–based related institution determined under the Program regulations applicable to skilled and intermediate care nursing facilities.

(5) Beginning July 1, 1989, the Department shall reimburse at rates determined under the Program regulations applicable to skilled and intermediate care nursing facilities.

(f) (1) In this subsection, "management firm" means an organization that:

(i) Is intended to have or has full responsibility and control for the day–to–day operations of a nursing home or related institution; and

(ii) Is under contract with:

1. An applicant for a license from the Secretary to establish, operate, or continue the operation of an existing nursing home or related institution; or

2. A holder of a license from the Secretary to operate a nursing home or related institution.

(2) The Department may not reimburse a nursing home or related institution if the nursing home or related institution or a management firm of a nursing home or related institution knowingly employs or retains as a consultant an individual who, for an activity described in § 9–314(b)(8), (9), or (10) of the Health Occupations Article, has:

(i) Surrendered a nursing home administrator license under § 9–313 of the Health Occupations Article; or

(ii) Had a nursing home administrator license revoked under § 9–314 of the Health Occupations Article.

§15–114.1.

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

(2) "Emergency medical services provider" has the meaning stated in § 13–561 of the Education Article.

(3) "Emergency service transporter" means a public entity or volunteer fire, rescue, or emergency medical service that provides emergency medical services.

(4) "Low–acuity health condition" means an illness, an injury, or a condition serious enough that a reasonable person would seek care immediately, but not so severe as to require emergency room care.

(5) "Mobile integrated health service" means a community–based preventive, primary, chronic, preadmission, or postadmission health care service or transport provided by an emergency medical services provider to an individual.

(b) (1) Subject to paragraph (2) of this subsection, if an emergency service transporter charges for its services and requests reimbursement from the Program, the Department shall reimburse the emergency service transporter, in an amount as specified by regulations adopted by the Department, for the cost of:

(i) Transportation the emergency service transporter provides to a Program recipient to a facility in response to a 911 call; and

(ii) Medical services the emergency service transporter provides to the Program recipient in response to a 911 call.

(2) The Department shall:

(i) Increase the amount of reimbursement authorized under paragraph (1) of this subsection for the cost of transportation and medical services by $50 in fiscal year 2023; and

(ii) Pay at least the amount established under item (i) of this paragraph in each subsequent fiscal year.

(c) (1) Subject to paragraph (3) of this subsection, the Department shall reimburse an emergency service transporter for mobile integrated health services provided to a Program recipient in an amount as specified by regulations adopted by the Department that is at least $100 per interaction.

(2) The services subject to reimbursement under paragraph (1) of this subsection shall include:

(i) Health care services, including health assessments, remote medical diagnostics, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow–up care, and minor medical procedures, provided by an emergency medical services provider that are:

1. Within the scope of practice of the emergency medical services provider;

2. Provided in a home or another community–based setting to a Program recipient who does not require emergency medical transport; and

3. Consistent with the protocols issued by the Emergency Medical Services Board; and

(ii) Transportation provided by the emergency service transporter to a Program recipient with a low–acuity health condition to a location in which urgent health care services are provided to individuals.

(3) The Department shall:

(i) Increase the amount of reimbursement authorized under paragraph (1) of this subsection for the cost of transportation and medical services by $50 in fiscal year 2023; and

(ii) Pay at least the amount established under item (i) of this paragraph in each subsequent fiscal year.

(d) The Department shall adopt any regulations necessary to carry out this section.

§15–114.2. ** CONTINGENCY – IN EFFECT UNLESS LETTER FROM U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES IS RECEIVED BY JUNE 1, 2027 – CHAPTER 867 OF 2026 **

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

(2) (i) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvements in human behavior.

(ii) "Applied behavior analysis" includes the direct observations, measurement, and functional analysis of the relations between environment and behavior.

(3) "Autism spectrum disorder" means a group of developmental disorders:

(i) Characterized by persistent deficits in social communication and social interaction across multiple contexts;

(ii) Characterized by restricted, repetitive patterns of behavior, interests, or activities; and

(iii) Whose symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

(4) "Behavior technician" means an individual who:

(i) Delivers applied behavior analysis services that are provided to individuals with autism spectrum disorder under the supervision of:

1. A licensed psychologist;

2. A board certified behavior analyst–doctoral; or

3. A board certified behavior analyst; and

(ii) Meets the requirements for providing behavior analysis services under the Program established by the Department in regulation.

(5) "Board certified behavior analyst" means a licensed professional who:

(i) Renders and provides direction for applied behavior analysis services that are provided to individuals with autism spectrum disorder; and

(ii) Has obtained a Board Certified Behavior Analyst certification.

(6) "Board certified behavior analyst–doctoral" means a licensed professional who:

(i) Renders and provides direction for applied behavior analysis treatments that are provided to individuals with autism spectrum disorder; and

(ii) Has obtained a Board Certified Behavior Analyst–Doctoral certification.

(b) (1) The Department shall provide reimbursement for applied behavior analysis services provided by behavior technicians to Program recipients with autism spectrum disorder.

(2) Except as provided under paragraph (3) of this subsection, the Department may not require as a condition of reimbursement under the Program that an individual receive a certification from a credentialing entity recognized by the Department to provide applied behavior analysis services as a behavior technician.

(3) The Department may require as a condition of reimbursement under the Program that an individual obtain a current certification issued by a credentialing entity recognized by the Department to provide applied behavior analysis services as a behavior technician within 150 days after the individual begins providing applied behavior analysis services to Program recipients as a behavior technician and maintain the certification.

(c) The Department shall adopt regulations necessary to carry out this section.

§15–115.

(a) The Department may not place a Program recipient in a skilled or intermediate nursing facility if, because of the condition of the Program recipient, the placement would cause undue risk to the Program recipient.

(b) To provide a basis for evaluating the placement of Program recipients who need skilled or intermediate nursing care in skilled or intermediate nursing

facilities, a Program recipient may be placed only in a nursing facility that has a transfer agreement with a general hospital.

§15–116.

The Department shall reimburse skilled nursing facilities for services provided to indigent or medically indigent patients under the age of 21 years.

§15–117.

(a) In this section, "leave of absence" includes:

(1) A visit with friends or relatives; and

(2) A leave to participate in a State approved therapeutic or rehabilitative program.

(b) To ensure that a bed is reserved for a Program recipient who is on leave of absence from a nursing facility that has made a provider agreement with the Department, the facility shall receive payment for each day that the Program recipient is absent and a bed is reserved and made available for the return of that Program recipient.

(c) (1) Payments under subsection (b) of this section may not be made for more than 18 days in any calendar year.

(2) Notwithstanding any rule or regulation, a leave of absence is not subject to any requirement that it may not exceed a particular number of days a visit, except that the leave of absence may not exceed a total of 18 days during any calendar year.

(d) Payments required under this section:

(1) Shall be made according to the per diem payment procedures that the Department sets; and

(2) May not include payment for nursing services.

(e) A nursing facility may not make additional charges against a Program recipient because the Program recipient is absent temporarily from the nursing facility.

§15–118.

(a) (1) Unless the prescriber directs otherwise on the form or on an attached signed certification of need, the generic form of the drug authorized under § 12-504 of the Health Occupations Article shall be used to fill the prescription.

(2) If the appropriate generic drug is not generally available, the Department may waive the requirement for generic substitution under paragraph (1) of this subsection.

(b) (1) Except as provided under paragraph (2) of this subsection, the Program shall establish maximum reimbursement levels for the drug products for which there is a generic equivalent authorized under § 12-504 of the Health Occupations Article, based on the cost of the generic product.

(2) If a prescriber directs a specific brand name drug, the reimbursement level shall be based on the cost of the brand name product.

(c) (1) Except as provided under paragraph (4) of this subsection and unless the change is made by an emergency regulation, the Program shall notify all pharmacies under contract with the Program in writing of changes in the Pharmaceutical Benefit Program rules or requirements at least 30 days before the change is effective.

(2) Changes that require 30 days' advance written notice under paragraph (1) of this subsection are:

(i) Exclusion of coverage for classes of drugs as specified by contract;

(ii) Changes in prior or preauthorization procedures; and

(iii) Selection of new prescription claims processors.

(3) If the Program fails to provide advance notice as required under paragraph (1) of this subsection, it shall honor and pay in full any claim under the Program rules or requirements that existed before the change for 30 days after the postmarked date of the notice.

(4) Notwithstanding any other provision of law, the notice requirements of this subsection do not apply to the addition of new generic drugs authorized under § 12-504 of the Health Occupations Article.

(d) The Secretary shall adopt regulations to carry out the provisions of this section.

(e) Except for a prescription for a prescription drug that contains a substance listed in Schedule II or that is determined by the Secretary to present an emerging threat in the State because of increasing abuse or diversion, the provisions of § 21-220(b)(1) of this article shall apply to the Program.

§15–118.1.

The Secretary may not consider drugs prescribed to treat diabetes, HIV, or AIDS to be specialty drugs for the purpose of providing services under the Program.

§15–120.

(a) If a Program recipient has a cause of action against a person, the Department shall be subrogated to that cause of action to the extent of any payments made by the Department on behalf of the Program recipient that result from the occurrence that gave rise to the cause of action.

(b) (1) An attorney representing a Program recipient in a cause of action to which the Department has a right of subrogation shall notify the Department prior to filing a claim, commencing an action, or negotiating a settlement.

(2) The attorney shall notify the Department in advance of the resolution of a cause of action and shall allow the Department 3 business days from the receipt of the notice to establish its subrogated interest.

(3) This subsection may not be construed to create a cause of action for notifying or failing to notify the Department.

(c) (1) Any Program recipient or attorney, guardian, or personal representative of a Program recipient who receives money in settlement of or under a judgment or award in a cause of action in which the Department has a subrogation claim shall, after receiving written notice of the subrogation claim, hold that money, for the benefit of the Department, to the extent required for the subrogation claim, after deducting applicable attorney's fees and litigation costs.

(2) A person who, after written notice of a subrogation claim and possible liability under this paragraph, disposes of the money, without the written approval of the Department, is liable to the Department for any amount that, because of the disposition, is not recoverable by the Department.

(3) The Department may compromise or settle and release its subrogation claim if, in its judgment, collection of the claim will cause substantial hardship:

(i) To the Program recipient; or

(ii) In a wrongful death action, to the surviving dependents of a deceased Program recipient.

(4) (i) The Department is not liable for payment of or contribution to any attorney's fees or litigation costs of any Program recipient or attorney, guardian, or personal representative of any Program recipient.

(ii) The deduction of applicable attorney's fees and litigation costs under paragraph (1) of this subsection may not be considered as payment for or contribution to those fees or costs by the Department.

(d) Any action brought under this section is not exclusive and is independent of and in addition to any right, remedy, or cause of action available to the State, the Department, any other State agency, or a Program recipient or any other individual.

(e) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Cigarette" means any roll of tobacco wrapped in:

1. Paper;

2. A substance not containing tobacco; or

3. A substance containing tobacco which because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be used by the consumers of ordinary paper–wrapped cigarettes.

(iii) 1. "Manufacturer of a tobacco product" means a designer, producer, or processor of a tobacco product engaged in the marketing or promotion of a tobacco product.

2. "Manufacturer of a tobacco product" includes an entity not otherwise a manufacturer of a tobacco product that imports a tobacco product or otherwise holds itself out as a manufacturer of a tobacco product.

3. "Manufacturer of a tobacco product" does not include:

A. A grower, buyer, dealer, distributor, or wholesaler of leaf tobacco; or

B. A retailer, distributor, or wholesaler of a tobacco product.

(iv) "Smokeless tobacco" means a product that consists of cut, ground, powdered, or leaf tobacco that is intended to be placed in the oral cavity.

(v) "Tobacco product" means cigarettes or smokeless tobacco.

(2) In any action under this section or pursuant to any other right, remedy, or cause of action brought by the State against a manufacturer of a tobacco product, the causation and the amount of medical assistance expenditures attributable to the use of a tobacco product may be proved or disproved by evidence of statistical analysis, without proof of the causation or the amount of expenditures for any particular Program recipient or any other individual.

(3) Nothing contained in paragraph (2) of this subsection prohibits or limits the right of any party to introduce any other evidence, otherwise admissible, that supports or rebuts the evidence of statistical analysis described in paragraph (2) of this subsection.

§15–121.

(a) In accordance with applicable federal law and rules and regulations, including those under Title XIX of the Social Security Act, the Department may make claim against the estate of a deceased Program recipient for the amount of any medical assistance payments under this title.

(b) The claim shall be waived by the Department if, in its judgment, enforcement of the claim will cause substantial hardship to the surviving dependents of the deceased.

§15–121.1.

(a) If a Program recipient has a claim for any medical, hospital or disability benefits under §§ 19-505 and 19-506 of the Insurance Article, the Department shall be subrogated to that claim to the extent of any payments made by the Department on behalf of the Program recipient that results from the occurrence that gave rise to the claim less:

(1) Applicable attorney's fees; and

(2) Any rights for loss of income.

(b) (1) An attorney representing a Program recipient under this subtitle on a claim to which the Department has a right of subrogation shall notify the Department prior to filing the claim.

(2) This subsection may not be construed to create a cause of action for notifying or failing to notify the Department.

(c) (1) Any Program recipient or attorney, guardian, or personal representative of a Program recipient who receives money for a claim to which the Department has a subrogation claim shall, after receiving written notice of the subrogation claim, hold that money, for the benefit of the Department, to the extent required for the subrogation claim, after deducting applicable attorney's fees.

(2) A person who, after written notice of a subrogation claim from the Department and possible liability under this paragraph, disposes of the money, without the written approval of the Department, is liable to the Department for any amount that, because of the disposition, is not recoverable by the Department.

(3) The Department may compromise or settle and release its subrogation claim if, in its judgment, collection of the claim will cause substantial hardship to the Program recipient or in a wrongful death action, the surviving dependent of a deceased Program recipient.

§15–121.2.

(a) If a Program recipient has a claim for any medical, hospital, or disability benefits under §§ 19-509 and 19-510 of the Insurance Article, the Department shall be subrogated to that claim to the extent of any payments made by the Department on behalf of the Program recipient that results from the occurrence that gave rise to the claim, less applicable attorney's fees.

(b) (1) An attorney representing a Program recipient under this subtitle on a claim to which the Department has a right of subrogation shall notify the Department prior to filing the claim.

(2) This subsection may not be construed to create a cause of action for notifying or failing to notify the Department.

(c) (1) Any Program recipient, attorney, guardian, or personal representative of a Program recipient who receives money for a claim to which the Department has a subrogation claim shall, after receiving written notice of the subrogation claim, hold that money, for the benefit of the Department, to the extent required for the subrogation claim, after deducting applicable attorney's fees.

(2) A person who, after written notice of a subrogation claim from the Department and possible liability under this paragraph, disposes of the money, without the written approval of the Department, is liable to the Department for any amount that, because of the disposition, is not recoverable by the Department.

(3) The Department may compromise or settle and release its subrogation claim if, in its judgment, collection of the claim will cause substantial hardship to the Program recipient or in a wrongful death action, the surviving dependent of a deceased Program recipient.

§15–121.3.

The Department may assign its right of subrogation under §§ 15-120, 15-121.1, and 15-121.2 of this subtitle to a managed care organization.

§15–122.

(a) (1) The spouse of a Program recipient is responsible for payments for the health care needs of the Program recipient to the extent that the spouse is able to pay any of the cost of care. Except as provided in paragraph (2) of this subsection, the total liability shall be limited to the amount spent for the care under the Program.

(2) In any case in which eligibility was based on the spouse's refusal to pay for the Program recipient's care, the liability of the spouse may include:

(i) The amount spent for care by the Program;

(ii) Administrative and enforcement costs incurred by the Program related to pursuing reimbursement from the spouse; and

(iii) Any penalties established by the Secretary by regulation for a violation of this section not to exceed $50 per day for each day a violation exists.

(b) (1) The Secretary shall adopt rules and regulations that set standards for payment by the spouse based on the ability of the spouse to pay all or part of the cost of care. To determine reasonably the ability to pay, the Secretary shall evaluate available income, ordinary living expenses, special expenses, and assets, other than the homestead of the spouse and its appurtenances.

(2) Notwithstanding the standards established under paragraph (1) of this subsection, the spouse may also be liable for costs and penalties under subsection (a)(2) of this section.

(c) (1) The Secretary may collect the money owed.

(2) The Central Collection Unit in the Department of Budget and Management shall collect delinquent accounts and debts.

§15–122.1.

(a) In this section, "participating provider" means any facility that participates in the Program and is:

(1) A skilled nursing facility;

(2) A comprehensive care facility; or

(3) An intermediate care facility.

(b) A participating provider shall not be required to repay the State for any depreciation for which the provider has been reimbursed as an allowable expense and which could otherwise be recaptured by the State upon a sale, scrapping, trade-in, donation, exchange, demolition, or abandonment of a facility, or involuntary conversion of a facility such as condemnation, fire, theft, or other casualty.

(c) This section has no effect if its operation would cause this State to lose any federal funds.

§15–122.2.

(a) In this section, "converted funds" means the amount received in payment by a person from an insurer for the cost of health services provided to a child which was not used to reimburse the Department for Medicaid costs incurred.

(b) Each year the Department may refer to the Central Collection Unit of the Department of Budget and Management for certification to the State Comptroller the name of any person who has received converted funds for the interception of any State tax refund.

(c) The Department shall notify the person certified under subsection (b) of this section that a certification has been made by the Department.

(d) The certification by the Central Collection Unit shall include, if known:

(1) The full name of the person certified and any other names known to be used by that person;

(2) The address and the Social Security number of the person certified; and

(3) The amount of the converted funds.

(e) The State Comptroller shall:

(1) Pay to the Department any income tax refund due to the person certified in an amount not more than the amount certified by the Department;

(2) Pay to the person certified any part of the income tax refund over the amount of the converted funds; and

(3) Notify the person certified of:

(i) The amount paid to the Department; and

(ii) The rights of the person certified under subsection (b) of this section.

(f) (1) On receipt of a notice of intercept from the State Comptroller, any person certified by the Department who disputes the existence or amount of the converted funds may file an appeal in accordance with Title 10 of the State Government Article.

(2) If the Department finds that an excessive amount was withheld from the person's income tax refund, the Department promptly shall pay to the taxpayer the excess amount withheld.

(g) The Comptroller shall honor refund interception requests in the following order:

(1) A refund interception request to collect an unpaid State, county, or municipal tax;

(2) A refund interception request under § 10-113 of the Family Law Article for arrears of support payments;

(3) A refund interception request for converted funds under this subtitle; and

(4) Any other refund interception request.

(h) The Secretary and the State Comptroller may adopt regulations to carry out this section.

§15–122.3.

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

(2) "Available income" means the portion of income of a Program recipient that the Program recipient is required to contribute to the cost of care for the Program recipient under the Program.

(3) "Disabled person" has the meaning stated in § 13–101 of the Estates and Trusts Article.

(4) "Guardian" means:

(i) A guardian of the person; or

(ii) A guardian of the property.

(5) "Guardian of the person" means a person who has been appointed by a court as a guardian of the person of a disabled person under § 13–705 of the Estates and Trusts Article.

(6) "Guardian of the property" means a person who has been appointed by a court as a guardian of the property of a disabled person under § 13–201 of the Estates and Trusts Article.

(7) "Guardianship services" means services provided to a recipient who is a disabled person by a guardian while acting in the capacity as a guardian.

(8) "Recipient" means a Program recipient who receives long–term care services and supports under the Program.

(b) Subject to subsection (c) of this section, when determining the available income of a recipient who is a disabled person and has a guardian, the Department shall include as part of the personal needs allowance guardianship fees payable for guardianship services.

(c) The personal needs allowance for guardianship fees shall be as follows:

(1) If one person is serving as both the guardian of the person and the guardian of the property of the recipient, the personal needs allowance shall be $50 per month; and

(2) If one person is serving as the guardian of the person of the recipient and a different person is serving as the guardian of the property of the recipient, the personal needs allowance shall be $50 per month for each guardian.

§15–123.

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

(2) "Convicted" includes being convicted after a plea of nolo contendere.

(3) "Fraud" includes the commission of or an attempt or conspiracy to commit the crimes of:

(i) Concealment of medical records;

(ii) Violation of Title 8, Subtitle 5, Part II of the Criminal Law Article;

(iii) False representations relating to Medicaid health plans;

(iv) Misappropriation by a fiduciary; and

(v) Theft.

(b) A health care provider who is convicted of fraud in connection with the Program or a similar federal or State program is ineligible for further payment under the Program.

§15–124.2.

(a) In this section, "Program" means the Maryland Medbank Program established under this section.

(b) There is a Maryland Medbank Program.

(c) The purpose of the Program is to improve the health status of individuals throughout the State who lack prescription drug coverage by providing access to medically necessary prescription drugs through patient assistance programs sponsored by pharmaceutical drug manufacturers.

(d) (1) Subject to paragraph (2) of this subsection, the Program shall be administered by the Medbank of Maryland, Inc.

(2) The Medbank of Maryland, Inc. shall contract with one or more government or nonprofit entities to operate the Program.

(e) (1) The Program shall be funded through a grant provided by the Department.

(2) Program funds may be used in part to:

(i) Purchase interim supplies of prescription drugs for enrollees who have applied to participate in a manufacturer's patient assistance program but have not yet received the approved prescription drug; and

(ii) Distribute medication to enrollees who have been approved to participate in a manufacturer's patient assistance program.

(f) (1) The Medbank of Maryland, Inc. shall ensure that the Program is available to residents in each of the following geographic regions of the State:

(i) Western Maryland;

(ii) The Eastern Shore;

(iii) The Baltimore metropolitan area;

(iv) The Maryland counties in the Washington, D.C. metropolitan area; and

(v) Southern Maryland, including Anne Arundel County.

(2) Medbank of Maryland, Inc. shall be the central coordinating office for the State.

(g) Eligibility for the Program shall be limited only by the criteria established by pharmaceutical manufacturers for their patient assistance programs.

(h) (1) The Department shall require detailed financial reports at least quarterly from Medbank of Maryland, Inc.

(2) The Medbank of Maryland, Inc. shall release funds to the entities that operate the Program as needed and justified by the quarterly reports filed in accordance with paragraph (1) of this subsection.

§15–124.3.

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

(2) "Enrollee" means an individual who is enrolled in the Program.

(3) "Medicare Modernization Act" means the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(4) "Medicare Part D prescription drug benefit" means the prescription drug benefit established by the Medicare Modernization Act under Part D of the federal Medicare Program.

(5) "Prescription drug plan" means a private health plan that provides a Medicare Part D prescription drug benefit in accordance with the requirements of the Medicare Modernization Act.

(6) "Program" means the Medicare Option Prescription Drug Program established under this section.

(b) There is a Medicare Option Prescription Drug Program within the Maryland Medical Assistance Program.

(c) The purpose of the Program is to:

(1) Assist low–income Medicare eligible individuals to make a seamless transition to, and coordinate prescription drug coverage with, the Medicare Part D prescription drug benefit; and

(2) Minimize the cost–sharing burden on the individuals.

(d) The Program shall be administered and operated by the Department as permitted by federal law or waiver.

(e) (1) The Program shall be open to any individual who:

(i) Is a resident of the State;

(ii) Is a Medicare beneficiary;

(iii) Is not enrolled in a Medicare Advantage Plan or other public or private insurance program, except for Medicaid and the Maryland Pharmacy Assistance Program, that provides prescription drug benefits at the time that the individual applies for enrollment in the Program;

(iv) Has an annual household income below 150 percent of the federal poverty level; and

(v) Meets the asset test established by the Medicare Modernization Act under Medicare Part D.

(2) Individuals who are dually eligible for Medicare and Medicaid, or Medicare and the Maryland Pharmacy Assistance Program, may be enrolled automatically in the Program, provided that they may elect to opt out of the Program.

(3) Enrollment in the Program for individuals who are dually eligible for Medicare and Medicaid shall begin not later than the date on which the auto–enrollment period for the federal Medicare Part D Program begins.

(4) The Department shall determine the procedures for automatic enrollment in, and election to opt out of, the Program.

(5) Individuals who meet the eligibility requirements of paragraph (1) of this subsection but who are not dually eligible for Medicare and either Medicaid or the Maryland Pharmacy Assistance Program may apply for enrollment in the Medicare Option Prescription Drug Program by submitting an application to the Department.

(f) The Department may:

(1) Enter into a contract with one or more prescription drug plans to coordinate the prescription drug benefits provided under the Program and the Medicare Part D prescription drug benefit;

(2) Require a pharmaceutical manufacturer to provide rebates in an amount not less than the rebates provided to the Medicaid Program under § 1927(c) of Title XIX of the Social Security Act (42 U.S.C. § 1396r–8) as a condition of the pharmaceutical manufacturer's products being available to enrollees;

(3) Enroll eligible individuals into a prescription drug plan under contract with the Department, with an opt–out provision at the individual's discretion;

(4) Specify procedures for individuals to apply for enrollment in the Program;

(5) Contract with a private entity to assist in administration of the Program or negotiations with prescription drug plans; and

(6) Pay all or part of the premiums, deductibles, coinsurance payments, and copayments required under the Medicare Part D Program for enrollees.

(g) Subject to available funds, the Program established under this subtitle shall provide benefits to the maximum number of individuals eligible for enrollment in the Program.

(h) The Secretary shall adopt regulations to implement the Program.

§15–125.

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

(2) "Children" means individuals under the age of 12 years.

(3) "Youth" means an individual at least 12 years old and under the age of 22 years.

(b) The Department is the agency of this State to administer a program of services for children and youth who have or are suspected of having special health care needs.

(c) The purpose of this program is to provide reimbursement for medical, diagnostic, corrective, and other services and care to children and youth who have or are suspected of having special health care needs.

(d) The Department may:

(1) Prepare and administer detailed plans for these purposes;

(2) Adopt rules and regulations for administering these plans;

(3) Receive and, in accordance with these plans, spend all funds made available to the Department for these purposes; and

(4) Cooperate with the federal government in extending and improving these services and in administering these plans.

§15–126.

The Secretary shall provide educational programs to meet the needs of each physically or mentally handicapped child in the custody of the Department. The cost

for each child shall be included and identified in the budget of the Department as submitted to the General Assembly by the Governor.

§15–128.

The Department may provide reimbursement, under the Maryland Medical Assistance Program, for services provided by a hospice care program, as defined in § 19-901 of this article.

§15–129.

(a) In this section, "durable medical equipment" means durable medical equipment listed in the medical assistance provider fee manual, as provided in regulations adopted by the Department.

(b) To determine whether the prices charged for durable medical equipment provided to Program recipients are reasonable, the Department shall establish regulations and procedures for reviewing the prices of durable medical equipment every 3 years.

(c) The Department, to the extent feasible and appropriate, shall recover all durable medical equipment from Program recipients that:

(1) Was purchased by the Department; and

(2) Is no longer required by the recipient.

(d) Except as provided in subsection (e) of this section and to the extent feasible and appropriate, the Department shall reuse the durable medical equipment recovered under subsection (c) of this section to meet the needs of other Program recipients for the same durable medical equipment.

(e) If the durable medical equipment recovered under subsection (c) of this section is not in a condition that would enable another Program recipient to use it, the Department may give the equipment to any organization that will:

(1) Repair or attempt to repair the equipment; and

(2) Provide the equipment at no charge to other persons who require the same equipment.

§15–130.

(a) In this section, "seriously emotionally disturbed" means a condition that is:

(1) Manifest in an individual younger than 18 years or, if the individual is in a residential treatment center, younger than 21 years;

(2) Diagnosed according to the current diagnostic classification system that is recognized by the Secretary; and

(3) Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

(b) (1) The Department shall apply to the Health Care Financing Administration of the federal Department of Health and Human Services for a home– and community–based services waiver under § 1915(c) of the federal Social Security Act in order to receive federal matching funds for services to seriously emotionally disturbed individuals who would otherwise require institutionalization in a residential treatment center.

(2) The Department shall apply to the Health Care Financing Administration of the federal Department of Health and Human Services for a home– and community–based services waiver under § 1915(c) of the federal Social Security Act in order to receive federal matching funds for services to autistic children aged 1 through 21 years who would otherwise require institutionalization in an institution for the developmentally disabled.

(c) In accordance with subsection (b)(1) and (2) of this section, the services to be provided for seriously emotionally disturbed individuals or autistic children may include:

(1) Respite services;

(2) Family training and education;

(3) Day treatment services;

(4) Therapeutic integration services;

(5) Intensive individual support services;

(6) Therapeutic living services;

(7) Intensive in–home intervention services; and

(8) Specialized case management services.

(d) The State matching funds required to cover the Medicaid costs under the waiver for autistic children shall be certified or otherwise provided by the Maryland State Department of Education, local school systems, and local lead agencies.

(e) The State matching funds required to cover the Medicaid costs under the waiver for seriously emotionally disturbed individuals shall be certified or otherwise provided by the Maryland State Department of Education, local school systems, local lead agencies, and the Behavioral Health Administration.

§15–130.1.

(a) The Department shall apply to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services for a psychiatric residential treatment demonstration waiver if the Centers announce in the Federal Register that the Centers are accepting applications for such a waiver.

(b) The waiver application required by subsection (a) of this section shall:

(1) Provide for services for a minimum of 150 individuals; or

(2) Provide for services for the maximum number of individuals that the Centers for Medicare and Medicaid Services allows, if the maximum number of individuals that the Centers allow to receive services under the waiver is fewer than 150 individuals.

(c) During the waiver application process, the Department shall conduct an analysis of both the short-term and long-term costs and benefits of implementing the waiver.

(d) The Department shall report to the General Assembly, in accordance with § 2-1257 of the State Government Article, every 6 months concerning the status of the Department's application required under this section until the waiver is approved or denied.

(e) (1) If the Centers for Medicare and Medicaid Services approve the waiver application required under this section, the Department shall report to the General Assembly, in accordance with § 2-1257 of the State Government Article, on its decision on whether to implement the waiver.

(2) The report required under this subsection shall include a summary of the analysis required under subsection (c) of this section.

§15–131.

(a) The Department shall investigate development of integrated care systems and the feasibility and desirability of applying for a home- and community-based services waiver in order to maximize federal matching funds for the provision of services to adults who:

(1) Have functional disabilities, including Alzheimer's disease and related disorders;

(2) Have family income not greater than 200% of the federal poverty level; and

(3) Would otherwise require nursing home institutionalization.

(b) The services covered under the waiver under this section may include:

(1) Routine and emergency respite care;

(2) Adult day care;

(3) Personal care;

(4) Case management; and

(5) Homemaker services.

(c) The Department may place a reasonable limit on the number of individuals or on the geographic area of the State included in the waiver under this section.

§15–132.

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

(2) "Assisted living program" has the meaning stated in § 19–1801 of this article.

(3) "Assisted living services" means services provided by an assisted living program as defined in regulations adopted by the Department.

(4) "Case management services" means services that assist waiver eligible individuals in gaining access to needed waiver services and other needed medical, social, housing, and other supportive services.

(5) "Health related care and services" includes:

(i) 24–hour supervision and observation by a licensed care provider;

(ii) Medication administration;

(iii) Inhalation therapy;

(iv) Bladder and catheter management;

(v) Assistance with suctioning; or

(vi) Assistance with treatment of skin disorders and dressings.

(6) "Home health care services" means those services defined in § 19–401 of this article and in 42 C.F.R. 440.70.

(7) "Medically and functionally impaired" means an individual who is assessed by the Department to require services provided by a nursing facility as defined in this section, and who, but for the receipt of these services, would require admission to a nursing facility within 30 days.

(8) "Nursing facility" means a facility that provides skilled nursing care and related services, rehabilitation services, and health related care and services above the level of room and board needed on a regular basis in accordance with § 1919 of the federal Social Security Act.

(9) "Waiver" means a home– and community–based services waiver under § 1915(c) of the federal Social Security Act, submitted by the Department to the Centers for Medicare and Medicaid Services.

(10) "Waiver services" means the services covered under an approved waiver that:

(i) Are needed and chosen by an eligible waiver participant as an alternative to admission to or continued stay in a nursing facility;

(ii) Are part of a plan of service approved by the program;

(iii) Assure the waiver participant's health and safety in the community; and

(iv) Cost no more per capita to receive services in the community than in a nursing facility.

(b) (1) If authorized by the Centers for Medicare and Medicaid Services, an individual shall be determined medically eligible to receive services if the individual requires:

(i) Skilled nursing care or other related services;

(ii) Rehabilitation services; or

(iii) Health–related services above the level of room and board that are available only through nursing facilities, including individuals who because of severe cognitive impairments or other conditions:

1. A. Are currently unable to perform at least two activities of daily living without hands–on assistance or standby assistance from another individual; and

B. Have been or will be unable to perform at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

2. Need substantial supervision for protection against threats to health and safety due to severe cognitive impairment.

(2) The Department shall adopt regulations to carry out the provisions of this subsection.

(c) The Department's waiver shall include the following:

(1) A cap on waiver participation of not fewer than 7,500 individuals;

(2) A plan for waiver participation of not fewer than 7,500 individuals;

(3) Financial eligibility criteria which include:

(i) The current federal and State medical assistance long–term care rules for using services provided by a nursing facility, per §§ 1902, 1919,

and 1924 of the federal Social Security Act, and applicable regulations adopted by the Department;

(ii) Medically needy individuals using services provided by a nursing facility under the current federal and State medical assistance eligibility criteria governed by regulations adopted by the Department and § 1919 of the federal Social Security Act; and

(iii) Categorically needy individuals with income up to 300% of the applicable payment rate for supplemental security income;

(4) Waiver services that include at least the following:

(i) Assisted living services;

(ii) Case management services;

(iii) Family training;

(iv) Dietitian and nutritionist services;

(v) Medical day care services; and

(vi) Senior center plus services;

(5) The opportunity to provide eligible individuals with waiver services under this section as soon as they are available without waiting for placement slots to open in the next fiscal year;

(6) An increase in participant satisfaction;

(7) The forestalling of functional decline;

(8) A reduction in Medicaid expenditures by reducing utilization of services; and

(9) The enhancement of compliance with the decision of the United States Supreme Court in the case of Olmstead v. L.C. (1999) by offering cost–effective community–based services in the most appropriate setting.

(d) This section may not be construed to affect, interfere with, or interrupt any services reimbursed through the Program under this title.

(e) (1) (i) If the Department maintains a waiting list or registry, each month the Department shall send a waiver application:

1. If there are fewer than 600 individuals on the waiting list or registry, to all individuals on the waiting list or registry; and

2. If there are 600 or more individuals on the waiting list or registry, to at least 600 individuals on the waiting list or registry.

(ii) A waiver application sent under subparagraph (i) of this paragraph shall state clearly and conspicuously that:

1. The applicant must submit the application within 6 weeks after receiving the application; and

2. The applicant is required to meet all of the eligibility criteria for participation in the waiver within 6 months after submitting the application.

(2) If a person determined to be eligible to receive waiver services under this section desires to receive waiver services and an appropriate placement is available, the Department shall authorize the placement.

(f) The Department, in consultation with representatives of the affected industry and advocates for waiver candidates, and with the approval of the Department of Aging, shall adopt regulations to implement this section.

§15–132.1.

(a) In this section, "self-employed provider" means an individual who:

(1) Provides health care services as an attendant, personal care aide, personal care provider, or respite care worker to Program recipients participating in:

(i) The Home- and Community-Based Services Waiver for Older Adults Program; or

(ii) The Medical Assistance Personal Care Program; and

(2) Is not employed by an agency.

(b) To the extent allowed under federal law, the Department shall provide voluntary withholding of federal income taxes under the Internal Revenue Code and

State income taxes under Title 10 of the Tax - General Article for self-employed providers.

(c) Nothing in this section shall be construed to alter a self-employed provider's contractual relationship with the Department or to confer to the self-employed provider any status of employment or benefits commensurate with that status.

§15–133.

(a) The State shall apply to the Health Care Financing Administration of the United States Department of Health and Human Services for grants to assist states in improving home– and community–based service systems, including:

(1) Real choice system change grants;

(2) Nursing facility transition grants and "access housing" grants; and

(3) Community–based attendant services with consumer control grants.

(b) The Department shall seek input from eligible individuals, the individuals' representatives, and service providers in developing and implementing the Program.

(c) On or before July 1, 2001, the Department shall notify the Health Care Financing Administration of the United States Department of Health and Human Services of Maryland's intent to expand the current Medicaid home– and community–based waiver for adults with physical disabilities, under § 1915(c) of the federal Social Security Act to redirect funds to develop appropriate funding for this Program.

§15–134.

(a) If the Department applies for a Medical Assistance Program waiver, modifies or amends an existing Medical Assistance Program waiver, or amends the Medicaid State Plan, the Department shall give notice of the application or amendment by:

(1) Publication in the Maryland Register; and

(2) Submission of the application or amendment to the Medicaid Advisory Committee for discussion at a Medicaid Advisory Committee meeting.

(b) For 30 days following publication of any notice published under subsection (a) of this section, the Department shall:

(1) Make the Medical Assistance Program waiver application or amendment to the Medicaid State Plan available to the public during business hours; and

(2) Provide an opportunity to receive public comments on the Medical Assistance Program waiver application or amendment to the Medicaid State Plan.

(c) If the Department submits to the federal Centers for Medicare and Medicaid Services an amendment to the Medicaid State Plan or Medical Assistance Program waiver application, the Department shall submit a copy of the amendment or waiver application to the members of the Medicaid Advisory Committee no later than five business days after the Department submits the amendment or waiver application to the federal Centers for Medicare and Medicaid Services.

(d) Subject to the limitations of the State budget and notwithstanding any other provision of law, the following are effective on the date specified in a Maryland Register notice:

(1) Amendments or modifications to the Medicaid State Plan or Medical Assistance Program; and

(2) Medical Assistance Program waiver applications and modifications.

§15–134.1.

(a) In this section, "legal resident" means an individual who maintains the State as the individual's principal establishment, home of record, or permanent home and to where, whenever absent due to uniformed services obligation, the individual intends to return.

(b) A dependent of a legal resident of the State who is determined eligible to receive home– and community–based waiver services or other waiver services from the Department under this title shall retain eligibility for the services:

(1) Regardless of whether the legal resident leaves the State due to the legal resident's uniformed services assignment outside the State; and

(2) If the dependent is otherwise eligible for the services.

(c) If a dependent of a legal resident is on a waiting list for home– and community–based waiver services or other waiver services to be provided under this title, the Department shall allow the dependent to remain on the waiting list for services while the legal resident is outside the State due to the legal resident's uniformed services assignment outside the State.

(d) The Department shall reinstate services provided under this title to a dependent who resides with the legal resident while the legal resident is outside the State due to the legal resident's uniformed services assignment outside the State:

(1) On the relocation of the dependent to the State; and

(2) If a request for services is made.

§15–135.

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

(2) "Designated protection and advocacy systems agency" means a protection and advocacy systems agency that is designated as an independent advocate for individuals with disabilities under the federal Developmental Disabilities Act.

(3) "Nursing facility" has the meaning stated in § 15–132(a)(8) of this subtitle.

(4) "Resident" means an individual receiving long–term care in a nursing facility.

(b) (1) A social worker shall provide to each resident information that:

(i) Explains the availability of services under home– or community–based waiver programs in the State that could enable the resident to live in the community;

(ii) Explains that if the resident's care is partially or fully reimbursed by the Program, the resident may be able to receive long–term care services in the community instead of in the nursing facility;

(iii) Provides information regarding how to obtain case management services or evaluation services related to home– and community–based waiver programs or other options for receiving long–term care services in the community;

(iv) If written, is in large, easily legible type and in formats accessible to the resident; and

(v) Includes a list of legal, advocacy, and government agency resources.

(2) The Department, in consultation with the State agencies that implement the home– and community–based services programs, shall prepare, distribute, and update as necessary the information required under paragraph (1) of this subsection.

(3) The information required under paragraph (1) of this subsection shall be made available to the resident:

(i) Upon admission and discharge of the resident; and

(ii) When the resident indicates a preference to live in the community, either during the resident's quarterly assessment or at any other time.

(4) The social worker shall request that the resident sign an acknowledgment of receipt of the information provided by the social worker that shall be kept in the resident's medical record.

(c) If a resident indicates an interest in or a preference for living in the community, the nursing facility shall refer the resident to the Department, or the Department's designee, for further assistance.

(d) The Department, or the Department's designee, shall review the quarterly assessments submitted to the Center for Medicare and Medicaid Services of the U.S. Department of Health and Human Services by each nursing facility that participates in the Program to identify individuals indicating a preference to live in the community.

(e) If a resident who would qualify for home– and community–based waiver services under § 15–137 of this subtitle indicates an interest or preference for living in the community, the Department, or the Department's designee, shall provide the resident with:

(1) Additional information regarding home– and community–based services, including services available under a medical assistance waiver and their right to access services under § 15–137 of this subtitle; and

(2) Assistance in:

(i) Completing any application forms or process, as needed; and

(ii) Moving from a nursing facility to a community–based setting appropriate to the resident's needs and expressed wishes.

(f) (1) Subject to paragraph (3) of this subsection, employees or representatives of designated protection and advocacy systems agencies and of certified centers for independent living shall have reasonable and unaccompanied access to residents of public or private nursing facilities in the State that receive reimbursement under the Program for the purpose of providing information, training, and referral to programs and services addressing the needs of people with disabilities, including participation in programs that would enable individuals with disabilities to live outside the nursing facility.

(2) Employees or representatives of designated protection and advocacy systems agencies and of certified centers for independent living shall maintain the confidentiality of the residents and may not disclose the information provided to or by a resident, except with the express consent of the resident or the resident's legal guardian or health care representative.

(3) Public or private nursing facilities may require the employees or representatives of designated protection and advocacy systems agencies and of certified centers for independent living to provide proof of their employment before authorizing the access required under paragraph (1) of this subsection.

(g) On or before January 1 of each year, the Department, and the Department's designee, shall report to the Governor and the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(1) The Department's efforts to promote home– and community–based services;

(2) The number of nursing facility residents referred or identified under subsections (c) and (d) of this section in the previous year;

(3) The number of nursing facility residents who transitioned from nursing facilities to home– and community–based waiver services;

(4) Any obstacles the Department confronted in assisting nursing home residents to make the transition from a nursing facility to a community–based residence; and

(5) The Department's recommendations for removing the obstacles.

§15–136.

(a) The Department shall use existing resources to establish a toll free Maryland Pharmacy Access Hotline that:

(1) Operates during regular business hours; and

(2) During nonbusiness hours allows callers to leave a message.

(b) (1) The Department shall distribute to all Program recipients information about the Maryland Pharmacy Access Hotline.

(2) The information shall state clearly in easily readable print:

(i) The toll free telephone number of the hotline; and

(ii) That the Program recipient should call the telephone number if the Program recipient is having problems getting necessary medicines.

(c) The Department shall notify all health care providers who participate in the Program about the Maryland Pharmacy Access Hotline.

(d) The Department shall:

(1) Develop a methodology to track the number and type of calls received by the Maryland Pharmacy Access Hotline; and

(2) Provide a quarterly report to the Pharmacy and Therapeutics Committee that summarizes the number and type of calls received by the Maryland Pharmacy Access Hotline.

§15–137.

(a) The Department may not deny an individual access to a home– and community–based services waiver due to a lack of funding for waiver services if:

(1) (i) The individual is living in a nursing facility at the time of the application for waiver services;

(ii) At least 30 consecutive days of the individual's nursing facility stay are eligible to be paid for by the Program;

(iii) The individual meets all of the eligibility criteria for participation in the home– and community–based services waiver; and

(iv) The home– and community–based services provided to the individual would qualify for federal matching funds; or

(2) (i) The individual is living at home or in the community at the time of the application for waiver services;

(ii) The individual received home– and community–based services through Community First Choice for at least 30 consecutive days;

(iii) The individual will be or has been terminated from participation in the Program on becoming entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B;

(iv) The individual meets all of the eligibility criteria for participation in the home– and community–based services waiver within 6 months after the completion of the application; and

(v) The home– and community–based services provided to the individual would qualify for federal matching funds.

(b) Nothing in this section is intended to result in a reduction of federal funds available to the Department.

§15–138.

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

(2) "EID Program" means the Employed Individuals with Disabilities Program operated under the Maryland Medical Assistance Program.

(3) "Independence account" means a financial account designated by a recipient of EID Program services:

(i) That consists of earned income of a recipient or funds from other sources deposited by or for the recipient;

(ii) For which there is an upper limit of the total amount of earned income received by the recipient in an enrollment year and deposited into the account; and

(iii) For which there are no restrictions under the EID Program on how funds may be expended by the recipient.

(b) The Department shall provide health care services for individuals under the EID Program in accordance with this section.

(c) The Department shall:

(1) Provide EID Program services to qualified applicants, including existing Program recipients, who are at least 16 years old;

(2) For initial applications to receive EID Program services, accept documents to verify income and resources that are dated up to 30 days before the date the application is received;

(3) Transition Program recipients who become eligible for the EID Program in a manner that is least disruptive to the recipient's access to services;

(4) Ensure that the application process for the EID Program, to the extent authorized by the Centers for Medicare and Medicaid Services, provides maximum flexibility and plain language information for applicants, including:

(i) Instructions for completing the application;

(ii) A description of documents the applicant must enclose with the application; and

(iii) Notice to the applicant of approval or denial of an application; and

(5) Establish a premium contribution for EID Program services.

(d) Subject to subsection (e) of this section, the Department may adopt regulations that develop specific eligibility criteria for participation in the EID Program.

(e) The Department may not:

(1) Limit eligibility to receive EID Program services based on:

(i) The earned or unearned income of the applicant or the applicant's spouse;

(ii) Any assets or resources of the applicant's or recipient's spouse that are not joint assets for a recipient;

(iii) Any retirement account assets or resources for an applicant or a recipient; or

(iv) Any assets or resources in an independence account established for a recipient of EID Program services; or

(2) Establish as a prerequisite for eligibility to receive EID Program services that an applicant apply for Social Security Disability Insurance benefits when the applicant does not receive the benefits and has earnings that are above the substantial gainful activity level established by the Social Security Administration.

(f) The Department shall:

(1) Meet with a State–based coalition of disability advocates twice a year to receive feedback on and discuss any needed changes to the EID Program; and

(2) Request feedback from the coalition before providing any information or materials on the EID Program to the public.

(g) The Department shall apply to the Centers for Medicare and Medicaid Services for any amendments to the State plan, waivers, or other federal approvals necessary to implement the requirements of this section.

§15–139.

(a) On or before December 1, 2003, the Department shall submit an application to the Centers for Medicare and Medicaid Services to amend the State Medical Assistance Program to allow the Department to receive federal matching funds for part of the nonroom–and–board portion of the costs of all eligible residential care that are related to the therapeutic components of care provided by State and local agencies through public or private providers to individuals under the age of 21 years.

(b) The application submitted by the Department under subsection (a) of this section:

(1) Shall apply to a residential care placement providing therapeutic or rehabilitative services in addition to room and board services to an individual who is:

(i) Under the age of 21 years; and

(ii) In the care or custody of, committed to, or voluntarily placed by any State or local agency in the State; and

(2) Shall include placements in residential programs that have rates set by the interagency rates committee.

(c) (1) For each fiscal year, the Governor may provide funds in the budget for the Children's Cabinet Interagency Fund established under Title 8, Subtitle 5 of the Human Services Article, to be used by the Children's Cabinet to create an interagency pool of funds to provide services to children with disabilities.

(2) The pool of interagency funds established under this subsection shall be used to fund the community–based services and community–based out–of–home placements needed by children with mental or developmental disabilities not in State custody, regardless of eligibility for the State Medical Assistance Program, if:

(i) The child is in an out–of–home placement and has been recommended for discharge but the child's family is unwilling or unable to have the child return home; or

(ii) The child remains in the home but the child's family is unable to provide appropriate care for the child without additional services and the child is either at risk of requiring an out–of–home placement or the treating professionals have recommended an out–of–home placement.

(d) (1) The Governor's Office for Children shall adopt regulations to carry out the provisions of subsection (c)(2) of this section.

(2) The regulations shall:

(i) Include the criteria for eligibility and for prioritization of eligible children; and

(ii) Be developed with input from parents of a child with disabilities, groups representing families of potentially eligible children, advocacy organizations, the protection and advocacy system for persons with disabilities, providers, local agencies serving children with disabilities, and Subcabinet agencies.

(e) (1) Nothing in this section is intended to result in the reduction of federal funds available to the Department of Human Services or the Department of Juvenile Services under Title IV–E of the Social Security Act for the room and board costs of eligible residential care.

(2) If, as a result of actions taken under this section, the federal matching funds available to the Department of Human Services and the Department of Juvenile Services under Title IV–E of the Social Security Act are reduced because the percentage of residential care costs allocated to Title IV–E is reduced, the Governor shall adjust the amount of funds provided under subsection (c) of this section to prevent any resulting loss to the Department of Human Services and the Department of Juvenile Services.

(3) The adjustment of funds under paragraph (2) of this subsection shall be based on determining the amount of Title IV–E reimbursement that would have been received by the Department of Human Services and the Department of Juvenile Services prior to October 1, 2003 using the current percentage of residential care costs that is allocated to Title IV–E.

§15–140.

The Department shall apply to the Centers for Medicare and Medicaid Services for a State plan amendment to the Family Planning Program that:

(1) Provides, subject to the limitations of the State budget, family planning services to an individual whose individual income is at or below 250% of the poverty level, as allowed by federal law;

(2) Does not impose age limitations on individuals who are able to receive family planning services;

(3) Establishes a presumptive eligibility process for enrollment in the Family Planning Program; and

(4) Exempts the Family Planning Program from federal coordination of benefits requirements if authorized under federal law.

§15–141.1.

(a) In this section, "Collaborative Care Model" means an evidence–based approach for integrating somatic and behavioral health services in primary care settings that includes:

(1) Care coordination and management;

(2) Regular, proactive outcome monitoring and treatment for outcome targets using standardized outcome measurement rating scales and electronic tools, such as patient tracking; and

(3) Regular systematic psychiatric and substance use disorder caseload reviews and consultation with a psychiatrist, an addiction medicine specialist, or any other behavioral health medicine specialist as allowed under federal regulations governing the model.

(b) This section may not be construed to prohibit referrals from a primary care provider to a specialty behavioral health care provider.

(c) The Department shall implement and provide reimbursement for services provided in accordance with the Collaborative Care Model statewide in primary care settings that provide health care services to Program recipients.

(d) The Department may not impose a copayment, coinsurance, or deductible requirement for services provided in accordance with the Collaborative Care Model statewide in primary care settings that provide health care services to Program recipients.

§15–141.2.

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

(2) "Distant site" means a site at which the distant site health care provider is located at the time the health care service is provided through telehealth.

(3) "Distant site provider" means the health care provider who provides medically necessary services to a patient at an originating site from a different physical location than the location of the patient.

(4) "Health care provider" means:

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

(ii) A mental health and substance use disorder program licensed in accordance with § 7.5–401 of this article;

(iii) A person licensed under Title 7, Subtitle 9 of this article to provide services to an individual with developmental disability or a recipient of individual support services; or

(iv) A provider as defined under § 16–201.4 of this article to provide services to an individual receiving long–term care services.

(5) "Originating site" means the location of the Program recipient at the time the health care service is provided through telehealth.

(6) "Remote patient monitoring services" means the use of synchronous or asynchronous digital technologies that collect or monitor medical, patient–reported, and other forms of health care data for Program recipients at an originating site and electronically transmit that data to a distant site provider to enable the distant site provider to assess, diagnose, consult, treat, educate, provide care management, suggest self–management, or make recommendations regarding the Program recipient's health care.

(7) (i) "Telehealth" means the delivery of medically necessary somatic, dental, or behavioral health services to a patient at an originating site by a distant site provider through the use of technology–assisted communication.

(ii) "Telehealth" includes:

1. Synchronous and asynchronous interactions;

2. An audio–only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service; and

3. Remote patient monitoring services.

(iii) "Telehealth" does not include the provision of health care services solely through:

1. Except as provided in subparagraph (ii)2 of this paragraph, an audio–only telephone conversation;

2. An e–mail message; or

3. A facsimile transmission.

(b) The Program shall:

(1) Provide health care services appropriately delivered through telehealth to Program recipients regardless of the location of the Program recipient at the time telehealth services are provided; and

(2) Allow a distant site provider to provide health care services to a Program recipient from any location at which the health care services may be appropriately delivered through telehealth.

(c) The services required to be provided under subsection (b) of this section shall include counseling and treatment for substance use disorders and mental health conditions.

(d) The Program may not:

(1) Exclude from coverage a health care service solely because it is provided through telehealth and is not provided through an in–person consultation or contact between a health care provider and a patient; or

(2) Exclude from coverage a behavioral health care service provided to a Program recipient in person solely because the service may also be provided through telehealth.

(e) The Program may undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered through an in–person consultation or through telehealth if the appropriateness of the health care service is determined in the same manner.

(f) The Program may not distinguish between Program recipients in rural or urban locations in providing coverage under the Program for health care services delivered through telehealth.

(g) (1) Subject to paragraph (3) of this subsection, the Program shall reimburse a health care provider for the diagnosis, consultation, and treatment of a Program recipient for a health care service covered by the Program that can be appropriately provided through telehealth.

(2) This subsection does not require the Program to reimburse a health care provider for a health care service delivered in person or through telehealth that is:

(i) Not a covered health care service under the Program; or

(ii) Delivered by an out–of–network provider unless the health care service is a self–referred service authorized under the Program.

(3) (i) When appropriately provided through telehealth, the Program shall provide reimbursement in accordance with paragraph (1) of this

subsection on the same basis and the same rate as if the health care service were delivered by the health care provider in person.

(ii) The reimbursement required under subparagraph (i) of this paragraph does not include:

1. Clinic facility fees unless the health care service is provided by a health care provider not authorized to bill a professional fee separately for the health care service; or

2. Any room and board fees.

(h) (1) The Department may specify in regulation the types of health care providers eligible to receive reimbursement for health care services provided to Program recipients under this section.

(2) If the Department specifies by regulation the types of health care providers eligible to receive reimbursement for health care services provided to Program recipients under this subsection, the regulations shall include all types of health care providers that appropriately provide telehealth services.

(3) For the purpose of reimbursement and any fidelity standards established by the Department, a health care service provided through telehealth is equivalent to the same health care service when provided through an in–person consultation.

(i) Subject to subsection (g)(2) of this section, the Program or a managed care organization that participates in the Program may not impose as a condition of reimbursement of a covered health care service delivered through telehealth that the health care service be provided by a third–party vendor designated by the Program.

(j) The Department may adopt regulations to carry out this section.

(k) The Department shall obtain any federal authority necessary to implement the requirements of this section, including applying to the Centers for Medicare and Medicaid Services for an amendment to any of the State's § 1115 waivers or the State plan.

(l) This section may not be construed to supersede the authority of the Health Services Cost Review Commission to set the appropriate rates for hospitals, including setting the hospital facility fee for hospital–provided telehealth.

§15–141.3.

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

(2) "Certified violence prevention professional" means a prevention professional who meets the requirements of subsection (c) of this section.

(3) "Community violence" means intentional acts of interpersonal violence committed in public areas by individuals who are not family members or intimate partners of the victim.

(4) (i) "Community violence prevention services" means evidence–based, trauma–informed, supportive, and nonpsychotherapeutic services provided by a certified violence prevention professional, within or outside a clinical setting, for the purpose of promoting improved health outcomes and positive behavioral change, preventing injury recidivism, and reducing the likelihood that an individual who is the victim of community violence will commit or promote violence.

(ii) "Community violence prevention services" includes peer support and counseling, mentorship, conflict mediation, crisis intervention, targeted case management referrals to certified or licensed health care professionals or social services providers, patient education, and screening services to victims of violence.

(5) "Interpersonal violence" means the intentional use of physical force or power against another individual by an individual or a small group of individuals.

(6) "Prevention professional" has the meaning provided by the National Uniform Claim Committee, or its successor, under Code Number 405300000X.

(b) The Program shall provide community violence prevention services to Program recipients who have:

(1) (i) Been exposed to community violence; or

(ii) A personal history of injury sustained as a result of an act of community violence; and

(2) Been referred by a certified or licensed health care provider or social services provider to a certified violence prevention professional to receive community violence prevention services after the provider makes a determination that the Program recipient is at an elevated risk of violent injury or retaliation resulting from another act of community violence.

(c) A prevention professional seeking certification as a certified violence prevention professional shall:

(1) Complete an accredited training and certification program for certified violence prevention professionals, approved in accordance with subsection (d) of this section; and

(2) Maintain the certification completed under item (1) of this subsection.

(d) On or before January 1, 2023, the Department shall approve at least one accredited training and certification program for certified violence prevention professionals, which shall include:

(1) At least 35 hours of initial training, addressing the following:

(i) The profound effects of trauma and violence and the basics of trauma–informed care;

(ii) Community violence prevention strategies, including conflict mediation and retaliation prevention related to community violence;

(iii) Case management and advocacy practices; and

(iv) Patient privacy and the federal Health Insurance Portability and Accountability Act of 1996; and

(2) At least 6 hours of continuing education every 2 years.

(e) An entity that employs or contracts with a certified violence prevention professional to provide community violence prevention services shall:

(1) Maintain documentation that the certified violence prevention professional has met the requirements of subsection (c) of this section; and

(2) Ensure that the certified violence prevention professional is providing community violence prevention services in compliance with any applicable standard of care, rule, regulation, and State or federal law.

(f) This section may not be construed to alter the scope of practice for any health care professional.

§15–141.4.

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

(2) "Birthing parent" means the individual giving birth and who is receiving doula services throughout the parent's pregnancy, including the prenatal, labor, and postpartum periods.

(3) "Certified doula" means a trained nonmedical professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the prenatal, labor, and postpartum periods who has received a certification to perform doula services approved by the Program.

(4) "Doula services" means continuous and nonclinical physical, emotional, and informational support, based on evidence–based practices and with respect for individual care needs, culture, and family traditions, to a birthing parent provided by a certified doula, including:

(i) Education and guidance, supplementing the services of health care providers, on childbirth, coping skills for new parents, breastfeeding, infant feeding, infant soothing, and making informed decisions about childbirth and postpartum care;

(ii) Prenatal coaching;

(iii) Support for other individuals providing care for a birthing parent, including a birthing parent's partner and family members; and

(iv) Facilitation of access to resources that can improve birth–related outcomes, including ongoing home visiting services, transportation, housing, the Special Supplemental Nutrition Program for Women, Infants and Children, the Supplemental Nutrition Assistance Program WIC, intimate partner violence resources, and alcohol, tobacco, and drug cessation.

(5) "Home" means the residence of the birthing parent.

(6) "Labor and delivery" means the period during which the fetus, membranes, umbilical cord, and placenta are expelled from the uterus through vaginal birth or through surgical delivery by a cesarean section.

(7) "Medically indicated" means that a service or benefit meets the coverage requirements set by the Department.

(8) "Participating doula" means an individual who:

(i) Meets the certification requirements as provided in subsection (d) of this section; and

(ii) Is authorized by the Department to provide health care services to a Program recipient.

(9) "Provider" means an individual, an association, a partnership, or an incorporated or unincorporated group of doulas certified to provide doula services and who, through an appropriate agreement with the Department, has been identified as a Program provider by the issuance of an individual account number.

(b) This section may not be construed to limit the authority of the Health Services Cost Review Commission to set the appropriate rates for hospital services.

(c) The Department shall:

(1) Ensure that doulas providing care under the Program are participating doulas;

(2) Review participation in the Program of participating doulas and Program recipients; and

(3) Evaluate the effectiveness of doula services covered by the Program.

(d) A provider shall:

(1) Be certified by an organization approved by the Department; and

(2) Present proof to the Department of completion of the associated certification from at least one organization before providing doula services through the Program.

(e) To participate in the Program, a provider shall:

(1) Meet the requirements of COMAR 10.09.36.03 to participate in the Program;

(2) Maintain up–to–date certification as required by the Program; and

(3) Hold adequate liability insurance.

(f) (1) The Program shall cover doula services that:

(i) Are medically indicated;

(ii) Are provided during the prenatal, labor and delivery, or postpartum period of a birthing parent; and

(iii) If provided remotely, comply with the telehealth requirements in COMAR 10.09.49 and other relevant State and federal law.

(2) Doula services covered by the Program are subject to any limitations adopted by the Department.

(g) (1) A provider shall submit a request for payment in the format designated by the Program.

(2) The Program may return to the provider, before payment, any invoices that are not properly:

(i) Signed;

(ii) Completed; or

(iii) Accompanied by properly completed forms required by the Program.

(3) (i) A provider may charge the Program and the Program shall reimburse a provider.

(ii) A charge by a provider may be different from a customary charge by the provider for the same service.

(iii) The Program shall pay for covered services at a rate equal to the lesser of:

1. The customary charge the provider charges to the general public, unless the services are free to individuals not covered by the Program; or

2. The Program's fee schedule.

(h) A managed care organization that participates in the Program shall provide medically indicated doula services to pregnant and postpartum enrollees.

§15–141.5.

(a) Subject to subsections (b) and (c) of this section, the Program shall provide remote ultrasound procedures and remote fetal nonstress tests using current procedural terminology codes if:

(1) The patient is in a residence or a location other than the office of the patient's provider; and

(2) The provider follows the same standard of care that the provider would follow when providing the services on–site.

(b) The Program shall require that a provider offering a remote ultrasound procedure or remote fetal nonstress test use digital technology:

(1) To collect any health data from the patient and electronically transmit the information in a secure manner to a health care provider in a different location for interpretation and recommendations;

(2) That is compliant with the federal Health Insurance Portability and Accountability Act of 1996; and

(3) That is approved by the federal Food and Drug Administration.

(c) (1) The Program shall provide reimbursement for a remote fetal nonstress test in the same manner as an on–site fetal nonstress test.

(2) A remote fetal nonstress test for which reimbursement is provided under paragraph (1) of this subsection shall require the use of remote monitoring solutions that are cleared by the federal Food and Drug Administration for on–label use for monitoring:

(i) Fetal heart rate;

(ii) Maternal heart rate; and

(iii) Uterine activity.

(d) The Program shall issue guidance for Program providers to carry out this section.

§15–141.6.

(a) In this section, "eligible Program recipient" means a Program recipient who:

(1) Is pregnant;

(2) Is postpartum; or

(3) Has been diagnosed with:

(i) Chronic kidney disease;

(ii) Diabetes;

(iii) Heart disease; or

(iv) A cardiometabolic disease.

(b) The Program shall provide coverage for self–measured blood pressure monitoring for all eligible Program recipients, including:

(1) The provision of validated home blood pressure monitors; and

(2) Reimbursement of health care provider and other staff time used for patient training, transmission of blood pressure data, interpretation of blood pressure readings and reporting, remote patient monitoring, and the delivery of co–interventions, including educational materials or classes.

§15–142.

(a) In this section, "Fund" means the Fair Share Health Care Fund.

(b) There is a Fair Share Health Care Fund.

(c) The purpose of the Fund is to support the operations of the Program.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.

(2) The Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Any revenue received from payments made by employers under Title 8.5 of the Labor and Employment Article; and

(2) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only to support the operations of the Program.

(g) (1) The Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be retained to the credit of the Fund.

(h) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2-1220 of the State Government Article.

§15–143.

The Governor shall include in the budget bill for fiscal year 2008 at least $3,000,000 in General Fund State support for an immigrant health initiative to provide health care services for all legal immigrant children under the age of 18 years and pregnant women who meet program eligibility standards and arrived in the United States on or after August 22, 1996.

§15–145.

(a) In this section, "carrier" means:

(1) A health insurer;

(2) A nonprofit health service plan;

(3) A health maintenance organization;

(4) A dental plan organization; and

(5) Any other person included as a third party in § 1902(a)(25)(A) of the Social Security Act, as amended by the federal Deficit Reduction Act of 2005.

(b) (1) A carrier shall provide, at the request of the Department, information about individuals who are eligible for benefits under the Program or are Program recipients so that the Department may determine whether an individual, the spouse of an individual, or the dependent of an individual is receiving health care coverage from a carrier and the nature of that coverage.

(2) A carrier shall provide the information required under this subsection in a manner prescribed by the Department.

(c) A carrier shall accept the Program's right of recovery and the assignment to the Program of any right of an individual or other entity to payment from the carrier for an item or service for which payment has been made under the Program if the carrier has a legal obligation to make payment for the item or service.

(d) As a condition of doing business in the State, a carrier shall comply with the requirements set forth in § 42 U.S.C. 1396a(a)(25)(I)(i) through (iv).

(e) A carrier subject to this section may not reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract for a reason based wholly or partly on:

(1) The eligibility of the individual for receiving benefits under the Program; or

(2) The receipt by an individual of benefits under the Program.

§15–146.

(a) In this section, "home– and community–based waiver services" includes services provided under the Living at Home Waiver, the Older Adults Waiver, and the Medical Day Care Waiver.

(b) At least 90 days prior to making any change to medical eligibility for Program long–term care services, including nursing facility services, home– and community–based waiver services, and other services that require a nursing facility level of care, the Department shall provide a report to:

(1) The Senate Finance Committee and the House Health Committee, in accordance with § 2–1257 of the State Government Article; and

(2) The Medicaid Advisory Committee.

(c) The report required under subsection (b) of this section shall include:

(1) The details of the intended change in medical eligibility;

(2) A description of how the intended change will affect current medical eligibility;

(3) The intended effective date of the change; and

(4) Whether the change will be pursued through departmental policy, by regulation, or by statute.

(d) The Department shall discuss any report submitted to the Medicaid Advisory Committee under subsection (b) of this section at a meeting of the Medicaid Advisory Committee.

§15–147.

Notwithstanding § 5–504 of the General Provisions Article, a former official or employee may not be considered to have participated significantly in a contract if the former official or employee:

(1) Did not develop a request for proposals resulting in the contract;

(2) Did not participate in an evaluation committee or other State entity charged with selecting a contractor for the contract; and

(3) Participated only by providing support or other assistance as directed by a senior manager after contract award as part of the transition process from a State–run Medicaid Management Information System to a private contracted operation.

§15–148.

(a) Except for a drug or device for which the U.S. Food and Drug Administration has issued a black box warning, the Program may not apply a prior authorization requirement for a contraceptive drug or device that is:

(1) (i) An intrauterine device; or

(ii) An implantable rod;

(2) Approved by the U.S. Food and Drug Administration; and

(3) Obtained under a prescription written by an authorized prescriber.

(b) The Program shall provide coverage for a single dispensing to an enrollee of a supply of prescription contraceptives for a 12–month period.

§15–149.

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

(2) (i) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce significant improvements in human behavior.

(ii) "Applied behavior analysis" includes the direct observations, measurement, and functional analysis of the relations between environment and behavior.

(3) "Early and periodic screening, diagnosis, and treatment (EPSDT)" means the provision, to individuals under the age of 21 years, of preventive health care under 42 C.F.R. Part 441, Subpart B, as amended, and other health care services, diagnostic services, and treatment services that are necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by those screening services.

(b) This section applies to EPSDT services available to Program recipients.

(c) (1) Subject to paragraph (2) of this subsection, the Department may not condition reimbursement of applied behavior analysis services provided to a Program recipient on the presence or availability of the parent or caregiver of the Program recipient in the setting where the applied behavior analysis services are provided to the Program recipient.

(2) Paragraph (1) of this subsection does not prohibit the Program from establishing reasonable standards for the involvement of a parent or caregiver, including requiring notification from the parent or caregiver of the decision of the parent or caregiver not to be present or available when the Program provides applied behavior analysis services to a Program recipient.

(d) On or before December 1, 2021, the Department, in consultation with stakeholders, shall adopt regulations to implement the provisions of this section.

§15–150.

(a) (1) (i) The Department shall develop plans to reduce the waitlists for the following waiver programs by 50%, beginning in fiscal year 2024:

1. The Community Pathways Waiver;

2. The Community Supports Waiver;

3. The Family Supports Waiver;

4. The Brain Injury Waiver;

5. The Home– and Community–Based Options Waiver;

6. The Medical Day Care Services Waiver; and

7. The Model Waiver for Medically Fragile Children.

(ii) The Department shall develop a plan to reduce the registry for the Autism Waiver that includes conducting eligibility determinations of individuals on the registry and, beginning in fiscal year 2024, providing services to at least 50% of individuals determined eligible.

(2) The plans required under this subsection shall include:

(i) An assessment of whether each waiver program needs to recruit and retain new providers;

(ii) Measures to recruit and retain providers for each waiver program to expand the capacity of the programs;

(iii) Any changes in reimbursement rates needed to ensure provider capacity to provide services under the waiver programs;

(iv) The expected time frame for conducting eligibility determinations for the Autism Waiver;

(v) The expected time frame for reducing the waitlist or registry for each waiver program by 50%; and

(vi) The projected cost of the measures to be implemented under the plans.

(3) Provisions of the plans relating to the Autism Waiver shall be developed in conjunction with the Maryland State Department of Education.

(b) On or before January 1, 2023, the Department shall submit the plans to the Governor and, in accordance with § 2–1257 of the State Government Article, the chairs of the Senate Budget and Taxation Committee, the Senate Education, Health, and Environmental Affairs Committee, the Senate Finance Committee, the House Appropriations Committee, and the House Health and Government Operations Committee.

(c) (1) Beginning in fiscal year 2024, the Governor shall include in the annual budget bill sufficient funds to carry out this section.

(2) Funding included in the annual budget bill under paragraph (1) of this subsection may be allocated to programs identified under subsection (a) of this section for the purpose of hiring and retaining providers.

§15–151.

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

(2) (i) "Gender–affirming treatment" means any medically necessary treatment consistent with current clinical standards of care prescribed by a licensed health care provider for the treatment of a condition related to the individual's gender identity.

(ii) "Gender–affirming treatment" includes:

1. Hormone therapy, hormone blockers, and puberty blockers;

2. Hair alteration for the purposes of altering secondary sex characteristics and surgical site preparation;

3. Alterations to voice, voice therapy, and voice lessons;

4. Alterations to abdomen, chest, trunk, and buttocks;

5. Alterations to the face and neck;

6. Alterations to the genitals and gonads;

7. Laser treatment for scars from gender–affirming treatment;

8. Standard fertility preservation procedures, as set forth in § 15–810.1 of the Insurance Article;

9. Revisions to previous treatments and reversal of treatments;

10. Combinations of gender–affirming procedures; and

11. Other treatments as prescribed to suppress the development of endogenous secondary sex characteristics, align the individual's appearance or physical body with gender identity, and alleviate symptoms of clinically significant distress resulting from gender dysphoria.

(iii) "Gender–affirming treatment" may include treatment described in the current clinical standards of care for gender–affirming treatment published by the World Professional Association for Transgender Health.

(3) "Gender identity" has the meaning stated in § 20–101 of the State Government Article.

(b) It is the intent of the General Assembly that the Program provide gender–affirming treatment to all Program recipients for whom gender–affirming treatment is medically necessary, including transgender, nonbinary, intersex, two–spirit, and other gender diverse individuals.

(c) (1) The Program shall provide coverage for medically necessary gender–affirming treatment in a nondiscriminatory manner.

(2) The gender–affirming treatment shall be assessed according to nondiscriminatory criteria that are consistent with current clinical standards of care.

(3) The Program may not deny or limit coverage for gender–affirming treatment when that treatment is:

(i) Prescribed to a Program recipient because of, related to, or consistent with the recipient's gender identity;

(ii) Medically necessary; and

(iii) Prescribed in accordance with current clinical standards of care.

(4) The Program may not deny or limit coverage for gender–affirming treatment based on the Program recipient's gender identity.

(5) The Program may not exclude gender–affirming treatment, including revisions to prior gender–affirming treatment, on the basis that the treatment is a cosmetic service.

(6) The Program may not establish a categorical exclusion for a particular gender–affirming treatment.

(7) The Program may not issue an adverse benefit determination denying or limiting access to gender–affirming treatment unless a health care provider with experience prescribing or delivering gender–affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

(d) (1) On or before December 1 each year, beginning in 2024, each managed care organization shall submit to the Department a report that includes, for each health care provider offering gender–affirming treatment with which the managed care organization has an active contract and that consents to the inclusion:

(i) The name and location of the health care provider;

(ii) The types of gender–affirming treatment provided by the health care provider; and

(iii) Whether the health care provider consents to being publicly listed as part of the Department's annual report required under paragraph (2) of this subsection.

(2) (i) On or before January 1 each year, beginning in 2025, the Department shall compile an annual report on geographic access to gender–affirming treatment across the State.

(ii) The report shall include, for each health care provider offering gender–affirming treatment to Program recipients and whose consent to the inclusion is indicated in a report submitted under paragraph (1) of this subsection:

1. The name and location of the health care provider;

2. The managed care organizations that have active contracts with the health care provider; and

3. The types of gender–affirming treatment provided by the health care provider.

(iii) The Department shall publish the report in a conspicuous manner on the Department's website.

(3) The Department and each managed care organization shall include the name, location, and types of services for each provider offering gender–affirming treatment in their provider directories.

§15–152.

(a) The Program shall provide coverage for services rendered to an enrollee by a licensed pharmacist acting within the pharmacist's lawful scope of practice to the same extent as services rendered by any other licensed health care provider.

(b) Reimbursement for services provided under subsection (a) of this section may not be conditioned on whether the licensed pharmacist is:

(1) Employed by a physician, pharmacy, or facility; or

(2) Acting under a physician's orders.

§15–153.

The Department shall annually evaluate reimbursement rates for dental services.

§15–154.

(a) Unless the child's family has requested that the child be removed, a child on the registry for the Autism Waiver shall remain on the registry if the child's family relocates out of the State for uniformed services assignment.

(b) If a child on the registry for the Autism Waiver becomes eligible for services through the waiver while the child's family is out of the State for uniformed services assignment, the child shall be eligible for services through the waiver if the family relocates to the State.

§15–155.

(a) In this section, "prenatal risk assessment form" means a standardized form developed by the Department in accordance with the Centers for Medicare and Medicaid Services guidelines for use by a licensed health care provider to evaluate risk factors for the health of a pregnant patient.

(b) A provider who receives reimbursement from the Program for providing obstetric services to a patient shall complete a prenatal risk assessment form for the patient during the initial visit with the patient.

(c) After completing a prenatal risk assessment form in accordance with subsection (b) of this section, the provider shall submit the form to the local health department for the county in which the patient resides.

(d) On or before October 1 each year, each local health department shall submit to the Department a report that includes the number and type of referrals

made to patients that were based on the information from the prenatal risk assessment form completed in accordance with subsection (b) of this section.

(e) The Department shall establish a process for a provider to submit a prenatal risk assessment form electronically.

§15–156.

(a) In this section, "personal care aide" means an individual who provides personal assistance services through a residential service agency.

(b) (1) Except as provided in paragraph (2) of this subsection, this section applies only to personal assistance services provided through a residential service agency under Community First Choice, Community Options, Community Personal Assistance Services, and any other home– and community–based services administered by the Department.

(2) This section does not apply to personal care services provided through the Developmental Disabilities Administration.

(c) (1) On or before September 1 each year, beginning in 2025, each residential service agency shall submit to the Maryland Department of Labor a report in the form and manner required by the Maryland Department of Labor.

(2) The annual report required under paragraph (1) of this subsection shall include:

(i) Documentation of the residential service agency's:

1. Average wage rate for personal care aides; and

2. Highest and lowest wage rates for personal care aides; and

(ii) Any other information that the Maryland Department of Labor determines appropriate.

(3) The annual report required under paragraph (1) of this subsection shall be signed by an authorized representative of the residential service agency.

§15–157.

(a) In this section, "Fund" means the Medicaid Primary Care Program Fund.

(b) There is a Medicaid Primary Care Program Fund in the Department.

(c) The purpose of the Fund is to serve as the foundation for advancing primary care in the State under the Advancing All–Payer Health Equity Approaches and Development (AHEAD) model.

(d) The Department shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Money appropriated in the State budget to the Fund;

(2) Hospital payments administered on a one–time basis, through a uniform and broad–based assessment via the Medicare savings component for calendar year 2023 by the Health Services Cost Review Commission; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used to:

(1) Implement a Medicaid primary care advanced payment model program as required under the AHEAD cooperative agreement; and

(2) Support primary care providers serving enrollees of the Medical Assistance Program through investments that include increased reimbursement for evaluation and management codes, care management fees to eligible practices, and quality incentives.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the General Fund of the State.

(i) Expenditures from the Fund may be made only in accordance with the State budget.

§15–158.

(a) (1) Subject to paragraph (2) of this subsection, the Program may not require prior authorization for a transfer to a special pediatric hospital.

(2) At the request of a special pediatric hospital, the Program and the Maryland Children's Health Program shall provide a prior authorization determination regarding a transfer to a special pediatric hospital within 3 business days after the request is received.

(b) (1) On or before December 31, 2026, the Department shall adopt regulations establishing a retrospective review process for special pediatric hospitals.

(2) The regulations adopted under paragraph (1) of this subsection shall:

(i) Provide for a peer–to–peer reconsideration of a medical necessity determination made by the Department or its agent on request of a pediatric specialty hospital;

(ii) Provide for retrospective review of any medical necessity determination issued by the Department or its agent denying:

1. Admission to a special pediatric hospital on or after January 1, 2025; or

2. Reimbursement for inpatient services or outpatient services provided by a special pediatric hospital on or after January 1, 2025;

(iii) Comply with Title 10, Subtitle 2 of the State Government Article; and

(iv) Provide that the retrospective review process be conducted by a licensed physician.

§15–159.

If the Program covers the delivery of anesthesia for a procedure for which a licensed medical professional issues an order, the Program:

(1) Shall provide coverage for:

(i) The delivery of anesthesia for the entire duration of the procedure; and

(ii) Medical care related to the delivery of anesthesia for the procedure that is provided immediately before and after the procedure; and

(2) May not establish, implement, or enforce a policy, practice, or procedure that places time limitations on the delivery of anesthesia.

§15–160. IN EFFECT

// EFFECTIVE UNTIL SEPTEMBER 30, 2029 PER CHAPTER 166 OF 2026 //

(a) In this section, "database" means the employment training and opportunity database developed and maintained under subsection (b) of this section.

(b) (1) The Department shall develop and maintain an employment training and opportunity database.

(2) The purpose of the database is to provide individuals in the State with assistance in finding employment training and other opportunities that may enable the individuals to become eligible and maintain eligibility for:

(i) The Program; and

(ii) The Supplemental Nutrition Assistance Program.

(3) In developing and maintaining the database, the Department shall coordinate with the following entities:

(i) The Maryland Department of Labor;

(ii) The Department of Human Services;

(iii) The Department of Service and Civic Innovation;

(iv) The Maryland Chamber of Commerce;

(v) Labor unions;

(vi) Trade associations;

(vii) Educational institutions;

(viii) Local workforce development boards; and

(ix) Any other entity that the Department determines appropriate.

(c) The database shall include:

(1) Vocational, workforce training, and job placement programs available in the State;

(2) Information regarding how to apply for a vocational, workforce training, or job placement program included in the database under item (1) of this subsection; and

(3) A mechanism that allows an individual to directly contact the vocational, workforce training, or job placement program in which the individual is interested.

(d) The Department shall:

(1) Make the database available to the public on a dedicated page on the Department's website;

(2) Assist individuals in enrolling in vocational, workforce training, and job placement programs listed in the database; and

(3) Update the database at least every 30 days.

§15–161.

(a) In this section, "comprehensive coverage for the treatment of obesity" includes coverage for intensive behavioral therapy, bariatric surgery, and any medication approved by the federal Food and Drug Administration with an indication for chronic weight management in patients with obesity.

(b) The Program may provide comprehensive coverage for the treatment of obesity.

(c) The Program may undertake utilization management to determine the medical necessity and appropriateness for treatment of obesity under this section if the determinations are made in the same manner as determinations are made for the treatment of any other illness, condition, or disorder covered by the Program.

(d) If the Department elects to provide comprehensive coverage for the treatment of obesity under this section, the Department shall provide notice to Program recipients.

§15–301.

(a) There is a Maryland Children's Health Program.

(b) The Maryland Children's Health Program shall provide, subject to the limitations of the State budget and any other requirements imposed by the State and as permitted by federal law or waiver, comprehensive medical care and other health care services to an individual who:

(1) Does not qualify for coverage under § 15–103(b) of this title; and

(2) Has a family income at or below 300 percent of the federal poverty guidelines and who is under the age of 19 years.

(c) (1) The Department shall provide eligible individuals and health care providers with an accurate directory or other listing of all available providers:

(i) In written form, made available upon request; and

(ii) On an Internet database.

(2) The Department shall update the Internet database at least every 30 days.

(3) The written directory shall include a conspicuous reference to the Internet database.

(d) The Department shall develop a process for providing information about the availability of the State's earned income tax credit established under § 10–704 of the Tax – General Article to each Program enrollee or potential Program enrollee when providing information about the Program.

§15–302.

(a) (1) The Department shall monitor applications to determine whether employers and employees have voluntarily terminated coverage under an employer sponsored health benefit plan that included dependent coverage in order to participate in the Maryland Children's Health Program established under § 15–301 of this subtitle.

(2) The Department, in particular, shall review applications of individuals who qualified for Program benefits under the Maryland Children's Health Program established under § 15–301 of this subtitle.

(b) (1) An application may be disapproved if it is determined that an individual under the age of 19 years to be covered under the Maryland Children's Health Program, for whom the application was submitted, was covered by an employer sponsored health benefit plan with dependent coverage which was voluntarily terminated within 6 months preceding the date of the application.

(2) In determining whether an applicant has voluntarily terminated coverage under an employer sponsored health benefit plan for purposes of paragraph (1) of this subsection, a voluntary termination may not be construed to include:

(i) Loss of employment due to factors other than voluntary termination;

(ii) Change to a new employer that does not provide an option for dependent coverage;

(iii) Change of address so that no employer sponsored health benefit plan is available;

(iv) Discontinuation of health benefits to all dependents of employees of the applicant's employer; or

(v) Expiration of the applicant's continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

§15–303.

(a) (1) The Department shall be responsible for enrolling program recipients in managed care organizations under the Maryland Children's Health Program established under § 15–301 of this subtitle.

(2) The Department may contract with an entity to perform any part or all of its enrollment responsibilities under paragraph (1) of this subsection.

(3) The Department or its enrollment contractor, to the extent feasible in its marketing, outreach, and enrollment programs, shall hire individuals receiving assistance under the Family Investment Program established under Title 5, Subtitle 3 of the Human Services Article.

(b) (1) To the extent allowed under federal law and regulations, the Secretary shall implement expedited eligibility for any individual who applies through the local health department for the Maryland Children's Health Program under § 15–301 of this subtitle, including any individual with associated food stamp, cash assistance, or medical assistance cases.

(2) The Secretary shall designate organizations that may:

(i) Assist individuals in the application process; and

(ii) Perform other outreach functions.

(3) In designating the organizations under paragraph (2) of this subsection, the Secretary shall ensure the inclusion of statewide and local organizations that provide services to children of all ages in each region of the State, and shall provide such organizations with:

(i) Forms that are necessary for parents, guardians, and other individuals to submit applications to the Maryland Children's Health Program on behalf of a child; and

(ii) Information on how to assist parents, guardians, and other individuals in completing and filing such applications.

§15–304.

(a) (1) For purposes of increasing the number of eligible individuals who enroll in the Maryland Children's Health Program established under § 15–301 of this subtitle, the Department shall develop and implement a school–based outreach program.

(2) As appropriate to carry out its responsibilities under paragraph (1) of this subsection, the Department may enter into contracts with county boards of education to provide information at public schools on the Maryland Children's Health Program established under § 15–301 of this subtitle.

(b) (1) For purposes of this subsection, "community–based organization" includes child care centers, schools, and school–based health clinics.

(2) In addition to the school–based outreach program established under subsection (a) of this section, the Department, in consultation with the Maryland Medicaid Advisory Committee established under § 15–103.2 of this title, shall develop mechanisms for outreach for the program with a special emphasis on

identifying children who may be eligible for program benefits under the Maryland Children's Health Program established under § 15–301 of this subtitle.

(3) From the mechanisms to be developed for outreach under paragraph (2) of this subsection, one mechanism shall include the development and dissemination of mail–in applications and appropriate outreach materials through community–based organizations, community–based providers, the Office of the State Comptroller, the Departments of Human Services and Health, county boards of education, and any other appropriate State agency or unit the Department considers appropriate.

(c) (1) The Department shall collaborate with the Office of the Comptroller or the Office of the State Treasurer to:

(i) Form a one–sentence statement advising that individuals who cannot afford health insurance may be eligible to enroll in the Maryland Children's Health Program; and

(ii) Print the statement formed under item (i) of this paragraph:

1. On each State–issued tax refund check stub;

2. Once each pay quarter, on each State–issued employee paycheck stub; and

3. On each State–issued child support payment check stub.

(2) The statement shall contain a telephone number or other contact information that an individual may use to receive more information on eligibility for the Maryland Children's Health Program.

(3) The statement may be altered by the Department in collaboration with the Office of the Comptroller or the Office of the State Treasurer to:

(i) Provide the most current information;

(ii) Fit within the space constraints of the different types of checks listed in paragraph (1)(ii) of this subsection; or

(iii) Combine it with the statement required under § 15–102.1(c) of this title, if appropriate.

§15–305.

(a) On or before January 1, 2025, subject to the limitations of the State budget and as permitted by federal law, the Department:

(1) Shall establish an Express Lane Eligibility Program to enroll individuals in the Program and the Maryland Children's Health Program based on eligibility findings by the Supplemental Nutrition Assistance Program;

(2) May not consider any other income or eligibility requirements;

(3) To the extent that a waiver is needed to maximize the number of State residents who may qualify for the Express Lane Eligibility Program, shall apply to the Centers for Medicare and Medicaid Services for one or more waivers under § 1115 of the federal Social Security Act to implement the Express Lane Eligibility Program; and

(4) Subject to subsection (b) of this section, shall make all reasonable efforts to expedite enrollment of eligible individuals in the Express Lane Eligibility Program.

(b) The Department may propose or implement the use of Express Lane Eligibility for renewals before proposing or implementing the use of Express Lane Eligibility for initial enrollment.

§15–306.

Subject to the limitations of the State budget and as permitted by federal law or waiver, the Maryland Children's Health Program may provide guaranteed eligibility for each enrollee for up to 6 months unless an enrollee obtains health insurance through another source.

§15–307.

(a) Except for a drug or device for which the U.S. Food and Drug Administration has issued a black box warning, the Maryland Children's Health Program may not apply a prior authorization requirement for a contraceptive drug or device that is:

(1) (i) An intrauterine device; or

(ii) An implantable rod;

(2) Approved by the U.S. Food and Drug Administration; and

(3) Obtained under a prescription written by an authorized prescriber.

(b) The Maryland Children's Health Program shall provide coverage for a single dispensing to an enrollee of a supply of prescription contraceptives for a 12–month period.

§15–308.

(a) The Maryland Children's Health Program shall provide coverage for services rendered to an enrollee by a licensed pharmacist acting within the pharmacist's lawful scope of practice to the same extent as services rendered by any other licensed health care provider.

(b) Reimbursement for services provided under subsection (a) of this section may not be conditioned on whether the licensed pharmacist is:

(1) Employed by a physician, pharmacy, or facility; or

(2) Acting under a physician's orders.

§15–309.

The Maryland Children's Health Program may not require prior authorization for a transfer to a special pediatric hospital.

§15–401.

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

(b) "Commissioner" means the Insurance Commissioner.

(c) "Program" means the Qualified State Long–Term Care Insurance Partnership.

§15–402.

(a) There is a Qualified State Long–Term Care Insurance Partnership.

(b) The purposes of the Program are to:

(1) Provide incentives for individuals to insure against the costs of providing for their long–term care needs;

(2) Provide mechanisms for individuals to qualify for coverage of the costs of their long–term care needs under the medical assistance program without first being required to substantially exhaust all their resources;

(3) Assist in developing methods for increasing access to and the affordability of a long–term care policy; and

(4) Alleviate the financial burden on the State's medical assistance program by encouraging pursuit of private initiatives.

(c) The Program shall:

(1) Be administered by:

(i) The Department; and

(ii) The Commissioner;

(2) Provide for the financing of long–term care services by:

(i) Private insurance; and

(ii) State medical assistance; and

(3) Comply with the requirements of § 1917(b) of the Social Security Act and any applicable federal guidelines.

§15–403.

(a) To be eligible for the Program, an individual must:

(1) Be covered by a long–term care policy that is approved for the Program by the Commissioner under § 15–404 of this subtitle; and

(2) Satisfy any other requirement for eligibility established by the Department.

(b) Program eligibility may not be denied under this section for policy benefits that are not available or appropriate for treating the insured's condition.

§15–404.

To qualify under the Program, a long–term care policy shall:

(1) Satisfy the requirements of § 1917(b) of the Social Security Act and any applicable federal guidelines;

(2) Satisfy the requirements of Title 18 of the Insurance Article; and

(3) Alert the purchaser to the availability of consumer information and public education provided by the Commissioner under § 15–406 of this subtitle in accordance with any applicable federal guidelines.

§15–405.

In determining eligibility for medical assistance, an amount of resources equal to the amount of benefits paid under the long–term care policy shall be excluded from the Department's calculation of the individual's resources.

§15–406.

The Commissioner, through the Consumer Education and Advocacy Program, shall undertake measures to educate the public as to:

(1) The need for long–term care;

(2) Mechanisms for financing long–term care;

(3) The availability of long–term care insurance; and

(4) The asset protection provided under this subtitle.

§15–407.

The Department and the Commissioner shall jointly:

(1) Adopt regulations necessary to carry out the provisions of this subtitle consistent with § 1917(b) of the Social Security Act and any applicable federal guidelines; and

(2) Beginning January 1, 2009, and on or before January 1 of each year thereafter, report to the General Assembly, in accordance with § 2–1257 of the State Government Article on:

(i) The effectiveness of the Program;

(ii) The impact of the Program on State expenditures for medical assistance;

(iii) The number of enrollees in the Program; and

(iv) The number of long–term care policies offered in the State under the Program.

§15–408.

The Department shall develop a process for providing information about the availability of the State's earned income tax credit established under § 10–704 of the Tax – General Article to each Program enrollee or potential Program enrollee when providing information about the Program.

§15–501.

(a) An individual who is eligible for medical assistance at the time of application for admission to a licensed nursing home or would become eligible within 6 months following admission shall be provided a comprehensive face–to–face evaluation prior to admission, at no charge to the individual. The Department, under the Maryland Medical Assistance Program, shall pay for the evaluation. The evaluation shall include an assessment of an individual's health, social and functional status, and recommendations for available services that could appropriately substitute for nursing home care. The evaluation is advisory only and may not serve as the basis for any action, including denial or commencement of benefits, that restricts the freedom of any individual to select from among any of the available services, including nursing home care, for which the individual is found to be medically eligible. Prior to beginning the evaluation process and annually thereafter, the Department shall prepare and publish an inventory of available services for use in the evaluation and shall provide this information for assistance to the individual upon completion of the evaluation.

(b) The Department shall adopt rules and regulations to carry out the provisions of this section.

(c) This section may not be construed to require a hospital or physician to detain a patient for an evaluation beyond the appropriate date of discharge.

§15–601.

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

(b) "Board" means the State Board of Pharmacy.

(c) "Dispense" means to provide:

(1) A prescription drug or medical supply in accordance with a prescription; or

(2) An over–the–counter drug or medical supply.

(d) "Drop–off site" means a pharmacy, other health care facility, or other entity participating in a drug donation or repository program and designated by the Board that:

(1) Has voluntarily agreed to accept donated prescription drugs, over–the–counter drugs, or medical supplies;

(2) Is located within the State or in another state; and

(3) Does not have a final disciplinary order issued against it by a health occupations board.

(e) "Eligible patient" means an individual who, through self–attestation, is indigent, uninsured, underinsured, or enrolled in a public health benefits program.

(f) "Program" means the Prescription Drug Repository Program.

(g) "Repository" means a licensed pharmacy that:

(1) If the licensed pharmacy is located in the State, does not have a final disciplinary order issued against it by the Board of Pharmacy;

(2) Has voluntarily agreed to participate in the Program;

(3) Is located in the State or in another state; and

(4) Has been approved by the Board to:

(i) Accept donated prescription drugs, over–the–counter drugs, or medical supplies from a designated drop–off site;

(ii) Dispense the donated prescription drugs, over–the–counter drugs, or medical supplies to eligible patients; or

(iii) Dispose of prescription drugs, over–the–counter drugs, or medical supplies not accepted for dispensing to eligible patients.

(h) "Tamper–evident packaging" means a packaging system that:

(1) May involve an immediate–container and closure system, secondary–container or carton system, tertiary–container system, or other combination of systems intended to provide a visual indication of package integrity;

(2) May contain unit–dose or multi–dose contents; and

(3) Has one or more indicators or barriers to entry that:

(i) If breached or missing, can reasonably be expected to provide visible evidence to consumers that tampering has occurred; and

(ii) If handled in a reasonable manner during manufacture, distribution, or retail display, is designed to remain intact.

§15–602.

(a) There is a Prescription Drug Repository Program regulated by the Board.

(b) The purpose of the Program is to:

(1) Accept prescription drugs, over–the–counter drugs, and medical supplies donated for the purpose of dispensing to eligible patients; and

(2) Accept prescription drugs, over–the–counter drugs, and medical supplies returned to a pharmacy for the purpose of proper disposal.

§15–603.

(a) Except as provided in subsection (b) of this section, the Program may accept for the purpose of dispensing only:

(1) Prescription drugs and over–the–counter drugs in their original unopened, sealed, and tamper–evident packaging, including drugs that have been packaged by a manufacturer or have been repackaged by an entity authorized to repackage drugs in the state in which the entity is located; and

(2) Medical supplies in their original unopened and sealed packaging.

(b) The Program may accept and dispense prescription drugs and over–the–counter drugs packaged in single unit doses when the outside packaging is opened if the single unit dose packaging is undisturbed.

(c) (1) The Program may not accept prescription drugs, over–the–counter drugs, or medical supplies for dispensing that:

(i) Except as provided in paragraph (2) of this subsection, bear an expiration date that is less than 90 days from the date the drug is donated;

(ii) May be adulterated, according to the standards of § 21–216 of this article; or

(iii) Belong to a category of unacceptable drugs established under § 15–608(b)(1) of this subtitle.

(2) (i) The Program may accept prescription drugs and over–the–counter drugs that bear an expiration date that is less than 90 days from the date the drug is donated if the prescription drug or over–the–counter drug is in high demand.

(ii) If the Program accepts a prescription drug or over–the–counter drug under subparagraph (i) of this paragraph, the Program may not dispense the prescription drug or over–the–counter drug if the expiration date occurs during the time period for which the prescription drug or over–the–counter drug is prescribed.

§15–604.

(a) (1) Any person may donate prescription drugs, over–the–counter drugs, or medical supplies to the Program.

(2) The Program may receive donated prescription drugs, over–the–counter drugs, or medical supplies from any person.

(b) Prescription drugs, over–the–counter drugs, or medical supplies may be donated only to a drop–off site designated for that purpose by the Board.

(c) A drop–off site located in the State shall:

(1) Require a donor to complete and sign a donor form releasing the prescription drugs, over–the–counter drugs, or medical supplies to the Program;

(2) Store donated prescription drugs, over–the–counter drugs, and medical supplies in a secure location used exclusively for the Program; and

(3) Forward, at the cost of the designated drop–off site, all donated prescription drugs, over–the–counter drugs, and medical supplies to a repository.

(d) A drop–off site located in the State may not:

(1) Dispense donated prescription drugs, over–the–counter drugs, or medical supplies;

(2) Resell prescription drugs, over–the–counter drugs, or medical supplies donated to the Program; or

(3) Charge a fee for accepting a donation.

(e) Consistent with its approval by the Board, an entity located in another state:

(1) May participate in the Program as a drop–off site; and

(2) May accept donated prescription drugs, over–the–counter drugs, and medical supplies from a person, unless otherwise prohibited by federal law or the laws of the state in which the entity is located.

§15–605.

(a) The Board may approve a licensed pharmacy to be a repository.

(b) Consistent with its approval by the Board, a repository located in the State shall:

(1) Accept only donated prescription drugs, over–the–counter drugs, and medical supplies forwarded by designated drop–off sites;

(2) Inspect all donated prescription drugs, over–the–counter drugs, and medical supplies;

(3) Accept for dispensing to eligible patients only those donated prescription drugs, over–the–counter drugs, and medical supplies that meet the requirements of § 15–603 of this subtitle;

(4) Dispose of donated prescription drugs, over–the–counter drugs, and medical supplies not accepted for dispensing to eligible patients in accordance with State and federal law;

(5) Maintain a separate inventory of donated prescription drugs, over–the–counter drugs, and medical supplies;

(6) Store donated prescription drugs, over–the–counter drugs, and medical supplies in a secure location used exclusively for the Program;

(7) Maintain separate prescription files for patients receiving donated prescription drugs and medical supplies; and

(8) Obliterate from the labels of donated prescription drugs and medical supplies any information specific to the patient for whom the donated prescription drugs, over–the–counter drugs, and medical supplies were originally dispensed or otherwise provided to the patient.

(c) A repository located in the State shall dispense donated prescription drugs, over–the–counter drugs, and medical supplies only:

(1) To an individual who meets the requirements of § 15–606(a) of this subtitle;

(2) On a new prescription, in the case of a prescription drug or medical supply that requires a prescription; and

(3) In accordance with State and federal laws pertaining to:

(i) Storage, distribution, and dispensing of prescription drugs; and

(ii) Confidentiality of patient information.

(d) A repository located in the State may:

(1) Charge a fee, not to exceed $10, for each prescription drug, over–the–counter drug, or medical supply dispensed; and

(2) Dispense a donated prescription drug, over–the–counter drug, or medical supply by mail.

(e) A repository may not establish or maintain a waiting list for any prescription drug, over–the–counter drug, or medical supply dispensed by the Program.

(f) A pharmacy may accept prescription drugs, over–the–counter drugs, and medical supplies taken to the pharmacy for disposal only if the pharmacy is approved by the Board as a repository for this purpose.

(g) Consistent with its approval by the Board, an entity located in another state:

(1) May participate in the Program as a repository; and

(2) Shall dispense donated prescription drugs, over–the–counter drugs, and medical supplies to residents of the State only in accordance with:

(i) Federal law;

(ii) Laws of the state in which the entity is located pertaining to storage and distribution of prescription drugs, over–the–counter drugs, and medical supplies; and

(iii) State laws pertaining to nonresident pharmacies.

(h) The Program may not require a private entity to establish, operate, or fund a drop–off site or disposal program.

(i) The Department shall develop a process for providing information about the availability of the State's earned income tax credit established under § 10–704 of the Tax – General Article to each individual receiving donated prescription drugs and medical supplies from a repository.

(j) A person donating, transferring, or receiving prescription drugs, over–the–counter drugs, and medical supplies, or facilitating the donation, transfer, or receipt, in accordance with this subtitle may not be required to hold a wholesale distribution license.

(k) A repository located in another state operating primarily for the purpose of participating in a drug donation or repository program may not be required to possess a comprehensive or minimum supply of prescription drugs, over–the–counter drugs, or medical supplies.

(l) A repository located in the State may transfer donated prescription drugs, over–the–counter drugs, and medical supplies to:

(1) Another repository located in the State; or

(2) A drop–off site located in another state, a repository located in another state, or another entity located in another state that participates in a drug donation or repository program in accordance with the laws of the state in which the entity is located only if there is no need for the donated prescription drugs, over–the–counter drugs, or medical supplies for use by eligible patients in the State, as determined by the transferring repository.

(m) Unless otherwise prohibited by federal law or the laws of the state in which it is located, a drop–off site or repository located in another state may perform and receive:

(1) Intracompany transfers of donated prescription drugs, over–the–counter drugs, and medical supplies; and

(2) Transfers of donated prescription drugs, over–the–counter drugs, and medical supplies from drop–off sites located in another state, repositories located in another state, or other entities participating in a drug donation or repository program in accordance with the laws of the state in which the entity is located.

§15–606.

(a) To be eligible to receive donated prescription drugs, over–the–counter drugs, or medical supplies from a repository located in the State, an individual must:

(1) Be a resident of the State; and

(2) Be an eligible patient.

(b) To be eligible to receive donated prescription drugs, over–the–counter drugs, or medical supplies from a repository located in another state, an individual must be an eligible patient.

§15–607.

(a) This section applies to:

(1) A person that donates prescription drugs, over–the–counter drugs, or medical supplies to the Program;

(2) A drop–off site;

(3) A repository;

(4) The Board;

(5) Pharmacists;

(6) Pharmacy technicians; and

(7) Staff employed by or volunteering for an entity participating in the Program.

(b) For matters related to donating, accepting, transferring, disposing of, or dispensing prescription drugs, over–the–counter drugs, or medical supplies under the Program, or facilitating the donation, acceptance, transfer, disposition of, or dispensing, a person described in subsection (a) of this section that acts in good faith may not be subject to:

(1) Criminal prosecution; or

(2) Liability in tort or other civil action for injury, death, or loss to person or property.

(c) A drug manufacturer acting in good faith may not be subject to criminal prosecution or liability in tort or other civil action for injury, death, or loss to person or property for matters related to the donation, acceptance, or dispensing of a drug manufactured by the drug manufacturer that is donated by any person under the Program, including liability for failure to transfer or communicate product or consumer information or the expiration date of the donated drug.

§15–608.

(a) On or before January 1, 2007, and in consideration of the recommendations of the Task Force on the Establishment of a Prescription Drug Repository Program, the Board shall adopt regulations governing the Program.

(b) The regulations shall include:

(1) Categories of drugs that a repository will not accept, including a statement as to why the drug is ineligible for donation;

(2) A standard form each donor donating to a drop–off site located in the State must sign stating that the donor is the owner of the drugs and intends to voluntarily donate them to the Program;

(3) Requirements for designation of drop–off sites to accept donated prescription drugs, over–the–counter drugs, and medical supplies under the Program;

(4) Requirements for designation of repositories to dispense or dispose of donated prescription drugs, over–the–counter drugs, and medical supplies under the Program;

(5) Standards and procedures for drop–off sites and repositories located in the State related to accepting, safely storing, dispensing, shipping, and disposing of donated prescription drugs, over–the–counter drugs, and medical supplies;

(6) Standards and procedures for repositories located in the State related to inspecting donated prescription drugs, over–the–counter drugs, and medical supplies intended for dispensing to determine that:

(i) The prescription drugs and over–the–counter drugs are in original unopened, sealed, and tamper–evident packaging, which may include packaging placed by the manufacturer and packaging placed by an entity authorized to repackage drugs in the state in which the entity is located;

(ii) The medical supplies are in their original unopened and sealed packaging; and

(iii) The prescription drugs, over–the–counter drugs, and medical supplies are unadulterated, safe, and suitable for dispensing;

(7) A standard form that an individual receiving a prescription drug, over–the–counter drug, or medical supply from a repository located in the State must sign before receiving the drug or supply to confirm that the individual understands that:

(i) The individual is receiving prescription drugs, over–the–counter drugs, or medical supplies that have been donated to the Program; and

(ii) Entities involved in the Program have certain immunity from liability;

(8) Record keeping and reporting requirements for a repository located in the State; and

(9) Any other standards and procedures the Board considers appropriate for drop–off sites and repositories located in the State.

§15–609.

(a) A repository located in the State shall:

(1) Maintain written or electronic records of donated prescription drugs, over–the–counter drugs, and medical supplies; and

(2) Submit periodic reports to the Board on its activities.

(b) To determine compliance with the requirements of this subtitle, the Board shall:

(1) Inspect designated drop–off sites and repositories located in the State;

(2) Inspect records of donated prescription drugs, over–the–counter drugs, and medical supplies maintained by repositories located in the State; and

(3) Beginning January 1, 2007, and each January 1 thereafter, report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the operation of the Program.

§15–701.

(a) In this subtitle, "Fund" means the Health Care Coverage Fund.

(b) There is a Health Care Coverage Fund.

(c) The purpose of the Fund is to:

(1) Support health care coverage for individuals and families with low or moderate income; and

(2) Subject to subsection (i) of this section, support the provision of health care services in Prince George's County.

(d) The Department and the Maryland Health Care Commission shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Money collected from any assessment by the State Health Services Cost Review Commission on hospitals under § 19–214(d) of this article;

(2) Any money made available from investment earnings; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(g) (1) The Fund shall be invested and reinvested in the same manner as other State funds.

(2) Any investment earnings shall be credited to the Fund.

(h) The Fund may be used only for expenses associated with:

(1) Expanding Medicaid eligibility for parents and caretaker relatives:

(i) Who have a dependent child living with them; and

(ii) Whose annual household income is at or below 116% of the federal poverty guidelines;

(2) Expanding Medicaid eligibility and benefits for individuals:

(i) Who do not meet requirements, such as age, disability, or parent or caretaker relative of a dependent child, for a federal category of eligibility for Medicaid;

(ii) Whose annual household income is at or below 116% of the federal poverty guidelines; and

(iii) Who are not enrolled in the federal Medicare program, as enacted by Title XVIII of the Social Security Act; and

(3) Supporting the provision of health care services in Prince George's County in accordance with subsection (i) of this section.

(i) (1) Subject to paragraph (2) of this subsection, in fiscal year 2010, $12,000,000, and in fiscal years 2011 through 2013, up to $10,000,000 may be transferred annually from the Fund to the Department for the purpose of providing a special fund operating grant to an independent entity with authority over the facilities currently operated and health care services currently provided by

Dimensions Healthcare System until the facilities and obligation to provide the services are transferred to a new owner or operator.

(2) The Department may not provide a special fund operating grant until a long–term, comprehensive solution to the control and operation of the facilities and provision of health care services currently operated and provided by Dimensions Healthcare System is reached through:

(i) An Act of the General Assembly; or

(ii) A memorandum of understanding between the State and Prince George's County.

(3) The long–term, comprehensive solution under paragraph (2) of this subsection shall address issues related to health care needs in Prince George's County and the surrounding region, including:

(i) The transfer to a new owner or operator of the facilities currently operated and the obligation to provide the health care services currently provided by Dimensions Healthcare System;

(ii) A plan for the assets currently held by Prince George's County related to the facilities currently operated by Dimensions Healthcare System;

(iii) A mechanism to provide a steady revenue stream to help support ongoing operations of the facilities currently operated by Dimensions Healthcare System and to retire the long–term bond indebtedness and satisfy the unfunded pension liability of Dimensions Healthcare System; and

(iv) A mechanism to assure equitable and sustainable funding from Prince George's County and the State.

(4) Money collected from an assessment by the State Health Services Cost Review Commission on hospitals may not be used for the purpose of this subsection.

(j) Expenditures from the Fund may be made only in accordance with the State budget.

(k) Money from the Fund shall supplement and may not supplant funding for the Maryland Medical Assistance Program.

(l) The Fund is subject to audit by the Office of Legislative Audits.

§15–702.

(a) The Department shall ensure that publicly owned specialty hospitals pay an assessment that is comparable to any uniform assessments imposed by the Health Services Cost Review Commission on specialty hospitals under § 19–214(d) of this article or under Section 16 of Chapter 397 (H.B. 72) of the Acts of the General Assembly of 2011.

(b) Revenues generated from any assessments authorized under subsection (a) of this section shall be used for the general operations of the Medicaid program.

§15–901.

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

(b) "Independent home care provider" means an individual who:

(1) Provides home care services that are directly reimbursed by the State or a fiscal intermediary functioning on behalf of the State, and not by an agency or business that employs employees or refers independent contractors as home care providers, under:

(i) The Medicaid Waiver for Older Adults that is jointly administered by the Department and the Department of Aging as established under § 15–132 of this title, or any successor program;

(ii) The Medicaid Personal Care Program under the State Medical Assistance Program, or any successor program; and

(iii) The In–Home Aide Service Program administered by the Department of Human Services, or any successor program;

(2) Is not employed or referred by an agency or business that employs employees or refers independent contractors as home care providers;

(3) Contracts directly with a program participant for home care services; and

(4) Provides home care services to a program participant personally and does not subcontract with any other party to provide the services to a program participant.

(c) (1) "Provider organization" means an organization that:

(i) Includes independent home care providers; and

(ii) Has as one of its purposes the representation of independent home care providers in their relations with the State.

(2) "Provider organization" does not include an agency or business that employs employees or refers independent contractors as home care providers.

§15–902.

In according independent home care providers and their representatives rights under this subtitle, it is the intent of the General Assembly that the State action exemption to the application of federal and State antitrust laws be fully available to the extent that the activities of the independent home care providers and their representatives are authorized under this title.

§15–903.

(a) There shall be only one appropriate bargaining unit of independent home care providers in the State.

(b) Independent home care providers may designate, in accordance with the provisions of this subtitle, which provider organization, if any, shall be the exclusive representative of all independent home care providers in the State.

(c) (1) The election and certification of the exclusive representative of independent home care providers shall be governed by the procedures set forth in Title 3, Subtitle 4 of the State Personnel and Pensions Article.

(2) All elections shall be conducted by the Public Employee Relations Board and subject to the requirements and limitations of Title 22, Subtitle 4 of the State Government Article.

(3) The Public Employee Relations Board may not conduct an election for an exclusive representative if an election or certification of an exclusive representative has taken place within the preceding 2 years.

(4) A provider organization designated as the exclusive representative shall represent all independent home care providers in the State fairly and without discrimination, whether or not the independent home care providers are members of the provider organization.

§15–904.

(a) The Department and the departments of Human Services and Aging shall designate appropriate representatives to participate in collective bargaining with the provider organization certified as the exclusive representative of independent home care providers.

(b) Except as otherwise provided in this subtitle, the parties shall adhere to the bargaining process set forth in § 3–501 of the State Personnel and Pensions Article.

(c) The State agencies specified in subsection (a) of this section that are engaged in bargaining shall negotiate, in consultation with the Department of Budget and Management, all matters that require appropriation of State funds.

(d) Collective bargaining shall include all matters relating to the terms and conditions of participation by independent home care providers in the provision of home care services under the programs specified in § 15–901(b) of this subtitle, including:

(1) Reimbursement rates;

(2) Benefits;

(3) Payment procedures;

(4) Contract grievance procedures;

(5) Training;

(6) Member dues deductions; and

(7) Other terms and conditions of participation by independent home care providers in the provision of home care services under the programs specified in § 15–901(b) of this subtitle.

(e) (1) (i) Subject to subparagraphs (ii) and (iii) of this paragraph, collective bargaining may include negotiations relating to the right of a provider organization that is the exclusive representative to receive service fees from nonmembers.

(ii) The representatives of the State may not reach an agreement containing a service fee provision unless the representatives of the State conclude that the agreement as a whole will not adversely impact nonmember providers.

(iii) The representatives of the State may only agree to a service fee provision if the service fee provision would require nonmembers to pay service fees on a sliding scale in approximate proportion to the amount each nonmember receives in reimbursement through:

1. The Medicaid Waiver for Older Adults that is jointly administered by the Department and the Department of Aging as established under § 15–132 of this title, or any successor program;

2. The Medicaid Personal Care Program under the State Medical Assistance Program, or any successor program; and

3. The In–Home Aide Service Program administered by the Department of Human Services, or any successor program.

(2) An independent home care provider whose religious beliefs are opposed to joining or financially supporting any collective bargaining organization:

(i) Is not required to pay a service fee; but

(ii) Shall pay an amount of money as determined in collective bargaining negotiations, not to exceed any service fee negotiated under paragraph (1) of this subsection, to any charitable organization exempt from taxation under § 501(c)(3) of the Internal Revenue Code and to furnish to the State agencies engaged in collective bargaining under this subtitle and the exclusive representative written proof of the payment.

(3) (i) An independent home care provider who provides home care services only to an immediate family member is not required to pay a service fee.

(ii) An independent home care provider who provides services to an immediate family member and any other individual who is not an immediate family member may be required to pay a service fee that is proportionate to the amount the provider receives in reimbursement for the provider's services to any individual who is not an immediate family member.

(iii) An independent home care provider may be required to provide written documentation of the provision of home care services to an immediate family member.

(f) Notwithstanding subsection (d) of this section, the representatives of the State:

(1) May not be required to negotiate any matter that is inconsistent with applicable law; and

(2) May negotiate and reach agreement with regard to any matter that is inconsistent with applicable law only if it is understood that the agreement with respect to the matter cannot become effective unless the applicable law is amended by the General Assembly in a manner that eliminates inconsistency.

(g) (1) The parties shall reduce their agreement to a Memorandum of Understanding that complies with the provisions of § 3–601 of the State Personnel and Pensions Article.

(2) If the Memorandum of Understanding contains a service fee provision, before the vote to ratify the Memorandum of Understanding is held, the exclusive representative shall provide notice that the Memorandum of Understanding contains a provision for a service fee that will be charged on a sliding scale to independent home care providers.

§15–905.

The certification of an exclusive representative of independent home care providers by the State agencies engaged in collective bargaining under this subtitle does not prevent the certified provider organization or any other organization or individual from communicating with any State official on matters of interest, including appearing before or making proposals to the State agencies engaged in collective bargaining at a public meeting or hearing or at any other forum of the State agencies.

§15–906.

(a) A provider organization may not call or direct a strike or other collective cessation of the delivery of services.

(b) This subtitle may not be construed to grant any right, or imply that independent home care providers have any right, to engage in a strike or other collective cessation of the delivery of services.

§15–907.

(a) This subtitle may not be construed to make independent home care providers employees of the State.

(b) This subtitle may not be construed in any way to deny program recipients of independent home care services the right to select, direct, and terminate the services of independent home care providers.

§15–1001. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2030 PER CHAPTER 48 OF 2024 //

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

(b) "Eligible individual" means an individual who:

(1) Is a resident of Maryland;

(2) Is a Medicare beneficiary enrolled in the Medicare Part D Voluntary Prescription Drug Benefit Program or a Medicare Advantage Plan that provides Part D coverage;

(3) Is not enrolled in a health benefit plan, other than a Medicare Part D prescription drug plan or a Medicare Advantage Plan, that provides prescription drug benefits at the time that the individual applies for enrollment in the Program;

(4) Has an annual household income at or below 300% of the federal poverty guidelines;

(5) Is not eligible for a full federal low–income subsidy under 42 C.F.R. § 423.772; and

(6) Pays the premium, and copayments or coinsurance, for the Program.

(c) "Enrollee" means an individual enrolled in the Program.

(d) "Fund" means the Senior Prescription Drug Assistance Program Fund established under § 15–1004 of this subtitle.

(e) "Program" means the Senior Prescription Drug Assistance Program established under this subtitle.

§15–1002. IN EFFECT

// EFFECTIVE DECEMBER 31, 2030 PER CHAPTER 48 OF 2024 //

(a) There is a Senior Prescription Drug Assistance Program.

(b) The purpose of the Program is to provide Medicare Part D beneficiaries, who meet Program eligibility requirements, with a State subsidy.

(c) The Department shall administer the Program.

§15–1003. IN EFFECT

// EFFECTIVE DECEMBER 31, 2030 PER CHAPTER 48 OF 2024 //

(a) The Program shall:

(1) Provide a prescription drug benefit subsidy, as determined by the Department, that may pay all or some of the deductibles, coinsurance payments, premiums, and copayments under the federal Medicare Part D Pharmaceutical Assistance Program for enrollees of the Program; and

(2) Provide the subsidy to the maximum number of individuals eligible for enrollment in the Program, subject to the money available in the Fund.

(b) The Program may limit payment of any subsidy by paying the subsidy only on behalf of eligible individuals enrolled in a Medicare Part D Prescription Drug Plan or Medicare Advantage Plan that coordinates with the Program in accordance with federal requirements.

(c) The Program may annually provide an additional subsidy, up to the full amount of the Medicare Part D Prescription Drug Plan premium, for individuals who qualify for a partial federal low–income subsidy.

(d) The Department shall maintain a waiting list of individuals who meet the eligibility requirements for the Program but who are not served by the Program due to funding limitations.

(e) The Department shall determine annually:

(1) The number of individuals to be enrolled in the Program;

(2) The amount of subsidy to be provided under subsection (a) of this section; and

(3) The amount of any additional subsidy provided under subsection (c) of this section.

§15–1004. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2030 PER CHAPTER 48 OF 2024 //

(a) There is a Senior Prescription Drug Assistance Program Fund.

(b) The purpose of the Fund is to support the administration, operation, and activities of the Program.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money transferred to the Fund by a nonprofit health service plan under § 14–106(d) of the Insurance Article;

(2) Money appropriated in the State budget to the Fund;

(3) Interest earnings of the Fund; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(f) (1) Except as provided in paragraphs (2) and (3) of this subsection, the Fund may be used only for the administration, operation, and activities of the Program.

(2) For fiscal year 2025 and each fiscal year thereafter, excess funds not required for the administration, operation, and activities of the Program may be used only to subsidize:

(i) The Kidney Disease Program under Title 13, Subtitle 3 of this article; or

(ii) The provision of mental health services to the uninsured under Title 10, Subtitle 2 of this article.

(3) For fiscal year 2025 and each fiscal year thereafter, excess funds not required for the administration, operation, and activities of the Program may be used for health reimbursement accounts established in accordance with § 105(h) of the Internal Revenue Code under § 2–509.1 of the State Personnel and Pensions Article.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) (1) Expenditures from the Fund may be made only in accordance with the State budget.

(2) The Program shall have its own program code within the State budget.

(i) (1) Beginning July 1, 2016, and quarterly thereafter, the nonprofit health service plan required to subsidize the Program under § 14–106(d) of the Insurance Article shall deposit to the Fund the amount that is necessary to operate and administer the Program for the following quarter.

(2) The amount deposited shall be determined by the Department based on enrollment, expenditures, and revenue for the previous year.

(3) The amount required by the Department under paragraph (2) of this subsection may not exceed the amounts specified in § 14–106(e) of the Insurance Article.

§15–1005. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2030 PER CHAPTER 48 OF 2024 //

(a) On or before June 30 of each year, the Department shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, to the General Assembly that includes a summary of Program activities for the year and any recommendations for consideration by the General Assembly.

(b) (1) The Department shall adopt regulations to carry out this subtitle.

(2) The Department may adopt regulations that require an insurance producer to receive training about the Program before the insurance producer may market the Program or assist a Medicare beneficiary to enroll in the Program.

(3) Subject to § 10–116(d) of the Insurance Article, training received under paragraph (2) of this subsection qualifies as continuing education under § 10–116(a) of the Insurance Article.

§15–1006. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2030 PER CHAPTER 48 OF 2030 //

(a) For the purpose of maximizing participation in the Program, the Department may develop outreach materials for distribution to eligible individuals.

(b) The Department shall publicize the existence and eligibility requirements of the Program through the following entities:

(1) The Department of Aging;

(2) Local health departments;

(3) Continuing care retirement communities;

(4) Places of worship;

(5) Civic organizations;

(6) Community pharmacies; and

(7) Any other entity that the Department determines appropriate.

(c) The Department of Aging, through its Senior Health Insurance Program, shall:

(1) Assist eligible individuals in applying for coverage under the Program; and

(2) Provide notice of the Program and its eligibility requirements to potentially eligible individuals who seek health insurance counseling services through the Department of Aging.

(d) The Department shall develop a mail–in application for the Program.

(e) Any outreach performed by the Department on behalf of the Program shall be funded through the Fund.

§15–1007.

The Department shall develop a process for providing information about the availability of the State's earned income tax credit established under § 10–704 of the Tax – General Article to each individual receiving services under this subtitle.

§15–1101.

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

(b) "Family–centered treatment" means an evidence–based practice used to stabilize youth in the home by addressing underlying functions of behavior in order to reduce disruptions in the home, school, and community.

(c) "Functional family therapy" means a family–based prevention and intervention program for high–risk youth that addresses complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive.

(d) "High–fidelity wraparound model" means a research–based model of care coordination that uses a highly structured, team–based, family–centered management process to meet the needs of children and adolescents who experience complex emotional, behavioral, or mental health needs.

(e) "Mental health case management program" means a program that provides an identified subset of wraparound services.

(f) "1915(i) model" means the 1915(i) Intensive Behavioral Health Services for Children, Youth, and Families program established under Title 10, Subtitle 9, Chapter 89 of the Code of Maryland Regulations.

(g) "Value–based purchasing" means financially incentivizing providers to meet selected outcome measures.

(h) "Wraparound services" means services provided to children and youth with intensive mental health needs and their families in their communities, including:

(1) Intensive care coordination;

(2) Child and family team meetings; and

(3) Plans of care that are individualized to each family and include:

(i) Formal supports, including individual and family therapy; and

(ii) Informal supports, including intensive in–home services, respite care, mobile crisis response and stabilization, family peer support, experiential therapies, and flexible funds for goods and services that are identified in the plan of care.

§15–1102.

(a) The Department shall ensure that care coordinators delivering services under the 1915(i) model or a mental health case management program receive training in the delivery of services under a high–fidelity wraparound model.

(b) The Department shall provide reimbursement for:

(1) Wraparound services delivered by care coordinators under a high–fidelity wraparound model under the 1915(i) model or a mental health case management program that is commensurate with industry standards for the reimbursement of the delivery of wraparound services;

(2) Intensive in–home services delivered by providers using family–centered treatment, functional family therapy, and other evidence–based practices under the 1915(i) model that is commensurate with the industry standards for the reimbursement of the delivery of family–centered treatment, functional family therapy, and other evidence–based practices; and

(3) At least one pilot program utilizing value–based purchasing for case management services.

(c) Beginning in fiscal year 2024, the Behavioral Health Administration shall fund 100 slots in the mental health case management program for children or youth who are not eligible for program services and who are at risk of out–of–home placement.

(d) The Governor shall include in the annual operating budget bill the following amounts to fund customized goods and services for youth receiving services under the 1915(i) model or mental health case management program:

(1) $150,000 for fiscal year 2025;

(2) $250,000 for fiscal year 2026; and

(3) $350,000 for fiscal year 2027 and each fiscal year thereafter.

§15–1103.

(a) On or before December 1 each year, beginning in 2023, the Department shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on enrollment in:

(1) The 1915(i) model; and

(2) Child and adolescent case management services.

(b) The report shall include:

(1) The total number of children and adolescents served by each program;

(2) Whether the number represents an increase or a decrease in the number served; and

(3) Any steps the Department has taken to increase enrollment in the programs.

§15–1201.

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

(b) "Advisory Group" means the Maryland Interested Parties Advisory Group established under § 15–1202 of this subtitle and required under 42 C.F.R. § 447.203.

(c) "Applicable service categories" means homemaker services, home health aide services, personal care services, and habilitation services.

(d) "Consumer" means an applicant for, a recipient of, or an individual eligible for Medicaid home– and community–based services, or the individual's authorized representative.

(e) "Consumer organization" means a State or local consumer advocacy group or other community–based organization that represents the interests of, or provides direct services to, consumers of Medicaid home– and community–based services.

(f) "Direct care worker" means an individual:

(1) Employed by a Medicaid provider, State agency, or third party;

(2) Who contracts with a Medicaid provider, State agency, or third party;

(3) Delivering services under a self–directed services delivery model; or

(4) Who is paid to provide home– and community–based services through an applicable service category.

(g) "Home– and community–based services" means Medicaid home– and community–based services delivered through the State plan, a waiver under § 1915(c) of the federal Social Security Act, a managed care program, or other demonstration program.

(h) "Personal care" has the meaning stated under § 19–301 of this article.

(i) "Provider association" means a trade association that represents direct care employers.

(j) "Worker organization" means an organization that:

(1) Is exempt from federal income taxation under §§ 501(c)(3) through (6) of the Internal Revenue Code;

(2) Is not dominated, controlled, or funded by a direct care employer; and

(3) Has at least 2 years of demonstrated experience engaging with and advocating for direct care workers.

§15–1202.

(a) There is a Maryland Interested Parties Advisory Group within the Department.

(b) The primary purpose of the Advisory Group is to advise and consult on Medicaid payment rate sufficiency, ensuring adequate access to applicable service categories.

§15–1203.

(a) The Advisory Group consists of:

(1) The Deputy Secretary of Health Care Financing, or the Deputy Secretary's designee;

(2) The Secretary of Labor, or the Secretary's designee; and

(3) The following members appointed by the Deputy Secretary of Health Care Financing, or the Deputy Secretary's designee:

(i) Three consumers;

(ii) Two representatives of consumer organizations;

(iii) Three direct care workers;

(iv) Two representatives of worker organizations; and

(v) Three representatives of provider associations, of whom:

1. Two shall be representatives of a residential service agency; and

2. One shall be a representative of an employer trade association.

(b) To the extent practicable, the members appointed to the Advisory Group shall reflect the diversity of lived experience with disability, as well as the geographic, racial, ethnic, cultural, gender, sexual orientation, gender identity, gender expression, age, and socioeconomic diversity of the State.

(c) (1) The Deputy Secretary of Health Care Financing, or the Deputy Secretary's designee, shall establish an application process that is accessible to the general public for the recruitment of members.

(2) The application and criteria for selection shall be published on the Department's website.

(d) (1) The Deputy Secretary of Health Care Financing, or the Deputy Secretary's designee, shall chair the Advisory Group.

(2) The Department shall provide staff and support for the Advisory Group, including appropriate logistical and informational support to ensure

meaningful participation of direct care workers and consumers in the Advisory Group.

(e) The Secretary may remove or suspend a member of the Advisory Group for misconduct, incompetence, or neglect of duties after an opportunity for the member to be heard.

(f) A member of the Advisory Group:

(1) May not receive compensation as a member of the Advisory Group; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) (1) Beginning November 1, 2025, the Advisory Group shall meet annually.

(2) Meeting dates, times, and locations shall be selected to maximize member attendance.

§15–1204.

(a) (1) The Department shall establish standardized procedures for the administration of the Advisory Group and make the procedures available to the public on a dedicated page of the Department's website.

(2) The dedicated page on the Department's website shall also include:

(i) A list of current Advisory Group members;

(ii) The application process and selection criteria for Advisory Group members;

(iii) The location, date, and time of each Advisory Group meeting with at least 30 calendar days' advance notice;

(iv) Options for virtual participation in meetings of the Advisory Group;

(v) Procedures to ensure meaningful participation for individuals with disabilities and limited English proficiency;

(vi) A notation of at which meetings the general public will have an opportunity to testify or make comments; and

(vii) In accordance with the Open Meetings Act, the agenda and meeting minutes of the previous meeting of the Advisory Group, including a list of meeting attendees.

(b) The Department shall provide sufficient data and resources at least 30 days in advance of a meeting to support informed participation in Advisory Group discussions, including:

(1) Current and proposed payment rates;

(2) Federally required information, including:

(i) Home– and community–based services payment transparency reports;

(ii) Payment adequacy reports as required under 42 C.F.R. § 441.311(e); and

(iii) Access–to–care data, as required under 42 C.F.R. § 441.311(d)(2);

(3) Bureau of Labor Statistics publicly available wage data and other labor market and workforce data;

(4) Benchmarking and rate studies for home– and community–based services conducted by the Department;

(5) Rate information from neighboring or similarly situated states; and

(6) Access–to–care metrics, including:

(i) The number of consumers receiving applicable services; and

(ii) The number of utilization hours for applicable service categories.

§15–1205.

(a) The Advisory Group shall:

(1) Evaluate the sufficiency of Medicaid payment rates for applicable service categories; and

(2) Evaluate challenges to accessing care for applicable Medicaid home– and community–based services.

(b) (1) On or before September 1 each year, beginning in 2026, the Advisory Group shall report its activities and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(2) Any recommendations adopted by the Advisory Group must receive a majority vote.

(c) The Department shall post the report to the Department's website within 30 days after the report has been finalized.

(d) The Advisory Group may hold opportunities to solicit and collect testimony from the public and invite input from employer organizations, worker organizations, consumer advocacy groups, and other stakeholders in the direct care industry.

(e) (1) An employer or State agency may not take retaliatory action against a direct care worker or consumer for participation in the Advisory Group.

(2) This section does not limit the rights of direct care workers under State or federal employment or labor law, or collective bargaining agreements.

§16–101.

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

(b) (1) As to a recipient of services under the Maryland Developmental Disabilities Law, a word used in this title has the same meaning as is indicated by a definition of the word in § 7–101 of this article.

(2) As to a recipient of services under the Maryland Mental Health Law, a word used in this title has the same meaning as is indicated by a definition of the word in § 7.5–101 or § 10–101 of this article.

(c) "Chargeable person" means:

(1) Any responsible relative;

(2) Except for a recipient of services, any other person who is legally responsible for the care of the individual; and

(3) Any person who maintains a policy of health insurance under which a recipient of services is insured.

(d) (1) "Cost of care" means the cost of care, maintenance, treatment, and support of a recipient of services.

(2) "Cost of care" includes the cost of:

(i) An evaluation of an individual required under the Maryland Developmental Disabilities Law; and

(ii) Any juvenile screening or treatment service provided to an individual under § 9–227(b)(1)(ii) of the Human Services Article.

(e) (1) "Recipient of services" means an individual who receives care, maintenance, treatment, or support in a facility or program that is operated or funded wholly or partly by the Department.

(2) "Recipient of services" includes:

(i) An individual in a public facility under the Maryland Mental Health Law;

(ii) An individual in a facility for an evaluation required under the Maryland Developmental Disabilities Law;

(iii) An individual in a residential, public facility or a facility from which this State obtains residential care under the Maryland Developmental Disabilities Law;

(iv) An individual to whom juvenile screening or treatment services are provided under § 9–227(b)(1)(ii) of the Human Services Article; and

(v) An individual in a private therapeutic group home from which this State obtains residential care under the Maryland Mental Health Law.

(f) "Responsible relative" means:

(1) The spouse of a recipient of services; and

(2) The parents of a recipient of services who is a minor.

§16–102.

(a) It is the policy of this State to obligate each recipient of services and, to the extent provided in this title, those legally responsible for the recipient to pay, if financially able, for the cost of care that is received by the recipient of services. Unless otherwise provided by statute, the recipient of services and the chargeable person shall be responsible for payment regardless of whether the recipient of services was admitted voluntarily, involuntarily, or by court order. If the recipient of services is involuntarily admitted to a public facility and released after evaluation, for failure to meet the standards for involuntary commitment, the recipient of services or chargeable person shall not be responsible for the cost of care.

(b) The total cost of care of each recipient of services is, in the first instance, the responsibility of the recipient of services and, as provided in this title, the chargeable person. Any uncollectible costs for services provided to the recipient shall become the responsibility of this State.

§16–201.

(a) The Secretary shall adopt rules and regulations that set charges for services that the Department provides for the physically ill, aged, mentally disordered, intellectually disabled, and developmentally disabled and other recipients of services in or through State–operated:

(1) Clinics;

(2) Day care, day treatment, and day hospital care;

(3) Group homes and small residential homes;

(4) Inpatient care in regional and State hospitals and centers; and

(5) Inpatient and outpatient care of any other kind.

(b) (1) The Secretary shall require political subdivisions and grantees to set, subject to approval and modifications of the Secretary, charges for services that are provided by the political subdivisions or grantees and that are supported wholly or partly by State or federal funds administered by the Department.

(2) If a health officer for a political subdivision considers it to be in the best interest of public health, the health officer may waive a charge set under this subsection.

(c) Charges for services shall be set at least annually.

(d) If the Secretary considers it to be in the best interest of the public health, the Secretary may designate specific services for which a charge may not be made.

§16–201.1.

(a) The Secretary shall make an assessment of the Department's health care services and ability-to-pay schedule for prenatal and infant care services offered through local health agencies.

(b) The assessment shall include the following:

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

(2) The identification of health care services that are not available;

(3) Access to health care;

(4) The need for specific health care;

(5) An evaluation of alternative means of providing health care services; and

(6) Financial and manpower resources required and available.

(c) An applicant for services under this section shall receive:

(1) A personal financial consultation without charge to assess the applicant's ability to pay for health care offered through local health agencies; and

(2) Notification of the right to obtain services offered through local health agencies regardless of ability to pay.

(d) (1) The Secretary shall adopt regulations necessary to carry out the provisions of this section.

(2) Local health agencies shall implement uniform procedures to notify and consult potential prenatal and infant care services recipients.

(3) Reduced rates for recipients of services shall be applied fairly and uniformly, and according to the sliding fee scale developed by the Department.

§16–201.2.

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

(2) "Community developmental disabilities services provider" means a community–based developmental disabilities program licensed by the Department.

(3) "Community mental health services provider" means a community–based mental health program approved by the Department or an individual practitioner who contracts with the Department or the appropriate core service agency or local behavioral health authority.

(4) "Core service agency" has the meaning stated in § 7.5–101 of this article.

(5) "Eligible individual" means a Medicaid recipient or an individual who receives developmental disabilities services or mental health services subsidized in whole or in part by the State.

(6) "Local behavioral health authority" has the meaning stated in § 7.5–101 of this article.

(b) Notwithstanding the provisions of this subtitle, the Department shall reimburse a community developmental disabilities services provider or a community mental health services provider for approved services rendered to an eligible individual as provided in this section.

(c) (1) Subject to the limitations of the State budget, beginning in fiscal year 2008 and in each fiscal year thereafter, the Department shall adjust for inflation the fees paid to a community developmental disabilities services provider and a community mental health services provider for approved services rendered to an eligible individual using the update factor recommended by the Community Services Reimbursement Rate Commission.

(2) Annual adjustments shall be funded with due regard to the expenditures necessary to meet the needs of individuals receiving services.

(3) The annual rate of change for the fees may not exceed a maximum rate of 5%.

§16–201.3.

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

(2) "Community provider" means a community–based agency or program funded by the Behavioral Health Administration or the Medical Care Programs Administration to serve individuals with mental disorders, substance–related disorders, or a combination of these disorders.

(3) "Rate" means the reimbursement rate paid by the Department to a community provider from the State General Fund, Maryland Medical Assistance Program funds, other State or federal funds, or a combination of these funds.

(b) This section does not apply to reimbursement for any service provided by a community provider whose rates are regulated by the Health Services Cost Review Commission.

(c) It is the intent of the General Assembly that a substantial portion of the rate adjustment provided under subsection (d) of this section be used to:

(1) Compensate direct care staff and licensed clinicians employed by community providers; and

(2) Improve the quality of programming provided by community providers.

(d) (1) The Governor's proposed budget for fiscal year 2019 and fiscal year 2020 shall include a 3.5% rate increase for community providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year for each of the following:

(i) Object 08 Contractual Services in Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursement – Medical Care Programs Administration;

(ii) Object 08 Contractual Services in Program M00L01.02 Community Services – Behavioral Health Administration; and

(iii) Object 08 Contractual Services in Program M00L01.03 Community Services for Medicaid State Fund Recipients – Behavioral Health Administration.

(2) The Governor's proposed budget for fiscal year 2021 shall include a 4% rate increase for community providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year for each of the following:

(i) Object 08 Contractual Services in Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursement – Medical Care Programs Administration;

(ii) Object 08 Contractual Services in Program M00L01.02 Community Services – Behavioral Health Administration; and

(iii) Object 08 Contractual Services in Program M00L01.03 Community Services for Medicaid State Fund Recipients – Behavioral Health Administration.

(3) The Governor's proposed budget for fiscal year 2022 shall include a 3.5% rate increase for community providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year for each of the following:

(i) Object 08 Contractual Services in Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursement – Medical Care Programs Administration;

(ii) Object 08 Contractual Services in Program M00L01.02 Community Services – Behavioral Health Administration; and

(iii) Object 08 Contractual Services in Program M00L01.03 Community Services for Medicaid State Fund Recipients – Behavioral Health Administration.

(4) The Governor's proposed budget for fiscal year 2023 shall include a 3.25% rate increase for community providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year for each of the following:

(i) Object 08 Contractual Services in Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursement – Medical Care Programs Administration;

(ii) Object 08 Contractual Services in Program M00L01.02 Community Services – Behavioral Health Administration; and

(iii) Object 08 Contractual Services in Program M00L01.03 Community Services for Medicaid State Fund Recipients – Behavioral Health Administration.

(5) The Governor's proposed budget for fiscal year 2024 shall include a 3% rate increase for community providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year for each of the following:

(i) Object 08 Contractual Services in Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursement – Medical Care Programs Administration;

(ii) Object 08 Contractual Services in Program M00L01.02 Community Services – Behavioral Health Administration; and

(iii) Object 08 Contractual Services in Program M00L01.03 Community Services for Medicaid State Fund Recipients – Behavioral Health Administration.

(6) The Governor's proposed budget for fiscal year 2019 and each fiscal year thereafter for community providers shall be presented in the same manner, including object and program information, as in the fiscal year 2018 budget.

(e) (1) In this subsection, "Commission" means the Maryland Health Care Commission.

(2) On or before June 30, 2028, the Department shall:

(i) Conduct an independent cost–driven, rate–setting study to set community provider rates for community–based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community–based behavioral health services;

(ii) Review and implement the recommendations of the Workgroup on Behavioral Health Rate Methodology Modernization established by Chapters 218 and 219 of the Acts of the General Assembly of 2026; and

(iii) Administer cost–reporting tools and oversee cost–report submissions required to support the study required under item (i) of this paragraph.

(3) The Commission shall assist the Department with the facilitation of the rate–setting study required under paragraph (2)(i) of this subsection, including by:

(i) Consulting with stakeholders, including community providers and individuals receiving services; and

(ii) Providing analytical support and technical assistance.

(4) The Behavioral Health Administration and the Medical Care Programs Administration jointly shall:

(i) Develop and implement a payment system incorporating the findings of the rate–setting study conducted under paragraph (2)(i) of this subsection; and

(ii) Consult with stakeholders, including community providers and individuals receiving services, in developing the payment system required under item (i) of this paragraph.

(5) The Administration shall adopt regulations to implement the payment system required by paragraph (4)(i) of this subsection.

(6) (i) The Secretary, or the Secretary's designee, shall designate a representative of the Administration to serve as a technical liaison between the Department and the Commission.

(ii) The technical liaison shall:

1. Provide technical input for the completion of the study required under paragraph (2)(i) of this subsection regarding Medicaid policy, behavioral health reimbursement structures, and existing data sources;

2. Ensure continuity between the Department's work regarding the completion of the study required under paragraph (2)(i) of this subsection and the Commission's facilitation of the Workgroup on Behavioral Health Rate Methodology Modernization established under Chapters 218 and 219 of the Acts of the General Assembly of 2026; and

3. Coordinate the Commission's access to existing analytical work or study preparation that has been completed by the Department in complying with paragraph (2) of this subsection.

(f) If services of community providers are provided through managed care organizations, the managed care organizations shall:

(1) Pay the rate in effect during the immediately preceding fiscal year for the first fiscal year the managed care organizations provide the services; and

(2) Adjust the rate for community providers each fiscal year by at least the same amount that otherwise would have been required under subsection (d) of this section.

(g) Increased funding provided under subsection (d) of this section may be used only to increase the rates paid to:

(1) Community providers accredited by a State–approved accrediting body and licensed by the State; and

(2) Health care providers who are acting within the scopes of practice of the health care providers' licenses or certificates as specified under the Health Occupations Article.

(h) (1) On or before January 1, 2028, the Commission shall submit an interim report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on:

(i) The delivery system through which community–based behavioral health services should be provided;

(ii) The status of the implementation of the recommendations of the Workgroup on Behavioral Health Rate Methodology Modernization established under Chapters 218 and 219 of the Acts of the General Assembly of 2026; and

(iii) Any preliminary recommendations regarding the payment system required under this section.

(2) On or before December 1, 2028, and on or before December 1 each year thereafter, the Commission shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the impact of the rate adjustments and the payment system required under this section on community providers, including the impact on:

(i) The wages and salaries paid and the benefits provided to direct care staff and licensed clinicians employed by community providers;

(ii) The tenure and turnover of direct care staff and licensed clinicians employed by community providers; and

(iii) The ability of community providers to recruit qualified direct care staff and licensed clinicians.

(3) The Commission may require a community provider to submit, in the form and manner required by the Commission, information that the Commission considers necessary for completion of the report required under paragraph (2) of this subsection.

§16–201.4.

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

(2) "Provider" means a provider of:

(i) Nursing home services;

(ii) Medical day care services;

(iii) Private duty nursing services;

(iv) Personal care services;

(v) Home– and community–based services; and

(vi) Services provided through the Community First Choice program.

(3) "Rate" means the reimbursement rate paid by the Department to providers of nursing home, medical day care, private duty nursing, personal care, and home– and community–based services and services provided through the Community First Choice program from the State General Fund, Maryland Medical Assistance Program funds, other State or federal funds, or a combination of these funds.

(b) (1) The Governor's proposed budget for fiscal year 2021 shall include a 4% rate increase for providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year in Program M00Q01.03 Medical Care Provider Reimbursements – Medical Care Programs Administration and Program M00Q01.07 Maryland Children's Health Program – Medical Care Programs Administration.

(2) The Governor's proposed budget for fiscal year 2022 shall include a 4% rate increase for providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year in Program M00Q01.03 Medical Care Provider Reimbursements – Medical Care Programs Administration and Program M00Q01.07 Maryland Children's Health Program – Medical Care Programs Administration.

(3) The Governor's proposed budget for fiscal year 2023 shall include a 4% rate increase for providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year in Program M00Q01.03 Medical Care Provider Reimbursements – Medical Care Programs Administration and Program M00Q01.07 Maryland Children's Health Program – Medical Care Programs Administration.

(4) The Governor's proposed budget for fiscal year 2024 shall include a 4% rate increase for providers over the funding provided in the legislative appropriation for the immediately preceding fiscal year in Program M00Q01.03 Medical Care Provider Reimbursements – Medical Care Programs Administration and Program M00Q01.07 Maryland Children's Health Program – Medical Care Programs Administration.

(5) The Governor's proposed budget for fiscal year 2021 and each fiscal year thereafter shall be presented in the same manner, including object and program information, as in the fiscal year 2020 budget.

§16–202.

(a) To determine the ability to pay for the cost of care of a recipient of services, the Department shall investigate the financial condition of:

(1) The recipient of services; and

(2) Each chargeable person to the extent that the recipient of services is unable to pay this cost of care.

(b) In determining the financial condition of persons under this section, public assistance payments shall be taken into consideration as financial resources.

(c) (1) In its investigations, the Department may require the recipient of services, any chargeable person, and any other person to submit reports to the Department on the forms that the Department provides.

(2) If any person refuses or otherwise fails to file a required report, on petition of the Department, the circuit court for the county where the person resides or does business may compel the filing of the report.

(d) (1) Notwithstanding any other provision of law to the contrary, the Department or its designated financial agent may obtain and use financial information and, if and when necessary, a summary of medical and psychological diagnoses regarding a recipient of services if the obtaining and use of this information is connected to the Department's billing and collection functions under this subtitle.

The Department shall obtain a release from the recipient of services or a chargeable person to secure information from a financial institution.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, all information obtained by the Department or its designated agent under paragraph (1) of this subsection shall be treated as confidential.

(ii) If the financial information is connected to the treatment or care of a recipient of services under this subtitle, the Department or its designated financial agent may disclose the financial information obtained under paragraph (1) of this subsection to a designated clinical representative of a facility.

(e) As to services that are provided by a political subdivision or grantee, the Department may delegate to the political subdivision or grantee the investigation of financial condition and the determination and collection of the amount payable. However, the political subdivision or grantee shall follow each law and each rule and regulation of the Department that relates to the investigation and determination.

§16–203.

(a) (1) The cost of care of a recipient of services shall be determined in accordance with the charges for services set under § 16–201 of this subtitle.

(2) Except as otherwise provided in this title:

(i) Payment for this cost of care shall be made by the recipient of services or a chargeable person;

(ii) Their liability for this payment is joint and several; and

(iii) The insured or policyholder may not withhold the payment and shall assign to the Department any benefits available under the policy for services rendered by the Department to any insured covered by the policy.

(3) Liability may not be imposed under this title on any spouse of a recipient of services, if the spouse has been abandoned by the recipient of services. The Department shall adopt rules and regulations that define abandonment for the purposes of this subsection.

(4) Liability may not be imposed under this title on a responsible relative if any responsible relative has been the victim of sexual abuse, physical abuse, or a crime of violence as defined in § 14–101 of the Criminal Law Article perpetrated by the recipient of services. The Department shall adopt regulations that

define "sexual abuse, physical abuse, or a crime of violence" as defined in § 14–101 of the Criminal Law Article for the purposes of this paragraph.

(b) (1) The Department:

(i) Shall set the time and amount of payments; and

(ii) May change its orders as to payments, as circumstances may warrant.

(2) In setting the amount of payments, the Department:

(i) Shall consider the financial means and abilities of the recipient of services and any chargeable person; and

(ii) May agree to accept less than the charges set for the services provided.

(c) (1) In this subsection, "total lifetime hospitalization" means the sum total of all periods of inpatient hospitalization for a recipient of services in any State hospital or facility whether these periods are intermittent or continuous.

(2) If a chargeable person has paid for the first 24 months of total lifetime hospitalization of a recipient of services, the liability of that chargeable person for care of the recipient of services after that period may not exceed 15 percent of the charges for services set under § 16-201 of this subtitle.

(3) The sum of any proceeds of applicable insurance, group health plan, or prepaid medical care that the insurer or plan pays because of liability for the payment of or repayment for the cost of care provided to the recipient of services does not count as payments paid by a chargeable person for the purpose of determining the total lifetime hospitalization of a recipient of services.

(d) The Department may set the amount of payments retroactively:

(1) For a period of not more than 6 months from the date when the Department sets the amount of payments; and

(2) After inquiry by the Department, for a greater period, if:

(i) The recipient of services, the responsible relatives of the recipient, or any other person, agency, or organization that has a summary of financial, medical, or psychological diagnoses about the recipient of services has failed or refused to give that information to the Department when the obtaining and use of

this information is connected to the Department's billing and collection functions under this subtitle; or

(ii) Any charges assessed third party insurers have been denied wholly or partly.

§16–204.

(a) (1) Except as provided in subsections (b) and (c) of this section, all payments made under this subtitle for services provided through a facility or program of the Department shall be:

(i) Made to and collected by the Department; and

(ii) Accounted for and paid into the General Fund of this State by the Department.

(2) If the Secretary has delegated to a political subdivision or grantee the collection of payments for services, the political subdivision or grantee shall collect and account for these payments in accordance with the rules and regulations of the Department.

(b) (1) The Department may collect fees from persons certified for Kidney Disease Program benefits prior to providing these benefits in accordance with Title 13, Subtitle 3 of this article. Any fee collected by the Department for kidney disease services may be kept by the Department only to maintain and operate the State Kidney Disease Program.

(2) Subject only to the limitations provided in Title 13, Subtitle 3 of this article and in the provisions of the State budget for the State Kidney Disease Program, the Department may require providers of services in State or privately operated kidney disease centers and providers of prescription drugs and other pharmaceutical products to seek all available third party reimbursement prior to billing the program.

(c) The Department may collect fees from a core service agency or local behavioral health authority for the cost of treatment of individuals whom the core service agency authorizes as eligible for admission into a State facility as described in Title 10, Subtitle 4 of this article. Any such fees collected by the Department for the admission and treatment of individuals authorized by the core service agency or local behavioral health authority shall be kept by the Department to be used to maintain and operate the respective State facility.

(d) (1) If a recipient of services dies, the Department may make a claim against the estate of the recipient for any unpaid fees established for that recipient.

(2) Except as provided in paragraph (4) of this subsection, a claim under this subsection may not include any fee for services provided more than 3 years before the recipient of services died.

(3) A claim made under this subsection is a preferred claim against the estate of a deceased recipient of services. The claim may be waived by the Department if, in its judgment, enforcement of the claim will cause substantial hardship to dependents of the deceased.

(4) If a responsible relative who is liable for the cost of care of the recipient of services has misrepresented assets or submitted fraudulent information and, by doing so, has avoided any part of the claim for the cost of care, there is no limitation on the time in which the claim may be brought against the estate.

(e) (1) The Department may institute any proceedings that the Department considers necessary to require collection of the established but uncollected payments.

(2) The Central Collection Unit in the Department of Budget and Management shall handle those delinquent accounts and debts that the Maryland Department of Health refers under § 3–202 of the State Finance and Procurement Article.

§16–205.

Instead of the requirements of this subtitle, the Department may accept those requirements that are set out in the Maryland Medical Assistance Plan or the federal laws and regulations under Title XIX of the Social Security Act and that govern the investigation of financial condition, standards of eligibility, and legal responsibility of recipients of services, their responsible relatives, legal representatives and estates, or other chargeable persons.

§16–206.

(a) For juvenile screening and treatment services that a unit of the Department provides under § 9–227(b)(1)(ii) of the Human Services Article, the Department shall bill and collect the cost of care as provided in this subtitle and as if the recipient of services were not a ward of this State.

(b) The Department of Juvenile Services shall pay for juvenile screening and treatment services that any person other than the Department provides under §

9–227(b)(1)(ii) of the Human Services Article. However, the Department later shall bill and collect this cost of care as provided in this subtitle.

§16–207.

The Department shall bill and collect the fee for a service of a public health and clinical laboratory as provided in this subtitle.

§16–208.

As far as practical, the rules and regulations enforcing this subtitle shall be applied uniformly to all individuals who receive services under programs that either are operated by the Department or supported wholly or partly by State or federal funds administered by the Department.

§16–301.

Except as otherwise provided in this subtitle, Subtitle 2 of this title applies to a recipient of services under the Maryland Mental Health Law.

§16–302.

(a) (1) Except as otherwise provided in this section, if any individual is examined under a court order by a representative of the Behavioral Health Administration, a reasonable cost of the examination shall be assumed by this State.

(2) The Administration is subrogated to any right or right of action that the individual examined has under the terms of any insurance policy to recover the costs of these services.

(b) If the examination is requested by the individual being examined:

(1) The individual is responsible for payment of the appropriate fee; and

(2) The Administration may ask and the court may require the individual to post a bond for payment of that fee.

§16–303.

(a) This section does not apply to funds that are derived from benefits payable under laws administered by the U.S. Department of Veterans Affairs.

(b) (1) If any property of an individual admitted under the Maryland Mental Health Law remains in the custody of a public facility for 1 year after the death or escape of the individual, the administrative head of the facility shall investigate to determine if any other person legally is entitled to that property.

(2) If such a person is not found:

(i) As much as possible of the account of the individual at the facility shall be paid from the property; and

(ii) Any balance becomes the property of this State and shall be paid into the General Fund of this State.

(c) (1) An action may not be brought more than 3 years after the death or escape of an individual to recover property of the individual left at or in the custody of the facility.

(2) This subsection does not waive any defense, including the defense of governmental immunity, available to any facility or other State agency in an action brought against it, even if the action is brought within 3 years after the death or escape of the individual.

§16–304.

State funding shall be as provided in the budget.

§16–401.

Except as otherwise provided in this subtitle, Subtitle 2 of this title applies to a recipient of services under the Maryland Developmental Disabilities Law.

§16–402.

When an individual enters a facility for comprehensive evaluation and when an individual with an intellectual disability is admitted to a public facility, each proponent of the admission shall be advised in writing, in clear and simple terms, of those provisions of this title that apply to that individual.

§16–403.

Notwithstanding any other provision of this title, the amount to be charged to chargeable persons for services received by a recipient of services under the Maryland Developmental Disabilities Law shall be as provided in this subtitle.

§16–404.

(a) If there is any insurance, group health plan, or prepaid medical care coverage for part or all of the cost of the care provided, the Department shall seek to collect the proceeds of the insurance, plan, or coverage to the full extent required to pay for the charges for services set under § 16–201 of this title. The insured or policyholder may not withhold the payment and shall assign to the Department any benefits available under the policy for services rendered by the Department to any insured covered by the policy.

(b) The liability of a chargeable person for services provided to an individual with an intellectual disability may not exceed the greater of:

(1) The sum of any proceeds of insurance, group health plan, or prepaid medical care that the insurer or plan pays because of liability for the payment of or repayment for the cost of care provided to the individual; or

(2) The lesser of:

(i) The amount determined under § 16–405 of this subtitle; or

(ii) The amount set by the Department under § 16–203(b) of this title.

(c) The liability of responsible relatives for the cost of care of an individual with an intellectual disability in a residential, State facility ceases when the cost of care of the individual with an intellectual disability has been charged for a period or periods that total 16 years.

§16–405.

(a) In this section, "taxable income" has the meaning that federal law gives to it for purposes of the Internal Revenue Code.

(b) For purposes of § 16–404(b)(2) of this subtitle, the liability of a chargeable person for the cost of care of an individual with an intellectual disability shall be determined in accordance with either of the following schedules, at the option of the chargeable person.

Schedule A

Schedule Based on Gross Monthly Income

Gross Monthly Income of Person Liable for Support	Monthly Rate of Contribution

At Least		Less Than	2 Dep.	3 Dep.	4 Dep.	5 Dep.	6 Dep.	7 Dep.	8 Dep.
$ 500	—	575	$16.00	$	$	$	$	$	$ .....
575	—	650	22.40	16.00	.....	.....	.....	.....	.....
650	—	725	25.60	22.40	19.20	16.00	.....	.....	.....
725	—	800	32.00	28.80	22.40	19.20	16.00	.....	.....
800	—	875	35.20	32.00	28.80	25.60	22.40	16.00	.....
875	—	950	43.20	39.20	35.20	32.00	25.60	22.40	19.20
950	—	1025	56.00	49.60	43.20	35.20	32.00	28.80	25.60
1025	—	1100	72.00	64.00	49.60	43.20	39.20	35.20	32.00
1100	—	1175	88.00	72.00	64.00	56.00	49.60	43.20	35.20
1175	—	1250	91.00	88.00	80.00	72.00	64.00	49.60	43.20
1250	—	1325	94.00	94.00	91.00	88.00	72.00	64.00	56.00
1325	—	1400	94.00	94.00	94.00	91.00	88.00	80.00	72.00
1400	—	1475	94.00	94.00	94.00	94.00	94.00	91.00	88.00
1475	—	1550	94.00	94.00	94.00	94.00	94.00	94.00	91.00
1550 and up			94.00	94.00	94.00	94.00	94.00	94.00	94.00

Schedule B

Schedule Based on Taxable Income Under Federal Internal Revenue Code

Annual Taxable Income of Person Liable for Support	Monthly Rate of Contribution
At least $4,000 but less than $5,000	$16.00
At least $5,000 but less than $6,000	22.40
At least $6,000 but less than $7,000	28.80
At least $7,000 but less than $8,000	35.20
At least $8,000 but less than $9,000	43.20
At least $9,000 but less than $10,000	56.00
At least $10,000 but less than $11,000	72.00
At least $11,000 but less than $12,000	88.00
At least $12,000	94.00

(c) To establish the taxable income, the chargeable person shall provide either a copy of a federal income tax return or an affidavit as to the taxable income reported on that federal income tax return.

(d) Any modification of liability for charges based on a federal income tax return shall become effective as of July 1 in each calendar year.

(e) (1) Within the time that the Secretary sets and on the forms that the Secretary provides, each chargeable person shall elect the schedule under which the chargeable person is to be billed.

(2) The election is effective as of the day that the individual with an intellectual disability first is admitted for service and remains in force until changed by the chargeable person.

(3) A change in the election is effective on July 1 after the date on which the Department is notified of the change.

(4) If a person fails to elect within the time that the Secretary sets, the Secretary shall determine which schedule is to apply.

(f) A person whose taxable income is less than $4,000 a year may not be charged any amount under this section.

(g) For purposes of this section, both parents of an individual with an intellectual disability shall be considered a single responsible relative.

§16–406.

(a) (1) Except as otherwise provided in this section, if any individual is examined under a court order by a representative of the Developmental Disabilities Administration, the cost of the examination shall be assumed by this State.

(2) The Administration is subrogated to any right or right of action that the individual examined has under the terms of any insurance policy to recover the costs of this service.

(b) If the examination is requested by the individual being examined:

(1) The individual is responsible for payment of the appropriate fee; and

(2) The Developmental Disabilities Administration may ask and the court may require the individual to post a bond for payment of that fee.

§16–407.

(a) This section does not apply to funds that are derived from benefits payable under laws administered by the Veterans' Administration.

(b) (1) If any property of an individual with an intellectual disability remains in the custody of a public facility for 1 year after the death or release of the individual with an intellectual disability, the Department shall investigate to locate the individual or to determine if any other person legally is entitled to that property.

(2) If such a person is not found:

(i) As much as possible of the account of the individual with an intellectual disability at the facility shall be paid from the property; and

(ii) Any balance becomes the property of this State and shall be paid into the General Fund of this State.

(c) (1) An action may not be brought more than 3 years after the death or release of an individual with an intellectual disability to recover any of this property left at or in the custody of the facility.

(2) This subsection does not waive any defense, including the defense of governmental immunity, available to any facility or other State agency in an action brought against it, even if the action is brought within 3 years after the death or release of the individual with an intellectual disability.

§17–101.

The Secretary shall determine the number and location of public health laboratories and maintain those laboratories as needed to provide testing, consulting, and regulatory support of infectious disease, epidemiology, environmental, and regulatory public health programs.

§17–102.

A public health and clinical laboratory shall provide services in connection with:

(1) Any inquiry that the Department or any health officer or physician makes about a communicable disease;

(2) Any inquiry that the Department makes about sewage;

(3) Any inquiry that the Department makes about a trade waste;

(4) Any inquiry the Department makes about a nuisance;

(5) Any examination or analysis of a water supply;

(6) Any examination or analysis of milk; and

(7) Any inquiry about any other matter that the Secretary requires.

§17–103.

(a) Except as otherwise provided, the Secretary may set a fee for any service of a public health and clinical laboratory in accordance with § 2–104 of this article.

(b) Except as provided in subsection (c) of this section, the Secretary may not impose any fee for any service of a public health and clinical laboratory in connection with:

(1) An examination or analysis of a water supply;

(2) An examination or analysis of milk; or

(3) An inquiry that any health officer or physician makes about a communicable disease.

(c) Subsection (b)(2) of this section does not apply to the production of farmstead cheese.

§17–103.1.

(a) In this section, "Fund" means the Laboratory Testing Fund.

(b) There is a Laboratory Testing Fund in the Department for the provision of laboratory services associated with the production of farmstead cheese.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) Any unspent portion of the Fund and any investment earnings of the Fund may not be transferred or revert to the General Fund of the State, but shall remain in the Fund.

(e) The Fund consists of any laboratory testing fees collected by the Department for laboratory services associated with the production of farmstead cheese.

(f) The Fund shall only be used to support the operations of the Laboratories Administration.

§17–104.

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

(2) "Mutual aid agreement" means a written agreement between a public health laboratory in the State and a public health laboratory operated by another state to establish and carry out a plan to assist each other in providing temporary testing services to alleviate an emergency at one of the laboratories.

(3) "Public health laboratory" means a laboratory operated by a state government to provide:

(i) Consulting and regulatory support of infectious disease, epidemiology, environmental, and regulatory public health programs; and

(ii) Tests or examinations in connection with:

1. The diagnosis and control of human diseases;

2. The assessment of human health, nutritional, or medical conditions; or

3. The environment.

(b) This section shall be liberally construed to promote its purpose of providing aid during an emergency at a public health laboratory.

(c) (1) A public health laboratory in the State may enter into or renew a mutual aid agreement with a public health laboratory operated by another state.

(2) A public health laboratory operated by another state that enters into a mutual aid agreement shall provide written documentation of the statutory authority required for that state to meet the responsibilities set forth in the agreement.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, a mutual aid agreement shall provide that the party requesting assistance under the agreement shall indemnify and hold harmless the public health laboratory that provides assistance and its authorized personnel from any claim by a third party for property damage, personal injury, or wrongful death that arises out of activities, including travel, that are authorized by the agreement.

(ii) The party that requests assistance need not indemnify the party that provides assistance if:

1. The party that provides assistance does not cooperate in defending against a claim made by a third party;

2. The claim by a third party arises out of a malicious or grossly negligent act of the party that provides assistance; or

3. The claim by a third party arises out of an act that is outside of the scope of the duties under the agreement of the party that provides assistance.

(4) A mutual aid agreement shall provide that each party to the agreement shall waive any claim against any other parties to the agreement if the claim arises out of the activities of a party that are within the scope of the agreement and that are performed without malice or gross negligence.

(d) (1) Subject to paragraph (2) of this subsection, an employee of a public health laboratory who has been trained and certified by the director of the employee's public health laboratory may travel to and provide services at the location of the emergency under a mutual aid agreement at the request of the Secretary, the Secretary's designee, or an individual from another state with equivalent authority under the agreement.

(2) An employee may not travel to or provide services at the location of the emergency under a mutual aid agreement until the Secretary, the Secretary's designee, or equivalent authority in another state approves the employee to travel to and provide services at the location of the emergency.

(e) For purposes of workers' compensation law or any other employment benefit that would apply to an individual who is performing a service for a public health laboratory under a mutual aid agreement:

(1) The individual is considered to have performed that service in the course of employment as a State employee and in the line of duty; and

(2) The workers' compensation law or employment benefit of the state that employs the individual shall be provided by that state when an individual is performing a service in another state.

(f) Necessary expenditures made under a mutual aid agreement or otherwise made under this section may be charged against any State or local appropriations that are usually available to a public health laboratory.

§17–201.

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

(b) "License" means a permit, letter of exception, certificate, or other document issued by the Secretary granting approval or authority to:

(1) Offer or perform medical laboratory tests or examinations in this State;

(2) Offer or perform medical laboratory tests or examinations on specimens acquired from health care providers in this State at a medical laboratory located outside this State; or

(3) Represent or service in this State a medical laboratory regardless of the laboratory's location.

(c) (1) "Medical laboratory" means any facility, entity, or site that offers or performs tests or examinations in connection with the diagnosis and control of human diseases or the assessment of human health, nutritional, or medical conditions or in connection with job-related drug and alcohol testing.

(2) "Medical laboratory" includes any laboratory owned or operated by the State or owned or operated by a county or municipal corporation in the State.

§17–202.

(a) (1) The Secretary shall adopt regulations that set standards and requirements for medical laboratories.

(2) The regulations shall contain the standards and requirements that the Secretary considers necessary to assure the citizens of this State that medical laboratories provide safe and reliable services.

(b) To assure compliance with the standards and requirements adopted in regulations pursuant to this subtitle, the Secretary shall:

(1) Conduct an inspection of each medical laboratory for which a license to operate is sought; and

(2) Conduct an inspection periodically of each medical laboratory for which a license has been issued.

(c) (1) In addition to the regulations adopted under subsection (a) of this section, the Secretary shall adopt regulations establishing specific standards for medical laboratories engaged in cytology, including regulations that:

(i) Limit the number of slides an individual may examine;

(ii) Require that the examination of cytology slides be performed in a medical laboratory that has a license issued by the Secretary;

(iii) Prohibit payment to cytotechnologists for the examination of cytology specimens or slides on a piecework basis;

(iv) Require cytology laboratories to review no less than 10 percent of all negative gynecological slides;

(v) Require that the cytology review be performed by an individual who qualifies as a supervisory cytotechnologist or a pathologist;

(vi) Require the individual who directs the laboratory to establish and administer an ongoing quality assurance program using standards acceptable to the Secretary;

(vii) Require cytology laboratories to reject unsatisfactorily prepared specimens, make appropriate comments regarding the quality of the specimen, and maintain records on unsatisfactorily prepared specimens for 5 years subject to review by the Department;

(viii) Require cytology laboratories to maintain and store for 5 years from the date of examination any slide that was examined;

(ix) Require all cytology reports to be retained for at least 10 years;

(x) Prohibit any person from sending cytology specimens to a laboratory, including out–of–state laboratories, not licensed by the Department;

(xi) Require all individuals who examine gynecological slides acquired from persons in this State to demonstrate satisfactory performance in an approved cytology proficiency testing program; and

(xii) Establish any additional standards the Secretary considers necessary to assure that medical laboratories engaged in cytology provide safe and reliable services.

(2) The requirements of paragraph (1) of this subsection are in addition to any other relevant provision of this subtitle or relevant regulation adopted in accordance with any other provision of this subtitle governing medical laboratories.

(d) (1) To assure compliance with standards adopted under subsection (c) of this section, the Secretary shall adopt regulations to establish and conduct a cytology proficiency testing program for all cytology personnel that examine gynecological cytology specimens.

(2) All cytology proficiency tests under the State cytology proficiency testing program shall be conducted by an employee of the Maryland Department of Health who shall:

(i) Hand carry all testing materials to the testing site; and

(ii) Directly supervise the on–site proficiency testing.

(3) The Secretary shall adopt regulations for the cytology proficiency testing program that:

(i) Define satisfactory cytology proficiency testing performance; and

(ii) Set standards and requirements that a cytology proficiency testing program must meet before it can be designated an approved program.

(4) The Secretary may accept the testing results of an approved cytology proficiency testing program as meeting the cytology proficiency testing requirement of this subtitle.

§17–202.1.

(a) On written request of an individual to a medical laboratory for a copy of the results of a laboratory examination of that individual, the medical laboratory shall send a copy of those results that are sought to that individual.

(b) (1) If the results of a laboratory examination are contained in or will be filed in a medical record, as defined in § 4-301 of this article, the request for a copy of the results shall be made to the facility pursuant to the provisions of § 4-302 of this article.

(2) In all other cases, the medical laboratory may require the individual requesting a copy of the results to pay the prevailing cost of copying and transmitting the copy.

(c) The medical laboratory shall notify the individual's physician before sending the results to the individual.

§17–203.

(a) The Secretary may adopt regulations that set qualifications for the following personnel of medical laboratories:

(1) Directors;

(2) Supervisory technologists;

(3) Technologists;

(4) Cytotechnologists; and

(5) Supervisory cytotechnologists.

(b) The director of a medical laboratory is not required to be a physician licensed under the Health Occupations Article.

§17–205.

(a) Except as provided in §§ 10–14A–03 and 10–14B–03 of the State Government Article, a person shall hold a license issued by the Secretary before the person may:

(1) Offer or perform medical laboratory tests or examinations in this State;

(2) Offer or perform medical laboratory tests or examinations on specimens acquired from health care providers in this State at a medical laboratory located outside this State; or

(3) Represent or service in this State a medical laboratory regardless of the laboratory's location.

(b) The Secretary shall issue a letter of exception to a laboratory that:

(1) Performs only limited medical laboratory tests or examinations; and

(2) Meets the exception requirements in regulations adopted by the Secretary pursuant to this subtitle.

(c) For the purposes of this section, "limited medical laboratory tests or examinations" means medical laboratory procedures as defined in regulations adopted by the Secretary pursuant to this subtitle.

(d) If preliminary screening procedures are performed by an operator who is trained under § 17–214(k) of this subtitle, an employer:

(1) Is not required to obtain a permit or to obtain a letter of exception from the Secretary under this section to perform testing; but

(2) Is required before performing preliminary screening procedures, as defined under § 17–214(a) of this subtitle, to register with the Secretary in accordance with requirements adopted in regulations by the Maryland Department of Health.

§17–206.

To qualify for a license, an applicant shall provide evidence to satisfy the Secretary that the medical laboratory and its personnel meet the standards and requirements of the subtitle and in regulations adopted by the Secretary pursuant to this subtitle.

§17–207.

(a) An applicant for a license shall submit an application to the Secretary on the form that the Secretary requires.

(b) An application for a license to operate a medical laboratory shall include:

(1) The name of the owner;

(2) The classes of services, complexity of testing, or the tests or examinations that the medical laboratory would provide; and

(3) Any other information that the Secretary requires.

§17–208.

(a) The Secretary shall issue a license to any applicant who meets the standards and requirements of this subtitle and in regulations adopted pursuant to this subtitle.

(b) A medical laboratory license shall include the name of the:

(1) Medical laboratory;

(2) Laboratory director; and

(3) Owner of the laboratory.

(c) A medical laboratory license shall designate the:

(1) Complexity of testing that the laboratory may offer or perform;

(2) Classes of services that may be offered;

(3) Tests or examinations that may be offered or performed by the laboratory; or

(4) Any combination of items (1), (2), and (3) of this subsection.

(d) A medical laboratory may not operate in any manner beyond what is designated by its license.

(e) A medical laboratory license issued by the Secretary under this subtitle is not transferable.

§17–210.

(a) The Secretary may deny a license to any applicant or suspend, revoke, or limit a license or the authority to offer or perform any class of service, complexity of testing, or tests that the license sets forth, if the medical laboratory or its director or other personnel fail to meet the standards and requirements under this subtitle and in regulations adopted pursuant to this subtitle.

(b) (1) If the Secretary finds that a laboratory issued a license under this subtitle no longer meets the standards and requirements under this subtitle and in regulations adopted pursuant to this subtitle, the Secretary may impose a directed plan of correction or limit the testing authorized by the license instead of suspending or revoking a license.

(2) (i) If the Secretary finds that a medical laboratory provided erroneous or questionable test results that pose a threat to the health and safety of patients, the Secretary may order the laboratory to:

1. Notify the physicians or other individuals who ordered the tests of the erroneous or questionable test results; and

2. Take any additional measures necessary to reduce or eliminate the threat to the health and safety of patients, including the notification of patients and the offering of retests.

(ii) A medical laboratory that fails to comply with an order issued by the Secretary under subparagraph (i) of this paragraph is subject to a civil penalty of up to $1,000 for each day of noncompliance after the deadline for compliance stated in the Secretary's order, not to exceed a maximum penalty of $50,000, instead of or in addition to any other sanction imposed under this section.

(c) Except as otherwise provided in the Administrative Procedure Act, before the Secretary denies, suspends or revokes a license, or imposes a civil penalty under this section, the Secretary shall give the applicant or licensee notice and an opportunity for a hearing.

§17–211.

(a) A laboratory issued a license under this subtitle shall enroll in and continue to demonstrate satisfactory performance as defined by the Secretary by regulations in a proficiency testing program or programs approved by the Secretary.

(b) The Secretary shall adopt regulations that:

(1) Define satisfactory proficiency testing performance; and

(2) Set the standards and requirements that a proficiency testing program must meet before it can be designated as an approved program.

§17–212.

Unless a person holds a license issued by the Secretary the person may not:

(1) Offer or perform medical laboratory tests or examinations in this State;

(2) Represent or service in this State a medical laboratory regardless of the laboratory's location; or

(3) Offer or perform medical laboratory tests or examinations on specimens acquired from health care providers in this State at a medical laboratory located outside this State.

§17–213.

Unless a medical laboratory has a valid license, no other person on the laboratory's behalf may:

(1) Offer or perform medical laboratory tests or examinations in this State;

(2) Offer or perform medical laboratory tests or examinations on specimens acquired from health care providers in this State at the medical laboratory located outside this State; or

(3) Represent or service in this State the medical laboratory regardless of the laboratory's location.

§17–214.

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

(2) "Alcohol or controlled dangerous substance testing" means a procedure used to determine whether or not a specimen contains a controlled dangerous substance or alcohol.

(3) "Certification" means the approval granted by the Department for a laboratory to engage in job–related alcohol or controlled dangerous substance testing.

(4) "Controlled dangerous substance" has the meaning stated in § 5–101 of the Criminal Law Article.

(5) "Job applicant" means an individual who:

(i) Has applied for a position with an employer; and

(ii) Is not currently employed by the employer.

(6) "Job–related" means any alcohol or controlled dangerous substance testing used by an employer for a legitimate business purpose.

(7) "Laboratory" means a facility or other entity that conducts job–related alcohol or controlled dangerous substance testing.

(8) "Medical review officer" means a licensed physician with knowledge of drug abuse disorders and drug and alcohol testing.

(9) "Preliminary screening procedure" means a controlled dangerous substance test that uses a single–use test device that:

(i) Is easily portable and can be administered at a work site or other appropriate collection site;

(ii) Meets the requirements of the federal Food and Drug Administration for commercial distribution; and

(iii) Meets generally accepted cutoff levels such as those in the federal Substance Abuse and Mental Health Services Administration Guidelines for drug–free workplace testing programs.

(10) "Single–use test device" means the reagent–containing unit of a test system that:

(i) Is in the form of a sealed container or cartridge that has a validity check, a nonresealable closure, or an evidentiary tape that ensures detection of any tampering;

(ii) Is self–contained and individually packaged;

(iii) Is discarded after each test; and

(iv) Does not allow any test component or constituent of a test system to interact between tests.

(11) "Specimen" means:

(i) Blood derived from the human body;

(ii) Urine derived from the human body;

(iii) Hair derived from the human body as provided in subsection (b)(3) of this section; or

(iv) Saliva derived from the human body.

(b) (1) Except as provided in paragraph (2) of this subsection, an employer who requires any person to be tested for job–related reasons for the use or abuse of any controlled dangerous substance or alcohol shall:

(i) Have the specimen tested by a laboratory that:

1. Holds a permit under this subtitle; or

2. Is located outside of the State and is certified or otherwise approved under subsection (f) of this section; and

(ii) At the time of testing, at the person's request, inform the person of the name and address of the laboratory that will test the specimen.

(2) (i) 1. Except as provided in subsubparagraph 2 of this subparagraph, an employer may use a preliminary screening procedure to test a job applicant for the use or abuse of any controlled dangerous substance.

2. Subsubparagraph 1 of this subparagraph does not apply to an employer that has entered into a collective bargaining agreement that prohibits the employer from using a preliminary screening procedure to test a job applicant for the use or abuse of any controlled dangerous substances.

(ii) If the result of a preliminary screening procedure is positive, the employer shall submit the specimen for testing by a laboratory as required under paragraph (1) of this subsection.

(iii) Following voluntary disclosure and documentation by an applicant of the taking of a legally prescribed medication, an employer may hire the applicant pending confirmation of a positive test result by the medical laboratory and review by the employer's medical review officer.

(iv) An employer may not use a preliminary screening procedure to test an individual who is not applying for a job with that employer.

(v) An employer may designate a medical laboratory licensed to perform job–related testing for controlled dangerous substances to also perform preliminary screening procedures on job applicants for the employer.

(3) (i) An employer who requires any person to be tested for job–related reasons for the use or abuse of any controlled dangerous substance may use hair derived from the human body as a specimen in accordance with this paragraph.

(ii) An employer may use hair derived from the human body only for pre–employment purposes.

(iii) If an employer uses hair derived from the human body as a specimen, the employer may not:

1. Use a specimen that is longer than one and one–half inches measured from the human body; or

2. Use the specimen for any purpose other than testing for controlled dangerous substances.

(c) (1) An employer who requires any employee, contractor, or other person to be tested for job–related reasons for the use or abuse of any controlled dangerous substance or alcohol and who receives notice from the laboratory under subsection (b) of this section that an employee, contractor, or other person has tested positive for the use or abuse of any controlled dangerous substance or alcohol shall, after confirmation of the test result, provide the employee, contractor, or other person with:

(i) A copy of the laboratory test indicating the test results;

(ii) A copy of the employer's written policy on the use or abuse of controlled dangerous substances or alcohol by employees, contractors, or other persons;

(iii) If applicable, written notice of the employer's intent to take disciplinary action, terminate employment, or change the conditions of continued employment; and

(iv) A statement or copy of the provisions set forth in subsection (e) of this section permitting an employee to request independent testing of the same sample for verification of the test result.

(2) The information required to be provided to the employee, contractor, or other person under paragraph (1) of this subsection shall be delivered to the employee, contractor, or other person:

(i) Either in person or by certified mail; and

(ii) Within 30 days from the date the test was performed.

(d) An employer that uses a preliminary screening procedure to test specimens for the use or abuse of a controlled dangerous substance under this section shall:

(1) In using a single–use test device, collect, handle, store, and ship each specimen in a manner that:

(i) Maintains the specimen donor's identity and confidentiality and the physical integrity of the specimen; and

(ii) Precludes contamination of the specimen; and

(2) Maintain a written record of the chain of custody of each specimen from the time that the specimen is collected until the time that the specimen is no longer needed for retesting.

(e) (1) A person who is required to submit to job–related testing, under subsection (b) or (c) of this section, may request independent testing of the same specimen for verification of the test results by a laboratory that:

(i) Holds a permit under this subtitle; or

(ii) If located outside of the State, is certified or otherwise approved under subsection (f) of this section.

(2) The person shall pay the cost of an independent test conducted under this subsection.

(f) (1) The Maryland Department of Health:

(i) Shall adopt regulations governing the certification of laboratories that conduct job–related alcohol or controlled dangerous substance testing; and

(ii) May adopt regulations governing the oversight of preliminary screening procedures administered by employers.

(2) In addition to any other laboratory standards, the regulations shall:

(i) Require that the laboratory comply with the guidelines for laboratory accreditation, if any, as set forth by the College of American Pathologists, the Centers for Medicare and Medicaid Services, or any other government agency or program designated to certify or approve a laboratory that is acceptable to the Secretary;

(ii) Require that a laboratory performing confirmation tests for controlled dangerous substances or alcohol be inspected and accredited in forensic drug analysis by the College of American Pathologists, the Centers for Medicare and Medicaid Services, or any other government agency or program designated to inspect and accredit a laboratory that is acceptable to the Secretary;

(iii) Require that, if the laboratory performs job–related drug testing, the laboratory be a participant in a program of proficiency testing of drug screening conducted by an organization acceptable to the Secretary;

(iv) Require that the laboratory comply with standards regarding cutoff levels for positive testing that are established by the United States Department of Health and Human Services or established by the Secretary as mandatory guidelines for workplace drug testing programs; and

(v) Include procedures for inspection.

(g) This section does not apply to:

(1) Alcohol or controlled dangerous substance testing of a person under arrest or held by a law enforcement or correctional agency;

(2) Alcohol testing procedures conducted by a law enforcement or correctional agency on breath testing equipment certified by the toxicologist in the Department of State Police Forensic Sciences Division; or

(3) Controlled dangerous substance testing by a laboratory facility of a law enforcement or correctional agency that maintains laboratory testing standards comparable to the standards in this section.

(h) This section applies to job–related alcohol and controlled dangerous substance testing of any person, including preemployment applicants, employees, and contractors.

(i) (1) Except as provided in paragraphs (2) and (3) of this subsection, in the course of obtaining information for, or as a result of, conducting job–related alcohol or controlled dangerous substance testing for an employer under this section, a laboratory, a physician, including a physician retained by the employer, or any other person may not reveal to the employer information regarding:

(i) The use of a nonprescription drug, excluding alcohol, that is not prohibited under the laws of the State; or

(ii) The use of a medically prescribed drug, unless the person being tested is unable to establish that the drug was medically prescribed under the laws of the State.

(2) The prohibitions against disclosure of information under paragraph (1) of this subsection do not apply to the extent that they prevent a person

from complying with the applicable provisions of the federal Commercial Motor Vehicle Safety Act of 1986 and the federal Motor Carrier Safety Regulations.

(3) The prohibitions against disclosure of information under paragraph (1) of this subsection do not apply if, prior to the administration of a preliminary screening for controlled dangerous substances, the test operator notifies the applicant that if the preliminary test is positive, the applicant may voluntarily disclose and provide documentation to the operator that the applicant is taking a legally prescribed medication.

(j) (1) An employer using preliminary screening procedures to test job applicants under this section shall have a medical review officer review a positive test result after laboratory confirmation of the positive test result.

(2) The employer may contract for the services of an outside medical review officer if the employer does not have a medical review officer on staff.

(k) (1) An employer using preliminary screening procedures shall establish a program to train individuals to collect specimens and perform controlled dangerous substance tests in the workplace.

(2) The employer may designate an employee or any other individual to be trained, including any individual employed by a medical laboratory designated under subsection (b)(2)(v) of this section who will perform preliminary screening procedures for the employer.

(3) A trainee shall receive appropriate and practical instruction, which includes:

(i) A reading of the test manufacturer's package insert sheet;

(ii) Observing the test manufacturer's training video or receiving training from the test manufacturer;

(iii) Completing the test manufacturer's self–administered test; and

(iv) The actual performance of tests and the actual interpretation of the results.

(4) (i) The employer shall:

1. Keep a record of the training received by each trainee; and

2. Establish a procedure for training each trainee as having received the minimum training required to properly perform the test.

(ii) After the trainee has demonstrated competency in performing the test, the employer shall maintain documentation that indicates that the trainee has been trained under this section.

(l) The provisions of a collective bargaining agreement that concern drug testing override and preempt the provisions of this section that authorize an employer to use a preliminary screening procedure to test a job applicant.

§17–215.

(a) Except as provided in subsection (b) of this section, a person may not directly or indirectly advertise for or solicit business in this State for any medical laboratory, regardless of location, from anyone except a physician, hospital, medical laboratory, clinic, clinical installation, or other medical care facility.

(b) (1) (i) This subsection applies only to:

1. A diagnostic laboratory test or procedure for the purpose of screening, diagnosing, managing, or treating a physical or mental condition or disease; and

2. Ancestry testing using Y–chromosome mitochondrial DNA or autosomal DNA testing limited to the detection and reporting of genetic evidence of parental lineage and genetic ethnicity.

(ii) This subsection does not apply to germline genetic or genomic testing done in connection with the analysis, diagnosis, or prediction of human diseases.

(2) Subject to paragraph (3) of this subsection, a person may directly or indirectly advertise for or solicit business in the State for a diagnostic laboratory test or procedure ordered by a physician and performed by a medical laboratory certified under 42 U.S.C. § 263a.

(3) A person that directly or indirectly advertises for or solicits business in the State for a diagnostic laboratory test or procedure under this subsection:

(i) Is a covered entity or business associate of a covered entity for purposes of the federal Health Insurance Portability and Accountability Act of

1996 and the federal Health Information Technology for Economic and Clinical Health Act;

(ii) May not make a claim about the reliability and validity of the test or procedure that is inconsistent with the test or procedure's performance as measured under 42 U.S.C. § 263a; and

(iii) Shall disclose that the diagnostic laboratory test or procedure may or may not be covered by health insurance.

(4) The Secretary may take legal action to restrict the marketing of a diagnostic laboratory test or procedure if the Secretary determines that:

(i) There is a public health threat; or

(ii) The diagnostic laboratory test or procedure is not in compliance with the requirements of this section.

§17–216.

A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 for the first offense and not exceeding $500 for each subsequent conviction for a violation of the same provision. Each day a violation is continued after the first conviction is a subsequent offense.

§17–217.

(a) The Secretary shall establish a Laboratory Advisory Committee to advise the Secretary on matters relating to the implementation of the provisions of this subtitle.

(b) The Advisory Committee shall consist of:

(1) At least the following representatives appointed biennially from a list of eligibles:

(i) 1 member of the American Academy of Family Practitioners;

(ii) 1 member of the American Academy of Pediatricians;

(iii) 1 member of the American College of Physicians;

(iv) 1 member of the American Society for Clinical Pathology; and

(v) 1 member of the American College of Pathology; and

(2) 1 representative of the Advanced Medical Technology Association.

(c) The Secretary may appoint any other individuals or representatives at the Secretary's discretion.

(d) The chairman of the Advisory Committee shall be designated by the Secretary every 2 years.

§17–2A–01.

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

(b) (1) "Forensic analysis" means a medical, chemical, toxicologic, firearms, or other expert examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal act.

(2) "Forensic analysis" includes an examination or test required by a law enforcement agency, prosecutor, criminal suspect or defendant, or court.

(3) "Forensic analysis" does not include:

(i) A test of a specimen of breath or blood to determine alcohol concentration or controlled dangerous substance content;

(ii) Forensic information technology;

(iii) A presumptive test performed at a crime scene;

(iv) A presumptive test performed for the purpose of determining compliance with a term or condition of community supervision or parole and conducted by or under contract with a county department of corrections or the State Department of Public Safety and Correctional Services; or

(v) An expert examination or test conducted principally for the purpose of scientific research, medical practice, civil or administrative litigation, or any other purpose unrelated to determining the connection of physical evidence to a criminal act.

(c) "Forensic information technology" means digital or electronic evidence that is stored or transmitted electronically.

(d) (1) "Forensic laboratory" means a facility, entity, or site that offers or performs forensic analysis.

(2) "Forensic laboratory" includes a laboratory owned or operated by the State, a county or municipal corporation in the State, or another governmental entity.

(3) "Forensic laboratory" does not include:

(i) A forensic laboratory operated by the federal government; or

(ii) A laboratory licensed or certified by the Department of Agriculture.

(e) "License" means a permit, letter of exception, certificate, or other document issued by the Secretary granting approval or authority to offer or perform forensic laboratory tests, examinations, or analyses in the State.

(f) "Limited forensic analysis" means a forensic laboratory test or analysis defined in regulations adopted by the Secretary.

(g) "Physical evidence" means any object, thing, or substance relating to a criminal act.

§17–2A–02.

(a) (1) The Secretary shall adopt regulations that set standards and requirements for forensic laboratories.

(2) The regulations shall contain the standards and requirements that the Secretary considers necessary to assure the citizens of the State that forensic laboratories provide safe, reliable, and accurate services.

(3) The regulations shall:

(i) Require the director of a forensic laboratory to establish and administer an ongoing quality assurance program using standards acceptable to the Secretary;

(ii) Require the director of a forensic laboratory to retain all case files for at least 10 years;

(iii) Establish qualifications for the personnel of forensic laboratories;

(iv) Establish procedures for verifying the background and education of the personnel of forensic laboratories; and

(v) Establish any additional standards that the Secretary considers necessary to assure that forensic laboratories provide accurate and reliable services.

(b) (1) A forensic laboratory that examines or analyzes physical evidence shall demonstrate satisfactory performance in an approved proficiency testing program specifically related to the particular forensic analysis being performed.

(2) The Secretary shall adopt regulations for the forensic proficiency testing program that:

(i) Define satisfactory proficiency testing performance; and

(ii) Set standards and requirements that a forensic proficiency testing program shall meet.

(3) The Department shall review a forensic laboratory's proficiency testing program.

(c) To assure compliance with the standards and requirements under this subtitle, the Secretary shall conduct:

(1) An inspection of each forensic laboratory for which a license to operate is sought; and

(2) An inspection of each forensic laboratory for which a license has been issued.

(d) To assure compliance with the standards and requirements under this subtitle, the Secretary may conduct:

(1) A complaint investigation; and

(2) A validation survey of an accredited forensic laboratory.

§17–2A–03.

(a) Forensic laboratory deficiency statements and plans of correction are public documents.

(b) A forensic laboratory shall make discrepancy logs, contamination records, and test results available to the public within 30 days of a written request.

(c) Except as provided in subsection (a) of this section, the proceedings, records, and files of an organization or State agency responsible for assuring compliance with this subtitle shall be confidential and not discoverable or admissible in evidence in a civil or criminal action.

§17–2A–04.

(a) After December 31, 2011, a forensic laboratory shall hold a license issued by the Secretary before the forensic laboratory may offer or perform forensic analysis in the State.

(b) The Secretary shall issue a letter of exception to a laboratory that:

(1) Performs only limited forensic analysis; and

(2) Meets the exception requirements in regulations adopted by the Secretary.

(c) The Secretary may grant an out–of–state forensic laboratory a waiver from the licensure requirements of this subtitle with conditions.

§17–2A–05.

To qualify for a license, an applicant shall provide evidence to satisfy the Secretary that the forensic laboratory and its personnel meet the standards and requirements of this subtitle.

§17–2A–06.

(a) An applicant for a license shall submit an application to the Secretary on the form that the Secretary requires.

(b) An application for a license to operate a forensic laboratory shall include:

(1) The name of the operator or owner;

(2) The tests or examinations that the forensic laboratory would provide; and

(3) Any other information that the Secretary requires.

§17–2A–07.

(a) The Secretary shall issue a license to an applicant that meets the standards and requirements of this subtitle.

(b) A forensic laboratory license shall include the name of the:

(1) Forensic laboratory;

(2) Laboratory director; and

(3) Operator or owner of the laboratory.

(c) A forensic laboratory license shall designate the tests, examinations, or analyses that may be offered or performed by the laboratory.

(d) A forensic laboratory may not operate in a manner not designated by the license issued under this subtitle.

(e) A forensic laboratory license issued by the Secretary under this subtitle is not transferable.

§17–2A–09.

(a) The Secretary may deny a license to an applicant or suspend, revoke, or limit a license or the authority of a licensee to offer or perform tests that a license sets forth, if the forensic laboratory or its director or other personnel fail to meet the standards and requirements of this subtitle.

(b) (1) If the Secretary finds that a forensic laboratory licensed under this subtitle no longer meets the standards and requirements of this subtitle, the Secretary may:

(i) Revoke the license of the forensic laboratory; or

(ii) Suspend the license of the forensic laboratory.

(2) If a deficiency exists, the Secretary may:

(i) Impose a directed plan of correction;

(ii) Regularly inspect the forensic laboratory to assure compliance with the directed plan of correction; or

(iii) Limit the testing authorized by the license.

(c) If the Secretary finds that a forensic laboratory provided erroneous or questionable test results, the Secretary may order the laboratory to provide written notification to:

(1) The person or agency that ordered the tests;

(2) The Office of the Public Defender or counsel of record; and

(3) The State's Attorney.

(d) A State's Attorney who receives notification from a laboratory under subsection (c) of this section shall notify the victim of the criminal act or the victim's representative of the erroneous or questionable test results.

(e) A forensic laboratory that fails to comply with an order issued by the Secretary under subsection (c) of this section is subject to a civil penalty of up to $1,000 for each day of noncompliance after the deadline for compliance stated in the Secretary's order, not to exceed a maximum penalty of $50,000.

(f) Except as otherwise provided in the Administrative Procedure Act, before the Secretary denies, suspends, or revokes a license, or imposes a civil penalty under this section, the Secretary shall give the applicant or licensee notice and an opportunity for a hearing.

§17–2A–10.

(a) In this section, "discriminate or retaliate" includes:

(1) Failing to promote an individual or to provide another employment–related benefit for which the individual would otherwise be eligible;

(2) Making an adverse evaluation or decision in relation to accreditation, certification, credentialing, or licensing of the individual; or

(3) Taking a personnel action that is adverse to the individual concerned.

(b) An employee who works in a forensic laboratory may disclose information to the Secretary that the employee believes evidences a violation of standards and requirements for forensic laboratories in the State.

(c) A forensic laboratory may not discriminate or retaliate against an employee because the employee:

(1) Discloses information under subsection (b) of this section; or

(2) Has agreed to cooperate with an investigation of the forensic laboratory.

(d) (1) The Secretary shall develop, through regulation, a document that informs the employees of a forensic laboratory of the procedures to report instances of noncompliance or other violations of the standards and requirements for forensic laboratories in the State.

(2) The Secretary shall distribute the document developed under paragraph (1) of this subsection to forensic laboratories in the State.

(e) A forensic laboratory shall post the document developed under subsection (d) of this section in a conspicuous place.

(f) An employee of a forensic laboratory who has been discriminated or retaliated against in violation of subsection (c) of this section may initiate an action and, on prevailing, shall be entitled to:

(1) Reinstatement;

(2) Reimbursement for lost wages;

(3) Work benefits lost as a result of the unlawful acts of the employing laboratory; and

(4) Reasonable attorney's fees and costs associated with pursuing the action.

(g) No action may be brought under this subsection more than 2 years after the discrimination or retaliation that is the basis for the action.

§17–2A–11.

(a) A person that violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to:

(1) A fine not exceeding $100 for the first offense; and

(2) A fine not exceeding $500 for each subsequent conviction for a violation of the same provision.

(b) Each day on which a violation occurs is a separate violation under this section.

§17–2A–12.

(a) The Governor shall establish a Forensic Laboratory Advisory Committee to advise the Secretary on matters relating to the implementation of the provisions of this subtitle.

(b) The Advisory Committee shall consist of the following 10 members:

(1) The Director of the Laboratories Administration in the Department, or the Director's designee;

(2) The Director of the Office of Health Care Quality in the Department, or the Director's designee; and

(3) The following members, appointed by the Governor:

(i) One from the American Society for Clinical Laboratory Science;

(ii) One from the University of Maryland School of Medicine, Department of Medical Research and Technology;

(iii) One from the American Association for Laboratory Accreditation;

(iv) One from the American Academy of Forensic Sciences;

(v) One from the ANSI–ASQ National Accreditation Board; and

(vi) Three directors of forensic laboratories in the State, including:

1. One from a forensic laboratory operated by the State;

2. One from a forensic laboratory operated by a county; and

3. One from a forensic laboratory operated by a municipal corporation.

(c) (1) The term of an appointed member is 3 years.

(2) The terms of appointed members are staggered as required by the terms provided for appointed members of the Advisory Committee on October 1, 2007.

(d) The Governor shall designate the chair of the Advisory Committee.

(e) A majority of the members serving on the Advisory Committee represents a quorum to conduct business.

(f) A member of the Advisory Committee may not receive compensation but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) The Department shall provide staff for the Advisory Committee.

§17–301.

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

(b) "Permit" means a permit issued by the Secretary:

(1) To operate a tissue bank in this State; or

(2) To represent or service in this State a tissue bank that is outside this State.

(c) (1) "Tissue bank" means an establishment that obtains, stores, processes, distributes, or sells human blood or other human tissue for use in the human body.

(2) "Tissue bank" includes a blood bank.

§17–302.

(a) (1) The Secretary shall adopt rules and regulations that set standards for tissue banks.

(2) The rules and regulations shall contain the standards that the Secretary considers necessary to assure the citizens of this State that tissue banks provide safe and reliable services.

(b) To assure compliance with the standards adopted under this subtitle, the Secretary shall:

(1) Have an inspection made of each tissue bank for which a permit to operate is sought; and

(2) Have an inspection made periodically or make an agreement with an organization to do, at no cost to this State, a periodic inspection of each tissue bank for which a permit has been issued.

§17–303.

(a) The Secretary shall adopt rules and regulations that set qualifications for directors of tissue banks.

(b) The rules and regulations shall require that a tissue bank in this State employ or retain under contract:

(1) A technical director, qualified by training and experience for the scope of activities being pursued, who will oversee and be responsible for all technical aspects of the tissue bank's operations; and

(2) A medical director who will be a physician licensed to practice medicine in this State and who will be responsible for all medical aspects of the tissue bank's operations, unless the technical director qualifies as a medical director under this section.

§17–305.

Except as provided in §§ 10–14A–03 and 10–14B–03 of the State Government Article, a person shall hold a permit issued by the Secretary before the person may:

(1) Operate a tissue bank in this State; or

(2) Represent or service in this State any tissue bank that is outside this State.

§17–306.

To qualify for a permit, an applicant shall satisfy the Secretary that the tissue bank to be operated, represented, or serviced and its director meet the requirements that the Secretary adopts under this subtitle.

§17–307.

(a) An applicant for a permit shall submit an application to the Secretary on the form that the Secretary requires.

(b) (1) An application for a permit to operate a tissue bank shall include:

(i) The name of the owner;

(ii) The classes of services that the tissue bank would provide; and

(iii) Any other information that the Secretary requires.

(2) An application for a permit to represent or service a tissue bank shall include satisfactory evidence that the tissue bank to be represented or serviced and its director meet the requirements that the Secretary adopts under this subtitle.

§17–308.

(a) The Secretary shall issue a permit to any applicant who meets the requirements of this subtitle.

(b) The Secretary shall include on each permit that the Secretary issues:

(1) The name of the tissue bank;

(2) The name of its director;

(3) The name of its owner; and

(4) The classes of services that the tissue bank may offer.

§17–309.

While it is effective, a permit authorizes the permit holder:

(1) To operate or to represent or service the tissue bank named in the permit; and

(2) To offer and perform the classes of services set forth in the permit.

§17–311.

(a) The Secretary may deny a permit to any applicant or suspend or revoke a permit or the authority to offer or perform any class of service that the permit sets forth, if the tissue bank or its director fails to meet the requirements that the Secretary adopts under this subtitle.

(b) Except as otherwise provided in the Administrative Procedure Act, before the Secretary takes any action under this section, the Secretary shall give the applicant or permit holder notice and an opportunity for a hearing.

§17–312.

(a) A person may not operate a tissue bank in this State unless the person holds a permit issued by the Secretary.

(b) A permit holder may not offer or perform any class of service of a tissue bank that is not authorized by the permit.

§17–313.

(a) A person may not represent or service any tissue bank, regardless of location, unless the tissue bank and its director meet the standards and qualifications that the Secretary adopts under this subtitle.

(b) A person may not represent or service in this State any tissue bank that is not in this State unless the person holds a permit to represent or service the tissue bank.

§17–314.

A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 for the first offense and not exceeding $500 for each subsequent conviction for a violation of the same provision. Each day a violation is continued after the first conviction is a subsequent offense.

§17–501.

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

(b) "Cholesterol testing" includes collecting a test specimen, testing to detect the amount of cholesterol in an individual's blood, and the reporting of test results.

(c) "Permit" means a permit issued by the Secretary to a person who:

(1) Offers to provide, with or without charge, a test to detect the amount of cholesterol in an individual's blood; and

(2) Conducts the test outside a permanently located medical laboratory issued a permit or excepted from a permit under Subtitle 2 of this title.

§17–502.

(a) Except as provided under subsection (b) of this section and § 17-503 of this subtitle, a person shall obtain a permit from the Department before:

(1) Offering to provide a test to detect the amount of cholesterol in an individual's blood; and

(2) Conducting the cholesterol test outside a permanently located medical laboratory issued a permit or excepted from a permit under Subtitle 2 of this title.

(b) A cholesterol testing permit is not required under this subtitle for a medical laboratory that:

(1) Is licensed under Subtitle 2 of this title; and

(2) As set forth in the license, provides tests or services in the discipline of chemistry or health awareness.

§17–503.

(a) Any local or county health department may submit to the Secretary its cholesterol testing plan for review.

(b) (1) The Secretary shall review all submissions under this section as soon as reasonably possible after the submission in order to determine whether it meets the standards necessary for adequate off-site cholesterol testing in accordance with this subtitle.

(2) If a plan submitted under this section meets the standards of this subtitle, the Secretary may waive the permit requirements of the subtitle and permit

the submitting local or county health department to conduct cholesterol testing under this subtitle for a period of 12 months, provided that:

(i) The submission adequately describes the cholesterol testing plan for the effective 12 months;

(ii) The local or county health department provides all information that the Secretary may reasonably require to determine compliance with this section;

(iii) The local or county health department agrees to make records available and submit reports to the Secretary as the Secretary may require;

(iv) Changes and amendments to the plan are submitted 60 days prior to proposed implementation; and

(v) All changes and amendments to the plan are approved by the Secretary.

(3) If a plan submitted under this section does not meet the standards of this subtitle, or if the information supplied in the submission is considered by the Secretary to be insufficient for a determination, the submitting local or county health department shall apply for a permit in accordance with this subtitle.

(c) The Secretary may cancel a waiver granted under this section at any time if the Secretary finds that the local or county health department does not continue to meet the standards of this subtitle.

§17–504.

(a) The Secretary shall adopt regulations to implement the provisions of this subtitle, including regulations that assure the citizens of this State that cholesterol testing conducted outside a permanently located medical laboratory meets appropriate national standards of quality assurance.

(b) The regulations shall include:

(1) Personnel training standards, including requirements for reasonable training, experience, and competency in:

(i) Simple procedures used in drawing blood for cholesterol testing; and

(ii) The operation of blood chemical analyzers used for cholesterol screening;

(2) Quality assurance standards;

(3) Standards for counseling and referral procedures;

(4) Standards for releasing and reporting test results; and

(5) A prohibition on the payment of any sum to any person for bringing or referring a patient.

(c) (1) The Secretary may not require that cholesterol testing personnel that conduct cholesterol tests under this subtitle be certified in a medical laboratory specialty.

(2) All cholesterol testing conducted under this subtitle shall be overseen by a supervisor knowledgeable in all aspects of cholesterol testing services.

§17–505.

To qualify for a permit, an applicant shall meet the requirements of this subtitle and any regulation that the Secretary adopts under this subtitle.

§17–506.

An applicant for a permit shall submit an application to the Secretary on the form that the Secretary requires.

§17–507.

(a) The Secretary shall issue a permit to any applicant who meets the requirements of this subtitle.

(b) The Secretary shall include on each permit:

(1) The name of the permittee;

(2) The address of the permittee; and

(3) The expiration date of the permit.

§17–509.

(a) The Secretary may deny a permit to an applicant or suspend or revoke an existing permit for failure to comply with the provisions of this subtitle and any regulation adopted under this subtitle.

(b) Except as otherwise provided in the Administrative Procedure Act, before the Secretary takes any action under this section, the Secretary shall give the applicant or permit holder notice and an opportunity for a hearing.

§17–510.

(a) Except as otherwise provided in this title, a person may not offer cholesterol testing in this State unless the person holds a permit from the Secretary.

(b) The permit is not transferable.

§17–511.

A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 for the first offense and not exceeding $500 for each subsequent conviction for a violation of the same provision. Each day a violation is continued after the first conviction is a subsequent offense.

§17–601.

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

(b) "Biological agent" means any biological agent as defined in Title 42, Part 73 of the Code of Federal Regulations, or Title 9, Part 121 of the Code of Federal Regulations.

(c) "Maryland Institute for Emergency Medical Services Systems" means the unit described in § 13-503 of the Education Article.

(d) "Person" includes State and federal units of government.

(e) "Program" means the Biological Agents Registry Program.

§17–602.

(a) There is a Biological Agents Registry Program in the Department.

(b) The Biological Agents Registry shall:

(1) Identify the biological agents possessed and maintained by any person in this State; and

(2) Contain other information as required by regulations adopted by the Department.

(c) The Department shall adopt regulations for the implementation of the Program that:

(1) Determine and list the biological agents required to be reported under this subtitle;

(2) Designate the persons required to make reports and the specific information required to be reported;

(3) Designate time limits for reporting, the form of reports, and the persons to whom reports are to be submitted;

(4) Require local jurisdictions to be informed of the location and nature of each biological agent in the Registry that is located within the local jurisdiction;

(5) Provide for the release of information in the Biological Agents Registry to:

(i) State and federal law enforcement agencies and the Centers for Disease Control and Prevention pursuant to a communicable disease investigation commenced or conducted by the Department or other State or federal law enforcement agency having investigatory authority, or in connection with any investigation involving release, theft, or loss of biological agents;

(ii) The Maryland Department of Emergency Management and the Maryland Department of the Environment for the purposes of planning for the protection of the public in relation to the release of a biological agent and the prevention of a release of a biological agent; and

(iii) The Maryland Institute for Emergency Medical Services Systems for the purposes of providing certain specified information to:

1. A police officer, as defined in § 3–201(f) of the Public Safety Article, responding to an emergency; and

2. A fire, rescue, or emergency medical services entity, as defined in § 7–101 of the Public Safety Article, performing emergency services,

responding to a fire or other emergency, or dispatched on a call for emergency services;

(6) Establish a system of safeguards that requires persons possessing, maintaining, and transferring biological agents subject to this subtitle to comply with the same federal standards that apply to persons registered to transfer the same agents under federal law; and

(7) Establish a process for persons that possess and maintain biological agents to alert appropriate authorities of unauthorized possession or attempted possession of biological agents.

§17–603.

(a) Except as provided in subsection (b) of this section, any person that possesses and maintains any biological agent shall report to the Department the information required by the Department for inclusion in the Biological Agents Registry.

(b) Subsection (a) of this section does not apply to a biological agent or a certified laboratory or facility that is exempt from the requirements for the interstate shipment of etiologic agents under Title 42, Part 72.6(h) or Part 72, Appendix A of the Code of Federal Regulations.

§17–604.

(a) Except as otherwise provided in this subtitle, information prepared for or maintained in the Biological Agents Registry shall be confidential and is not subject to Title 4 of the General Provisions Article.

(b) Release of information from the Registry as authorized by regulations adopted under § 17-602(c) of this subtitle shall not render the information released a public record.

(c) A person or entity to whom specified information has been released from the Registry as authorized by regulations adopted under § 17-602(c) of this subtitle may not release the information unless the release is approved by the Biological Agents Registry Program.

§17–605.

(a) A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 for the first

offense and not exceeding $500 for each subsequent conviction for a violation of the same provision.

(b) Each day a violation is continued after the first conviction is a subsequent offense.

§17–701.

(a) In this section, "BSL–3 laboratory" means a laboratory designated as a biosafety level 3 (BSL–3) laboratory by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institutes of Health, Biosafety in Microbiological and Biomedical Laboratories, as applicable, based on:

(1) Usage of biological agents that may cause serious or potentially lethal disease after inhalation, ingestion, or absorption; and

(2) Required biocontainment precautions.

(b) This section applies to each BSL–3 laboratory in Frederick County that:

(1) Does not work with federally regulated biological select agents and toxins or their products; and

(2) (i) Is a commercial or for–profit laboratory;

(ii) Is owned by or is part of a teaching hospital or an institution of postsecondary education; or

(iii) Is a privately funded biomedical research laboratory.

(c) The Department shall develop and make available a standardized form for a BSL–3 laboratory subject to this section to use to provide the information required under subsection (d) of this section.

(d) On or before October 30 each year, each BSL–3 laboratory subject to this section shall report to the Department:

(1) The address of the laboratory;

(2) The name, telephone number, and e–mail address of a contact person for the laboratory; and

(3) Any other information required by the Department to determine the location of the laboratory.

(e) On or before December 31 each year, the Department shall report to:

(1) The Maryland Department of Emergency Management and the health officer and emergency management officials of Frederick County the number and location of BSL–3 laboratories subject to this section; and

(2) The Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly the total number of BSL–3 laboratories subject to this section.

(f) (1) Except as provided in paragraph (2) of this subsection and subsection (e) of this section, any information the Department collects from BSL–3 laboratories subject to this section is confidential and not subject to inspection under the Public Information Act.

(2) Any information the Department collects from BSL–3 laboratories subject to this section shall be made available if requested by the BSL–3 laboratory's insurance carrier or in a legal proceeding.

(g) (1) Activity of a BSL–3 laboratory subject to this section that fails to report the information required under subsection (d) of this section shall be considered ultrahazardous and abnormally dangerous.

(2) A BSL–3 laboratory subject to this section that fails to report the information required under subsection (d) of this section is strictly liable for damages for any injury, death, or loss to person or property that is caused by the BSL–3 laboratory.

§18–101.

The Secretary shall investigate:

(1) The causes of disease and, particularly, the causes of epidemics;

(2) The causes of mortality; and

(3) The influence of locality, employment, habit, and other conditions on health.

§18–102.

(a) The Secretary shall adopt rules and regulations necessary to prevent:

(1) The introduction of an infectious or contagious disease into this State or other disease that endangers public health in this State; or

(2) The spread of an infectious or contagious disease or other disease that endangers public health in this State.

(b) When the Secretary has reason to believe that an infectious or contagious disease or other disease that endangers public health exists within the State, the Secretary shall:

(1) Investigate the suspected disease; and

(2) Act properly to prevent the spread of the disease.

(c) (1) Except as provided in paragraph (2) of this subsection, an individual enrolled in an institution of higher education who resides in on-campus student housing shall be vaccinated against meningococcal disease.

(2) An individual is exempt from the vaccination requirement in paragraph (1) of this subsection if:

(i) The institution of higher education provides detailed information on the risks associated with meningococcal disease and the availability and effectiveness of any vaccine to:

1. The individual, if the individual is 18 years of age or older; or

2. The individual's parent or guardian, if the individual is a minor; and

(ii) 1. The individual is 18 years of age or older and the individual signs a written waiver in a form approved by the Secretary stating that the individual has received and reviewed the information provided and has chosen not to be vaccinated against meningococcal disease; or

2. The individual is a minor and the individual's parent or guardian signs a written waiver in a form approved by the Secretary stating that the parent or guardian has received and reviewed the information provided and has chosen to not have the individual vaccinated against meningococcal disease.

(3) Nothing in this subsection shall be construed to require any institution of higher education to provide or pay for vaccinations against meningococcal disease.

(4) The Secretary, in consultation with the Maryland Higher Education Commission, shall adopt regulations necessary to implement this subsection.

(d) The Secretary may enter on and inspect private property to determine the presence, cause, and source of an infectious or contagious disease or other disease that endangers public health in this State.

§18–103.

(a) The Secretary shall:

(1) Obtain accurate and complete reports on communicable diseases in this State;

(2) Determine the prevalence of each communicable disease; and

(3) Devise means to control communicable diseases.

(b) The Secretary shall publish monthly a communicable disease bulletin for health officers and other related health professionals.

§18–104.

(a) The Secretary shall investigate, if feasible, means to prevent, treat, and cure cancer.

(b) The Secretary may adopt procedures to obtain information about cancers that are caused by carcinogens and about the incidence of these cancers.

§18–105.

The Secretary may adopt procedures to obtain information about diseases that are caused by toxic substances and about the incidence of these diseases.

§18–106.

(a) The Secretary shall establish and administer a Lead Poisoning Screening Program that will assure the appropriate screening of children in Maryland for lead poisoning.

(b) The Lead Poisoning Screening Program shall:

(1) Encourage continuity of care with the child's continuing care health care provider;

(2) Promote timely, appropriate screening of children at risk of being poisoned by lead;

(3) Utilize all of the payment mechanisms available to cover lead poisoning screening, including:

(i) Third party payments from insurers;

(ii) The Medical Assistance Program;

(iii) Primary care medical assistance programs established under waiver from the federal government;

(iv) Health maintenance organizations;

(v) Federally qualified and Maryland qualified community health centers; and

(vi) Any other Medicaid reimbursement or waiver to which the State may be entitled under this section;

(4) Target children under 6 years of age;

(5) Provide lead poisoning screening on a sliding fee scale at sites designated by local health departments for children unable to afford lead poisoning screening; and

(6) Employ an initial questionnaire to assess children's exposure to potential lead hazards, except that children residing in at risk areas identified under subsection (c) of this section shall be screened by a blood test for lead poisoning.

(c) The Secretary shall target efforts to promote and to provide blood tests for lead poisoning in at risk areas, as identified by:

(1) Census tract and zip code information noting areas with large concentrations of pre-1978 housing; and

(2) Highest rates of lead poisoning as evidenced by information provided to and by the Childhood Lead Registry established and maintained by the Department of the Environment.

(d) The Secretary shall require providers caring for children in areas designated as at risk for lead poisoning, as determined under subsection (c) of this section, to administer a blood test for lead poisoning of children:

(1) Within the time frame specified in regulations adopted by the Department; or

(2) In accordance with the guidelines of the Centers for Disease Control and Prevention for children over age 24 months who have not received a blood test for lead poisoning.

(e) The Secretary may include information on blood testing for lead poisoning collected under this section, § 7-403 of the Education Article, and §§ 6-303 and 6-304 of the Environment Article on any immunization registry developed by the Department.

(f) (1) Subject to paragraph (2) of this subsection, this section does not require blood testing of a child whose parent or guardian, in accordance with regulations adopted by the Secretary, objects to the testing on the ground that it conflicts with the parent's or guardian's bona fide religious beliefs and practices.

(2) Paragraph (1) of this subsection does not apply if the responses of the child's parent or guardian on a questionnaire furnished by the Secretary and administered by a pediatrician indicate that the child is at high risk for lead poisoning.

§18–107.

(a) The Secretary shall:

(1) Devise and institute means to prevent and control morbidity and mortality associated with:

(i) Pregnancy;

(ii) Childbirth;

(iii) Infancy; and

(iv) Early childhood; and

(2) Promote the welfare and hygiene of maternity and infancy.

(b) (1) The Secretary shall establish a Morbidity, Mortality, and Quality Review Committee in the Department.

(2) The Committee shall:

(i) Conduct confidential and anonymous case reviews of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood; and

(ii) Develop and implement interventions to improve the system of care for pregnancy, childbirth, infancy, and early childhood based on the findings from case reviews conducted under item (i) of this paragraph.

(3) (i) The Secretary shall adopt regulations to implement the requirements of this section.

(ii) The regulations shall include:

1. The types of case reviews conducted by the Committee;

2. The confidentiality of case reviews;

3. A description of the types of records and information needed by the Committee to conduct the case reviews under this section; and

4. The process for obtaining records, including patient medical records, and any other necessary information in accordance with § 4–305(b) of this article.

(c) This section does not enable the Secretary:

(1) To take charge of a child if the parent, guardian, or other person who has custody of the child objects; or

(2) To treat the child for a disease without the consent of the parent, guardian, or other person who has custody of the child.

§18–108.

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

(2) "Food instrument" means a voucher, check, coupon, or other document that is used by a participant to obtain supplemental foods.

(3) "Local agency" means a public or private, nonprofit health or human service agency that:

(i) Provides health services either directly or through contract; and

(ii) By written agreement with the State agency, provides Program services in a designated area.

(4) "Participant" means an individual who is receiving supplemental foods or food instruments under the Program and includes:

(i) Pregnant women;

(ii) Breast–feeding women up to 1 year postpartum who are breast–feeding their infants;

(iii) Postpartum women up to 6 months after termination of pregnancy;

(iv) Infants under 1 year of age; and

(v) Children who are at least 1 year old but under the age of 5 years.

(5) "Program" means the Special Supplemental Food Program for Women, Infants, and Children authorized by § 17 of the Child Nutrition Act of 1966, as amended.

(6) "Supplemental foods" means those foods containing nutrients determined to be beneficial for pregnant, breast–feeding, and postpartum women, infants, and children, as prescribed by the Secretary of the U.S. Department of Agriculture.

(b) (1) Except as otherwise provided in this subsection, a local agency shall include in its proposed written agreement the option to require a participant in the Program to report monthly, bimonthly, or trimonthly to a designated site at designated times to receive food instruments prepared for that participant and to acknowledge receipt of the instruments.

(2) Food instruments may be mailed or otherwise delivered to participants by a local agency only if approved by the Department on the basis of

hardships which may be encountered by the target population of the local agency, such as seasonally inclement weather.

(3) (i) On presentation by the participant of a written request, including justification, a local agency may mail or otherwise deliver food instruments to an individual on the basis of the difficulty of the participant and the participant's proxies in obtaining the food instruments.

(ii) The justification may include:

1. Illness;

2. Imminent childbirth;

3. Difficulty of access to the local agency; or

4. Handicapping condition.

(4) (i) The Secretary shall institute at least one pilot program in a local subdivision or part of a subdivision utilizing a credit card system along with or in place of a food instrument system.

(ii) Implementation must take place within a reasonable period of time from the date of enactment of this section, unless such a pilot program is found to be inconsistent with subsection (d) of this section and a waiver is not granted.

(c) The Department shall maximize distribution of administrative funds to local agencies in a manner that assures equity among the local agencies.

(d) The provisions of this section are effective only to the extent that they are not inconsistent with applicable federal law or regulations.

§18–109.

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

(2) "Authorized user" means:

(i) A child care facility;

(ii) A health care provider;

(iii) A health insurer;

(iv) A health maintenance organization;

(v) An institution of higher learning;

(vi) A local health department;

(vii) A long–term care facility;

(viii) A managed care organization;

(ix) A nonprofit health service plan;

(x) A patient;

(xi) A school;

(xii) A school–based health center;

(xiii) In the case of a minor child, a parent or guardian; and

(xiv) Any other user designated by the Secretary.

(3) "Health care provider" means a licensed health care practitioner authorized under the Health Occupations Article to administer vaccines in the State.

(4) "ImmuNet" means a computerized information and reminder system to:

(i) Improve the timely and appropriate delivery of immunizations;

(ii) Provide a coordinated network for reminder notices when immunizations are due;

(iii) Provide and collect information to be shared by authorized users; and

(iv) Provide a quality indicator for the insurers' health care provider practices and public health purposes.

(5) "Immunization" means the process by which an individual becomes protected against a disease including, as the result of having a disease, receiving a vaccination, or receiving preformed antibodies.

(6) "Refusal to permit" means the right of an individual or the parent or guardian of a minor to prevent disclosure to authorized users of individual identifiable information that was reported to ImmuNet.

(7) "Vaccination" means the administration of a killed or weakened infectious organism to prevent disease caused by that organism.

(8) "Vaccine" means a substance that:

(i) May be administered by injection, mouth, or aerosol; and

(ii) Produces immunity that protects the body from a disease.

(b) There is an ImmuNet program in the Department.

(c) Subject to subsection (d) of this section, an authorized user may use the information in ImmuNet for the following purposes:

(1) To provide coordinated immunization services, including sending reminder notices to individuals who need immunizations;

(2) To obtain an individual immunization history;

(3) To identify geographic areas or population groups that are underimmunized;

(4) To compile aggregate data and distribute statistical reports on the status of immunizations in geographic areas and population groups;

(5) To assist in the management of State and local immunization programs;

(6) To monitor the safety of vaccines;

(7) To assess compliance with immunization requirements by monitoring admissions to schools, institutions of higher learning, and child care facilities; and

(8) For any other purpose that the Secretary deems necessary to prevent the spread of communicable diseases.

(d) (1) An individual, or the parent or guardian of a minor child who has received a vaccination, may refuse to permit disclosure of confidential information collected by ImmuNet, to an authorized user.

(2) If the individual or the parent or guardian of a minor child does not want the release of the individual's or child's confidential information, the individual or the parent or guardian of a minor child shall complete a "refusal to permit" form, provided by the Department, to be returned to the Department.

(3) The Secretary shall make available "refusal to permit" forms to each health care provider who gives vaccinations.

(4) The Department shall:

(i) Develop brochures about ImmuNet that:

1. Describe the benefits of ImmuNet for authorized users;

2. Describe privacy protections in ImmuNet;

3. Notify an individual of the right to refuse to permit disclosure to an authorized user;

4. Notify an individual that the individual may correct any inaccurate information;

5. Provide a list of addresses where an individual may obtain a form to request the correction or removal of inaccurate information from ImmuNet;

6. Explain the right of an individual who has received a vaccination to have the individual's personal information kept confidential;

7. Describe the kind of information collected and retained by ImmuNet about an individual who receives a vaccination;

8. Describe who has access to the information in ImmuNet; and

9. Describe how the information is used by ImmuNet; and

(ii) Make the brochure available to each health care provider who administers vaccines.

(5) Prior to administering vaccines to a newborn child, each birth hospital or birthing center shall distribute the form and the brochure described in paragraphs (2) and (4) of this subsection to the parent of a newborn child.

(6) A health care provider who administers a vaccine, or the agent of the health care provider, shall:

(i) Provide the individual with a copy of the form and the brochure described in paragraphs (2) and (4) of this subsection;

(ii) Notify the individual or the parent or guardian of a minor of the right to refuse to disclose to ImmuNet; and

(iii) Report to ImmuNet all vaccines administered.

(e) Subject to the provisions of subsection (d) of this section, information for ImmuNet may be obtained from:

(1) Any records owned or controlled by the Department, including Medicaid records, clinic records, and vital records;

(2) Any authorized user; and

(3) Any other source of information authorized by the Secretary for use.

(f) Authorized users may not use the information in ImmuNet:

(1) To release or disclose information in ImmuNet that an individual has refused to disclose;

(2) To solicit new patients or clients; or

(3) For any other purpose unless authorized by the Secretary.

(g) (1) A local health department may operate a local immunization system.

(2) A local health department operating a local immunization system shall be subject to the provisions of subsections (c) through (f) of this section.

(3) A local health department is required to submit information maintained in a local immunization system to ImmuNet in accordance with regulations adopted by the Secretary.

(h) An authorized user who in good faith discloses or does not disclose information to ImmuNet is not liable in any cause of action arising from the disclosure or nondisclosure of that information.

(i) An authorized user, including an officer or employee of a governmental unit, who knowingly and willfully violates subsection (f) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for the first offense and not exceeding $5,000 for each subsequent offense.

(j) If the confidentiality of records of Maryland citizens is protected, the Secretary may enter into collaborative agreements with other states for the purpose of sharing information about immunizations.

(k) The Secretary shall adopt regulations to implement this section, including regulations specifying:

(1) The type and kind of information to be collected;

(2) Procedures for protecting the confidentiality of information in ImmuNet;

(3) The permissible use of information compiled by ImmuNet; and

(4) Standards for maintaining security and reliability of collected information in the system.

§18–110.

The Department, in partnership with the Department of Aging, the Virginia I. Jones Alzheimer's Disease and Related Dementias Council, and the Greater Maryland Chapter of the Alzheimer's Association, shall incorporate information into relevant public health outreach programs administered by the Department to:

(1) Educate health care providers regarding:

(i) The importance of early detection and timely diagnosis of cognitive impairment;

(ii) Validated assessment tools for the detection and diagnosis of cognitive impairment;

(iii) The value of a Medicare annual wellness visit or other annual physical for an individual at least 65 years old for cognitive health;

(iv) The Medicare care planning billing code for individuals with cognitive impairment; and

(v) Treatments approved by the Food and Drug Administration for Alzheimer's disease and related dementias, including relevant information on treatment use and outcomes; and

(2) Increase public understanding and awareness of:

(i) The early warning signs of Alzheimer's disease and related dementias;

(ii) The value of early detection, diagnosis, and treatment of Alzheimer's disease and related dementias;

(iii) How to reduce the risk of cognitive decline, particularly among individuals in Black and Latino communities who are at greater risk of developing Alzheimer's disease and related dementias; and

(iv) Treatments approved by the U.S. Food and Drug Administration for Alzheimer's disease and related dementias and relevant information on treatment use and outcomes, including information related to treatment outcomes based on biological sex.

§18–111.

(a) The Department, in collaboration with the State–designated health information exchange, shall establish and maintain a publicly accessible website that includes in a downloadable format the following information:

(1) The prevalence of Alzheimer's disease and related dementias in the State;

(2) The hospitalization rate related to Alzheimer's disease and related dementias; and

(3) To the extent possible, the prevalence and hospitalization rate of Alzheimer's disease and related dementias disaggregated based on:

(i) Age, including age of diagnosis;

(ii) Sex;

(iii) Race;

(iv) Ethnicity;

(v) Number of cases by county;

(vi) Co–occurrence of Down Syndrome (Trisomy–21); and

(vii) Type of dementia.

(b) The website required under subsection (a) of this section shall:

(1) Include the data available for the immediately preceding 5–year period ending September 30, 2025; and

(2) Be updated on or before January 1 each year, beginning in 2027, to include any newly available data.

§18–112.

(a) The Secretary shall issue recommendations for immunizations, screenings, and preventive services for infants, children, and adults that follow the generally accepted consensus within the scientific community and sound clinical guidance as specified in subsection (b) of this section and subject to subsection (c) of this section.

(b) The recommendations shall:

(1) Be made in accordance with the applicable recommendations of the following authoritative medical organizations:

(i) The American Academy of Pediatrics;

(ii) The American College of Obstetricians and Gynecologists; or

(iii) The American Academy of Family Physicians; and

(2) Take into consideration the applicable guidance of:

(i) The Maryland Statewide Advisory Commission on Immunizations;

(ii) The U.S. Department of Health And Human Services, including the Health Resources and Services Administration;

(iii) The U.S. Centers for Disease Control and Prevention, including the Advisory Committee on Immunization Practices;

(iv) The U.S. Food and Drug Administration, including the Vaccines and Related Biological Products Advisory Committee; and

(v) The U.S. Preventive Services Task Force.

(c) Before adopting a recommendation for a preventive service that is not an immunization and has not received a recommendation from the U.S. Department of Health and Human Services or an A or B rating from the U.S. Preventive Services Task Force, the Secretary shall:

(1) Hold a notice and comment period of at least 30 days;

(2) Obtain an analysis from the Maryland Health Care Commission on the service that meets the requirements of § 15–1501 of the Insurance Article; and

(3) Cite the applicable recommendations of the authoritative medical organizations on which a recommendation would be based.

(d) The Secretary shall:

(1) Publish recommendations issued under this section on the Department's website; and

(2) Distribute the recommendations issued under this section to licensed health professionals in the State and to the Maryland Insurance Administration.

§18–201.

(a) A physician with reason to suspect that a patient under the physician's care has a condition or an infectious or contagious disease, except human immunodeficiency virus or acquired immunodeficiency syndrome, that endangers public health and that has been designated by the Secretary as reportable shall submit immediately a report to the health officer for the county where the physician cares for that patient.

(b) The report shall:

(1) Contain the information and be in a format specified or approved by the Secretary; and

(2) Be transmitted as directed by the Secretary.

(c) (1) Except as provided in paragraphs (2) through (5) of this subsection, all reports and all information collected in connection with a report from a health care provider, the subject of the report, or other individuals who might be affected by the condition or disease in the report are:

(i) Confidential;

(ii) Not medical records under Title 4, Subtitle 3 of this article;

(iii) Not open to public inspection; and

(iv) Not discoverable or admissible in evidence in any civil or criminal matter except in accordance with a court order sealing the court record.

(2) This subsection does not apply to reports, information, and records otherwise available to the public or required to be publicly disclosed.

(3) The Secretary may prepare and disseminate nonindividually identifiable information about one or more cases of a condition or disease based on any report received under this section, for any purpose consistent with the Secretary's lawful duties as authorized by an act of the Maryland General Assembly.

(4) This subsection does not apply to or restrict the use or publication of any statistics, information, or other material that summarizes or refers to confidential records in the aggregate, without disclosing the identity of any individual who is the subject of the confidential record.

(5) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress where the Secretary determines that:

(i) The agency to whom the information is disclosed will maintain the confidentiality of the disclosure; and

(ii) The disclosure is necessary to protect the public health or to prevent the spread of an infectious or contagious disease.

§18–201.1.

(a) A health care provider who has diagnosed an individual under the health care provider's care with HIV infection or acquired immunodeficiency syndrome according to the current definition published in the Morbidity and Mortality Weekly Report by the Centers for Disease Control and Prevention of the Department of Health and Human Services shall submit immediately a report to the health officer for the county where the health care provider cares for that individual.

(b) The report shall:

(1) Be on the form that the Secretary provides;

(2) Identify the disease;

(3) State the name, age, race, sex, and residence address of the individual;

(4) State the pregnancy status of the individual, if applicable; and

(5) Be signed by the health care provider.

(c) (1) A health care provider shall submit a report as described in subsection (b) of this section to the Secretary within 48 hours of:

(i) The birth of an infant whose mother has tested positive for HIV; and

(ii) A pregnant woman testing positive for HIV, for the purpose of intervention.

(2) If a newborn infant does not become HIV positive after 18 months from the infant's date of birth, the Secretary shall have the newborn infant's name removed from the HIV registry.

(d) (1) All health care provider reports required under this section are:

(i) Confidential and subject to Title 4, Subtitle 1 of this article; and

(ii) Not medical records under Title 4, Subtitle 3 of this article, but are subject to the confidentiality requirements of Title 4, Subtitle 1 of this article.

(2) The reports and any proceedings, records, or files relating to the reports required under this section are not discoverable and are not admissible in evidence in any criminal, civil, or administrative action.

(3) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties pursuant to State or federal law where the Secretary determines the agency to whom the information is disclosed will maintain the confidentiality of the disclosure.

§18–202.

(a) In this section, "institution" includes:

(1) A hospital; and

(2) A lodging facility.

(b) When the administrative head of an institution has reason to believe that an individual on the premises of the institution has a condition or an infectious or contagious disease, except human immunodeficiency virus or acquired immunodeficiency syndrome, that has been designated by the Secretary as reportable, the administrative head immediately shall submit a report to the health officer for the county where the institution is located.

(c) The report shall:

(1) Contain the information and be in a format specified or approved by the Secretary; and

(2) Be transmitted as directed by the Secretary.

(d) (1) Except as provided in paragraphs (2) through (5) of this subsection, all reports and all information collected in connection with a report from a health care provider, the subject of the report, or other individuals who might be affected by the condition or disease in the report are:

(i) Confidential;

(ii) Not medical records under Title 4, Subtitle 3 of this article;

(iii) Not open to public inspection; and

(iv) Not discoverable or admissible in evidence in any civil or criminal matter except in accordance with a court order sealing the court record.

(2) This subsection does not apply to reports, information, and records otherwise available to the public or required to be publicly disclosed.

(3) This subsection does not apply to or restrict the use or publication of any statistics, information, or other material that summarizes or refers to confidential records in the aggregate, without disclosing the identity of any individual who is the subject of the confidential record.

(4) The Secretary may prepare and disseminate nonindividually identifiable information about one or more cases of a condition or a disease based on any report received under this section, for any purpose consistent with the Secretary's lawful duties as authorized by an act of the Maryland General Assembly.

(5) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress where the Secretary determines that:

(i) The agency to whom the information is disclosed will maintain the confidentiality of the disclosure; and

(ii) The disclosure is necessary to protect the public health or to prevent the spread of an infectious or contagious disease.

§18–202.1.

(a) In this section, "institution" includes:

(1) A hospital;

(2) A nursing home;

(3) A hospice facility;

(4) A medical clinic in a correctional facility;

(5) An inpatient psychiatric facility; and

(6) An inpatient drug rehabilitation facility.

(b) When an institution has an individual in the care of the institution with a diagnosis of HIV or acquired immunodeficiency syndrome according to the current definition published in the Morbidity and Mortality Weekly Report by the Centers for Disease Control and Prevention, a clinical or infection control practitioner shall submit a report within 48 hours to the health officer for the county where the institution is located.

(c) The report shall:

(1) Be on the form that the Secretary provides;

(2) Identify the disease;

(3) State the name, age, race, sex, and residence address of the individual with the disease;

(4) State the pregnancy status of the individual, if applicable;

(5) State the name of the administrative head of the institution; and

(6) State the address of the institution.

(d) (1) All institution reports required under this section are:

(i) Confidential and subject to Title 4, Subtitle 1 of this article; and

(ii) Not medical records under Title 4, Subtitle 3 of this article, but are subject to the confidentiality requirements of Title 4, Subtitle 1 of this article.

(2) The reports and any proceedings, records, or files relating to the reports required under this section are not discoverable and are not admissible in evidence in any criminal, civil, or administrative action.

(3) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties in accordance with State or federal law where the Secretary determines the agency to whom the information is disclosed will maintain the confidentiality of the disclosure.

§18–203.

Notwithstanding any other provision of law, the Department may provide patient-identifying information for patients treated in this State for cancer to a cancer control agency in another state if:

(1) The patient is a resident of the other state;

(2) The Department determines that the agency will preserve the confidentiality of the information; and

(3) The other state has authority to provide equivalent information on Maryland residents to this State.

§18–204.

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

(2) "Cancer report" means a 1–time abstract of the medical record of a patient diagnosed or treated for cancer or a central nervous system tumor which contains:

(i) Reasonably obtained patient demographic information, including risk factors;

(ii) Relevant information on the:

1. Initial histologically precise diagnosis;

2. Initial treatment;

3. Extent of the disease by the end of the first hospitalization; and

4. Extent of the disease within 2 months of diagnosis if the information is available to the reporting facility and the reporting facility has a tumor registry; and

(iii) Facility and other provider identification information.

(3) (i) "Central nervous system tumor" means, irrespective of histologic type or behavior, a primary tumor in the following sites:

1. The brain;

2. The caudea equina;

3. A cranial nerve;

4. The craniopharyngeal duct;

5. The meninges;

6. The pineal gland;

7. The pituitary gland; or

8. The spinal cord.

(ii) "Central nervous system tumor" includes a primary intracranial tumor.

(4) "Freestanding ambulatory care facility" has the meaning stated in § 19–3B–01 of this article.

(b) (1) Each hospital that has care of a patient with cancer or a central nervous system tumor, each freestanding laboratory, freestanding ambulatory care facility, or therapeutic radiological center that has care of or has diagnosed cancer or a central nervous system tumor for a nonhospitalized patient, and each physician who has care of or has diagnosed cancer or a central nervous system tumor for a nonhospitalized patient not otherwise reported shall:

(i) 1. Submit a cancer report to the Secretary, on the form that the Secretary provides or in a computerized file;

2. Make available to the Secretary, or an agent of the Secretary, at the facility the information necessary to compile a cancer report; or

3. Enter into an agreement with a hospital or other facility or agency that agrees to report to the Maryland Cancer Registry to act as the reporting source for a cancer or central nervous system tumor patient who has been referred to or from that facility, or reported to that agency with regard to cancer or central nervous system tumor screening, diagnosis, or treatment; and

(ii) Effective July 1, 1993, submit a cancer report in a computerized file on a quarterly basis to the Secretary, or an agent of the Secretary, for all patients initially diagnosed, treated, or admitted to a facility for cancer or a central nervous system tumor during that calendar quarter.

(2) To assure compliance with this section, the Secretary, or an agent of the Secretary, may inspect upon reasonable notice a representative sample of the medical records of patients diagnosed, treated, or admitted for cancer or a central nervous system tumor at the facility.

(3) (i) Information obtained under this subsection shall be confidential and subject to Title 4, Subtitle 1 of this article.

(ii) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties pursuant to State or federal law where the Secretary determines that the agency to whom the information is disclosed will maintain the confidentiality of the disclosure.

(iii) A cancer report is not a medical record under Title 4, Subtitle 3 of this article, but is subject to the confidentiality requirements of Title 4, Subtitle 1 of this article.

(4) Each hospital, freestanding laboratory, freestanding ambulatory care facility, therapeutic radiological center, or physician who in good faith submits a cancer report to the Secretary is not liable in any cause of action arising from the submission of the report.

(5) The Secretary, after consultation with the Cancer Registry Advisory Committee, the Maryland Hospital Association, and representatives of freestanding laboratories and therapeutic radiological centers, shall adopt regulations to implement the requirements of this section.

§18–205.

(a) In this section, "clinical material" means:

(1) An organism isolated from a clinical specimen;

(2) Material derived or prepared from a clinical specimen in which evidence of a communicable disease has been identified or detected; or

(3) If the organism or material described in subparagraph (i) or (ii) of this paragraph is not available, material from an individual that has already been obtained by the medical laboratory, in the following order of preference:

(i) A patient specimen;

(ii) Microbial genetic material; or

(iii) Other laboratory material.

(b) (1) Except for the director of the State's public health laboratory system, the director of a medical laboratory located in this State shall submit a report

to the health officer for the county where the laboratory is located after an examination of a human specimen shows evidence of any infectious or contagious disease or condition that has been designated by the Secretary as reportable.

(2) The director of the State's public health laboratory system shall submit a report to the Secretary if an examination of a human specimen shows evidence of any infectious or contagious disease or condition that has been designated by the Secretary as reportable.

(3) The director of a medical laboratory located outside of this State that performs a medical laboratory test on a human specimen acquired from a person in this State shall submit a report to the Secretary after an examination of that specimen shows evidence of any infectious or contagious disease or condition that has been designated by the Secretary as reportable.

(4) A director of a medical laboratory shall submit clinical material to the Secretary as directed by the Secretary.

(c) (1) When more than 1 specimen is taken from a patient during 1 disease episode, the director of the medical laboratory need not report every test result of a specimen that shows evidence of the same disease in that patient if:

(i) At least 1 positive test result is reported; and

(ii) The health officer has approved the reporting of less than all test results.

(2) The director of the medical laboratory need not report vibriosis, noncholera, if the disease is found in a specimen obtained from the patient's teeth, gingival tissues, or oral mucosa.

(d) The report shall:

(1) Contain the information and be in a format specified or approved by the Secretary; and

(2) Be transmitted as directed by the Secretary.

(e) This section does not relieve a person of the duty to report under § 18–201, § 18–201.1, § 18–202, or § 18–202.1 of this subtitle.

(f) (1) A health officer shall inform the Secretary of each laboratory examination report received under subsection (b)(1) of this section.

(2) The Secretary shall inform the health officer of the jurisdiction where the patient resides of a laboratory examination report received under this section from a medical laboratory located outside this State.

(g) The Secretary, a health officer, or an agent of the Secretary or health officer may discuss a laboratory report with the attending physician or another health care provider caring for a patient, but, if the physician or another health care provider caring for a patient is not reasonably available, may communicate with a patient directly in a manner prescribed by the Secretary.

(h) (1) Except as provided in paragraphs (2) through (5) of this subsection, all reports and all information collected in connection with a report from a health care provider, the subject of the report, or other individuals who might be affected by the condition or disease in the report are:

(i) Confidential;

(ii) Not medical records under Title 4, Subtitle 3 of this article;

(iii) Not open to public inspection; and

(iv) Not discoverable or admissible in evidence in any civil or criminal matter except in accordance with a court order sealing the court record.

(2) This subsection does not apply to reports, information, and records otherwise available to the public or required to be publicly disclosed.

(3) The Secretary may prepare and disseminate nonindividually identifiable information about one or more cases of a condition or a disease based on any report made under this section, for any purpose consistent with the Secretary's lawful duties as authorized by an act of the Maryland General Assembly.

(4) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress where the Secretary determines that:

(i) The agency to whom the information is disclosed will maintain the confidentiality of the disclosure; and

(ii) The disclosure is necessary to protect the public health or to prevent the spread of an infectious or contagious disease.

(5) This subsection does not apply to or restrict the use or publication of any statistics, information, or other material that summarizes or refers to confidential records in the aggregate, without disclosing the identity of any individual who is the subject of the confidential record.

(i) To assure compliance with this section, the Secretary, a health officer, or an agent of the Secretary or health officer may inspect pertinent laboratory records.

(j) The Secretary shall adopt regulations that designate the diseases or conditions that are reportable by a director of a medical laboratory under this section.

§18–206.

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

(2) "Birth defect" means an abnormality of the structure or a function of the human body present at birth that may result in:

(i) A physical or mental disability; or

(ii) Death.

(3) "Health care provider" has the meaning stated in § 4–301 of this article.

(b) (1) A hospital shall make a report on each child who is live–born or stillborn in the hospital and has a birth defect. If a child is born outside the hospital, the person filling out the birth certificate shall make a report under this section.

(2) The Secretary shall appoint a committee of physicians, hospital representatives, epidemiologists, parents or guardians of children with birth defects, and officials from the Department to determine the information required under paragraph (1) of this subsection.

(3) The hospital shall submit the reports required under paragraph (1) of this subsection to the Department within 1 month after the date of release of the child's mother from the hospital.

(c) A health care provider shall allow the Department to inspect and obtain the following medical information regarding a child with a birth defect:

(1) The medical records of:

(i) A child through the child's second year of life; and

(ii) A child's mother regarding the mother's pregnancy with the child;

(2) Records of any laboratory tests relating to a child's birth defect; and

(3) Any other medical information relating to a child's birth defect.

(d) (1) The hospital shall disclose the identity of the child with a birth defect to the Secretary so that the Secretary may:

(i) Use the information to protect the public health; or

(ii) Provide the parents or guardians of the child with information on birth defects and public and private services available in accordance with subsection (g)(1) and (4) of this section.

(2) If the Department shows a need for the individual identity of children without birth defects to conduct an investigation that aids in the protection of the public health, the hospital shall obtain the written consent of the parent or guardian of the child to disclose the child's name to the Secretary.

(3) The Secretary shall assure that the identity of a child under this section may not be released outside the Department without the written consent of the parent or guardian of the child.

(e) (1) The Department shall keep any medical information obtained under this section confidential.

(2) Medical information requested under this section shall be only as intrusive as necessary and used for the purpose of:

(i) Assuring the quality of the data reported;

(ii) Providing information or services to a child's family;

(iii) Conducting an epidemiological investigation related to a birth defect; or

(iv) Conducting the Department's research into the causes of birth defects.

(3) (i) The release of medical information obtained in accordance with this section to the Department is not a violation of the confidential relationship between a health care provider and a patient.

(ii) A health care provider who discloses medical records to the Department under this section:

1. Is not liable in any suit for civil damages for the disclosure of the medical records;

2. Is not subject to disciplinary action by any licensing or disciplining authority for disclosure of confidential information; and

3. May not be subject to any criminal penalties.

(4) The medical information obtained by the Department under this section is not subject to subpoena, discovery, or introduction into evidence in any administrative, civil, or criminal proceeding.

(f) While conducting research using human subjects under this section, the Department shall comply with the requirements for the protection of human subjects under:

(1) Title 13, Subtitle 20 of this article; and

(2) 42 U.S.C. § 289.

(g) (1) The Department shall assure that information is prepared and periodically updated on:

(i) Birth defects; and

(ii) Public and private services for children with birth defects.

(2) (i) The Secretary shall appoint a committee to determine the information required under paragraph (1) of this subsection.

(ii) The committee shall consist of:

1. Physicians;

2. Educators;

3. Social service specialists;

4. Representatives of the Department;

5. Representatives of the Department of Human Services;

6. Representatives of the State Department of Education; and

7. Parents or guardians of children with birth defects.

(3) The information provided under this subsection shall be distributed to each hospital and made available to parents or guardians of children with birth defects by the child's physician before the child is discharged from the hospital and with an explanation, to the extent possible, of the birth defect to the parents or guardians.

(4) (i) The Secretary shall send a letter to the parent or guardian of each child reported under this section with a birth defect before the child is 6 months old.

(ii) The letter shall offer information about the birth defect and available services with emphasis on needs identified after discharge from the hospital.

(iii) Before sending a letter to a parent or guardian, the Secretary shall implement appropriate procedures to assure that a letter is not sent to a parent or guardian of a child who has died.

(h) The Department and the Department of the Environment shall jointly develop procedures to monitor the data on birth defect trends which may be caused by environmental hazards.

§18–207.

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

(2) "Designated anonymous HIV test site" means an HIV counseling and testing site approved by the Maryland Department of Health as a site where a patient may have an anonymous HIV test.

(3) "HIV/AIDS case report" means an abstract of the medical record of a patient diagnosed with human immunodeficiency virus or acquired immunodeficiency syndrome which contains:

(i) Reasonably obtained patient demographic information, including name and risk factors;

(ii) Relevant information on the:

1. Initial diagnosis;

2. Treatment and referral; and

3. Clinical condition; and

(iii) Facility and other provider identification information.

(4) "Report" means:

(i) A laboratory examination report for HIV or CD 4+ count as required by § 18–205 of this subtitle;

(ii) A report for HIV or AIDS as required by § 18–201.1, § 18–202, or § 18–202.1 of this subtitle; or

(iii) An HIV/AIDS case report.

(b) (1) Except for a designated anonymous HIV test site, a facility or office that orders a test for HIV and receives a test result that documents the presence of HIV as defined by the CDC laboratory criteria shall, upon the Secretary's request, make available to the Secretary, or an agent of the Secretary, the information necessary to compile an HIV/AIDS case report.

(2) A report or information assembled or obtained under this section:

(i) Is confidential and subject to Title 4, Subtitle 1 of this article; and

(ii) Is not a medical record under Title 4, Subtitle 3 of this article, but is subject to the confidentiality requirements of Title 4, Subtitle 1 of this article.

(3) This subsection does not apply to a disclosure by the Secretary to another governmental agency performing its lawful duties pursuant to State or federal law where the Secretary determines that the agency to which the information is disclosed will maintain the confidentiality of the disclosure.

(4) The report and any proceedings, records, or files relating to the reports required under this section are not discoverable and are not admissible in evidence in any civil action.

§18–208.

(a) (1) When a health officer has reason to believe that a disease that endangers public health exists within the county, the health officer shall:

(i) Report immediately to the appropriate county board of health; and

(ii) With the approval of the board:

1. Investigate the suspected disease; and

2. Act properly to prevent the spread of the disease.

(2) (i) Except in Baltimore City, the attending physician of an individual who has the disease may act properly to prevent the spread of the disease and does not need the approval of the county board of health to act.

(ii) A physician may act under this paragraph only until the health officer completes the investigation under paragraph (1) of this subsection or, if sooner, until the emergency ends.

(3) A county board of health shall pay the necessary and legitimate expenses that a health officer incurs under this subsection.

(b) When a health officer is notified of an infectious or contagious disease within the county, the health officer:

(1) Shall act immediately to prevent the spread of the disease;

(2) Within 24 hours after receiving notice of the disease, shall give the Secretary all information obtained on the disease; and

(3) Shall cooperate with the Secretary to prevent the spread of the disease.

(c) (1) When a health officer knows of any unusual disease or mortality in the county or a contiguous county, the health officer promptly shall give the Secretary notice of the disease or mortality.

(2) If a health officer is unsure whether a disease is infectious or contagious, the health officer shall notify the Secretary.

§18–209.

When a health officer receives notice of an infectious or contagious disease that affects or is likely to endanger the health of school children within the county, the health officer immediately shall give written notice to the county board of education.

§18–210.

(a) To prevent the spread of an infectious or contagious disease that endangers public health, a health officer may have:

(1) Any part of a house disinfected if the house has been exposed to the disease; and

(2) Any article in the house disinfected or destroyed if the article has been exposed to the disease.

(b) The county where the house is located shall:

(1) Incur the expense of disinfecting the house; and

(2) Reasonably compensate a person who suffers damage from the exercise of a power granted by this section, if the person is not at fault.

§18–211.

(a) A health officer may have an individual moved to a suitable place for the reception of the sick if:

(1) A physician certifies that the individual has an infectious disease that endangers public health;

(2) The individual:

(i) Is staying in a room occupied by more than 1 family;

(ii) Is on board a vessel; or

(iii) Otherwise does not have proper housing; and

(3) The administrative head of the place for the reception of the sick consents to the move.

(b) The city or county where the infected individual is found shall pay for the cost of moving the individual.

(c) A person may not willfully disobey an order or obstruct the carrying out of an order of the health officer to move an individual.

§18–212.

(a) The health officer shall keep a record of each report that is submitted to the health officer under § 18-201 of this subtitle.

(b) The record shall:

(1) Be on the form that the Secretary provides;

(2) State the date of the report;

(3) State the name of the physician who submits the report;

(4) State the disease identified in the report;

(5) State the name and residence address of the patient named in the report; and

(6) State the actions taken to prevent the spread of the disease.

§18–212.1.

If the Governor has strong grounds to believe that there is a danger of a malignant and contagious disease being introduced into the State, the Governor may:

(1) Quarantine a vessel that is entering the waters of the State;

(2) Prohibit or restrict contact between the State and the place affected by the disease; and

(3) Take other actions that appear to the Governor to be necessary to carry out this section.

§18–213.

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

(2) "Contagious disease or virus" means:

(i) Human immunodeficiency virus (HIV);

(ii) Meningococcal meningitis;

(iii) Tuberculosis;

(iv) Mononucleosis;

(v) Any form of viral hepatitis, including but not limited to hepatitis A, B, C, D, E, F, and G;

(vi) Diphtheria;

(vii) Plague;

(viii) Hemorrhagic fevers; or

(ix) Rabies.

(3) "Correctional institution" means a place of detention or correctional confinement operated by or for the State or a local government.

(4) (i) "Correctional officer" means a member of a correctional unit who is charged with and actually performs those duties that relate to the investigation, care, custody, control, or supervision of persons confined to places of incarceration.

(ii) "Correctional officer" includes any sheriff, warden, superintendent, or any other person having an equivalent title.

(5) "Law enforcement officer" means any person who, in an official capacity, is authorized by law to make arrests and who is a member of one of the following law enforcement agencies:

(i) The Department of State Police;

(ii) The Baltimore City Police Department;

(iii) The police department, bureau, or force of any county;

(iv) The police department, bureau, or force of any incorporated city or town;

(v) The office of the sheriff of any county;

(vi) The police department, bureau, or force of any bicounty agency or constituent institution of the University System of Maryland, Morgan State University, St. Mary's College, or of any institution under the jurisdiction of the Maryland Higher Education Commission;

(vii) The Maryland Transit Administration police force of the Department of Transportation, the Maryland Transportation Authority Police Force, and the Maryland Port Administration police force of the Department of Transportation;

(viii) The law enforcement officers of the Department of Natural Resources;

(ix) The Field Enforcement Bureau of the Comptroller's Office;

(x) The Field Enforcement Division of the Alcohol, Tobacco, and Cannabis Commission;

(xi) The Crofton Police Department;

(xii) The Intelligence and Investigative Division of the Department of Public Safety and Correctional Services; or

(xiii) The Ocean Pines Police Department.

(6) "Medical care facility" means a hospital as defined in § 19–301 of this article or a health care facility of a correctional institution.

(b) While treating or transporting an ill or injured patient to a medical care facility or while acting in the performance of duty, if a paid or volunteer firefighter, emergency medical technician, or rescue squad member comes into contact with a patient who is subsequently diagnosed as having a contagious disease or virus, as a result of information obtained in conjunction with the services provided during the visit to the facility, the attending physician, medical examiner, a designee of the medical care facility who receives the patient, the Chief Medical Examiner, or the Chief Medical Examiner's designee shall notify the firefighter, emergency medical technician, or rescue squad member, and the employer or employer's designee of the individual's possible exposure to the contagious disease or virus.

(c) If, while treating or transporting an ill or injured patient to a medical care facility or while acting in the performance of duty, a law enforcement officer comes into contact with a patient who is subsequently diagnosed, as a result of information obtained in conjunction with the services provided during the visit to the facility, as having a contagious disease or virus, the attending physician, medical examiner, a designee of the medical care facility who receives the patient, the Chief Medical Examiner or the Chief Medical Examiner's designee shall notify the law enforcement officer and the officer's employer or employer's designee of the officer's possible exposure to the contagious disease or virus.

(d) If, while treating or transporting an ill or injured incarcerated individual to a medical care facility or while acting in the performance of duty, a correctional officer comes into contact with an incarcerated individual who is subsequently diagnosed, as a result of information obtained in conjunction with the services provided during the visit to the facility, as having a contagious disease or virus, the attending physician, medical examiner, a designee of the medical care facility that receives the incarcerated individual, the Chief Medical Examiner, or the Chief Medical Examiner's designee shall notify the correctional officer and the correctional officer's correctional institution or the correctional institution's designee of the officer's possible exposure to the contagious disease or virus.

(e) The notification required under subsection (b), (c), or (d) of this section shall:

(1) Be made within 48 hours, or sooner, of confirmation of the patient's diagnosis;

(2) Include subsequent written confirmation of possible exposure to the contagious disease or virus;

(3) Be conducted in a manner that will protect the confidentiality of the patient; and

(4) To the extent possible, be conducted in a manner that will protect the confidentiality of the firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer.

(f) The written confirmation required under subsection (e)(2) of this section shall constitute compliance with this section.

(g) Each medical care facility shall develop written procedures for the implementation of this section, and, upon request, make copies available to the local fire authority, the local fire authority's designee, the local law enforcement authority,

the local law enforcement authority's designee, the correctional officer, or the correctional institution's designee having jurisdiction.

(h) A medical care facility, physician, Chief Medical Examiner, or the Chief Medical Examiner's designee acting in good faith to provide notification in accordance with this section may not be liable in any cause of action related to the breach of patient confidentiality.

(i) A medical care facility, physician, Chief Medical Examiner, or the Chief Medical Examiner's designee acting in good faith to provide notification in accordance with this section may not be liable in any cause of action for:

(1) The failure to give the required notice, if the firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer fails to properly initiate the notification procedures developed by the health care facility under subsection (g) of this section; or

(2) The failure of the employer or employer's designee to subsequently notify the firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer of the possible exposure to a contagious disease or virus.

(j) A firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer shall receive from their employers or local governmental bodies, at the expense of the employer or local governmental body, as part of their training, education on:

(1) (i) The routes of transmission of HIV and hepatitis B virus; and

(ii) The routes by which a firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer may be exposed to HIV and hepatitis B virus; and

(2) The current Centers for Disease Control and Prevention guidelines for preventing prehospital exposure to HIV and hepatitis B while rendering emergency medical care.

(k) A firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer shall receive from their employers, associations, or local governmental bodies, at the employers', associations', or local governmental bodies' expense, equipment recommended by the Centers for Disease Control and Prevention to protect a firefighter, emergency medical technician, rescue

squad member, law enforcement officer, or correctional officer from exposure to HIV and hepatitis B while rendering emergency medical care.

(l) (1) The fire department, law enforcement agency, and all other agencies or organizations employing a firefighter, emergency medical technician, rescue squad member, law enforcement officer, or correctional officer shall develop written procedures for the implementation of this section.

(2) On request, copies of the procedures developed in this subsection shall be made available to employees, employee unions, volunteer associations, and the Secretary.

(m) A person under this section may not refuse to treat or transport an individual because the individual is HIV positive.

§18–213.1.

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

(2) (i) "Body fluids" means:

1. Any fluid containing visible blood, semen, or vaginal secretions; or

2. Cerebral spinal fluid, synovial, or amniotic fluid.

(ii) "Body fluid" does not include saliva, stool, nasal secretions, sputum, tears, urine, or vomitus.

(3) "Contact exposure" means as between a patient and a sworn member of the State Fire Marshal's office:

(i) Percutaneous contact with blood or body fluids;

(ii) Mucocutaneous contact with blood or body fluids;

(iii) Open wound, including dermatitis, exudative lesions, or chapped skin, contact with blood or body fluids for a prolonged period; or

(iv) Intact skin contact with large amounts of blood or body fluids for a prolonged period.

(4) "Contagious disease or virus" means:

(i) Human immunodeficiency virus (HIV);

(ii) Meningococcal meningitis;

(iii) Tuberculosis;

(iv) Mononucleosis;

(v) Any form of viral hepatitis, including but not limited to hepatitis A, B, C, D, E, F, and G;

(vi) Diphtheria;

(vii) Plague;

(viii) Hemorrhagic fevers; or

(ix) Rabies.

(5) "Medical care facility" means a hospital as defined in § 19–301 of this article or a health care facility of a correctional institution.

(b) If, while treating or transporting an ill or injured patient to a medical care facility or while acting in the performance of duty, a sworn member of the State Fire Marshal's office comes into contact exposure with a patient who is subsequently diagnosed, as a result of information obtained in conjunction with the services provided during the visit to the facility, as having a contagious disease or virus, the attending physician, medical examiner, a designee of the medical care facility who receives the patient, the Chief Medical Examiner, or the Chief Medical Examiner's designee shall notify the sworn member of the State Fire Marshal's office and the State Fire Marshal or the State Fire Marshal's designee of the officer's possible contact exposure to the contagious disease or virus.

(c) The notification required under subsection (b) of this section shall:

(1) Be made within 48 hours of confirmation of the patient's diagnosis;

(2) Include subsequent written confirmation of possible contact exposure to the contagious disease or virus;

(3) Be conducted in a manner that will protect the confidentiality of the patient; and

(4) To the extent possible, be conducted in a manner that will protect the confidentiality of the sworn member of the State Fire Marshal's office.

(d) The written confirmation required under subsection (c)(2) of this section shall constitute compliance with this section.

(e) Each medical care facility shall develop written procedures for the implementation of this section, and upon request, make copies available to the State Fire Marshal's office.

(f) A medical care facility, physician, Chief Medical Examiner, or the Chief Medical Examiner's designee acting in good faith to provide notification in accordance with this section may not be liable in any cause of action related to the breach of patient confidentiality.

(g) A medical care facility, physician, Chief Medical Examiner, or the Chief Medical Examiner's designee acting in good faith to provide notification in accordance with this section may not be liable in any cause of action for:

(1) The failure to give the required notice, if the sworn member of the State Fire Marshal's office fails to properly initiate the notification procedures developed by the health care facility under subsection (e) of this section; or

(2) The failure of the State Fire Marshal or the State Fire Marshal's designee to subsequently notify the sworn member of the State Fire Marshal's office of the possible contact exposure to a contagious disease or virus.

(h) A sworn member of the State Fire Marshal's office shall receive from the State Fire Marshal's office, at the expense of the State Fire Marshal's office, as part of the member's training, education on:

(1) (i) The routes of transmission of HIV and hepatitis B virus; and

(ii) The routes by which a sworn member of the State Fire Marshal's office may be exposed to HIV and hepatitis B virus; and

(2) The current Centers for Disease Control and Prevention guidelines for preventing prehospital exposure to HIV and hepatitis B while rendering emergency medical care.

(i) A sworn member of the State Fire Marshal's office shall receive from the State Fire Marshal's office, at the State Fire Marshal's expense, equipment recommended by the Centers for Disease Control and Prevention to protect a sworn

member of the State Fire Marshal's office from exposure to HIV and hepatitis B while rendering emergency medical care.

(j) (1) The State Fire Marshal's office shall develop written procedures for the implementation of this section.

(2) On request, copies of the procedures developed under this subsection shall be made available to employees, employee unions, volunteer associations, and the Secretary.

(k) A person under this section may not refuse to treat or transport an individual because the individual is HIV positive.

§18–213.2.

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

(2) (i) "Body fluids" means:

1. Any fluid containing visible blood, semen, or vaginal secretions; or

2. Cerebral spinal fluid, synovial, or amniotic fluid.

(ii) "Body fluids" does not include saliva, stool, nasal secretions, sputum, tears, urine, or vomitus.

(3) "Contact exposure" means as between a decedent and a first responder:

(i) Percutaneous contact with blood or body fluids;

(ii) Mucocutaneous contact with blood or body fluids;

(iii) Open wound, including dermatitis, exudative lesions, or chapped skin, contact with blood or body fluids for a prolonged period; or

(iv) Intact skin contact with large amounts of blood or body fluids for a prolonged period.

(4) "Contagious disease or virus" means:

(i) Human immunodeficiency virus (HIV);

(ii) Meningococcal meningitis;

(iii) Tuberculosis;

(iv) Mononucleosis;

(v) Any form of viral hepatitis, including but not limited to hepatitis A, B, C, D, E, F, and G;

(vi) Diphtheria;

(vii) Plague;

(viii) Hemorrhagic fevers; or

(ix) Rabies.

(5) "Correctional institution" means a place of detention or correctional confinement operated by or for the State or a local government.

(6) (i) "Correctional officer" means a member of a correctional unit who is charged with and actually performs those duties that relate to the investigation, care, custody, control, or supervision of individuals confined to places of incarceration.

(ii) "Correctional officer" includes any sheriff, warden, superintendent, or other individual having the equivalent title.

(7) "First responder" means a:

(i) Firefighter;

(ii) Emergency medical technician;

(iii) Rescue squad member;

(iv) Law enforcement officer;

(v) Correctional officer; or

(vi) Sworn member of the State Fire Marshal's office.

(8) "Law enforcement officer" means any individual who, in an official capacity, is authorized by law to make arrests and who is a member of one of the following law enforcement agencies:

(i) The Department of State Police;

(ii) The Baltimore City Police Department;

(iii) The police department, bureau, or force of any county;

(iv) The police department, bureau, or force of any incorporated city or town;

(v) The office of the sheriff of any county;

(vi) The police department, bureau, or force of any bicounty agency or constituent institution of the University System of Maryland, Morgan State University, St. Mary's College, or of any institution under the jurisdiction of the Maryland Higher Education Commission;

(vii) The Maryland Aviation Administration police force of the Department of Transportation, the Maryland Transit Administration police force of the Department of Transportation, the Maryland Transportation Authority police force, and the Maryland Port Administration police force of the Department of Transportation;

(viii) The law enforcement officers of the Department of Natural Resources;

(ix) The Field Enforcement Bureau of the Comptroller's Office;

(x) The Intelligence and Investigative Division of the Department of Public Safety and Correctional Services; or

(xi) The Maryland Capitol Police of the Department of General Services.

(9) "Medical care facility" means a hospital, or a health care facility of a correctional institution.

(10) "Physician performing a postmortem examination" means any of the following persons who perform a postmortem examination on a decedent:

(i) The Chief Medical Examiner; or

(ii) The Chief Medical Examiner's designee.

(b) If, while transporting a person to a medical care facility or while acting in the performance of duty, a first responder comes into contact exposure while treating or transporting a person who dies at the scene or while being transported and who is subsequently determined, as a result of information obtained in conjunction with a postmortem examination by the Chief Medical Examiner or a designee of the Chief Medical Examiner to have had a contagious disease or virus at the time of death, the physician performing the postmortem examination shall notify the first responder and the first responder's employer or the employer's designee of the first responder's possible contact exposure to the contagious disease or virus.

(c) The notification required under subsection (b) of this section shall:

(1) Be made within 48 hours of confirmation of the determination that the deceased person had a contagious disease or virus at the time of death;

(2) Include subsequent written confirmation of possible contact exposure to the contagious disease or virus;

(3) Be conducted in a manner that will protect the confidentiality of the deceased person; and

(4) To the extent possible, be conducted in a manner that will protect the confidentiality of the first responder.

(d) The written confirmation required under subsection (c)(2) of this section shall constitute compliance with this section.

(e) A medical care facility or physician performing a postmortem examination acting in good faith to provide notification in accordance with this section is not liable in any cause of action related to a breach of patient confidentiality.

(f) A medical care facility or physician performing a postmortem examination acting in good faith to provide notification in accordance with this section is not liable in any cause of action for:

(1) The failure to give the required notice if the first responder fails to properly initiate the notification procedures developed by the medical care facility and the Chief Medical Examiner under subsection (g) of this section; or

(2) The failure of the employer or the employer's designee to subsequently notify the first responder of the possible contact exposure to a contagious disease or virus.

(g) (1) The State Fire Marshal, the Chief Medical Examiner, and each fire department, rescue squad company, medical care facility, correctional institution, and law enforcement agency in the State shall develop written procedures for the implementation of this section.

(2) On request, the State Fire Marshal and each fire department, rescue squad company, medical care facility, correctional institution, and law enforcement agency shall make copies of the procedures developed in this subtitle available to employees, employee unions, volunteer associations, and the Secretary.

(h) A person covered under subsection (a)(5), (6), (7), (8), (9), and (10) of this section may not refuse to treat or transport a deceased person because the deceased person was HIV positive at the time of death.

§18–214.

(a) In this section, "vaccine" means a product intended to elicit, in humans, active or passive immunity against an infectious agent or product of an infectious agent.

(b) There is a Statewide Advisory Commission on Immunizations.

(c) The following members shall serve without term limits:

(1) The State Superintendent of Schools or the State Superintendent's designee with knowledge of the immunizations required of children entering schools;

(2) One local health officer;

(3) One representative from the Department's Vaccines for Children Program; and

(4) The Maryland State Epidemiologist.

(d) The following members are subject to term limits:

(1) One representative from a public health consumer advocacy group;

(2) One nurse practitioner;

(3) One representative from a health insurance carrier;

(4) One consumer;

(5) One pharmacist;

(6) One physician member of MedChi, The Maryland State Medical Society;

(7) Two physician members of the Maryland Chapter of the American Academy of Pediatrics with experience in private practice and infectious diseases;

(8) One physician member of the Maryland Academy of Family Physicians;

(9) One school–based health care provider member of the Maryland Assembly on School–Based Health Care;

(10) One school nurse member of the Maryland Association of School Health Nurses or the Maryland Nurses Association;

(11) One physician member of the American College of Physicians – Internal Medicine Society of Maryland;

(12) One physician assistant member of the Maryland Academy of Physician Assistants; and

(13) Up to three additional members selected by the Secretary.

(e) Except for the members listed in subsection (c)(1), (2), and (4) of this section, the Secretary shall appoint the membership of the Commission, based on the recommendation of the appropriate medical society or agency.

(f) (1) The Secretary, in consultation with MedChi, The Maryland State Medical Society, shall appoint the chair of the Commission.

(2) The chair of the Commission shall:

(i) Establish subcommittees to facilitate the work of the Commission; and

(ii) Appoint subcommittee chairs from among the Commission members.

(g) (1) This subsection applies only to members who are subject to term limits.

(2) The term of an appointed member is 4 years.

(3) Subject to paragraph (5) of this subsection, a member may serve two consecutive terms.

(4) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(5) A member who serves two consecutive full 4–year terms may not be reappointed for 4 years after the completion of those terms.

(6) The terms of the members of the Commission are staggered as required by the terms provided for the members of the Commission on June 1, 2010.

(h) If a vacancy for an appointed member of the Commission occurs, the Secretary shall promptly appoint a successor.

(i) A member of the Commission may not receive compensation but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(j) The Department shall provide the staffing for the Commission.

(k) The Commission shall:

(1) Determine where community vaccine shortages exist and which vaccines are in short supply;

(2) Develop a recommendation for a plan to effectuate the equitable distribution of vaccines;

(3) Review:

(i) Potential provider reimbursement barriers to increasing immunizations;

(ii) The relative effectiveness of outreach programs that educate the public about the benefits of immunizations;

(iii) Potential cost–shifting of immunization expenses for privately insured patients who receive immunizations at local health departments; and

(iv) Potential administrative burdens associated with State purchasing of vaccines;

(4) Based on the review required under item (3) of this subsection, make recommendations on how to increase immunizations, including catch–up immunizations, among adults, adolescents, and children who are recommended to receive immunizations; and

(5) Study and make recommendations about other related issues as determined by the Commission, including:

(i) Immunizations required of children entering schools;

(ii) All available options for the purchasing of vaccines, including the development of a Universal Vaccine Purchasing System, or a similar program to increase access to necessary vaccines, for the State;

(iii) An update on the status of the use of thimerosal in vaccines, including the availability and affordability of thimerosal–free vaccines, and any other issue related to the use of thimerosal in vaccines that is identified by the Commission;

(iv) Elimination of any vaccine distribution disparities;

(v) A public education campaign in the event of a vaccine shortage or public health emergency involving immunizations; and

(vi) The availability and affordability of adult, adolescent, and childhood vaccines.

(l) The Commission may recommend to the Department that information on vaccine safety be communicated to health care providers.

(m) On or before December 15 of each year, the Commission shall submit a report on its findings and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee.

§18–214.1.

(a) The purpose of expedited partner therapy is to provide antibiotic therapy to any partner of a patient diagnosed with an infection transmitted through sexual activity identified in subsection (b) of this section in order to:

(1) Contain and stop the further spread of the infection; and

(2) Reduce the likelihood of reinfection in the diagnosed patient.

(b) Notwithstanding any other provision of law, the following health care providers may prescribe, dispense, or otherwise provide antibiotic therapy to a sexual partner of a patient diagnosed with chlamydia, gonorrhea, trichomoniasis, or bacterial vaginosis without making a personal physical assessment of the patient's partner:

(1) A physician licensed under Title 14 of the Health Occupations Article;

(2) An advanced practice registered nurse with prescriptive authority licensed under Title 8 of the Health Occupations Article acting in accordance with § 8–508 of the Health Occupations Article;

(3) An authorized physician assistant licensed under Title 15 of the Health Occupations Article acting in accordance with § 15–302.2 of the Health Occupations Article;

(4) A registered nurse employed by a local health department who complies with:

(i) The formulary developed and approved under § 3–403(b) of this article; and

(ii) The requirements established under § 8–512 of the Health Occupations Article; and

(5) A certified midwife licensed under Title 8, Subtitle 6D of the Health Occupations Article.

(c) This section may not be construed to otherwise expand the prescribing or dispensing authority of an advanced practice registered nurse with prescriptive authority or a physician assistant.

(d) Notwithstanding any other provision of law, a pharmacist licensed under Title 12 of the Health Occupations Article may dispense antibiotic therapy prescribed in accordance with subsection (b) of this section.

(e) The Secretary shall adopt regulations to implement the requirements of this section in public and private health care settings in the State.

§18–214.2.

(a) (1) In this section, "public institution of higher education" means:

(i) A public senior higher education institution, as defined in § 10–101 of the Education Article; and

(ii) A community college.

(2) A public institution of higher education does not include an institution without residential housing or a health center.

(b) (1) On or before August 1 each year, beginning in 2021, each public institution of higher education shall submit an outbreak response plan to the Department.

(2) If there is an outbreak of a contagious disease at a public institution of higher education, the public institution of higher education shall implement the outbreak response plan required under paragraph (1) of this subsection.

(c) The outbreak response plan required under subsection (b) of this section shall be customized to the public institution of higher education and include:

(1) A process for expediently notifying students, families of students, faculty, and staff of:

(i) The outbreak of a contagious disease;

(ii) Subpopulations that are at high risk of severe complications from the contagious disease;

(iii) Guidance on how students, families of students, faculty, and staff can take reasonable protective measures; and

(iv) Information on the availability of laboratory testing for students, faculty, and staff;

(2) Processes for implementing evidence–based outbreak response measures;

(3) The provision of staff to successfully implement the outbreak response plan during an outbreak of a contagious disease at the public institution of higher education;

(4) A process for reporting an outbreak of a contagious disease at the public institution of higher education to:

(i) The Department;

(ii) The local health department;

(iii) Campus health providers;

(iv) Local community health providers; and

(v) Regional hospitals; and

(5) Any other measure required by the Department.

§18–215.

(a) In addition to any other penalty provided by law, a physician who fails to submit the report required under § 18–204 of this subtitle, on conviction, is subject to a fine not exceeding $10.

(b) A person who violates any provision of § 18–202 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50.

(c) In addition to any other penalty provided by law, a physician who fails to submit the report required under § 18–201 of this subtitle, on conviction, is subject to a fine not exceeding $100.

(d) A person who violates any provision of § 18–205 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500.

(e) A health care provider or any other person, including an officer or employee of a governmental unit, who knowingly and willfully discloses personal identifying health information acquired for the purposes of HIV and AIDS reporting under § 18–201.1, § 18–202.1, § 18–205, or § 18–207 of this subtitle to any person who is not authorized to receive personal identifying health information under this

subtitle or otherwise in violation of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $2,000 for the first offense and not exceeding $10,000 for each subsequent conviction for a violation of any provision of this subtitle.

(f) (1) A health care provider or any other person, including an officer or employee of a governmental unit, who knowingly and willfully requests or obtains information on HIV and AIDS developed under § 18–201.1, § 18–202.1, § 18–205, or § 18–207 of this subtitle under false pretenses or through deception, on conviction is subject to:

(i) A fine not exceeding $100,000, imprisonment for not more than 5 years, or both; and

(ii) If the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, a fine not exceeding $250,000, imprisonment for not more than 10 years, or both.

(2) This subsection does not apply to an officer or employee of a governmental unit that is conducting a criminal investigation.

(g) A health care provider or any other person who knowingly violates subsection (e) or (f) of this section is liable for actual damages.

(h) A physician, laboratory, or institution as defined in § 18–202.1 of this subtitle that in good faith submits a report or otherwise discloses information in accordance with this subtitle is not liable in any action arising from the disclosure of the information.

§18–216.

A person who violates any provision of § 18-211(c) of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $200 or imprisonment not exceeding 6 months.

§18–217.

The General Assembly finds and declares that it is in the public interest to ensure the public health, safety, and welfare by strictly regulating in this State the importation, transportation, sale, transfer, breeding, raising, keeping, and possession of certain animals which pose a possibility of the introduction of a disease or pest harmful to humans, or endangers the physical safety of human beings.

§18–218.

In this part, "animal" means any nonhuman living creature, whether native to Maryland or not, which is:

(1) Wild by nature; and

(2) Endowed with sensation and power of voluntary motion.

§18–219.

(a) The Secretary may prohibit the importation, selling, trading, purchasing, bartering, breeding, raising, keeping, or possession of any animals found to be dangerous to human health and safety.

(b) This section does not apply to:

(1) Domestic cats;

(2) Domestic dogs;

(3) Domestic ferrets;

(4) Animals used for agricultural purposes;

(5) Animals used for scientific purposes;

(6) Animals used for educational purposes;

(7) Animals used for public exhibitions; or

(8) Any animal that the Secretary determines is not a threat to human health and safety.

(c) This section may not be construed to prohibit the breeding, raising, keeping, or possession of turtles by a person who has obtained a permit under Title 10, Subtitle 9 of the Natural Resources Article.

§18–220.

Nothing in this part prevents or prohibits any county, municipal corporation, or Baltimore City from imposing stricter possession requirements or banning possession of certain animals.

§18–221.

When prohibiting animals that may also be harmful to indigenous wildlife or agricultural animals under § 18-219 of this subtitle, the Secretary shall coordinate with the Departments of Natural Resources and Agriculture.

§18–222.

(a) Any person who imports, transports, sells, transfers, breeds, raises, keeps, or possesses any animal which is prohibited under § 18-219 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500, or imprisonment not exceeding 1 year, or both.

(b) Any animal, whose possession or keeping is prohibited under § 18-219 of this subtitle shall be considered a nuisance and a contraband, and is subject to seizure by any authorized law-enforcement officer.

§18–301.

(a) Except for a physician or a dentist, a person may not:

(1) Treat or prescribe a treatment for cancer; or

(2) Represent to the public that the person can cure, treat, or prescribe a treatment for cancer.

(b) A person may not sell, offer to sell, or give away a drug, medicine, or device that the manufacturer or seller represents as a cancer cure unless a physician or dentist prescribes the drug, medicine, or device.

§18–303.

(a) (1) The Secretary shall establish and promote a statewide public information campaign on diethylstilbestrol (DES).

(2) The public information campaign shall:

(i) Try to reach each individual who has been exposed to diethylstilbestrol and each offspring of those individuals, to encourage the individuals and offspring to seek medical care for the prevention or treatment of cancer that results from the exposure to diethylstilbestrol; and

(ii) Include any other matter that the Secretary considers appropriate.

(b) The Secretary shall expand existing cancer screening programs to detect any cancer or other abnormal condition that results from exposure to diethylstilbestrol, including breast, cervical, testicular, or vaginal cancer or vaginal adenosis.

(c) The Secretary shall establish a program to train physicians, physician's assistants, and nurses in:

(1) Identifying individuals who have been exposed to diethylstilbestrol;

(2) Diagnosing and treating any cancer or other abnormal condition that results from the exposure; and

(3) Preventing exposure to diethylstilbestrol.

(d) To carry out this section, the Secretary:

(1) On request, shall receive the help of or information from any agency of this State or of a political subdivision; and

(2) May contract for any necessary services.

(e) (1) The Secretary may set a sliding fee schedule for services provided under this section.

(2) This State shall reimburse a provider of screening and diagnosis under this section in the amount that the screening and diagnosis exceeds the total of the fee charged for the service and of all third party payments for the service.

§18–304.

A person who violates any provision of § 18-301 or § 18-302 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 5 years or both.

§18–307.

(a) This section does not apply to a woman who objects to a standard serological syphilis test because the test is against the religious beliefs and practices of the woman.

(b) (1) The health care provider attending a woman for pregnancy shall submit to a medical laboratory:

(i) A blood sample taken from the woman at the time that the health care provider first examines the woman;

(ii) A blood sample taken from the woman in the third trimester at:

1. The prenatal visit at 28 weeks of gestation; or

2. The first prenatal visit after 28 weeks of gestation; and

(iii) 1. A blood sample taken from the woman who delivers a live born infant at the time of delivery; or

2. A blood sample taken from the woman who delivers a stillborn infant:

A. At 20 weeks of gestation or later; or

B. Weighing at least 500 grams.

(2) The medical laboratory to which a blood sample is submitted shall do a standard serological syphilis test that is approved by the Department.

(c) A hospital shall determine the syphilis serologic status of the mother before discharging the newborn for the purposes of neonatal evaluation and treatment.

(d) The Department may adopt rules, regulations, and standards under this section.

§18–308.

(a) Immediately after the birth of a child, the attending physician or attending nurse midwife shall use in the eyes of the child a prophylactic, approved by the Department, against gonococcal ophthalmia neonatorum.

(b) If, within 2 weeks after the birth of a child, an eye of the child becomes inflamed or swollen:

(1) The attending physician shall test to determine if gonococcal ophthalmia neonatorum is the cause of the inflammation or swelling; or

(2) If there is no attending physician, any other individual who has care of the child shall report the condition immediately to a physician or to the health officer for the county where the child is located, so that testing may be done.

(c) Within 48 hours after a physician knows that a child under the physician's care has gonococcal ophthalmia neonatorum, the physician shall submit a report to the Department.

(d) An individual other than a physician may not treat the inflammation or swelling.

(e) A person who violates any provision of subsection (b)(2) or (d) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 or imprisonment not exceeding 6 months or both.

§18–309.

(a) (1) To the extent that funds are available for this purpose, the Secretary, in collaboration with other State agencies, shall establish and promote a statewide public information, awareness, and education campaign on Fetal Alcohol Syndrome and other effects of prenatal alcohol exposure.

(2) The campaign shall:

(i) Reach out to the general public and specific populations determined to be at high risk for contracting Fetal Alcohol Syndrome;

(ii) Disseminate the information about Fetal Alcohol Syndrome through written materials, television, radio, posters, or any other medium the Secretary considers appropriate and effective for conveying the information;

(iii) Distribute informational materials free of charge to prenatal clinics and to establishments that serve alcoholic beverages; and

(iv) Include any other matter that the Secretary considers appropriate.

(b) To carry out this section, the Secretary:

(1) On request, shall receive aid or information from any agency of this State, or from a political subdivision;

(2) May request the services of interested advocacy groups; and

(3) May contract for any necessary services.

§18–312.

In Part III of this subtitle, "public health veterinarian" means the veterinarian whom the Secretary designates as responsible for the veterinary public health program of the Department.

§18–313.

The Secretary of Health shall provide a statewide system:

(1) To control rabies;

(2) To grant authority to the public health veterinarian and the local health officer in matters pertaining to the disposition of animals that bite or otherwise expose rabies to an individual;

(3) To assist local political subdivisions regarding the laboratory testing of rabid animals;

(4) To treat each individual who is exposed or suspected of having been exposed to rabies;

(5) To distribute, in accordance with the conditions set by the Secretary of Agriculture, the biological products that are needed to prevent and treat rabies; and

(6) To allow a veterinary technician, as defined in § 2–301 of the Agriculture Article, or other clinical staff who work in or for an animal shelter, as defined in § 2–1701 of the Agriculture Article, or an animal control facility, as defined in § 2–305 of the Agriculture Article, to administer rabies vaccines if:

(i) The animal shelter or animal control facility is licensed to administer drugs under § 2–305 of the Agriculture Article;

(ii) The animal being vaccinated is under the custody or control of an animal shelter or animal control facility;

(iii) The veterinary practitioner who signs the rabies vaccination certificate has ensured that the individual administering the rabies

vaccine was appropriately trained on administering rabies vaccines, including proper storage, handling, administration, and management of adverse reactions; and

(iv) The individual administering the vaccine is identified on the rabies vaccination certificate.

§18–314.

The Department shall provide preexposure immunization, without charge, to any individual who provides rabies control services at the request of the Department.

§18–315.

(a) With the county health department for each county, the Department shall provide for an antirabies clinic in the county.

(b) Each clinic shall be staffed by a graduate veterinarian.

(c) The clinic for a county shall be offered on or before June 30 of each year, on the date and at the location that the Department and the health department for the county determine.

(d) Each county health department may charge fees that are set so as to produce funds to cover the cost of material and services that the clinic provides.

(e) The public health veterinarian shall set the vaccination procedures to be used at the clinics.

§18–316.

(a) (1) Except as provided in paragraph (2) of this subsection, an individual immediately shall report to the local police or sheriff if the individual:

(i) Knows that a dog, cat, or other warm blooded animal has bitten, scratched, or otherwise exposed an individual to a possible rabies infection; or

(ii) Suspects that an animal has rabies.

(2) In Frederick County, the individual shall report to the animal control center of Frederick County.

(b) On receipt of a report under this section, the police, sheriff, or animal control center staff shall:

(1) Notify the health officer for the county where the report is made; and

(2) Enforce all orders of the health officer and the public health veterinarian.

(c) If the public health veterinarian or the local health officer issues an order to surrender an animal that is suspected of having rabies, a person may not hide or secret the animal:

(1) In the custody of the person; or

(2) In the custody or with the cooperation of any other person.

(d) A person who fails or refuses to comply with any provision of this section or any order issued under this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500.

§18–317.

The Department shall pay the cost of any antirabies treatment that an individual requires, if the individual is unable to pay for the treatment.

§18–318.

(a) Each person who owns or keeps a dog, cat, or ferret that is 4 months old or older shall have the dog, cat, or ferret vaccinated adequately against rabies.

(b) (1) A county may not register or license a dog, cat, or ferret unless the person who owns or keeps the dog, cat, or ferret submits, with the application for registration or license, proof that the dog, cat, or ferret has been vaccinated adequately against rabies.

(2) The public health veterinarian shall determine the proof of vaccination that is acceptable.

§18–319.

(a) A licensed veterinarian who vaccinates a dog, cat, or ferret against rabies:

(1) May select the vaccine to be used;

(2) Shall administer the vaccine in a manner that is consistent with the recommendations of the National Association of State Public Health Veterinarians;

(3) Shall issue to the owner of the dog, cat, or ferret a vaccination certificate, on the form that the Department approves; and

(4) Shall keep a record of the vaccination for a period of 5 years.

(b) The information in the rabies vaccination record that a licensed veterinarian keeps may not be used:

(1) To license the dog, cat, or ferret; or

(2) To tax the owner of the dog, cat, or ferret.

§18–320.

(a) Except as provided in subsection (e) of this section, an apparently healthy dog, cat, or ferret that has been adequately vaccinated against rabies in accordance with § 18-318 of this subtitle or any other animal that bites a human or otherwise exposes a human to rabies shall be quarantined as provided in subsection (b) of this section.

(b) An animal under quarantine shall be quarantined in a place, which may include the residence of the owner, in the manner designated by the local health officer or the public health veterinarian for a suitable period as determined by the health officer or the public health veterinarian.

(c) (1) At any time during the quarantine period, the public health veterinarian or local health officer may order the owner of a biting animal to have the animal monitored for rabies by a licensed veterinarian.

(2) The owner of the animal shall pay for the cost of any examination or other associated cost.

(d) An animal under quarantine may not be moved from the place of quarantine without the written permission of the local health officer or public health veterinarian.

(e) The public health veterinarian or local health officer or the designee of the public health veterinarian or local health officer may order the immediate and humane destruction of a biting animal for rabies testing if:

(1) It is necessary to preserve human health;

(2) A licensed veterinarian determines that a quarantined animal is inhumanely suffering; or

(3) The animal is considered wild and is not claimed by an owner within 24 hours.

§18–322.

(a) The Secretary shall keep a register of each individual who has tuberculosis.

(b) The Secretary:

(1) Shall have exclusive control of the register; and

(2) May not disclose information in the register about any individual to any person who is not authorized by law to have the information.

§18–323.

The Secretary shall provide printed instructions and any supplies that the Secretary considers necessary to prevent and control the spread of tuberculosis, on the request of any health officer or any physician attending an individual who has tuberculosis.

§18–324.

(a) The Secretary or a health officer may have an individual examined, if the Secretary or the health officer knows or is notified in writing by a physician that the individual is suspected of having tuberculosis.

(b) (1) If, after the examination, the Secretary or the health officer finds that the individual has tuberculosis and that the condition of the individual endangers, or may endanger, the public health of the community, the Secretary or the health officer may order the individual to receive appropriate medical care.

(2) If the individual fails to comply with the order, the Secretary or the health officer may order the individual to be placed in any of the following types of medical quarantine in order to protect the public health:

(i) Medical isolation at home;

(ii) Domiciliary care, nursing home care, or hospital care; or

(iii) Other medically appropriate living arrangement.

(3) The order of the Secretary or the health officer may also contain such other conditions as the Secretary or the health officer believes are necessary to protect either the health of the infected individual or the public health.

(c) The Secretary or a health officer may not require an individual to have a physical examination, other than a chest X–ray and to render sputum samples. The Secretary or a health officer may not restrict the right of the individual to select a treatment method, if the individual:

(1) In good faith relies on spiritual means through prayer for healing; and

(2) Complies with the laws, rules, and regulations that relate to sanitation for and quarantine of infectious, contagious, and communicable diseases.

§18–325.

(a) An individual may not refuse to comply with the placement ordered under § 18-324 of this subtitle.

(b) While an individual is in any placement for tuberculosis treatment, the individual may not:

(1) Behave in a disorderly manner; or

(2) Leave the placement before being discharged properly.

(c) An individual who violates any provision of this section is guilty of a misdemeanor and on conviction shall be imprisoned in a penal institution with facilities for tuberculosis treatment until the Secretary or the Health Department of Baltimore City finds that the condition of the individual no longer endangers the health of the community, or the Secretary obtains a court order that states that the individual:

(1) Is to be moved to a specified less restrictive setting for continuation of treatment;

(2) Must comply with the treatment until the Secretary determines the treatment has been completed;

(3) May not behave in a disorderly manner or leave the placement until the Secretary determines that the individual has completed the treatment; and

(4) Following a hearing, will be reimprisoned until the Secretary determines that the individual has completed the treatment, if the individual does not comply with the terms of the order.

§18–333.

(a) (1) The Secretary shall establish and promote a statewide public information program on acquired immune deficiency syndrome (AIDS).

(2) The public information program shall:

(i) Attempt to reach individuals at risk for contracting AIDS;

(ii) Encourage those individuals at risk for contracting AIDS to take the necessary precautions to prevent transmission of the HTLV-III virus; and

(iii) Include any other aspects that the Secretary considers appropriate.

(b) The Secretary shall establish a program to train physicians, physician's assistants, nurses, and other health professionals in:

(1) Diagnosing and treating AIDS or other conditions associated with AIDS; and

(2) Methods to prevent the transmission of the HTLV-III virus.

(c) To carry out this section, the Secretary:

(1) On request, shall receive the help of or information from any agency of this State or of a political subdivision; and

(2) May contract for any necessary services.

(d) The Secretary may set a sliding fee schedule for services provided under this section.

§18–334.

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

(2) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome.

(3) "Institution" means:

(i) An ambulatory surgical facility or center, as defined in § 19-114 of this article;

(ii) A health maintenance organization, as defined in § 19-701 of this article;

(iii) A hospital or related institution, as defined in § 19-301 of this article;

(iv) A tissue bank; or

(v) The office of 1 or more physicians.

(4) "Laboratory" means a public laboratory, medical laboratory, or medical test unit as those terms are defined in Title 17 of this article.

(5) "Physician" means a person licensed to practice under Title 14 of the Health Occupations Article.

(6) (i) "Tissue bank" means an establishment that obtains, stores, processes, distributes, or sells human blood or other human tissue for use in the human body.

(ii) "Tissue bank" includes a blood bank or sperm bank.

(b) (1) Subject to the provisions of paragraph (2) of this subsection, an institution that obtains or processes semen, blood, or tissue shall obtain and send a blood sample from each potential donor of semen, blood, or tissue to a laboratory approved by the Department to test for HIV antibodies.

(2) Before obtaining a blood sample from a potential semen, blood, or tissue donor the institution shall:

(i) Inform the potential donor, in layman's terms, that a blood sample of the donor will be tested for HIV antibodies and if the donor's blood sample tests positive for HIV antibodies the result will be reported to the Department; and

(ii) Obtain written consent from the potential donor on a form provided by the Department for the administration of the HIV antibody tests and for the disclosure of a positive test result to the Department.

(c) An institution that obtains a positive HIV antibody test result under subsection (b) of this section shall:

(1) Notify the potential donor from whom the blood sample was obtained of the positive result;

(2) Inform the individual of available counseling; and

(3) Report the result to the Department on the form the Department provides.

(d) A test result reported by an institution under subsection (c) of this section may not contain any information that identifies the subject of the test.

(e) An institution may not use a semen, blood, or tissue specimen from a donor with a positive HIV antibody test result obtained under the provisions of this section.

§18–335.

To properly ensure the quality and effectiveness of condoms sold by means of a vending machine or other automatic devices, the Secretary shall adopt regulations:

(1) To protect the health, welfare, and safety of the public; and

(2) To provide for the enforcement of this section.

§18–336.

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

(2) "Health care facility" has the same meaning stated in § 18–338.2 of this subtitle.

(3) "Health care provider" means a physician, nurse, or designee of a health care facility.

(4) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome.

(b) (1) Except as provided in Title 11, Subtitle 1, Part II of the Criminal Procedure Article or § 18–338.3 of this subtitle, before obtaining a fluid or tissue sample from the body of an individual for the purpose of testing the fluid or tissue for the presence of HIV infection, a health care provider shall:

(i) Inform the individual verbally or in writing that HIV testing will be performed on a specimen obtained from the individual unless the individual refuses HIV testing;

(ii) Provide the individual verbal or written information or show a video that includes an explanation of HIV infection and the meaning of positive and negative test results;

(iii) Offer the individual an opportunity to ask questions and decline HIV testing; and

(iv) If the individual refuses HIV testing, document in the medical record the individual's decision.

(2) (i) Consent for HIV testing shall be included in a patient's general informed consent for medical care in the same category as other screening and diagnostic tests.

(ii) Except as otherwise provided in this section, a health care provider may not be required to obtain consent for HIV testing using a separate consent form.

(3) A health care provider shall make available to individuals for whom HIV testing is performed easily understood informational materials in the languages of the commonly encountered populations of the health care provider.

(c) Subject to subsection (b) of this section, a health care provider shall obtain a fluid or tissue sample for the purpose of testing the fluid or tissue for the presence of HIV infection from:

(1) A pregnant woman during delivery; and

(2) A newborn when the pregnant woman's HIV status is unknown.

(d) (1) If the HIV test is ordered at a location that is not a health care facility, informed consent shall be in writing and signed by the individual on an informed consent for HIV testing document that is approved by the Department.

(2) The informed consent for HIV testing document shall be distinct and separate from all other consent forms.

(3) A patient identifying number obtained from an anonymous and confidential test site which is approved by the Department may be evidence of a patient's informed consent in lieu of a patient's signature.

(e) An individual's refusal to undergo an HIV test or a positive test result may not be used as the sole basis by an institution or laboratory to deny services or treatment.

(f) If the individual is unable to give informed consent, substitute consent may be given under § 5–605 of this article.

(g) A health care provider who obtains a result from an HIV test conducted in accordance with the provisions of subsection (b) of this section shall:

(1) Notify the individual from whom the fluid or tissue sample was obtained of the result; and

(2) If the test is positive:

(i) Provide a referral for treatment and supportive services;

(ii) Counsel the individual to inform all sexual and needle–sharing partners of the individual's positive HIV status;

(iii) Offer to assist in notifying the individual's sexual and needle–sharing partners or refer the individual to the local health officer to assist the individual with notifying the individual's sexual and needle–sharing partners; and

(iv) If necessary, take action appropriate to comply with § 18–337 of this subtitle.

(h) Local health officers shall make available to health care providers in their jurisdiction information on referral resources for an individual with an HIV positive status, including counseling, testing, needs assessment, treatment, and support services.

§18–337.

(a) In this section, "health care provider" means a physician, a physician's designee, or a designee of a health care facility licensed or otherwise authorized to provide health care services.

(b) If an individual informed of the individual's HIV positive status under § 18-336 of this subtitle refuses to notify the individual's sexual and needle-sharing partners, the individual's physician may inform the local health officer and/or the individual's sexual and needle-sharing partners of:

(1) The individual's identity; and

(2) The circumstances giving rise to the notification.

(c) When the local health officer is notified, the health officer shall enforce the provisions of §§ 18-208 through 18-213.1 of this title:

(1) Within a reasonable time; and

(2) To the extent feasible.

(d) Each local health officer shall refer the infected individual and any known sexual or needle-sharing partners of the individual to appropriate services for the care, support, and treatment for HIV infected individuals.

(e) A physician acting in good faith to provide notification in accordance with this section may not be held liable in any cause of action related to a breach of patient confidentiality.

(f) A physician acting in good faith may not be held liable in any cause of action for choosing not to disclose information related to a positive test result for the presence of human immunodeficiency virus to an individual's sexual and needle-sharing partners.

(g) A hospital or any other health care provider acting in good faith pursuant to a physician's order to perform or interpret a test for the presence of HIV may not be held liable in any cause of action related to:

(1) A breach of patient confidentiality; or

(2) A physician's decision to disclose or not to disclose information related to a positive test result to a local health officer and/or an individual's sexual and needle-sharing partners.

§18–338.

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

(2) "Correctional employee" means:

(i) A person who is employed by a correctional institution; or

(ii) A person who performs duties in a correctional institution by virtue of federal, State, or local government employment.

(3) "Correctional institution" means a place of detention or correctional confinement operated by or for the State or a local government.

(4) "Court" means a district or circuit court of the State.

(5) "Exposure" means, as between a correctional employee and an incarcerated individual:

(i) Percutaneous contact with blood, semen, or blood contaminated fluids;

(ii) Mucocutaneous contact with blood, semen, or blood contaminated fluids;

(iii) Open wound, including dermatitis, exudative lesions, or chapped skin, contact with blood, semen, or blood contaminated fluids; and

(iv) Intact skin contact with large amounts of blood, semen, or blood contaminated fluids for a prolonged period.

(6) "Health care provider" means:

(i) Any person, including a physician or hospital, who is licensed or otherwise authorized in this State to provide health care services and is under contract with or operated by the correctional facility; or

(ii) An employee's private physician.

(b) An incarcerated individual shall furnish to the correctional institution a blood sample or buccal (cheek) swab to be tested for the presence of human immunodeficiency virus (HIV) when:

(1) There has been an exposure involving the incarcerated individual;

(2) The exposure occurred in connection with the incarcerated individual's violation of institutional regulations;

(3) The incarcerated individual has been found guilty of the violation of institutional regulations described in paragraph (2) of this subsection;

(4) The correctional employee involved in the exposure has given written notice of the exposure to the managing official of the correctional institution, or the official's designee; and

(5) The exposure is confirmed by a health care provider.

(c) The correctional institution shall collect the blood sample from the incarcerated individual, and shall have the sample tested for human immunodeficiency virus (HIV) by a test and test procedure approved by the Department.

(d) (1) If the incarcerated individual refuses to furnish to the correctional institution a blood sample or buccal (cheek) swab to be tested for the presence of human immunodeficiency virus (HIV) as required under subsection (b) of this section, a court may order the incarcerated individual to furnish the blood sample or buccal (cheek) swab if:

(i) The correctional employee involved in the exposure or the correctional employee's representative requests the testing in writing to the State's Attorney in the county where the exposure occurred; and

(ii) The court finds probable cause to believe that the exposure occurred.

(2) Before ordering a test under paragraph (1) of this subsection and subject to the provisions of paragraph (6) of this subsection, the court shall hold a hearing at which the correctional employee or the correctional employee's representative and the incarcerated individual or the incarcerated individual's representative have the right to be present.

(3) The correctional employee or the correctional employee's representative and the incarcerated individual or the incarcerated individual's representative shall be notified of:

(i) The date, time, and location of the hearing; and

(ii) Their right to be present at the hearing.

(4) During the hearing, the court may admit into evidence only affidavits, counter–affidavits, and medical records that:

(i) Relate to the material facts of the case; and

(ii) Support or rebut a finding of probable cause to issue a court order.

(5) The written request of the correctional employee or the correctional employee's representative shall be:

(i) Filed by the State's Attorney with the court; and

(ii) Sealed by the court.

(6) Except for good cause, the court shall:

(i) Hold the hearing within 15 days after the State's Attorney's presentment to the court of the written request of the correctional employee or the correctional employee's representative; and

(ii) Issue an order granting or denying the request within 3 days after the conclusion of the hearing.

(e) The correctional employee shall be notified of the results of the test for the presence of human immunodeficiency virus (HIV) conducted under the provisions of this section.

(f) The notification required under subsection (e) of this section shall:

(1) Be made within 48 hours of confirmation of the incarcerated individual's diagnosis;

(2) Include subsequent written confirmation of the possible exposure to human immunodeficiency virus (HIV); and

(3) To the extent possible, be made in a manner that will protect the confidentiality of the correctional employee and the incarcerated individual.

(g) If the results of the blood sample test are positive for the presence of human immunodeficiency virus (HIV), then the correctional employee and the incarcerated individual shall be provided appropriate counseling.

(h) All correctional institutions shall develop written procedures to carry out the provisions of this section.

(i) A health care provider acting in good faith to provide notification in accordance with this section may not be held liable in any cause of action related to a breach of patient confidentiality.

(j) A health care provider acting in good faith to provide notification in accordance with this section may not be held liable in any cause of action for:

(1) The failure to give the required notice, if the correctional employee fails to properly initiate the notification procedures developed by the correctional institution under subsection (h) of this section; or

(2) The failure of the managing official of the correctional institution within which the correctional employee is employed to subsequently notify the correctional employee of the possible exposure to human immunodeficiency virus (HIV).

(k) A health care provider may not be held liable in any cause of action related to obtaining a blood sample or performing and interpreting an approved HIV test without the incarcerated individual's informed consent.

§18–338.1.

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

(2) (i) "Body fluids" means:

1. Any fluid containing visible blood, semen, or vaginal secretions; or

2. Cerebrospinal fluid, synovial, or amniotic fluid.

(ii) "Body fluid" does not include saliva, stool, nasal secretions, sputum, tears, urine, or vomitus.

(3) "Exposure" means as between a patient and a health care provider:

(i) Percutaneous contact with blood or body fluids;

(ii) Mucocutaneous contact with blood or body fluids;

(iii) Open wound, including dermatitis, exudative lesions, or chapped skin, contact with blood or body fluids for a prolonged period; or

(iv) Intact skin contact with large amounts of blood or body fluids for a prolonged period.

(4) "Health care facility" means a facility or office where health or medical care is provided to patients by a health care provider, including:

(i) A health care facility as defined in § 19–114(d)(1) of this article;

(ii) A facility operated by the Department or a health officer;

(iii) The office of a health care provider; or

(iv) A medical laboratory.

(5) (i) "Health care provider" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health or medical care in:

1. The ordinary course of business or practice of a profession; or

2. In an approved education or training program.

(ii) "Health care provider" includes any agent or employee of a health care facility.

(iii) "Health care provider" does not include any individual who is eligible to receive notification under the provisions of § 18–213 of this title, including any law enforcement officer or any member of any fire department, ambulance company, or rescue squad.

(6) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome.

(b) Except as provided in § 18–338.3 of this subtitle, a physician, nurse, or designee of a health care facility shall, at the request of an exposed health care provider, seek the informed consent of a patient to test a blood sample of the patient for the presence of HIV when:

(1) There has been an exposure between the patient and the health care provider;

(2) The health care provider involved in the exposure has given prompt written notice of the exposure, in accordance with the standards of the health care facility, to the chief executive officer or the chief executive officer's designee of the health care facility where the exposure occurred;

(3) The exposure occurred based on the judgment of a physician who is not the health care provider involved in the exposure; and

(4) The health care provider involved in the exposure has given informed consent and has submitted a blood sample to be tested for the presence of HIV in accordance with the provisions of subsection (d) of this section.

(c) If, by virtue of the physical or mental condition of a patient, a physician, nurse, or designee of a health care facility is unable to obtain the informed consent of the patient to test a blood sample of the patient for the presence of HIV in accordance with subsection (b) of this section, the physician, nurse, or designee of the health care facility shall seek the consent of any person who has authority to consent to medical care for the patient as provided under § 5–605 of this article or as otherwise authorized by law.

(d) If the patient's informed consent has been obtained in accordance with subsection (b) of this section or substitute consent has been obtained in accordance with subsection (c) of this section and the other requirements of subsection (b) of this section have been satisfied, a physician or the physician's designee shall:

(1) Collect the blood sample from the patient and health care provider involved in the exposure; and

(2) Have the blood samples tested for the presence of HIV using a test procedure approved by the Department.

(e) When a physician obtains the results of a test for the presence of HIV that was conducted in accordance with the provisions of subsection (d) of this section, the physician or a designee of the health care facility shall directly notify the health care provider and the patient of the results of the patient's HIV test.

(f) The notification required under subsection (e) of this section shall:

(1) Be made within 48 hours of confirmation of the results of the patient's HIV test;

(2) Include subsequent written confirmation of the possible exposure to HIV; and

(3) To the extent possible, be made in a manner that will protect the confidentiality of the health care provider and the patient.

(g) If the results of a test for the presence of HIV that was conducted in accordance with the provisions of subsection (d) of this section are positive, a physician or the physician's designee shall provide or arrange for the provision of appropriate counseling to the health care provider and the patient.

(h) (1) Notwithstanding the provisions of Title 4, Subtitle 3 of this article, the records, including any physician order for an HIV test or the results of an HIV test performed on a blood sample of a patient or a health care provider in accordance with the provisions of this section, may not be documented in the medical record of the patient or health care provider.

(2) The health care facility shall maintain a separate confidential record or incident report for all HIV tests performed on a blood sample of a patient or health care provider in accordance with the provisions of this section.

(3) The health care facility shall adopt procedures for the confidential testing of blood samples obtained in accordance with the provisions of this section.

(4) Except as provided in paragraph (5) of this subsection, the records, including any physician order for an HIV test or the results, of any HIV test performed on a blood sample of a patient or health care provider in accordance with the provisions of this section are:

(i) Confidential; and

(ii) Not discoverable or admissible in evidence in any criminal, civil, or administrative action.

(5) If the identity of the patient or any other information that could be readily associated with the identity of the patient is not disclosed, the results of an HIV test performed on a patient or health care provider in accordance with the provisions of this section may be introduced into evidence in any criminal, civil, or administrative action including the adjudication of a workers' compensation claim.

(i) The costs incurred in performing an HIV test on a patient or health care provider in accordance with the provisions of this section shall be paid by the health care facility.

(j) All health care facilities shall develop written procedures to implement the provisions of this section.

(k) A health care provider or health care facility acting in good faith to provide notification or maintain the confidentiality of the results of a test for the presence of HIV in accordance with the provisions of this section may not be held liable in any cause of action related to a breach of patient or health care provider confidentiality.

(l) The Medical and Chirurgical Faculty of the State of Maryland in consultation with the Centers for Disease Control and Prevention, the Maryland Hospital Association, and the Maryland Department of Health shall develop a practice protocol for physicians who are infected with HIV.

§18–338.2.

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

(2) "Health care facility" means a facility or office where health or medical care is provided to patients by a health care provider, including:

(i) A hospital as defined in § 19–301 of this article;

(ii) A facility operated by the Department or a health officer; and

(iii) The office of a health care provider.

(3) "Health care provider" means a physician, nurse, licensed direct–entry midwife, or designee of a health care facility.

(4) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome (AIDS).

(5) "Prenatal care" means obstetric and gynecologic services performed as part of a prenatal care program, including:

(i) Screening;

(ii) Physical examination;

(iii) Laboratory and diagnostic testing procedures and interpretation; and

(iv) Counseling.

(b) The Department, in consultation with stakeholders, shall adopt regulations establishing requirements for prenatal HIV testing.

(c) (1) A health care provider who provides prenatal medical care shall follow the requirements for prenatal HIV testing that are adopted by the Department.

(2) The Department shall provide the requirements established under subsection (b) of this section to:

(i) Hospitals that offer obstetric services;

(ii) The American College of Obstetricians and Gynecologists;

(iii) The American College of Nurse Midwives; and

(iv) The Association of Independent Midwives of Maryland.

(d) (1) Except as otherwise provided in paragraph (2) of this subsection, the record of an HIV test performed under this section is confidential and not discoverable or admissible in evidence in any criminal, civil, or administrative action.

(2) Provided that the identity or any other information that could readily be associated with the identity of the pregnant woman is not disclosed, the results of an HIV test performed under this section may be introduced into evidence in any criminal, civil, or administrative action, including the adjudication of a workers' compensation claim.

(e) A health care provider may not be subject to disciplinary action by the professional licensing board that licenses the health care provider for following the requirements for prenatal HIV testing established by the Department.

§18–338.3.

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

(2) (i) "Body fluids" means:

1. Any fluid containing visible blood, semen, or vaginal secretions; or

2. Cerebrospinal fluid, synovial fluid, or amniotic fluid.

(ii) "Body fluids" does not include saliva, stool, nasal secretions, sputum, tears, urine, or vomitus.

(3) "Exposure" means:

(i) Percutaneous contact with blood or body fluids;

(ii) Mucocutaneous contact with blood or body fluids;

(iii) Open wound, including dermatitis, exudative lesions, or chapped skin, contact with blood or body fluids for a prolonged period; or

(iv) Intact skin contact with large amounts of blood or body fluids for a prolonged period.

(4) "First responder" means an individual who:

(i) Is licensed or certified under § 13–516 of the Education Article; and

(ii) Provides services to an individual before the individual is admitted to a hospital.

(5) (i) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article or this article to provide health or medical care in:

1. The ordinary course of business or practice of a profession; or

2. An approved education or training program.

(ii) "Health care provider" includes any agent or employee of a hospital.

(iii) "Health care provider" does not include an individual who is eligible to receive notification under the provisions of § 18–213 of this title, including any law enforcement officer or any member of any fire department, ambulance company, or rescue squad.

(6) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome.

(7) "Hospital" has the meaning stated in § 19–301 of this article.

(8) "Public safety worker" means:

(i) A career or volunteer member of a fire, rescue, or emergency medical services department, company, squad, or auxiliary;

(ii) A law enforcement officer;

(iii) The State Fire Marshal or a sworn member of the State Fire Marshal's office; or

(iv) A forensic scientist who works under the direction of a law enforcement agency.

(b) Notwithstanding the provisions of § 18–338.1 of this subtitle, the designated infectious disease/communicable disease officer of a hospital shall order a test for the presence of antibodies to the human immunodeficiency virus (HIV) under subsection (d) of this section when:

(1) There has been an exposure in a hospital between a patient and a health care provider, an exposure between a patient and a first responder, or an exposure between a patient and a public safety worker before admission of the patient to a hospital, that, in accordance with the Centers for Disease Control and Prevention recommendations, would warrant recommending or offering chemoprophylaxis treatment for the health care provider, first responder, or public safety worker;

(2) (i) Informed consent, or substitute consent as required under § 18–338.1(c) of this subtitle, of the patient to test a blood sample of the patient for the presence of HIV was sought and the patient was unavailable or unable to consent; or

(ii) Informed consent, or substitute consent as required under § 18–338.1(c) of this subtitle, of the patient to test a blood sample already obtained from the patient for the presence of HIV was sought, the patient refused, and the patient was informed of the provisions of this subsection;

(3) (i) In accordance with hospital procedures, the health care provider involved in the exposure has given prompt notice of the exposure to the designated hospital infectious disease/communicable disease officer where the exposure occurred; or

(ii) 1. A. The first responder involved in the exposure has given prompt notice to the medical director with jurisdiction over the first responder; or

B. The public safety worker involved in the exposure has given prompt notice to the medical director with jurisdiction over the public safety worker; and

2. The medical director has given prompt notice to the designated hospital infectious disease/communicable disease officer where the patient is admitted;

(4) The health care provider, first responder, or public safety worker involved in the exposure has given informed consent and has submitted a blood sample to be tested for the presence of HIV; and

(5) The designated hospital infectious disease/communicable disease officer has made a determination, in accordance with the Centers for Disease Control and Prevention recommendations, that the testing of blood samples or other body fluids of the patient for the presence of antibodies to the human immunodeficiency virus (HIV) would be helpful in managing the risk of disease and health outcome of the health care provider, first responder, or public safety worker.

(c) If there has been an exposure between a first responder and an individual or a public safety worker and an individual before the admission of the individual to a hospital:

(1) The first responder or public safety worker shall give notice to the first responder's or public safety worker's medical director in accordance with subsection (b)(3)(ii)1 of this section;

(2) The medical director shall act as an intermediary at all times between the first responder or public safety worker and the designated hospital infectious disease/communicable disease officer; and

(3) The medical director and the designated hospital infectious disease/communicable disease officer shall ensure that all communications and information related to the exposure of the first responder or public safety worker are confidential.

(d) If the requirements of subsections (b) and (c) of this section are satisfied, the designated hospital infectious disease/communicable disease officer shall order tests to be conducted for the presence of antibodies to the human immunodeficiency virus (HIV) using a test procedure approved by the Department on:

(1) Blood samples already obtained from the patient; or

(2) Blood samples or other body fluids collected for the purpose of HIV testing under this section.

(e) When the designated hospital infectious disease/communicable disease officer obtains the results of an HIV test conducted in accordance with the provisions of subsection (d) of this section, the designated hospital infectious disease/communicable disease officer shall attempt to directly notify the patient of the results of the HIV test and, to the extent possible, in a manner that will protect the confidentiality of the health care provider, the first responder, or the public safety worker and the patient.

(f) If the results of an HIV test conducted in accordance with the provisions of subsection (d) of this section are positive, the designated hospital infectious disease/communicable disease officer shall provide or arrange for the provision of appropriate counseling and treatment recommendations to the health care provider, first responder, or public safety worker and the patient.

(g) (1) Notwithstanding the provisions of Title 4, Subtitle 3 of this article, the medical records, including any physician order for an HIV test or the results of an HIV test conducted under this section, may not be documented in the medical record of the patient, health care provider, first responder, or public safety worker.

(2) The hospital where the exposure occurred shall maintain a separate confidential record or incident report for all HIV tests conducted under this section.

(3) Each hospital shall adopt procedures for the confidential HIV testing of blood samples or other body fluids used or collected for purposes of this section.

(4) Except as provided in paragraph (5) of this subsection, the medical records, including any physician order for an HIV test or the results of any HIV test conducted under this section, are:

(i) Confidential; and

(ii) Not discoverable or admissible in evidence in any criminal, civil, or administrative action.

(5) If the identity of the patient or any other information that could be readily associated with the identity of the patient is not disclosed, the results of an HIV test conducted on a patient for purposes of this section may be introduced into

evidence in any criminal, civil, or administrative action including the adjudication of a workers' compensation claim.

(h) The costs incurred in performing an HIV test on a patient in accordance with the provisions of this section shall be paid by the hospital.

(i) Each hospital shall develop written procedures to implement the provisions of this section.

(j) A health care provider, first responder, public safety worker, or hospital or designee of a hospital acting in good faith to provide notification or maintain the confidentiality of the results of a test conducted under this section may not be held liable in any cause of action related to a breach of patient, health care provider, first responder, or public safety worker confidentiality.

§18–401.

(a) A person lawfully administering a drug or vaccine shall have the immunity from liability described under § 5-629(b) of the Courts and Judicial Proceedings Article.

(b) If the Secretary or a designee of the Secretary finds that a proposed immunization project would conform to good medical and public health practice and gives written approval for the project to be administered in this State, a physician, nurse, or other person participating in the project shall have the immunity from liability described under § 5-629(c) of the Courts and Judicial Proceedings Article.

§18–402.

A legally authorized person who obtains, processes, stores, distributes, or uses whole human blood, tissue, organs, or bones or any substance derived from human blood, tissue, organs, or bones shall have the immunity from liability described under § 5-630 of the Courts and Judicial Proceedings Article.

§18–403.

(a) Unless the Secretary declares an emergency or disease epidemic, the Department may not require the immunization of an individual if:

(1) The individual objects to immunization because it conflicts with the individual's bona fide religious beliefs and practices; or

(2) The individual is a minor and the individual's parent or guardian objects to immunization because it conflicts with the parent or guardian's bona fide religious beliefs and practices.

(b) The Secretary shall adopt rules and regulations for religious exemptions under this section.

§18–404.

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

(2) "Employee" means an individual employed full–time or part–time directly, through contract with another entity, or as an independent contractor, by a related institution.

(3) "Medically contraindicated" means that a medical treatment is potentially detrimental to the health of the individual intended to be treated.

(4) "Related institution" has the meaning provided under § 19–301 of this article.

(b) (1) Subject to subsection (e) of this section, each related institution in the State shall immunize residents against the influenza virus and pneumococcal disease.

(2) Subject to subsection (e) of this section, each related institution in the State shall immunize employees against the influenza virus.

(3) Before an immunization under this section is administered, the related institution shall obtain written consent to administer the immunization from:

(i) The resident or employee receiving the immunization; or

(ii) The legal guardian of the resident receiving the immunization.

(c) Each related institution shall conduct the immunizations required under subsection (b) of this section:

(1) In accordance with the recommendations established by the Advisory Committee on Immunization Process of the United States Centers for Disease Control and Prevention that are in effect at the time the related institution conducts the immunizations; and

(2) By December 1 of each year that the immunization is required.

(d) A related institution that accepts an individual as a new resident or accepts an individual as a new employee after December 1 but before April 1 shall:

(1) Determine the individual's status for immunization as required under subsection (b) of this section; and

(2) If necessary, provide or arrange for an immunization as required under subsection (b) of this section.

(e) A resident or employee is not required to receive a vaccine under this section if:

(1) The vaccine is medically contraindicated for the resident or employee;

(2) The vaccine is against the resident's or employee's religious beliefs; or

(3) After being fully informed by the related institution of the health risks associated with not receiving a vaccine, the resident or employee refuses the vaccine.

(f) (1) (i) Each related institution shall document the annual immunization against influenza virus and immunization against pneumococcal disease received by each resident in the resident's medical record.

(ii) Each related institution shall document the annual immunization against influenza virus received by each employee in the employee's personnel file.

(2) If a resident or employee refuses to be immunized as required under subsection (b) of this section, the related institution shall document the refusal and the reason for the refusal.

(g) Each related institution shall:

(1) Notify each prospective resident and each prospective employee of the immunization requirements of this section and request that the resident or employee agree to be immunized in accordance with subsection (b)(3) of this section; and

(2) Make available to all residents and employees of the related institution educational and informational materials relating to immunization against influenza virus and immunization against pneumococcal disease.

§18–4A–01.

In this subtitle, "parent" means:

(1) A natural or adoptive parent of a minor;

(2) A guardian of a minor; or

(3) Any other person who, under court order, is authorized to give consent for a minor.

§18–4A–02.

(a) Subject to the provisions of this section, a parent may delegate verbally or in writing the parent's authority to consent to the immunization of a minor to any of the following individuals, not in order of priority:

(1) A grandparent;

(2) An adult brother or sister;

(3) An adult aunt or uncle;

(4) A stepparent; or

(5) Any other adult who has care and control of the minor.

(b) If a parent verbally delegates the parent's authority to consent to the immunization of a minor under this subtitle, the person delegated the authority shall confirm the verbal delegation in writing and the written confirmation shall be included in the minor's medical record.

(c) A grandparent, adult brother or sister, adult aunt or uncle, or stepparent of a minor who is the primary caregiver of the minor and who may consent to the immunization of the minor under subsection (a) of this section may delegate the authority to consent to immunization of the minor to another adult in the manner permitted under subsection (b) of this section.

(d) A health care provider may rely on a notarized document from another state or country that contains substantially the same information as is required in

any immunization consent regulations of the Department if the document is presented for consent by a person listed in subsection (a) of this section.

(e) A person who consents to immunization of a minor under this subtitle shall provide the health care provider with sufficient and accurate health information about the minor for whom the consent is given and, if necessary, sufficient and accurate health information about the minor's family to enable the person providing the consent and the health care provider to determine adequately the risks and benefits inherent in the proposed immunization and determine whether the immunization is advisable.

§18–4A–03.

(a) Subject to the provisions of this section, the following individuals, not in order of priority, may consent to the immunization of a minor if a parent is not reasonably available and the authority to consent is not denied under subsection (b) or (c) of this section:

(1) A grandparent;

(2) An adult brother or sister;

(3) An adult aunt or uncle;

(4) A stepparent;

(5) Any other adult who has care and control of the minor;

(6) A court that has jurisdiction of a suit affecting the parent-child relationship of which the minor is the subject;

(7) An adult who has care and control of the minor under an order of a court or by commitment by a court to the care of an agency of the State or county if the adult reasonably believes the minor needs immunization; or

(8) For minors in its care and custody, the Department of Juvenile Services.

(b) A person may not consent to the immunization of a minor under subsection (a) of this section if:

(1) The person has actual knowledge that the parent has expressly refused to give consent to the immunization; or

(2) The parent has told the person that the person may not consent to the immunization of the minor or, in the case of a written authorization, has withdrawn the authorization in writing.

(c) When a parent has been contacted and requested to consent to the immunization of a minor, the Department of Juvenile Services may consent to the immunization of a minor in its care and custody if the parent:

(1) Has not acted on the request; and

(2) Has not expressly denied to the Department of Juvenile Services the authority to consent to the immunization of the minor.

(d) For purposes of this section, a person is not reasonably available if:

(1) The location of the person is unknown;

(2) (i) A reasonable effort made by a person listed in subsection (a) of this section to locate and communicate with the parent for the purpose of obtaining consent has failed; and

(ii) Not more than 90 days have passed since the date that the effort was made; or

(3) The parent has been contacted by a person listed in subsection (a) of this section and requested to consent to the immunization of the minor, and the parent:

(i) Has not acted on the request; and

(ii) Has not expressly denied authority to the person listed in subsection (a) of this section to consent to immunization of the minor.

(e) A person authorized to consent to the immunization of a minor under this section shall confirm that the parent is not reasonably available in writing and the written confirmation shall be included in the minor's medical record.

§18–4A–04.

The responsibility of a health care provider to provide information to a person consenting to the immunization of a minor under § 18-4A-02 or § 18-4A-03 of this subtitle is the same as the health care provider's responsibility to a parent.

§18–4A–05.

(a) In the absence of willful misconduct or gross negligence, a health care provider who accepts the health history and other information given by a person who is delegated the authority to consent to the immunization of a minor under § 18-4A-02 or § 18-4A-03 of this subtitle is not liable for an adverse reaction related to an immunization of the minor resulting from factual errors in the health history or information given by the person to the health care provider.

(b) Except for acts of willful misconduct or gross negligence, a person who consents to the immunization of a minor under § 18-4A-02 or § 18-4A-03 of this subtitle, a health care provider licensed to practice in the State, or a medical facility is not liable for damages arising from an immunization administered to a minor as authorized under § 18-4A-02 or § 18-4A-03 of this subtitle.

§18–501.

The intent of this subtitle is:

(1) To educate parents and physicians regarding homozygous sickle cell anemia;

(2) To monitor each affected infant's health in that regard; and

(3) To provide resources for detecting sickle cell disease and supporting individuals with sickle cell disease.

§18–502.

(a) After securing the written approval of one of the parents or guardian of an infant at risk, the person in charge of the institution in which the infant is born, or the person who is required to prepare and register the certificate of birth for an infant born outside an institution, shall have administered a test for sickle cell anemia to the infant at risk.

(b) In addition to testing, the Department shall undertake a prenatal education program for pregnant females in the population group at risk on the subject of sickle cell anemia and related diseases.

§18–503.

(a) On determination of the presence of sickle cell anemia, the Department shall:

(1) Notify in writing:

(i) The physician of record or the institution at which the child is born; and

(ii) The parents or guardian of the infant;

(2) Provide the parents or guardian of the infant and the physician of record with educational materials; and

(3) Offer referral for genetic counseling.

(b) Within 2 months after a positive finding of sickle cell anemia, a confirmatory test shall be administered and the results of this test shall be reported to the Department.

§18–504.

(a) The Department and all persons shall maintain and treat all information derived from testing as confidential medical records as provided in § 13-109 of this article.

(b) Notwithstanding any other provision to the contrary, the Department may disclose confidential information, obtained pursuant to this title, to the Department of the Environment, as determined to be appropriate and necessary by the Secretary and consistent with the statutory responsibilities vested in the Secretary of the Environment.

§18–505.

(a) The Department shall designate any type of blood test for sickle cell anemia to be administered under this subtitle.

(b) The blood shall be tested only by a licensed laboratory that periodically undergoes standard proficiency testing for quality assurance.

§18–506.

(a) In this section, "Steering Committee" means the Statewide Steering Committee on Sickle Cell Disease.

(b) There is a Statewide Steering Committee on Sickle Cell Disease.

(c) The Steering Committee shall include representatives from:

(1) Local and national groups that advocate for individuals with sickle cell disease;

(2) Interest and support groups for individuals with sickle cell disease;

(3) Community and consumer groups;

(4) Academic and private clinical settings with knowledge and experience caring for adults with sickle cell disease;

(5) Area hospitals caring for individuals with sickle cell disease; and

(6) Pediatric clinics that care for children with sickle cell disease.

(d) The Steering Committee shall:

(1) Establish institution and community partnerships;

(2) Establish a statewide network of stakeholders who care for individuals with sickle cell disease;

(3) Educate individuals with sickle cell disease, the public, and health care providers about the State options for care of sickle cell disease; and

(4) Identify funding sources for implementing or supporting the actions, studies, policies, regulations, or laws recommended by the Steering Committee, including funding from:

(i) State, federal, and local government sources; and

(ii) Private sources.

§18–507.

(a) The Department may, in consultation with the Statewide Steering Committee on Sickle Cell Disease, provide services relating to sickle cell disease, including:

(1) Educational programs on sickle cell disease for individuals affected by the disease, including:

(i) Individuals with sickle cell disease;

(ii) Families of individuals with sickle cell disease;

(iii) Caregivers of individuals with sickle cell disease;

(iv) Employees at primary and secondary schools; and

(v) Health care providers;

(2) Social services support to individuals with sickle cell disease, including support from social workers and community health workers to provide information on services that may be available to the individual;

(3) Testing;

(4) Genetic counseling;

(5) Assistance with any available reimbursement for medical expenses related to sickle cell disease;

(6) Education and counseling services after the receipt of sickle cell trait test results from the State's Newborn Screening Program; and

(7) Any other programs or services that are necessary to decrease the use of acute care services by individuals who have sickle cell disease.

(b) The Department shall provide the services in subsection (a) of this section through community–based organizations to the extent practicable.

§18–508.

(a) The Department, in consultation with the Statewide Steering Committee on Sickle Cell Disease, shall establish and implement a system of providing information on the sickle cell trait or the thalassemia trait to:

(1) An individual who has the sickle cell trait or the thalassemia trait, including as determined through a newborn screening under § 18–502 of this subtitle; and

(2) If the individual is a minor, the individual's family.

(b) The Department shall include the following in the information provided under subsection (a) of this section:

(1) How the sickle cell trait or the thalassemia trait impacts the health of an individual with the trait; and

(2) How the sickle cell trait or the thalassemia trait is passed from a parent to a child.

§18–509.

The Department shall maintain in a conspicuous location on its website a list of resources for health care practitioners to use to improve their understanding and clinical treatment of individuals with sickle cell disease or the sickle cell trait, including information on the health impacts of carrying the sickle cell trait.

§18–601.

(a) An individual who has an infectious disease that endangers public health may not willfully:

(1) Be in a public place without taking proper precautions against exposing other individuals to the disease; or

(2) Transfer to another individual any article that has been exposed to the disease without thoroughly disinfecting the article.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 1 year or both.

§18–602.

(a) A person may not:

(1) Willfully or knowingly take an individual who has an infectious disease that endangers public health to the home of another individual;

(2) Carelessly expose an individual to another who has an infectious disease that endangers public health; or

(3) Permit a child who has an infectious disease that endangers public health to be in a public place while in charge of the child.

(b) A person who violates any provision of this section is subject to a fine not exceeding $100.

§18–604.

A person who violates any rule or regulation that the Secretary adopts under § 18-102 of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500.

§18–701.

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

(b) "Advisory Council" means the Advisory Council to the Center for the Study of the Health Effects of Fire.

(c) "Center" means the Center for the Study of the Health Effects of Fire.

§18–702.

There is a Center for the Study of the Health Effects of Fire.

§18–703.

(a) The Chief Medical Examiner is the Director of the Center.

(b) The Chief Medical Examiner shall employ a staff for the Center in accordance with the State budget.

§18–704.

The Center shall:

(1) Study the long and short term health effects of exposure to fire;

(2) Gather and analyze information concerning the morbidity and mortality of fire-related injury or death;

(3) Establish and maintain a registry of individuals who suffer fire-related injury or death;

(4) Establish a computerized data base concerning injuries and health effects of fire;

(5) Be a common repository for information routinely collected concerning fires;

(6) Communicate with national data bases of scientific literature in toxicology, chemistry, epidemiology, and other related scientific disciplines;

(7) Establish and maintain communication and collaboration with existing agencies, such as the National Institute of Standards and Technology, involved in programs related to the health effects of fire;

(8) Encourage and facilitate interest in fire-related issues at the educational institutions located in the State;

(9) In accordance with the State budget, provide funding for pilot studies addressing issues or factors affecting injuries or health effects of fire;

(10) Apply for federal or private research grants to investigate issues relating to the health effects of fire;

(11) Solicit and follow the recommendations of the Advisory Council concerning future activities or projects of the Center; and

(12) Provide staff support to the Advisory Council, as needed.

§18–705.

Information collected by the Center and intended for use in a research project or study is:

(1) Confidential; and

(2) Not discoverable or admissible in evidence in a civil or criminal action to determine:

(i) Cause of death; or

(ii) Liability for injury or death.

§18–706.

There is an Advisory Council to the Center for the Study of the Health Effects of Fire.

§18–707.

(a) (1) The Advisory Council consists of 7 members.

(2) (i) The Secretary shall appoint the members from a list submitted to the Secretary by:

1. Appropriate academic or research facilities having expertise in this area;

2. The Chief Medical Examiner; and

3. The Secretary of the Department of the Environment.

(ii) The number of names on the list shall be 3 times the number of vacancies.

(b) Each member shall be an individual with demonstrated scientific and technical expertise in the field of toxicology, epidemiology, or occupational medicine.

(c) (1) The term of a member is 5 years.

(2) The terms of members are staggered as required by the terms provided for members of the Council on July 1, 1988.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(d) The Secretary may remove a member for incompetence or misconduct.

§18–708.

(a) From among its members, the Advisory Council shall elect a chairperson.

(b) The manner of election of the chairperson shall be as the Advisory Council determines.

§18–709.

(a) The Advisory Council shall determine the times and places of its meetings.

(b) A member of the Advisory Council:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§18–710.

The Advisory Council shall:

(1) Review the work of the Center;

(2) Advise the Director of the Center concerning the scientific evaluation of the information collected by the Center; and

(3) Assist the Center in setting priorities concerning issues to be researched.

§18–711.

The Secretary, in consultation with the State Postmortem Examiners Commission, may adopt regulations to carry out the provisions of this subtitle.

§18–801.

The Secretary shall establish and promote the Oral Health Program to prevent and detect oral cancer in the State, with a primary focus of meeting the needs of high-risk underserved populations, with the intent to reduce oral cancer mortality.

§18–802.

(a) In consultation with dental care providers, the Secretary shall develop and implement ongoing oral cancer educational programs in the State:

(1) To train health care providers to screen and properly refer patients with oral cancers; and

(2) To promote smoking cessation with a primary focus of meeting the needs of high-risk underserved populations.

(b) The programs developed and implemented under subsection (a) of this section shall address:

(1) The risk factors that lead to oral cancer;

(2) The signs and symptoms of oral cancer;

(3) The high-risk behaviors that may lead to oral cancer; and

(4) The accessibility of screening to detect oral cancer.

§18–901.

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

(b) "Catastrophic health emergency" has the meaning stated in § 14-3A-01 of the Public Safety Article.

(c) "Deadly agent" has the meaning stated in § 14-3A-01 of the Public Safety Article.

(d) "Exposure to a deadly agent" has the meaning stated in § 14-3A-01 of the Public Safety Article.

(e) "Health care facility" has the meaning stated in § 19–114(d)(1) of this article.

(f) (1) "Health care practitioner" has the meaning stated in § 19–114(e) of this article.

(2) "Health care practitioner" includes an individual licensed or certified as an emergency medical services provider under § 13–516 of the Education Article.

(g) "Health care provider" means:

(1) A health care facility; or

(2) A health care practitioner.

§18–902.

Notwithstanding any other provision of law, the Secretary may exercise the authority granted in this subtitle to:

(1) Continuously evaluate and modify existing disease surveillance procedures in order to detect a catastrophic health emergency;

(2) Investigate actual or potential exposures to a deadly agent; and

(3) Treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

§18–903.

(a) (1) In accordance with procedures to be adopted by the Department, the Secretary, in consultation with health care facilities, may require health care facilities to develop and implement contingency plans addressing:

(i) Staff training needs;

(ii) Stockpiling of equipment, medication, and supplies necessary to address a catastrophic health emergency;

(iii) Treatment and decontamination protocols;

(iv) The coordination of services with other public and private entities; and

(v) Any other area that the Secretary determines is necessary to assist in the early detection and treatment of an individual exposed to a deadly agent.

(2) To the extent feasible, the procedures to be adopted by the Department under paragraph (1) of this subsection shall be consistent with accreditation requirements of the Joint Commission on Accreditation of Healthcare Organizations.

(b) After consulting with the appropriate licensing board, the Secretary:

(1) Shall publish protocols to assist health care practitioners in developing plans to respond to a catastrophic health emergency; and

(2) May, if necessary, require health care practitioners to implement the plans developed under item (1) of this subsection.

(c) The Secretary shall coordinate with the health occupations boards to develop a process to license, certify, or credential both licensed health care practitioners and out–of–state health care practitioners who may be needed to respond to a catastrophic health emergency.

§18–904.

(a) In this section, "information" means medical, epidemiological, or other data concerning a specific individual or a group of individuals, regardless of whether the information is otherwise deemed confidential under Title 4 of this article or as otherwise provided under law.

(b) In order to maintain an effective disease surveillance system for detecting whether individuals have been exposed to a deadly agent, the Secretary may by order, directive, or regulation:

(1) Require a health care provider or other person to report information to the Secretary or other public official on the following:

(i) The presence of an individual or group of individuals with specified illnesses or symptoms;

(ii) Diagnostic and laboratory findings relating to diseases caused by deadly agents;

(iii) Statistical or utilization trends relating to potential disease outbreaks;

(iv) Information needed to conduct contact tracing for exposed individuals; and

(v) Other data deemed by the Secretary to have epidemiological significance in detecting possible catastrophic health emergencies;

(2) Obtain access to information in the possession of a health care provider;

(3) Require or authorize a health care provider to disclose information to an agency of the federal, State, or local government or another health care provider;

(4) Require a health care provider or other person to submit reports to the Department containing information detailing the presence and use of deadly agents;

(5) Obtain access to premises in order to secure environmental samples and otherwise investigate actual or potential exposures to deadly agents; and

(6) Require a veterinarian or other person to report data relating to specified illnesses or symptoms in animal populations.

(c) The Secretary, in acquiring information under subsection (b) of this section, shall:

(1) Request and use nonidentifying information whenever possible; and

(2) Limit the use of confidential information to the extent necessary to detect and investigate actual or potential exposures to a deadly agent.

(d) (1) Any information that the Secretary receives under subsection (b) of this section is confidential and may be used or disclosed only in accordance with this section.

(2) If the information requested in subsection (b) of this section is otherwise confidential under Title 4 of this article or as otherwise provided under law, the Secretary or person that receives the information may not redisclose the information except as provided in paragraph (3) of this subsection.

(3) A person may redisclose the information to another health care provider or public official provided that:

(i) The health care provider or public agency to whom the information is disclosed will maintain the confidentiality of the disclosure; and

(ii) The Secretary determines the disclosure is necessary to treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

§18–905.

(a) In investigating actual or potential exposures to a deadly agent, the Secretary:

(1) (i) May issue an order requiring individuals whom the Secretary has reason to believe have been exposed to a deadly agent to seek appropriate and necessary evaluation and treatment;

(ii) When the Secretary determines that it is medically necessary and reasonable to prevent or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent, may order an individual or group of individuals to go to and remain in places of isolation or

quarantine until the Secretary determines that the individual no longer poses a substantial risk of transmitting the disease or condition to the public; and

(iii) If a competent individual over the age of 18 refuses vaccination, medical examination, treatment, or testing under this paragraph, may require the individual to go to and remain in places of isolation or quarantine until the Secretary determines that the individual no longer poses a substantial risk of transmitting the disease or condition to the public;

(2) May coordinate and direct the efforts of any health officer or health commissioner of any subdivision in seeking to detect or respond to threats posed by a deadly agent; and

(3) May order any sheriff, deputy sheriff, or other law enforcement officer of the State or any subdivision to assist in the execution or enforcement of any order issued under this subtitle.

(b) The Secretary may issue an order under subsection (a) of this section:

(1) If, prior to the issuance of a proclamation under § 14-3A-02 of the Public Safety Article, the Secretary determines that the disease or outbreak can be medically contained by the Department and appropriate health care providers; and

(2) As necessary to implement an order issued by the Governor under § 14-3A-02 of the Public Safety Article.

§18–906.

(a) (1) If the Secretary requires an individual or a group of individuals to go to and remain in places of isolation or quarantine under § 18–905 of this subtitle, the Secretary shall issue a directive to the individual or group of individuals.

(2) The directive shall specify:

(i) The identity of the individual or group of individuals subject to isolation or quarantine;

(ii) The premises subject to isolation or quarantine;

(iii) The date and time at which isolation or quarantine commences;

(iv) The suspected deadly agent causing the outbreak or disease, if known;

(v) The basis upon which isolation or quarantine is justified; and

(vi) The availability of a hearing to contest the directive.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, the directive shall be in writing and given to the individual or group of individuals prior to the individual or group of individuals being required to go to and remain in places of isolation and quarantine.

(ii) 1. If the Secretary determines that the notice required under subparagraph (i) of this paragraph is impractical because of the number of individuals or geographical areas affected, the Secretary shall ensure that the affected individuals are fully informed of the directive using the best possible means available.

2. If the directive applies to a group of individuals and it is impractical to provide written individual copies under subparagraph (i) of this paragraph, the written directive may be posted in a conspicuous place in the isolation or quarantine premises.

(b) (1) An individual or group of individuals isolated or quarantined under subsection (a) of this section may request a hearing in circuit court contesting the isolation or quarantine.

(2) A request for a hearing may not stay or enjoin an isolation or quarantine directive.

(3) Upon receipt of a request under this subsection, the court shall conduct a hearing within 3 days from receipt of the request.

(4) (i) In any proceedings brought for relief under this subsection, the court may extend the time for a hearing upon a showing by the Secretary or other designated official that extraordinary circumstances exist that justify the extension.

(ii) In granting or denying an extension, the court shall consider the rights of the affected individual, the protection of the public health, the severity of the catastrophic health emergency, and the availability, if necessary, of witnesses and evidence.

(5) (i) 1. The court shall grant the request for relief unless the court determines that the isolation or quarantine directive is necessary and

reasonable to prevent or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

2. If feasible, in making a determination under this subparagraph, the court may consider the means of transmission, the degree of contagion, and, to the extent possible, the degree of public exposure to the disease.

(ii) 1. An order authorizing the isolation or quarantine issued under this paragraph shall:

A. Identify the isolated or quarantined individual or group of individuals by name or shared characteristics;

B. Specify factual findings warranting isolation or quarantine; and

C. Except as provided in subsubparagraph 2 of this subparagraph, be in writing and given to the individual or group of individuals.

2. If the court determines that the notice required in subsubparagraph 1C of this subparagraph is impractical because of the number of individuals or geographical areas affected, the court shall ensure that the affected individuals are fully informed of the order using the best possible means available.

(iii) An order authorizing isolation or quarantine is effective for a period not to exceed 30 days.

(iv) 1. Prior to the expiration of an order, the Secretary or designated official may move to continue isolation or quarantine for subsequent 30–day periods.

2. The court shall base its decision on the standards provided under this paragraph.

(6) In the event that an individual cannot personally appear before the court, proceedings may be conducted:

(i) By an individual's authorized representative; and

(ii) Through any means that allow other individuals to fully participate.

(7) In any proceedings brought under this subsection, the court may order the consolidation of individual claims into group claims where:

(i) The number of individuals involved or affected is so large as to render individual participation impractical;

(ii) There are questions of law or fact common to the individual claims or rights to be determined;

(iii) The group claims or rights to be determined are typical of the affected individual's claims or rights; or

(iv) The entire group will be adequately represented in the consolidation.

(c) The court shall appoint counsel to represent individuals or a group of individuals who are not otherwise represented by counsel.

(d) The Supreme Court of Maryland shall develop emergency rules of procedure to facilitate the efficient adjudication of any proceedings brought under this section.

(e) It shall be unlawful for any public or private employer to discharge an employee who is under an order of isolation or quarantine or because of such an order.

§18–907.

(a) (1) A person may not knowingly and willfully fail to comply with any order, regulation, or directive issued in accordance with § 18-905 of this subtitle.

(2) A person who violates paragraph (1) of this subsection is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $3,000 or both.

(b) If a health care facility fails to comply with an order, regulation, or directive issued under § 18-903 or § 18-904 of this subtitle, the Secretary may impose a civil penalty not to exceed $3,000 for each offense.

(c) If a health care practitioner fails to comply with an order, regulation, or directive issued under § 18-903 or § 18-904 of this subtitle, the Secretary may request the appropriate licensing board to take disciplinary action against the health care practitioner, including:

(1) Placing the licensee or certificate holder on probation;

(2) Suspending or revoking the license or certificate holder; or

(3) Imposing a civil penalty not to exceed $3,000 for each offense.

(d) A health care provider acting in good faith and in accordance with a catastrophic health emergency disease surveillance and response program is immune from civil or criminal liability related to those actions, unless the health care provider acts with willful misconduct.

§18–908.

(a) On or before December 31, 2002, the Secretary shall submit a report to the Governor and to the General Assembly in accordance with § 2–1257 of the State Government Article regarding any plans, procedures, or protocols developed under this subtitle or any recommendations for additional legislation that may be necessary to respond to a catastrophic health emergency.

(b) The Secretary shall update the report required under subsection (a) of this section every 3 years or when any plan, procedure, or protocol developed under this subtitle or any other provision of this subtitle is used in order to detect a catastrophic health emergency.

§18–9A–01.

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

(b) "COVID–19" means, interchangeably and collectively, the coronavirus known as COVID–19 or 2019–nCoV and the SARS–CoV–2 virus.

(c) "COVID–19 test" means an in vitro diagnostic test for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, as described in § 3201 of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

§18–9A–02.

(a) On or before June 1, 2021, the Department, in collaboration with local health departments in the State and the Maryland State Department of Education, shall adopt and implement a 2–year plan to respond to the outbreak of COVID–19.

(b) The plan required under this section shall:

(1) Include measures to enhance public health efforts at the State and local level to monitor, prevent, and mitigate the spread of COVID–19;

(2) (i) Assess the COVID–19 public and private testing infrastructure in place both statewide and in each local jurisdiction;

(ii) Identify and address the unmet needs for COVID–19 testing statewide and in each local jurisdiction, including the number and location of public and private testing providers required to ensure access to testing on demand for all residents of the State;

(iii) Establish specific monthly goals for COVID–19 testing statewide and in each local jurisdiction to ensure access to testing for all residents of the State, including:

1. A goal to achieve the capacity to perform the surveillance testing required to safely reopen and keep open schools, institutions of higher education, workplaces, and other community facilities in the State while minimizing the community spread of COVID–19 in calendar years 2021 and 2022 through a network of public and private testing providers; and

2. For each local jurisdiction, a goal to establish the required number of public or private COVID–19 testing locations to achieve the surveillance testing goal described in item 1 of this item; and

(iv) Estimate the funding required to implement the surveillance testing goal described in item (iii)1 of this item and the extent to which federal funding already received by the State in fiscal year 2021 and federal funding that is provided to the State and received after March 1, 2021, can be used to cover the cost required to achieve that goal;

(3) (i) Assess the contact tracing infrastructure in place for COVID–19 both statewide and in each local jurisdiction;

(ii) Determine the optimal number of contact tracing, case management, care resource coordination, and other personnel per 100,000 residents needed in each jurisdiction to effectively monitor, prevent, and mitigate the spread of COVID–19;

(iii) Identify and address the unmet needs for COVID–19 contact tracing and related outbreak prevention and mitigation efforts both statewide and in each local jurisdiction; and

(iv) 1. Establish goals for identifying, locating, and testing individuals who have been in close contact with individuals who test positive for COVID–19 that are in alignment with Centers for Disease Control and Prevention guidance for effective contact tracing programs; and

2. Include a mechanism for monitoring performance of contact tracing and testing of contacts both statewide and for each local jurisdiction;

(4) Require the Department to assist local jurisdictions that adopt strategies to:

(i) Accelerate access to and the use of at–home collection and point–of–care tests for COVID–19; and

(ii) Incentivize and encourage pharmacies and health care providers, including primary care providers, to provide COVID–19 testing; and

(5) Allow each local jurisdiction to establish and implement a program for COVID–19 contact tracing that is independent from the contact tracing program performed by the State or the entity with whom the State has contracted to perform contact tracing for the State.

(c) The plan required under this section shall have a design that addresses the disproportionate impact of the COVID–19 pandemic on underserved and minority communities in the State.

(d) On or before June 1, 2021, the Department shall submit the plan required under this section to the General Assembly, in accordance with § 2–1257 of the State Government Article.

(e) (1) (i) For fiscal years 2021 and 2022, the Department shall provide $25,000,000 each year in grants to local jurisdictions to expand capacity for COVID–19 testing and contact tracing, or for any other public health purpose related to COVID–19 response for which federal funding is authorized.

(ii) Grant funding provided for COVID–19 response under subparagraph (i) of this paragraph shall be divided between local jurisdictions in proportion to their respective populations.

(iii) The Department shall provide additional grant funding to a local jurisdiction to supplement the grant funding allocated to the local jurisdiction under subparagraphs (i) and (ii) of this paragraph if the Department determines that the initial allocation of grant funding is not sufficient to meet the COVID–19 testing and contact tracing needs of the local jurisdiction.

(iv) A local jurisdiction may use grant funding provided under this subsection to expand COVID–19 testing capacity through direct testing efforts

by the health department of the local jurisdiction or by contracting with other entities to provide testing.

(2) (i) For fiscal years 2021 and 2022 and in addition to any funding provided under paragraph (1) of this subsection, the Department shall provide funding to local jurisdictions that elect to establish and implement a program for COVID–19 contact tracing that is independent from the contact tracing program performed by the State or the entity with whom the State has contracted to perform contact tracing for the State.

(ii) The amount of funding provided to a local jurisdiction for COVID–19 contact tracing under subparagraph (i) of this paragraph shall be equivalent to the cost per case amount provided to the entity with whom the State has contracted to perform contact tracing for the State.

(3) (i) For fiscal years 2021 and 2022, the Department shall provide $15,000,000 each year in grants to local jurisdictions to vaccinate residents of the local jurisdiction against COVID–19.

(ii) Grant funding provided for COVID–19 vaccination under this subsection shall be divided between local jurisdictions in proportion to their respective populations.

(iii) The Department shall provide additional grant funding to a local jurisdiction to supplement the grant funding allocated to the local jurisdiction under subparagraphs (i) and (ii) of this paragraph if the Department determines that the initial allocation of grant funding is not sufficient to meet the COVID–19 vaccination needs of the local jurisdiction.

(4) The Department may use only federal funding allocated to the State under the Coronavirus Response and Relief Supplemental Appropriations Act and any other federal legislation enacted in calendar years 2020 through 2022 to provide funding required under this section.

(f) (1) To the extent practicable, the Department shall provide up to $9,000,000 in fiscal year 2021 and $36,000,000 in fiscal year 2022 in grant funding to assisted living programs and home health agencies in calendar year 2021 to cover the cost of COVID–19 testing for residents, patients, and staff.

(2) The Department may use only federal funding allocated to the State under the Coronavirus Response and Relief Supplemental Appropriations Act and any other federal legislation enacted in calendar years 2020 through 2022 to provide funding required under this subsection.

§18–9A–03.

(a) (1) On or before June 1, 2021, the Department, with input from subject matter experts and other relevant stakeholders, shall develop and submit to the General Assembly a comprehensive plan for vaccinating residents of the State against COVID–19.

(2) The plan required under paragraph (1) of this subsection shall include:

(i) Detailed information on:

1. The categories of residents of the State who will receive priority access to vaccines for COVID–19;

2. The timeline for providing vaccines for COVID–19 to residents in each of the priority categories and to members of the general public who are not included in priority categories; and

3. Target metrics for vaccinating residents in each of the priority categories and for members of the general public who are not included in priority categories;

(ii) A dedication of time and resources to target vaccine distribution and vaccine safety outreach efforts to communities that have been disproportionately impacted by COVID–19 infection, morbidity, and mortality;

(iii) A vaccine distribution strategy that allocates resources and vaccines across all partners and vaccination sites in an equitable manner that ensures that the vaccine allocation by jurisdiction accounts for the disproportionate impact of the COVID–19 pandemic on underserved and minority communities; and

(iv) A strategy for outreach and distribution of vaccines to individuals who are not receiving the vaccine, due to either lack of access or vaccine hesitancy.

(b) After submitting the COVID–19 vaccine plan to the General Assembly as required under subsection (a) of this section, the Department shall provide weekly progress reports on implementation of the COVID–19 vaccine plan to the General Assembly for the duration of calendar year 2021.

(c) The COVID–19 vaccine plan and progress reports required under this section shall be submitted to the General Assembly in accordance with § 2–1257 of the State Government Article.

§18–9A–04.

(a) The Department shall convene a Maryland Public Health Modernization Workgroup.

(b) The Workgroup shall include representatives of the Department, local health departments, subject matter experts, and any other relevant stakeholders.

(c) The Workgroup shall:

(1) Assess the current public health infrastructure and resources in the State;

(2) Make recommendations for how to establish a modern and effective public health system with a capacity to:

(i) Monitor, prevent, control, and mitigate the spread of infectious disease; and

(ii) Achieve State Health Improvement Process goals;

(3) Make recommendations regarding the establishment of a Maryland Public Health Job Corps to respond to the outbreak of COVID–19 or similar outbreaks; and

(4) Consider, where appropriate, the use of federal funds to implement any recommendations made under this subsection.

(d) On or before December 1, 2021, the Department shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, that includes the findings and recommendations of the Workgroup established under this section.

§18–1001.

As funds are available, the Department shall:

(1) Conduct a needs assessment to determine the incidence of the hepatitis B virus and hepatitis C virus in the State;

(2) Initiate a statewide public awareness campaign targeting vulnerable populations and health care providers in the State to urge hepatitis B virus and hepatitis C virus education and testing;

(3) Coordinate with other units of State government, including the Department of Public Safety and Correctional Services and the Veterans' Administration, to activate a hepatitis C virus plan for the education, testing, and treatment of the populations within the jurisdiction of the units;

(4) Solicit funding from the private sector and units of federal, State, and local government for hepatitis B virus and hepatitis C virus outreach;

(5) Provide funding for hepatitis C virus pilot programs, which may include programs in methadone clinics or programs for the Department of Correctional Services population;

(6) Review and recommend initiatives to promote advocacy, education, physician outreach, and awareness of the hepatitis B virus and hepatitis C virus;

(7) Assess the feasibility of creating a Hepatitis C Virus Administration in the Department and examine methods to maximize existing resources to raise awareness of the hepatitis C virus;

(8) Implement the 2005 Report of the Hepatitis C Advisory Council;

(9) Coordinate with the Maryland Office of Minority Health and Health Disparities to develop a hepatitis B virus plan and a hepatitis C virus plan for the education, testing, and treatment of high risk populations and ethnic and racial populations who are affected disproportionately by the hepatitis B and hepatitis C viruses, including the Asian population and African immigrants;

(10) Develop a plan to increase the availability of hepatitis B virus vaccinations in the State, in accordance with recommendations from the Centers for Disease Control and Prevention;

(11) Develop recommendations to improve the awareness and the affordability of medications for treating the hepatitis C virus; and

(12) Collaborate with the Maryland Insurance Administration to make recommendations regarding insurance coverage for the treatment of the hepatitis C virus.

§18–1101.

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

(b) "Fund" means the Academic Health Center Immunotherapy Research Fund.

(c) "Statewide academic health center" means:

(1) The University of Maryland Medical System Corporation, the University of Maryland Medical School, and the University of Maryland, Baltimore Campus; or

(2) The Johns Hopkins University and the Johns Hopkins Health Systems.

§18–1102.

(a) There is an Academic Health Center Immunotherapy Research Fund.

(b) The purpose of the Fund is to provide matching grants to statewide academic health centers for immunotherapy research.

(c) The Secretary shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund; and

(2) Any other money from any other source accepted for the benefit of the Fund.

(f) (1) The Fund may be used only for immunotherapy research.

(2) To qualify for a grant from the Fund, a statewide academic health center must dedicate funding from other sources to be used for the purpose described under subsection (b) of this section.

(3) The amount of a grant awarded from the Fund may not exceed the amount of funding dedicated by the statewide academic health center under paragraph (2) of this subsection.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the General Fund of the State.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund is supplemental to and is not intended to take the place of funding that otherwise would be appropriated to a statewide academic health center.

§18–1201.

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

(b) "Advisory Committee" means the Parkinson's Disease Registry Advisory Committee.

(c) "Parkinson's disease" means a chronic and progressive disorder resulting from deficiency of the neurotransmitter dopamine as the consequence of specific degenerative changes in the area of the brain called the basal ganglia, characterized by tremors at rest, slow movements, muscle rigidity, stooped posture, and unsteady or shuffling gait.

§18–1202.

There is a Parkinson's Disease Registry Advisory Committee in the Department.

§18–1203.

(a) The Advisory Committee shall:

(1) Assist in the development and implementation of a State Parkinson's Disease Registry;

(2) Determine what data shall be collected and be stored in a State Parkinson's Disease Registry and the methods to ensure the privacy and confidentiality of data collected and stored in the registry;

(3) Advise the Department on Parkinson's disease and maintaining a State Parkinson's Disease Registry; and

(4) Consult with entities that may be able to collect data and work in partnership with the federal Centers for Disease Control and Prevention to aid the federal Centers for Disease Control and Prevention in creating a national Parkinson's Disease Registry.

(b) Entities that may be consulted under subsection (a)(4) of this section include:

(1) The State–designated health information exchange;

(2) Nonprofit organizations; and

(3) Colleges or universities.

(c) (1) The Secretary shall appoint individuals to serve on the Advisory Committee, including:

(i) A neurologist;

(ii) A movement disorder specialist;

(iii) A primary care provider;

(iv) A physician informaticist;

(v) A patient with Parkinson's disease;

(vi) A public health professional;

(vii) A population health researcher familiar with disease registries;

(viii) A Parkinson's disease researcher; and

(ix) Any other individuals the Secretary determines are necessary.

(2) The Secretary shall establish:

(i) The duration of term limits for members of the Advisory Committee;

(ii) Rules and procedures for conducting business of the Advisory Committee; and

(iii) Any other rules necessary for the Advisory Committee to function effectively.

(d) Beginning July 1, 2023, the Advisory Committee shall meet at least quarterly.

§18–1204.

(a) The Department, in collaboration with the State–designated health information exchange, shall establish and maintain a publicly accessible website that has the following information in a downloadable format:

(1) The incidence of Parkinson's disease in the State; and

(2) To the extent possible, the incidence of Parkinson's disease disaggregated based on:

(i) Age, including age of diagnosis;

(ii) Gender;

(iii) Sex;

(iv) Race;

(v) Ethnicity; and

(vi) Cases by county.

(b) The website required under subsection (a) of this section shall:

(1) Include the data available for the 5–year period ending on September 30, 2023; and

(2) Be updated on or before January 1 each year, to include any newly available data.

§19–101.

In this subtitle, "Commission" means the Maryland Health Care Commission.

§19–102.

(a) The General Assembly finds that the health care regulatory system in this State is a highly complex structure that needs to be constantly reevaluated and modified in order to better reflect and be more responsive to the ever changing health care environment and the needs of the citizens of this State.

(b) The purpose of this subtitle is to establish a streamlined health care regulatory system in this State in a manner such that a single State health policy can be better articulated, coordinated, and implemented in order to better serve the citizens of this State.

§19–103.

(a) There is a Maryland Health Care Commission.

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

(c) The purpose of the Commission is to:

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

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by:

(i) Advocating policies and systems to promote the efficient delivery of and improved access to health care services; and

(ii) Enhancing the strengths of the current health care service delivery and regulatory system;

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

(4) Establish and develop a medical care database on health care services rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and

the availability of information to consumers, providers, and purchasers of health care services;

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan;

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

(8) Ensure utilization of the medical care database as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

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

(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

(11) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article;

(12) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors;

(13) Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Health Services Cost Review Commission; and

(14) Establish policies and standards to protect the confidentiality of patient and health care practitioner information related to legally protected health care as defined in § 4–301 of this article.

(d) The Commission shall coordinate the exercise of its functions with the Department and the Health Services Cost Review Commission to ensure an integrated, effective health care policy for the State.

§19–104.

(a) (1) The Commission shall consist of 15 members appointed by the Governor with the advice and consent of the Senate.

(2) Of the 15 members:

(i) Eight shall be individuals who do not have any connection with the management or policy of a health care provider or payor; and

(ii) Of the remaining seven members:

1. Two shall be physicians;

2. Two shall be payors, as defined in § 19–132 of this subtitle;

3. One shall be an administrator of a hospital, as defined in § 19–301 of this title;

4. One shall be a nursing home administrator in the State; and

5. One shall be a nonphysician health care practitioner.

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

(2) The terms of members are staggered as required by the terms provided for members of the Commission on October 1, 1999.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

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

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

(c) When appointing members to the Commission, the Governor shall:

(1) Assure that:

(i) At least four members are residents of different counties with a population of 300,000 or more; and

(ii) At least three members are residents of different counties with a population of less than 300,000, of which at least:

1. One shall be a resident of the Eastern Shore;

2. One shall be a resident of Allegany County, Garrett County, Washington County, Carroll County, or Frederick County; and

3. One shall be a resident of Southern Maryland; and

(2) To the extent practicable, assure geographic balance and promote racial, ethnic, and gender diversity in the Commission's membership.

§19–105.

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

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

§19–106.

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

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

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

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

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

§19–107.

(a) (1) A majority of the full authorized membership of the Commission is a quorum.

(2) The decision of the Commission shall be by a majority of the quorum present and voting.

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

(c) Each member of the Commission is entitled to:

(1) Compensation in accordance with the State budget; and

(2) Reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) (1) The Commission may employ a staff in accordance with the State budget.

(2) The Commission, in consultation with the Secretary, may set the compensation of a Commission employee in a position that:

(i) Is unique to the Commission;

(ii) Requires specific skills or experience to perform the duties of the position; and

(iii) Does not require the employee to perform functions that are comparable to functions performed in other units of the Executive Branch of State government.

(3) The Secretary of Budget and Management, in consultation with the Secretary, shall determine the positions for which the Commission may set compensation under paragraph (2) of this subsection.

§19–108.

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission:

(1) Shall adopt regulations specifying the Comprehensive Standard Health Benefit Plan to apply under Title 15, Subtitle 12 of the Insurance Article; and

(2) On or before March 1, 2008, in consultation with the Department, shall propose regulations to:

(i) Specify the components of wellness benefits, offered under Title 15, Subtitle 12 of the Insurance Article, that include incentives or differential cost–sharing for employees based on their participation in wellness activities; and

(ii) Require small employers receiving a subsidy of small employer health benefit plan premium contributions under Title 15, Subtitle 12A of the Insurance Article to agree to purchase a wellness benefit.

(b) In carrying out its duties under this section, the Commission shall comply with the provisions of § 15–1207 and Title 15, Subtitle 12A of the Insurance Article.

§19–108.1.

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission shall maintain on its website an application that a small business may use to compare premiums of health benefit plans offered by health insurance carriers under Title 15, Subtitle 12 of the Insurance Article.

(b) The application required under this section shall provide information on:

(1) Premiums for health benefit plans sold under Title 15, Subtitle 12 of the Insurance Article, categorized by age bands; and

(2) Premiums for health benefit plans sold under Title 15, Subtitle 12 of the Insurance Article that include riders typically purchased by small employers in the State.

(c) The Commission shall update the information required under this section at least quarterly.

§19–108.2.

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

(2) "Health care service" has the meaning stated in § 15–10A–01 of the Insurance Article.

(3) "Payor" means:

(i) An insurer or nonprofit health service plan that provides hospital, medical, or surgical benefits to individuals or groups on an expense–

incurred basis under health insurance policies or contracts that are issued or delivered in the State;

(ii) A health maintenance organization that provides hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; or

(iii) A pharmacy benefits manager that is registered with the Maryland Insurance Commissioner.

(4) "Provider" has the meaning stated in § 19–7A–01 of this title.

(5) "Step therapy or fail–first protocol" has the meaning stated in § 15–142 of the Insurance Article.

(b) In addition to the duties stated elsewhere in this subtitle, the Commission shall work with payors and providers to attain benchmarks for:

(1) Standardizing and automating the process required by payors for preauthorizing health care services; and

(2) Overriding a payor's step therapy or fail–first protocol.

(c) The benchmarks described in subsection (b) of this section shall include:

(1) On or before October 1, 2012 ("Phase 1"), establishment of online access for providers to each payor's:

(i) List of health care services that require preauthorization; and

(ii) Key criteria for making a determination on a preauthorization request;

(2) On or before March 1, 2013 ("Phase 2"), establishment by each payor of an online process for:

(i) Accepting electronically a preauthorization request from a provider; and

(ii) Assigning to a preauthorization request a unique electronic identification number that a provider may use to track the request during the preauthorization process, whether or not the request is tracked electronically, through a call center, or by fax;

(3) On or before July 1, 2013 ("Phase 3"), establishment by each payor of an online preauthorization system to approve:

(i) In real time, electronic preauthorization requests for pharmaceutical services:

1. For which no additional information is needed by the payor to process the preauthorization request; and

2. That meet the payor's criteria for approval;

(ii) Within 1 business day after receiving all pertinent information on requests not approved in real time, electronic preauthorization requests for pharmaceutical services that:

1. Are not urgent; and

2. Do not meet the standards for real–time approval under item (i) of this item; and

(iii) Within 2 business days after receiving all pertinent information, electronic preauthorization requests for health care services, except pharmaceutical services, that are not urgent;

(4) On or before July 1, 2015, establishment, by each payor that requires a step therapy or fail–first protocol, of a process for a provider to override the step therapy or fail–first protocol of the payor; and

(5) On or before July 1, 2015, utilization by providers of:

(i) The online preauthorization system established by payors; or

(ii) If a national transaction standard has been established and adopted by the health care industry, as determined by the Commission, the provider's practice management, electronic health record, or e–prescribing system.

(d) The benchmarks described in subsections (b) and (c) of this section do not apply to preauthorizations of health care services requested by providers employed by a group model health maintenance organization as defined in § 19–713.6 of this title.

(e) The online preauthorization system described in subsection (c)(3) of this section shall:

(1) Provide real–time notice to providers about preauthorization requests approved in real time; and

(2) Provide notice to providers, within the time frames specified in subsection (c)(3)(ii) and (iii) of this section and in a manner that is able to be tracked by providers, about preauthorization requests not approved in real time.

(f) (1) The Commission shall establish by regulation a process through which a payor or provider may be waived from attaining the benchmarks described in subsections (b) and (c) of this section for extenuating circumstances.

(2) For a provider, the extenuating circumstances may include:

(i) The lack of broadband Internet access;

(ii) Low patient volume; or

(iii) Not making medical referrals or prescribing pharmaceuticals.

(3) For a payor, the extenuating circumstances may include:

(i) Low premium volume; or

(ii) For a group model health maintenance organization, as defined in § 19–713.6 of this title, preauthorizations of health care services requested by providers not employed by the group model health maintenance organization.

(g) (1) On or before October 1, 2012, the Commission shall reconvene the multistakeholder workgroup whose collaboration resulted in the 2011 report "Recommendations for Implementing Electronic Prior Authorizations".

(2) The workgroup shall:

(i) Review the progress to date in attaining the benchmarks described in subsections (b) and (c) of this section; and

(ii) Make recommendations to the Commission for adjustments to the benchmark dates.

(h) If necessary to attain the benchmarks, the Commission may adopt regulations to:

(1) Adjust the Phase 2 or Phase 3 benchmark dates;

(2) Require payors and providers to comply with the benchmarks; and

(3) Establish penalties for noncompliance.

§19–108.3.

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

(2) "Carrier" includes insurers, nonprofit health service plans, health maintenance organizations, third–party administrators, and pharmacy benefits managers.

(3) "Health care provider" includes hospitals, physicians, nurse practitioners, pharmacists, and other persons entitled to reimbursement under § 15–701(a) of the Insurance Article.

(4) "Workgroup" means the Health Care Provider–Carrier Workgroup.

(b) The Commission shall establish a Health Care Provider–Carrier Workgroup.

(c) The purpose of the Workgroup is to provide a mechanism for health care providers and carriers to resolve disputes on issues over which no State agency has statutory or regulatory authority.

(d) The Workgroup shall be composed of representatives of:

(1) Professional organizations or associations of health care providers who bill and receive reimbursement for health care services from carriers;

(2) Carriers or organizations or trade associations representing carriers that reimburse health care providers for health care services provided under health benefit plans; and

(3) Subject to subsection (e)(1)(iii) of this section, consumer organizations.

(e) (1) The Commission shall invite the following to appoint members to the Workgroup:

(i) Professional organizations or associations of health care providers;

(ii) Carriers or organizations or trade associations representing carriers; and

(iii) When appropriate to the issue under discussion, consumer organizations.

(2) Membership in the Workgroup may change depending on the issues before the Workgroup.

(3) The size of the Workgroup shall be at the discretion of the Commission but large enough to represent the appropriate range of stakeholders.

(f) Workgroup members may not receive compensation or reimbursement for serving on the Workgroup.

(g) The Workgroup shall meet at least quarterly.

(h) Commission staff shall facilitate Workgroup meetings and provide research and other support to the Workgroup.

(i) (1) At least annually, Commission staff shall solicit issues for consideration by the Workgroup.

(2) Issues shall be solicited from:

(i) Members of the General Assembly;

(ii) Professional organizations or associations of health care providers and carriers or organizations or trade associations representing carriers;

(iii) State agencies, including the Department, health occupations boards, the Maryland Insurance Administration, and the Commission; and

(iv) Consumer organizations.

(j) After soliciting issues under subsection (i) of this section, Commission staff shall select the issues to be considered by the Workgroup.

(k) Commission staff shall:

(1) Research each issue before the issue is considered by the Workgroup;

(2) Use the results of the research to inform Workgroup meetings;

(3) Facilitate Workgroup meetings in a way that promotes resolution of disputes on issues and is satisfactory to the members of the Workgroup; and

(4) On or before January 1, 2016, and each year thereafter, submit a report to the Commission and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee regarding the issues considered by the Workgroup during the preceding year and the outcome of the Workgroup's consideration of each issue.

§19–108.4.

(a) In this section, "primary care" means health care provided in the following fields' outpatient settings:

(1) Family medicine;

(2) General pediatrics;

(3) Primary care internal medicine;

(4) Primary care obstetrics and gynecology;

(5) Primary care nurse practitioner services; and

(6) Primary care midwifery.

(b) On or before December 1 each year, beginning in 2024, the Commission shall provide a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly that includes:

(1) An analysis of primary care investment over the immediately preceding year, including data stratified by zip code and county, in relation to total health care spending over the previous year;

(2) Ways to improve the quality of and access to primary care services, with special attention to increasing health care equity, reducing health care disparities, and avoiding increased costs to patients and the health care system; and

(3) Any findings and recommendations of the Commission.

(c) (1) The Commission shall form a workgroup to develop the report required under subsection (b) of this section, including by interpreting the results of the required analysis and making the recommendations.

(2) The workgroup required under this subsection shall include representatives of:

(i) The Maryland Primary Care Program;

(ii) The Health Services Cost Review Commission;

(iii) The Maryland Insurance Administration;

(iv) The Health Care Financing Division of the Maryland Department of Health;

(v) The primary care community, including from the Maryland Academy of Family Physicians, the Maryland Chapter of the American Academy of Pediatrics, the Maryland Section of the American College of Obstetricians and Gynecologists, the Maryland Nurses Association, the Maryland Affiliate – American College of Nurse Midwives, the Maryland Community Health System, and the MidAtlantic Association of Community Health Centers;

(vi) Payors of primary care services, including carriers and managed care organizations;

(vii) Health services researchers with expertise in primary care; and

(viii) Other interested stakeholders.

§19–108.5.

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

(2) "Carrier" has the meaning stated in § 15–1301 of the Insurance Article.

(3) "Health care provider" has the meaning stated in § 19–108.3 of this subtitle.

(b) (1) On or before July 1, 2026, a carrier shall establish and maintain an online process that:

(i) Links directly to all e–prescribing systems and electronic health record systems that use the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard;

(ii) Can accept electronic prior authorization requests from a health care provider;

(iii) Can approve electronic prior authorization requests:

1. For which no additional information is needed by the carrier to process the prior authorization request;

2. For which no clinical review is required; and

3. That meet the carrier's criteria for approval; and

(iv) Links directly to real–time patient out–of–pocket costs, including copayment, deductible, and coinsurance costs, and more affordable medication alternatives made available by the carrier.

(2) A carrier may not:

(i) Impose a fee or charge on a person for accessing the online process required under paragraph (1) of this subsection; or

(ii) Access, without health care provider consent, health care provider data via the online process other than for the insured or enrollee.

(c) On or before July 1, 2025, a carrier shall:

(1) On request of a health care provider, provide contact information for each third–party vendor or other entity that the carrier will use to meet the requirements of subsection (b) of this section; and

(2) Post the contact information required to be provided under item (1) of this subsection on its website.

(d) (1) On or before July 1, 2026, each health care provider shall ensure that each e–prescribing system or electronic health record system owned or contracted for by the health care provider to maintain a health record of an insured or enrollee has the ability to access, at the point of prescribing:

(i) The electronic prior authorization process established by a carrier under subsection (b) of this section; and

(ii) The real–time patient out–of–pocket cost information and available medication alternatives required under subsection (b) of this section.

(2) The Commission shall establish by regulation a process through which a health care provider may request and receive a waiver of compliance from the requirements of this subsection.

(e) (1) On or before July 1, 2026, each carrier, or a pharmacy benefits manager on behalf of the carrier, shall:

(i) Provide real–time patient–specific benefit information to insureds and enrollees and contracted health care providers, including any out–of–pocket costs and more affordable medication alternatives or prior authorization requirements; and

(ii) Ensure that the information provided under item (i) of this paragraph is accurate.

(2) Each carrier, or a pharmacy benefits manager on behalf of the carrier, shall make available the information required to be provided under paragraph (1) of this subsection to the health care provider at the point of prescribing in an accessible and understandable format, such as through the health care provider's e–prescribing system or electronic health record system that the carrier, pharmacy benefits manager, or designated subcontractor has adopted that uses the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard from which the health care provider makes the request.

§19–108.6.

On or before December 1 every 4 years, beginning in 2026, the Commission shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly that includes:

(1) Advances or developments in the area of telehealth, including:

(i) Evolving modalities of telehealth delivery; and

(ii) Changes in the costs of delivering telehealth services; and

(2) Any findings or recommendations of the Commission.

§19–109.

(a) In addition to the powers set forth elsewhere in this subtitle, the Commission may:

(1) Adopt rules and regulations to carry out the provisions of this subtitle;

(2) Create committees from among its members;

(3) Appoint advisory committees, which shall include consumers and may include representatives of interested public or private organizations, to make recommendations to the Commission on community–based services, long–term care, acute patient services, ambulatory surgical services, specialized health care services, residential treatment centers for emotionally disturbed children and adolescents, mental health and alcohol and drug abuse services, and any other topic or issue that the Commission considers necessary;

(4) Apply for and accept any funds, property, or services from any person or government agency;

(5) Subject to subsection (d) of this section, award any funds received from any person or government agency;

(6) Make agreements with a grantor or payor or with a grantee or payee of funds, property, or services, including an agreement to make any study, plan, demonstration, or project;

(7) Publish and give out any information that relates to the financial aspects of health care and is considered desirable in the public interest; and

(8) Subject to the limitations of this subtitle, exercise any other power that is reasonably necessary to carry out the purposes of this subtitle, including adopting regulations that set reasonable deadlines for filing of information or reports required under this subtitle and impose reasonable penalties for failure to file information or reports as required.

(b) In addition to the duties set forth elsewhere in this subtitle, the Commission shall:

(1) Adopt rules and regulations that relate to its meetings, minutes, and transactions;

(2) Keep minutes of each meeting;

(3) Prepare annually a budget proposal that includes the estimated income of the Commission and proposed expenses for its administration and operation;

(4) Beginning December 1, 2000, and each December 1 thereafter, submit to the Governor, the Secretary, and, subject to § 2–1257 of the State Government Article, the General Assembly an annual report on the operations and activities of the Commission during the preceding fiscal year, including:

(i) A copy of each summary, compilation, and supplementary report required by this subtitle; and

(ii) Any other fact, suggestion, or policy recommendation that the Commission considers necessary;

(5) Except for confidential or privileged medical or patient information, make:

(i) Each report filed and each summary, compilation, and report required under this subtitle available for public inspection at the office of the Commission during regular business hours; and

(ii) Each summary, compilation, and report available to any other State agency on request; and

(6) In collaboration with the Office of Health Care Quality, develop a process to receive the following information and publish it on the Commission's Maryland Quality Reporting website for each applicable facility:

(i) The date of the Office's most recent inspection; and

(ii) Any associated ratings or other quality metrics calculated.

(c) (1) The Commission may contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Commission.

(2) Unless permission is granted specifically by the Commission, a third party hired by the Commission may not release, publish, or otherwise use any information to which the third party has access under its contract.

(d) (1) In awarding funds under subsection (a)(5) of this section, the Commission shall:

(i) Use a competitive process that affords interested persons an opportunity to submit a proposal for funding; and

(ii) Evaluate proposals for funding using a panel that consists of internal and external evaluators.

(2) The Commission shall:

(i) Provide on its website information that is easily accessible to the general public about funds to be awarded under subsection (a)(5) of this section and how to submit a proposal; and

(ii) Submit, in accordance with § 2–1257 of the State Government Article, an annual report to the General Assembly listing all funds awarded under subsection (a)(5) of this section.

§19–110.

(a) Except as expressly provided in this subtitle, the power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any regulation, decision, or determination that the Commission makes under authority specifically delegated by law to the Commission.

(b) (1) The power of the Secretary to transfer, by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Commission.

(2) The Secretary may assess an administrative charge, consistent with the indirect cost charge assessed to federal grants, to fund services provided to the Commission by the Executive Branch.

(c) (1) The power of the Secretary over the procurement procedure for units in the Department does not apply to the procurement procedure for the Commission.

(2) Subject to the provisions of paragraph (1) of this subsection, any procurement for services to be performed or for supplies to be delivered to the

Commission is subject to the purposes and requirements of the State Finance and Procurement Article.

§19–111.

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

(2) "Fund" means the Maryland Health Care Commission Fund.

(3) "Health benefit plan" has the meaning stated in § 15–1201 of the Insurance Article.

(4) "Health care practitioner" means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "Nursing home" means a related institution that is classified as a nursing home.

(6) "Payor" means:

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

(ii) A health maintenance organization that holds a certificate of authority in the State.

(b) Subject to the provisions of subsection (d) of this section, the Commission shall assess a fee on:

(1) All hospitals;

(2) All nursing homes;

(3) All payors; and

(4) All health care practitioners.

(c) (1) The total fees assessed by the Commission may not exceed $20,000,000.

(2) (i) The fees assessed by the Commission shall be used exclusively to cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle.

(ii) The costs of the Commission include the administrative costs incurred by the Department on behalf of the Commission.

(iii) The amount to be paid by the Commission to the Department for administrative costs, not to exceed 30.5% of the salaries of the Commission, shall be based on indirect costs or services benefiting the Commission, less overhead costs paid directly by the Commission.

(3) The Commission shall pay all funds collected from the fees assessed in accordance with this section into the Fund.

(4) The fees assessed may be expended only for purposes authorized by the provisions of this subtitle.

(5) The amount in paragraph (1) of this subsection limits only the total fees the Commission may assess in a fiscal year.

(d) In determining assessments of the total fees, the Commission shall:

(1) Use a methodology that accounts for the portion of the Commission's workload attributable to each industry assessed; and

(2) Recalculate workload distribution every 4 years.

(e) (1) The fees assessed in accordance with this section on health care practitioners shall be:

(i) Included in the licensing fee paid to the health care practitioner's licensing board; and

(ii) Transferred by the health care practitioner's licensing board to the Commission on a quarterly basis.

(2) The Commission may adopt regulations that waive the fee assessed under this section for a specific class of health care practitioners.

(3) (i) Subject to subparagraph (ii) of this paragraph, the Commission shall adopt regulations to permit a waiver of the fee assessment requirements for certain health care practitioners.

(ii) In adopting regulations to permit a waiver of the fee assessment requirements for certain health care practitioners, the Commission shall:

1. Consider the hourly wages of the health care practitioners; and

2. Give preference to exempting health care practitioners with an average hourly wage substantially below that of other health care practitioners.

(f) (1) There is a Maryland Health Care Commission Fund.

(2) The Fund is a special continuing, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The Treasurer shall separately hold, and the Comptroller shall account for, the Fund.

(4) The Fund shall be invested and reinvested in the same manner as other State funds.

(5) Any investment earnings shall be retained to the credit of the Fund.

(6) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2–1220 of the State Government Article.

(7) This section may not be construed to prohibit the Fund from receiving funds from any other source.

(8) The Fund shall be used only to provide funding for the Commission and for the purposes authorized under this subtitle.

(g) The Commission shall:

(1) (i) Assess fees on payors in a manner that apportions the total amount of the fees to be assessed on payors under subsection (d)(1) of this section among each payor based on the ratio of each payor's total premiums written in the State for health benefit plans to the total written premiums of all payors written in the State; and

(ii) On or before June 30 of each year, assess each payor a fee in accordance with item (i) of this item;

(2) (i) Assess fees for each hospital equal to the sum of:

1. The amount equal to one–half of the total fees to be assessed on hospitals under subsection (d)(1) of this section times the ratio of admissions of the hospital to total admissions of all hospitals; and

2. The amount equal to one–half of the total fees to be assessed on hospitals under subsection (d)(1) of this section times the ratio of gross operating revenue of each hospital to total gross operating revenues of all hospitals;

(ii) Establish minimum and maximum assessments; and

(iii) On or before June 30 of each year, assess each hospital a fee in accordance with item (i) of this item; and

(3) (i) Assess fees for each nursing home equal to the sum of:

1. The amount equal to one–half of the total fees to be assessed on nursing homes under subsection (d)(1) of this section times the ratio of admissions of the nursing home to total admissions of all nursing homes; and

2. The amount equal to one–half of the total fees to be assessed on nursing homes under subsection (d)(1) of this section times the ratio of gross operating revenue of each nursing home to total gross operating revenues of all nursing homes;

(ii) Establish minimum and maximum assessments; and

(iii) On or before June 30 of each year, assess each nursing home a fee in accordance with item (i) of this item.

(h) (1) On or before September 1 of each year, each payor, hospital, and nursing home assessed under this section shall make payment to the Commission.

(2) The Commission shall make provisions for partial payments.

(i) Any bill not paid within 30 days of the payment due date may be subject to an interest penalty to be determined and collected by the Commission.

§19–112.

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

(2) "Center" means a Patient Safety Center designated by the Commission.

(3) "Fund" means the Maryland Patient Safety Center Fund.

(b) (1) On or before December 31, 2025, the Commission shall designate a Center for the State.

(2) The Center designated under paragraph (1) of this subsection shall continue to act as the State–designated Center for the duration of the designation period, as determined by the Commission, if the Center continuously meets the standards and requirements established by the Commission.

(c) The designated Center shall:

(1) Develop, coordinate, and implement patient safety initiatives across the State;

(2) Be a model for patient safety innovation and implementation in the State;

(3) Convene health care providers, patients, and families to:

(i) Improve the quality of health care and reduce preventable and avoidable harm; and

(ii) Provide safe and equitable health care for State citizens; and

(4) Share information relating to best practices among providers and patients in the State.

(d) (1) There is a Patient Safety Center Fund.

(2) The purpose of the Fund is to subsidize a portion of the costs of the Center so that the Center may perform the duties described under subsection (c) of this section.

(3) The Commission shall administer the Fund.

(4) (i) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(ii) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(5) The Fund consists of:

(i) Money appropriated in the State budget to the Fund;

(ii) Interest earnings; and

(iii) Any other money from any other source accepted for the benefit of the Fund.

(6) The Fund may be used only to subsidize a portion of the costs of the Center so that the Center may perform the duties described under subsection (c) of this section.

(7) (i) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(ii) Any interest earnings of the Fund shall be credited to the Fund.

(e) (1) (i) For fiscal years 2023 through 2025, the Governor shall include in the annual budget bill an appropriation of $1,000,000 for the Fund.

(ii) For fiscal year 2027 and each fiscal year thereafter, the Governor shall include in the annual budget bill an appropriation of $1,000,000 for the Fund.

(2) The Commission may provide an annual grant from the Fund to the Center in the amount appropriated under paragraph (1) of this subsection, plus any interest and other income distributed to the Fund.

(3) Expenditures from the Fund may be made only in accordance with the State budget.

(4) Money expended from the Fund for the Center is supplemental to, and is not intended to take the place of, funding that otherwise would be appropriated for the Center.

(f) On or before October 1 each year, the Commission, in conjunction with the Center, shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on:

(1) The Center's statewide activities related to the development, coordination, and implementation of patient safety initiatives; and

(2) How the Center's statewide initiatives align with State–designated priorities.

§19–114.

(a) In this Part II of this subtitle the following words have the meanings indicated.

(a–1) "Acquisition" means:

(1) A transfer of stock or assets that results in a change of the person that controls a health care facility; or

(2) The transfer of more than 25% of stock or ownership interest in a health care facility.

(b) "Ambulatory surgical facility" means any center, service, office, facility, or office of one or more health care practitioners or a group practice that:

(1) Has three or more operating rooms;

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

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

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

(d) (1) "Health care facility" means:

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

(ii) A limited service hospital, as defined in § 19–301 of this title;

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

(iv) An ambulatory surgical facility;

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

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

(vii) A hospice, as defined in § 19–901 of this title;

(viii) A freestanding medical facility, as defined in § 19–3A–01 of this title; and

(ix) Any other health institution, service, or program for which this Part II of this subtitle requires a certificate of need.

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

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

(ii) For the purpose of providing an exception to the requirement for a certificate of need under § 19–120 of this subtitle, a facility to provide comprehensive care constructed by a provider of continuing care, as defined in § 10–401 of the Human Services Article, if:

1. Except as provided under § 19–123 of this subtitle, the facility is for the exclusive use of the provider's subscribers who have executed continuing care agreements, including continuing care at home agreements, and paid entrance fees that are at least equal to the lowest entrance fee charged for an independent living unit, an assisted living unit, or a continuing care at home agreement before entering the continuing care community, regardless of the level of care needed by the subscribers at the time of admission;

2. The facility is located on the campus of the continuing care community; and

3. The number of comprehensive care nursing beds in the community does not exceed:

A. 24 percent of the number of independent living units in a community having less than 300 independent living units; or

B. 20 percent of the number of independent living units in a community having 300 or more independent living units;

(iii) For the purpose of providing an exception to the requirement for a certificate of need under § 19–120 of this subtitle, a facility to provide comprehensive care that:

1. Is owned and operated by the Maryland Department of Veterans and Military Families; and

2. Restricts admissions to individuals who meet the residency requirements established by the Maryland Department of Veterans and Military Families and are:

A. Veterans who were discharged or released from the uniformed services under honorable conditions;

B. Former members of a reserve component, as defined in § 9–901 of the State Government Article; or

C. Nonveteran spouses of eligible veterans;

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

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

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

(e) "Health care practitioner" means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

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

(g) "Local health planning agency" means the health department of a jurisdiction or a body designated by the local health department to perform health planning functions.

(h) "State health plan" means the State health plan for facilities and services.

§19–115.

(a) In addition to the duties set forth elsewhere in this subtitle, in this Part II of this subtitle, the Commission shall:

(1) Act as the State agency to represent the State under Title VI of the federal Public Health Service Act; and

(2) Periodically participate in or perform analyses and studies that relate to:

(i) Adequacy of services and financial resources to meet the needs of the population;

(ii) Distribution of health care resources;

(iii) Allocation of health care resources;

(iv) Costs of health care in relationship to available financial resources; or

(v) Any other appropriate matter.

(b) In addition to the duties set forth elsewhere in this Part II of this subtitle, the Governor shall direct, as necessary, a State officer or agency to cooperate in carrying out the functions of the Commission.

(c) This State recognizes the federal act and any amendment to the federal act that does not require State legislation to be effective. However, if the federal act is repealed or expires, this Part II of this subtitle remains in effect.

§19–116.

(a) (1) The Secretary shall provide for a study of systems capacity in health services.

(2) The study shall:

(i) Determine for all health delivery facilities and settings where capacity should be increased or decreased to better meet the needs of the population;

(ii) Examine and describe the implementation methods and tools by which capacity should be altered to better meet the needs; and

(iii) Assess the impact of those methods and tools on the communities and health care delivery system.

(b) (1) In addition to information that an applicant for a certificate of need must provide, the Commission may request, collect, and report any statistical or other information that:

(i) Is needed by the Commission to perform its duties described in this Part II of this subtitle; and

(ii) Is described in regulations of the Commission.

(2) If a health care facility fails to provide information as required in this subsection, the Commission may:

(i) Impose a penalty of not more than $100 per day for each day the violation continues after consideration of the willfulness and seriousness of the withholding, as well as any past history of withholding of information;

(ii) Issue an administrative order that requires the applicant to provide the information; or

(iii) Apply to the circuit court in the county in which the facility is located for legal relief considered appropriate by the Commission.

(3) The Commission may send to the Department or a local health planning agency any statistical or other information the Commission is authorized to collect under paragraph (1) of this subsection.

§19–117.

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

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

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

§19–118.

(a) (1) On or before October 1 each year, the Commission shall adopt a State health plan.

(2) The plan shall:

(i) Be consistent with the Maryland All Payer Model Contract;

(ii) Include methodologies, standards, and criteria for certificate of need review; and

(iii) Prioritize conversion of acute capacity to alternative uses where appropriate.

(b) Annually or on petition by any person, the Commission shall:

(1) Assess each State health plan chapter;

(2) Determine the chapter or chapters of the State health plan that should be reviewed and revised;

(3) Establish, at a public meeting, the priority order and timeline of the State health plan chapter review and revision; and

(4) Publish any changes in the State health plan that the Commission considers necessary, subject to the review and approval granted to the Governor under this subtitle.

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

(d) (1) The Commission shall develop standards and policies consistent with the State health plan that relate to the certificate of need program.

(2) The standards:

(i) Shall address the availability, accessibility, cost, and quality of health care; and

(ii) Are to be reviewed and revised periodically to reflect new developments in health planning, delivery, and technology.

(3) In adopting standards regarding cost, efficiency, cost–effectiveness, or financial feasibility, the Commission shall take into account the relevant methodologies of the Health Services Cost Review Commission.

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

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

(g) In carrying out their responsibilities under this Part II of this subtitle for hospitals, the Commission and the Secretary shall recognize, but may not apply, develop, or duplicate standards or requirements related to quality which have been adopted and enforced by national or State licensing or accrediting authorities.

(h) The Commission shall transfer to the Maryland Department of Health health planning functions and necessary staff resources for licensed entities in the State health plan that are not required to obtain a certificate of need or an exemption from the certificate of need program.

§19–119.

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

(b) The institution-specific plan shall address:

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

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

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

(4) Accessibility and availability of beds;

(5) Quality of care;

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

(7) Hospitals in high growth areas; and

(8) Utilization.

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

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

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

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

(4) A State health plan developed or adopted after the incorporation of the institution-specific plan into the State health plan shall include the criteria in subsection (b) of this section in addition to the criteria in § 19-118 of this subtitle.

§19–120.

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

(2) "Consolidation" and "merger" include increases and decreases in bed capacity or services among the components of an organization that:

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

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

(3) (i) "Health care service" means any clinically related patient service.

(ii) "Health care service" includes a medical service.

(4) "Hospital capital threshold" means the lesser of:

(i) 25% of the hospital's gross regulated charges for the immediately preceding year; or

(ii) $50,000,000.

(5) "Limited service hospital" means a health care facility that:

(i) Is licensed as a hospital on or after January 1, 1999;

(ii) Changes the type or scope of health care services offered by eliminating the facility's capability to admit or retain patients for overnight hospitalization;

(iii) Retains an emergency or urgent care center; and

(iv) Complies with the regulations adopted by the Secretary under § 19–307.1 of this title.

(6) "Medical service" means:

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

1. Medicine, surgery, gynecology, addictions;

2. Obstetrics;

3. Pediatrics;

4. Psychiatry;

5. Rehabilitation;

6. Chronic care;

7. Comprehensive care;

8. Extended care;

9. Intermediate care; or

10. Residential treatment; or

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

(b) The Commission may set an application fee for a certificate of need for health care facilities not assessed a user fee under this subtitle.

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

(d) The Commission may adopt, after October 1, 1983, new thresholds or methods for determining the circumstances or minimum cost requirements under which a certificate of need application must be filed.

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

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

(f) Except as provided in subsections (g)(2)(iii) and (p) of this section, a certificate of need is required before a new health care facility is built, developed, or established.

(g) (1) A certificate of need is required before an existing or previously approved, but unbuilt, health care facility is moved to another site.

(2) This subsection does not apply if:

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

(ii) The relocation is the result of a partial or complete replacement of an existing hospital or related institution, as defined in § 19–301 of

this title, and the relocation is to another part of the site or immediately adjacent to the site of the existing hospital or related institution;

(iii) Subject to the provisions of subsections (i) and (j) of this section, the relocation is of an existing health care facility owned or controlled by a merged asset system and is to:

1. A site within the primary service area of the health care facility to be relocated if:

A. The proposed relocation is not across county boundaries; and

B. At least 45 days prior to the proposed relocation, notice is filed with the Commission;

2. A site outside the primary service area of the health care facility to be relocated but within the primary service area of the merged asset system if:

A. At least 45 days prior to the proposed relocation, notice is filed with the Commission; and

B. The Commission in its sole discretion, and in accordance with the criteria adopted by regulation, finds that the relocation is in the public interest, is not inconsistent with the State health plan, and will result in the more efficient and effective delivery of health care services; or

3. For a limited service hospital, a site within the immediate area as defined in regulation by the Commission; or

(iv) The relocation involves moving a portion of a complement of comprehensive care beds previously approved by the Commission after January 1, 1995, for use in a proposed new related institution, as defined in § 19–301 of this title, but unbuilt on October 1, 1998, if:

1. The comprehensive care beds that were originally approved by the Commission in a prior certificate of need review were approved for use in a proposed new related institution to be located in a municipal corporation within Carroll County in which a related institution is not located;

2. The comprehensive care beds being relocated will be used to establish an additional new related institution that is located in another

municipal corporation within Carroll County in which a related institution is not located;

3. The comprehensive care beds not being relocated are intended to be used to establish a related institution on the original site; and

4. Both the previously approved comprehensive care beds for use on the original site and the relocated comprehensive care beds for use on the new site will be used as components of single buildings on each site that also offer independent or assisted living residential units.

(3) Notwithstanding any other provision of this subtitle, a certificate of need is not required for a relocation described under paragraph (2)(iv) of this subsection.

(h) (1) A certificate of need is required before the bed capacity of a health care facility is changed.

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

(i) For a health care facility that is not a hospital, during a 2–year period the increase or decrease would not exceed the lesser of 10 percent of the total bed capacity or 10 beds;

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

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

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

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

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

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

A. Is pursuant to the consolidation or merger of two or more health care facilities, conversion of a health care facility or part of a facility to a nonhealth–related use, or a change in bed capacity at an intermediate care facility that offers medically managed residential substance use disorder treatment services and has a current license issued by the Secretary;

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

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

D. Is in the public interest; and

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

(iv) The increase or decrease in bed capacity is the result of the annual licensed bed recalculation provided under § 19–307.2 of this title; or

(v) 1. The increase or decrease in bed capacity will occur in an existing general hospice program that has a current license issued by the Secretary; and

2. At least 45 days before increasing or decreasing bed capacity, written notice of the intent to change bed capacity is filed with the Commission.

(i) (1) Except as provided in paragraph (2) of this subsection, for a hospital located in a county with three or more hospitals, a certificate of need is not required before the bed capacity is increased or decreased if the change:

(i) Occurs on or after July 1, 2000;

(ii) Is between hospitals in a merged asset system located within the same health service area;

(iii) Does not involve comprehensive or extended care beds; and

(iv) Does not occur earlier than 45 days after a notice of intent to reallocate bed capacity is filed with the Commission.

(2) A hospital may not create a new health care service through the relocation of beds from one county to another county pursuant to this subsection.

(j) (1) A certificate of need is required before the type or scope of any health care service is changed if the health care service:

(i) Is offered:

1. By a health care facility;

2. In space that is leased from a health care facility; or

3. In space that is on land leased from a health care facility; or

(ii) Results in a change in operating room capacity in a hospital, a freestanding medical facility, or an ambulatory surgical facility.

(2) This subsection does not apply if:

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

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

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

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

2. Establishment of a cardiac surgery, organ transplant surgery, or burn or neonatal intensive health care service;

3. Except as provided in § 19–120.1 of this subtitle, establishment of percutaneous coronary intervention services;

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

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

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

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

A. Is pursuant to:

I. The consolidation or merger of two or more health care facilities;

II. The conversion of a health care facility or part of a facility to a nonhealth–related use;

III. The conversion of a hospital to a limited service hospital; or

IV. The conversion of a licensed general hospital to a freestanding medical facility in accordance with subsection (o)(3) of this section;

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

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

D. Is in the public interest; and

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

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

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

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

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

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

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

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

(k) (1) A certificate of need is required before any of the following capital expenditures are made by or on behalf of a hospital:

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

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

2. The expenditure is made as part of a replacement of any plant and equipment of the hospital and is more than the hospital capital threshold after adjustment for inflation as provided in the regulations of the Commission;

3. The expenditure results in a substantial change in the bed capacity of the hospital; or

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

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

1. The expenditure is made as part of an acquisition, improvement, or expansion, and the total expenditure, including the cost of each study, survey, design, plan, working drawing, specification, and other essential activity, is more than the hospital capital threshold;

2. The expenditure is made as part of a replacement of any plant and equipment and is more than the hospital capital threshold after adjustment for inflation as provided in the regulations of the Commission;

3. The expenditure results in a substantial change in the bed capacity of the hospital; or

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

(2) A certificate of need is required before any of the following capital expenditures are made by or on behalf of a health care facility other than a hospital:

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

1. The expenditure results in a substantial change in the bed capacity of the health care facility other than a hospital; or

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

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

1. The expenditure results in a substantial change in the bed capacity of the health care facility other than a hospital; or

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

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

(4) A certificate of need is required before any equipment or plant is transferred to a health care facility at less than fair market value if a certificate of need would be required under paragraph (1) or (2) of this subsection for the transfer at fair market value.

(5) A certificate of need is required before a person acquires a health care facility if a certificate of need would be required under paragraph (1) or (2) of this subsection for the acquisition by or on behalf of the health care facility.

(6) This subsection does not apply to:

(i) Site acquisition;

(ii) An acquisition of a health care facility if:

1. At least 30 days before making the contractual arrangement to acquire the facility, written notice of the intent to make the arrangement is filed with the Commission and the Commission does not find, within 30 days after the Commission receives notice, that the health services or bed capacity of the facility will be changed, provided that, for a merger with or acquisition of an existing general hospice, the purchaser of the general hospice may only acquire the authority to provide home–based hospice services in jurisdictions in which the seller of the general hospice is licensed to provide home–based hospice services; and

2. For an acquisition of a nursing home, the acquisition has been approved in accordance with § 19–120.2 of this subtitle;

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

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

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

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

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

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

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

C. Is in the public interest; and

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

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

1. Is not directly related to patient care; and

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

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

1. Is not directly related to patient care; and

2. Does not increase patient charges or hospital rates;

(viii) A capital expenditure by a hospital, as defined in § 19–301 of this title, for a project in excess of the hospital capital threshold and is for construction or renovation that:

1. May be related to patient care;

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

3. At least 45 days before the proposed expenditure is made, the hospital notifies the Commission;

4. A. Within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under item 2 of this item; or

B. The Commission has not made the financial determination required under item 2 of this item within 60 days of the receipt of the relevant financial information; and

5. The relevant financial information to be submitted by the hospital is defined in regulations adopted by the Commission, after consultation with the Health Services Cost Review Commission;

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

1. At least 45 days before the proposed donation is made, the hospital notifies the Commission;

2. A. Within 45 days of receipt of the relevant financial information, the Commission makes the financial determination required under this item (ix) of this paragraph; or

B. The Commission has not made the financial determination required under this item (ix) of this paragraph within 60 days of the receipt of the relevant financial information; and

3. The relevant financial information to be submitted by the hospital is defined in regulations adopted by the Commission after consultation with the Health Services Cost Review Commission; or

(x) A capital expenditure made as part of a conversion of a licensed general hospital to a freestanding medical facility in accordance with subsection (o)(3) of this section.

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

(l) (1) A certificate of need is not required to close any health care facility or part of a health care facility if at least 90 days before the closing or if at least 45 days before the partial closing of the health care facility, including a State hospital, a person proposing to close all or part of the health care facility files notice of the proposed closing or partial closing with the Commission.

(2) A hospital shall hold a public informational hearing in the county where the hospital is located if the hospital:

(i) Files a notice of the proposed closing of the hospital with the Commission;

(ii) Requests an exemption from the Commission under subsection (o)(3) of this section to convert to a freestanding medical facility; or

(iii) Is located in a county with fewer than three hospitals and files a notice of the partial closing of the hospital with the Commission.

(3) The Commission may require a health care facility other than a hospital described in paragraph (2) of this subsection that files notice of its proposed closing or partial closing to hold a public informational hearing in the county where the health care facility is located.

(4) A public informational hearing required under paragraph (2) or (3) of this subsection shall be held by the health care facility, in consultation with the Commission, within 30 days after:

(i) The health care facility files with the Commission a notice of its proposed closing or partial closing; or

(ii) The hospital files with the Commission a notice of intent to convert to a freestanding medical facility.

(5) (i) The Commission shall establish by regulation requirements for a public informational hearing required under paragraph (2) or (3) of this subsection.

(ii) For a hospital proposing to close, partially close, or convert to a freestanding medical facility, the regulations shall require the hospital to address:

1. The reasons for the closure, partial closure, or conversion;

2. The plan for transitioning acute care services previously provided by the hospital to residents of the hospital service area;

3. The plan for addressing the health care needs of the residents of the hospital service area;

4. The plan for retraining and placing displaced employees;

5. The plan for the hospital's physical plant and site; and

6. The proposed timeline for the closure, partial closure, or conversion to a freestanding medical facility.

(6) Within 10 working days after a public informational hearing held by a hospital under this subsection, the hospital shall provide a written summary of the hearing to:

(i) The Governor;

(ii) The Secretary;

(iii) The governing body of the county in which the hospital is located;

(iv) The local health department and the local board of health or similar body for the county in which the hospital is located;

(v) The Commission; and

(vi) Subject to § 2–1257 of the State Government Article, the Senate Finance Committee, the House Health and Government Operations Committee, and the members of the General Assembly who represent the district in which the hospital is located.

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

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

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

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

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

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

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

(n) The Commission may not issue a certificate of need or a determination with respect to an acquisition that authorizes a general hospice to provide home–based hospice services on a statewide basis.

(o) (1) Except as provided in paragraphs (2) and (3) of this subsection, a person shall have a certificate of need issued by the Commission before a person establishes or operates a freestanding medical facility.

(2) A certificate of need is not required for the establishment or operation of a freestanding medical facility pilot project established under § 19–3A–07 of this title.

(3) (i) A certificate of need is not required to establish or operate a freestanding medical facility if:

1. The freestanding medical facility is established as the result of the conversion of a licensed general hospital;

2. Through the conversion, the licensed general hospital will eliminate the capability of the hospital to admit or retain patients for overnight hospitalization, except for observation stays;

3. Except as provided in subparagraph (ii) of this paragraph, the freestanding medical facility will remain on the site of, or on a site adjacent to, the licensed general hospital;

4. At least 60 days before the conversion, written notice of intent to convert the licensed general hospital to a freestanding medical facility is filed with the Commission;

5. The Commission in its sole discretion finds that the conversion:

A. Is consistent with the State health plan;

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

C. Will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board; and

D. Is in the public interest; and

6. Within 60 days after receiving notice under item 4 of this subparagraph, the Commission notifies the licensed general hospital of the Commission's findings.

(ii) The Commission may approve a site for a freestanding medical facility that is not on the site of, or on a site adjacent to, the licensed general hospital if:

1. The licensed general hospital is:

A. The only hospital in the county; or

B. One of two hospitals in the county that are part of the same merged asset system, and are the only two hospitals in the county; and

2. The site is within a 5–mile radius and in the primary service area of the licensed general hospital.

(iii) Notwithstanding subparagraph (i) of this paragraph, a licensed general hospital located in Kent County may not convert to a freestanding medical facility in accordance with subparagraph (i) of this paragraph before July 1, 2020.

(p) A certificate of need is not required for the establishment or operation of an intermediate care facility that offers medically managed residential substance use disorder treatment services if:

(1) Written notice of the intent to establish or operate the intermediate care facility is filed with the Commission at least 45 days before establishment; and

(2) The Commission in its sole discretion finds that the proposed intermediate care facility:

(i) Is not inconsistent with the State health plan;

(ii) Will result in the delivery of more efficient and effective health care services; and

(iii) Is in the public interest.

§19–120.1.

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

(2) "Certificate of conformance" means an approval issued by the Commission that allows an acute general hospital to establish emergency PCI services or elective PCI services without a certificate of need.

(3) "Certificate of ongoing performance" means an approval issued by the Commission that the cardiac surgery services, emergency PCI services, or elective PCI services provided by an acute general hospital meet standards evidencing continued quality.

(4) "Elective PCI" (also known as "nonprimary PCI") includes PCI provided to a patient who is not suffering from an acute coronary syndrome, but whose condition is appropriately treated with PCI based on regulations established by the Commission.

(5) "Emergency PCI" (also known as "primary PCI") includes PCI capable of relieving coronary vessel narrowing associated with STEMI or, as defined by the Commission in regulations, STEMI equivalent.

(6) "PCI" means percutaneous coronary intervention.

(7) (i) "Percutaneous coronary intervention" means a procedure in which a catheter is inserted into a blood vessel and guided to the site of the narrowing of a coronary artery to relieve coronary narrowing.

(ii) "Percutaneous coronary intervention" includes a variety of catheter–based techniques, including balloon angioplasty.

(8) "STEMI" (ST–segment–elevation myocardial infarction) means a type of heart attack or myocardial infarction that is caused by a prolonged period of blocked blood supply, which affects a large area of the heart muscle and causes changes on an electrocardiogram and in the blood levels of key chemical markers.

(b) (1) Beginning July 1, 2012, before an acute general hospital may establish emergency PCI services or elective PCI services, the hospital shall obtain a certificate of conformance from the Commission.

(2) The Commission may not issue a certificate of conformance unless the Commission finds that the proposed emergency PCI services or proposed elective PCI services:

(i) Are consistent with the State Health Plan for Facilities and Services;

(ii) Will result in the delivery of more efficient and effective health care services; and

(iii) Are in the public interest.

(c) Notwithstanding subsection (b) of this section, a certificate of conformance is not required for an acute general hospital to establish emergency PCI services if:

(1) The acute general hospital was providing emergency PCI services on January 1, 2012; and

(2) The Commission determines that the emergency PCI services are consistent with the State Health Plan for Facilities and Services.

(d) Notwithstanding subsection (b) of this section, a certificate of conformance is not required for an acute general hospital to establish elective PCI services if:

(1) On January 1, 2012, the acute general hospital was providing elective PCI services through the C–PORT E registry under authority of a research waiver issued by the Commission;

(2) The Commission finds that the C–PORT E study produced results that should guide public policy; and

(3) The Commission determines that the elective PCI services provided by the acute general hospital continue to be consistent with:

(i) The requirements of the C–PORT E registry; and

(ii) Except for the requirements under COMAR 10.24.05.05, the requirements for maintaining a research waiver under COMAR 10.24.05 and 10.24.17, Table A–1.

(e) (1) This subsection applies to an acute general hospital that provides cardiac surgery or PCI services under:

(i) A certificate of need issued under § 19–120 of this subtitle;

(ii) A certificate of conformance issued under this section; or

(iii) An exception from the certificate of conformance requirements under subsection (c) or (d) of this section.

(2) An acute general hospital shall obtain and maintain a certificate of ongoing performance to continue to provide:

(i) Cardiac surgery services;

(ii) Emergency PCI services; or

(iii) Elective PCI services.

(f) An acute general hospital that is providing elective PCI services under a research waiver issued by the Commission and does not meet the requirements of subsection (d) of this section shall obtain a certificate of conformance for its elective PCI services before the acute general hospital may obtain a certificate of ongoing performance to provide the elective PCI services.

(g) (1) The Commission shall adopt regulations through an update to the State Health Plan for Facilities and Services to implement this section.

(2) The regulations shall:

(i) Address quality, access, and cost;

(ii) Establish a process and minimum standards for obtaining a certificate of conformance;

(iii) Establish a process and minimum standards for obtaining and maintaining a certificate of ongoing performance;

(iv) Set an appropriate time period for the expiration of a certificate of ongoing performance;

(v) Require, as a condition of the issuance of a certificate of conformance or a certificate of ongoing performance, that an acute general hospital agree to voluntarily relinquish its authority to provide cardiac surgery services, emergency PCI services, or elective PCI services if the hospital fails to meet the applicable standards established by the Commission;

(vi) Establish a process for an acute general hospital that is out of compliance with minimum standards for a certificate of ongoing performance to return to good standing;

(vii) Require that an acute general hospital, except for an acute general hospital located in a part of the State that does not have sufficient access to emergency PCI services, have provided emergency PCI services in accordance with established standards before seeking a certificate of conformance for elective PCI services;

(viii) Prohibit an acute general hospital from providing elective PCI services unless the acute general hospital also provides emergency PCI services;

(ix) Incorporate, to the extent appropriate, the standards for cardiac surgery services, emergency PCI services, and elective PCI services recommended by the clinical advisory group established under paragraph (3) of this subsection;

(x) Include requirements for peer or independent review, consistent with the ACCF/AHA/SCAI Guidelines for Percutaneous Coronary Intervention (Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions), of difficult or complicated cases and for randomly selected cases; and

(xi) For a certificate of conformance for elective PCI services, give weight to the experience, performance, investment, and scope of interventional capabilities of an applicant hospital that was providing emergency PCI services on January 1, 2012.

(3) (i) The Commission shall establish a clinical advisory group to advise the Commission and recommend standards for cardiac surgery services, emergency PCI services, and elective PCI services for inclusion in regulations adopted under this subsection.

(ii) The clinical advisory group shall be composed of experts in cardiac surgery services and PCI services, including:

1. Clinicians and representatives from hospitals in the State with and without on–site cardiac surgery services and with and without PCI services;

2. At least one representative of an acute general hospital that is not part of a merged asset system and provides only emergency PCI services; and

3. Other persons with needed expertise from inside and outside the State.

(4) (i) On or before September 30, 2013, after obtaining advice from the clinical advisory group and other appropriate stakeholders, the Commission shall:

1. Develop recommended regulations under this subsection;

2. Post the recommended regulations on its website for public comment; and

3. Submit the recommended regulations to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

(ii) The Senate Finance Committee and the House Health and Government Operations Committee shall have 60 days from receipt of the recommended regulations for review and comment.

§19–120.2.

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

(2) "Executive Director" means the Executive Director of the Commission.

(3) "Nursing home" has the meaning stated in § 19–1401 of this title.

(4) "Request for acquisition" means a request for the Commission to approve the acquisition of a nursing home.

(b) A person shall provide notice to the Commission at least 30 days before the closing of a change of ownership of a nursing home that:

(1) Involves at least a 5% transfer in ownership interest; and

(2) Is not an acquisition that requires approval under subsection (c) of this section.

(c) (1) This subsection does not apply to an acquisition that involves only changes of ownership interests among existing owners of a nursing home.

(2) At least 60 days before the closing date of the acquisition of a nursing home, a person shall:

(i) Submit to the Commission a request for acquisition; and

(ii) Provide notice to the residents, resident representatives, and employees of the nursing home that:

1. The request for acquisition was submitted to the Commission; and

2. There will be an opportunity to submit comments in accordance with subsection (f) of this section.

(d) (1) The Executive Director shall review a completed request for acquisition within 45 days after receiving the completed request from the applicant.

(2) The Executive Director, in consultation with the Secretary or the Secretary's designee, may:

(i) Approve the acquisition;

(ii) Approve the acquisition with conditions;

(iii) Deny the acquisition; or

(iv) Refer the request for acquisition to the Commission for a final decision.

(e) To approve a request submitted under subsection (c) of this section, the Executive Director must find that the acquisition:

(1) Is consistent with the State Health Plan; and

(2) Subject to subsection (f) of this section, is in the public interest.

(f) In determining whether an acquisition of a nursing home is in the public interest, the Executive Director shall:

(1) Solicit and accept comments from individuals who:

(i) Reside in the nursing home;

(ii) Have family members who reside in the nursing home; or

(iii) Are employees of the nursing home; and

(2) Consult with the Attorney General on whether the acquisition raises public interest concerns.

(g) If the Executive Director refers a request for acquisition to the Commission under subsection (d)(2)(iv) of this section, the Commission shall use the criteria specified in subsections (e) and (f) of this section and regulations adopted by the Commission to make a final decision within 60 days after receiving the completed request from the applicant.

(h) If the Executive Director denies a request for acquisition or imposes a condition on the approval of the acquisition, a person that is a party to the acquisition may submit a written request for the Commission to review the decision in accordance with regulations adopted by the Commission.

(i) (1) A decision of the Commission under subsection (g) or (h) of this section shall be a final decision for the purpose of judicial review.

(2) A person that is a party to the acquisition may take a direct judicial appeal within 30 days after the Commission makes the final decision.

(3) The Commission shall send each final decision to the Secretary, the Secretary of Aging, the Office of Health Care Quality, the Office of the Attorney General, and the State Long–Term Care Ombudsman.

(j) (1) On or before July 1 immediately following the acquisition of a nursing home and each year for 3 years thereafter, the person that acquired the nursing home shall submit a report to the Commission in accordance with regulations adopted by the Commission.

(2) The Commission shall provide the report required under paragraph (1) of this subsection to the Secretary, the Secretary of Aging, the Office of Health Care Quality, the Office of the Attorney General, and the State Long–Term Care Ombudsman.

(k) (1) The Commission shall adopt regulations through an update to the State Health Plan for Facilities and Services to carry out the provisions of this section.

(2) The regulations adopted under this subsection shall:

(i) Require the person that acquired ownership of a nursing home to:

1. Reduce the number of resident rooms in the nursing home that contain more than two beds in accordance with standards established by the Commission; or

2. Receive a waiver from the requirement established under item 1 of this item from the Executive Director in accordance with standards established by the Commission;

(ii) 1. If necessary, allow the person that acquired ownership of a nursing home to temporarily delicense beds for at least 3 years immediately following the acquisition to reduce the number of resident rooms that contain more than two beds; and

2. Authorize the Commission to extend the period the beds are temporarily delicensed beyond 3 years for good cause shown, including demonstrated progress toward eliminating multibedded rooms by expanding the existing facility or transferring the beds to another facility within a merged asset system in the same jurisdiction;

(iii) Establish standards for the evaluation of the quality of the nursing homes currently or previously owned, whether in the State or outside the State, by the person that submitted a request for acquisition; and

(iv) Subject to paragraph (3) of this subsection, establish criteria for the Executive Director and the Commission to consider when making a decision regarding a request for acquisition.

(3) The criteria established by the Commission under paragraph (2)(iv) of this subsection shall require that the Commission take into consideration whether any nursing home currently or previously owned, within or outside the State,

by the person submitting the request, for the period of 3 years immediately preceding the submission of the request:

(i) Maintained a quality assessment and assurance committee that met at least quarterly;

(ii) Was the subject of an enforcement action, a special focus facility designation, or a deficiency involving serious or immediate threat, actual harm, or immediate jeopardy to a resident; or

(iii) Was the subject of a lawsuit judgment, or an arbitration finding, following a complaint filed by a resident, resident representative, or a government agency.

§19–121.

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

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

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

(ii) Any other health care project for which a certificate of need is required under § 19–120 of this subtitle unless at least 90% of the patients who will receive health care services from the project will be individuals enrolled in that health maintenance organization.

(2) Notwithstanding paragraph (1)(ii) of this subsection, a health maintenance organization or a health care facility that either controls, directly or indirectly, or is controlled by a health maintenance organization is not required to obtain a certificate of need before purchasing an existing ambulatory surgical facility or center, as defined in § 19–114(b) of this subtitle.

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

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

(2) Is not inconsistent with those sections of the State health plan or those sections of the institution–specific plan that govern hospitals, as defined in § 19–301 of this title, and ambulatory surgical facilities or centers, as defined in § 19–114(b) of this subtitle, or health care projects for which a certificate of need is required under subsection (b)(1)(ii) of this section.

§19–122.

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

§19–123.

Notwithstanding the provisions of § 19-114(d)(2)(ii) of this subtitle, a continuing care community does not lose its exemption from certificate of need requirements when the continuing care community admits an individual directly to a nursing facility within the continuing care community if:

(1) The admittee's spouse or relative is admitted at the same time under a joint contract to an independent living unit or assisted living unit within the continuing care community; or

(2) An individual having a long-term significant relationship with the admittee is admitted at the same time under a joint contract to an independent living unit or assisted living unit within the continuing care community.

§19–124.

(a) Notwithstanding the provisions of § 19-114(d)(2)(ii) of this part, a continuing care community that qualifies for an exemption from a certificate of need under § 19-114(d)(2)(ii) of this part may admit a subscriber directly into a comprehensive care nursing bed only if, at the time of admission, the subscriber has the potential for an eventual transfer to an independent living unit or an assisted living unit, as determined by the subscriber's personal physician who is not an owner or employee of the continuing care retirement community.

(b) Notwithstanding the provisions of subsection (a) of this section and § 19-114(d)(2)(ii) of this part, the total number of comprehensive care nursing beds occupied by subscribers who have been directly admitted to a comprehensive care

nursing bed may not exceed 20 percent of the total number of comprehensive care nursing beds that are available in the continuing care nursing facility.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section and § 19-114(d)(2)(ii) of this part, a continuing care retirement community that qualifies for an exemption from a certificate of need under § 19-114(d)(2)(ii) of this part may not admit a subscriber directly into a comprehensive care nursing bed if the direct admission would cause the occupancy of the comprehensive care nursing beds in the continuing care community to exceed 95 percent of full capacity.

§19–125.

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

(1) Offers any health service:

(i) Through a health care facility;

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

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

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

(3) Does anything else for which the federal act requires a certificate of need and that the Commission has not exempted from that requirement.

§19–126.

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

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

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

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

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

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

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

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

(3) Unless the Commission finds that the facility or service for which the proposed expenditure is to be made is not needed or is not consistent with the State health plan, the Commission shall approve an application for a certificate of need required under § 19–120(k) of this subtitle to the extent that the expenditure is to be made to:

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

(ii) Comply with State licensing standards; or

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

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

(2) A majority of the full authorized membership of the Commission shall be a quorum to act on an application for a certificate of need.

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

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

(ii) May request further information from the applicant.

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

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

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

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

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

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

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

(i) The staff of the Commission;

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

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

(iv) A local health planning agency for a jurisdiction or region in which the proposed facility or service will be located; and

(v) In the review of a replacement acute general hospital project proposed by or on behalf of a regional health system that serves multiple contiguous jurisdictions, a jurisdiction within the region served by the regional health system that does not contain the proposed replacement acute general hospital project.

(9) The reviewer shall review the application, any written comments on the application, and any other materials permitted by this section or by the

Commission's regulations, and present a recommended decision on the application to the full Commission.

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

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

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

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

(13) The decision of the Commission shall be by a majority of the quorum present and voting.

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

(1) Have satisfactorily met all applicable standards;

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

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

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

(f) (1) If any party or interested person requests an evidentiary hearing with respect to a certificate of need application for any health care facility other than an ambulatory surgical facility and the Commission, in accordance with criteria it

has adopted by regulation, considers an evidentiary hearing appropriate due to the magnitude of the impact that the proposed project may have on the health care delivery system, the Commission or a committee of the Commission shall hold the hearing in accordance with the contested case procedures of the Administrative Procedure Act.

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

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

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

(h) (1) The applicant or any aggrieved party, as defined in § 19–128(a) of this subtitle, may petition the Commission within 15 days for a reconsideration.

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

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

(i) (1) Except as provided in paragraph (2) of this subsection, if the Commission does not act on an application within the required period, the applicant may file with a court of competent jurisdiction within 60 days after expiration of the period a petition to require the Commission to act on the application.

(2) (i) This paragraph does not apply to an application for a certificate of need involving:

1. The establishment of a health care facility;

2. The relocation of a health care facility; or

3. The introduction by a hospital of cardiac surgery or organ transplantation.

(ii) A certificate of need filed after October 1, 2019, shall be deemed approved if:

1. The certificate of need is uncontested; and

2. Final action by the Commission does not occur within 120 days after the application for the certificate of need was docketed.

§19–127.

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

§19–128.

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

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

(ii) The Secretary.

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

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

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

(c) An aggrieved party may take a direct judicial appeal within 30 days of the final decision of the Commission.

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

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

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

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

§19–129.

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

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

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

(3) Is in the public interest.

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

§19–130.

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

(2) "Fund" means the Maryland Trauma Physician Services Fund.

(3) "Maryland Trauma Specialty Referral Centers" means:

(i) The Johns Hopkins Health System Burn Program;

(ii) The Eye Trauma Center at the Wilmer Eye Institute at The Johns Hopkins Hospital; and

(iii) The Curtis National Hand Center at Union Memorial Hospital.

(4) "Reasonable compensation equivalent" means the limitation on the cost established by the Centers for Medicare and Medicaid Services that a provider may claim for compensation of services.

(5) "Rehabilitation hospital" means a facility classified as a special rehabilitation hospital as described in § 19–307 of this title that is affiliated with a trauma center by common ownership.

(6) (i) "Trauma center" means a facility designated by the Maryland Institute for Emergency Medical Services Systems as:

1. The State primary adult resource center;

2. A Level I trauma center;

3. A Level II trauma center;

4. A Level III trauma center;

5. A pediatric trauma center; or

6. The Maryland Trauma Specialty Referral Centers.

(ii) "Trauma center" includes an out–of–state pediatric trauma center that has entered into an agreement with the Maryland Institute for Emergency Medical Services Systems.

(7) "Trauma health care practitioner" means a health care practitioner licensed under the Health Occupations Article who provides care in a trauma center or in a rehabilitation hospital to trauma patients on the State trauma registry as defined by the Maryland Institute for Emergency Medical Services Systems.

(8) "Trauma physician" means a physician who provides care in a trauma center or in a rehabilitation hospital to trauma patients on the State trauma registry as defined by the Maryland Institute for Emergency Medical Services Systems.

(9) "Uncompensated care" means care provided by a trauma physician or a trauma health care practitioner to a trauma patient on the State trauma registry who:

(i) Has no health insurance, including Medicare Part B coverage;

(ii) Is not eligible for medical assistance coverage; and

(iii) Has not paid the trauma physician or trauma health care practitioner for care provided by the trauma physician or trauma health care practitioner, after documented attempts by the trauma physician or trauma health care practitioner to collect payment.

(b) (1) There is a Maryland Trauma Physician Services Fund.

(2) The purpose of the Fund is to subsidize the documented costs:

(i) Of uncompensated care incurred by a trauma physician or trauma health care practitioner in providing trauma care to a trauma patient on the State trauma registry;

(ii) Of undercompensated care incurred by a trauma physician or trauma health care practitioner in providing trauma care to an enrollee of the Maryland Medical Assistance Program who is a trauma patient on the State trauma registry;

(iii) Incurred by a trauma center to maintain trauma physicians on–call as required by the Maryland Institute for Emergency Medical Services Systems;

(iv) Incurred by the State primary adult resource center to maintain trauma surgeons, orthopedic surgeons, neurosurgeons, and anesthesiologists on–call and on standby as required by the Maryland Institute for Emergency Medical Services Systems; and

(v) Incurred by the Commission and the Health Services Cost Review Commission to administer the Fund and audit reimbursement requests to assure appropriate payments are made from the Fund.

(3) The Commission and the Health Services Cost Review Commission shall administer the Fund.

(4) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(5) Interest on and other income from the Fund shall be separately accounted for and credited to the Fund, and are not subject to § 6–226(a) of the State Finance and Procurement Article.

(c) The Fund consists of:

(1) Motor vehicle registration surcharges paid into the Fund in accordance with § 13–954(b)(2) of the Transportation Article;

(2) At least 20% of the fines collected under § 21–902(a)(1), (b)(2), (c)(2), and (d)(1) of the Transportation Article; and

(3) Any other money transferred from the General Fund of the State.

(d) (1) Disbursements from the Fund shall be made in accordance with a methodology established jointly by the Commission and the Health Services Cost Review Commission to calculate costs incurred by trauma physicians and trauma centers that are eligible to receive reimbursement under subsection (b) of this section.

(2) The Fund shall transfer to the Maryland Department of Health an amount sufficient to fully cover the State's share of expenditures for the costs of undercompensated care incurred by a trauma physician in providing trauma care to an enrollee of the Maryland Medical Assistance Program who is a trauma patient on the State trauma registry.

(3) The methodology developed under paragraph (1) of this subsection shall:

(i) Take into account:

1. The amount of uncompensated care provided by trauma physicians;

2. The amount of undercompensated care attributable to the treatment of Medicaid enrollees in trauma centers;

3. The cost of maintaining trauma physicians on–call;

4. The number of patients served by trauma physicians in trauma centers;

5. The number of Maryland residents served by trauma physicians in trauma centers; and

6. The extent to which trauma–related costs are otherwise subsidized by hospitals, the federal government, and other sources; and

(ii) Include an incentive to encourage hospitals to continue to subsidize trauma–related costs not otherwise included in hospital rates.

(4) The methodology developed under paragraph (1) of this subsection shall use the following parameters to determine the amount of reimbursement made to trauma physicians and trauma centers from the Fund:

(i) 1. The cost incurred by a Level II trauma center to maintain trauma surgeons, orthopedic surgeons, and neurosurgeons on–call shall be reimbursed:

A. At a rate of up to 60% of the reasonable compensation equivalent hourly rate for the specialty, inflated to the current year by the physician compensation component of the Medicare economic index as designated by the Centers for Medicare and Medicaid Services; and

B. For the minimum number of trauma physicians required to be on–call, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for Level II trauma centers;

2. The cost incurred by a Level III trauma center to maintain trauma surgeons, orthopedic surgeons, neurosurgeons, and anesthesiologists on–call shall be reimbursed:

A. At a rate of up to 60% of the reasonable compensation equivalent hourly rate for the specialty, inflated to the current year by the physician compensation component of the Medicare economic index as designated by the Centers for Medicare and Medicaid Services; and

B. For the minimum number of trauma physicians required to be on–call, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for Level III trauma centers;

3. The cost incurred by a Level I trauma center or pediatric trauma center to maintain trauma surgeons, orthopedic surgeons, and neurosurgeons on–call when a post–graduate resident is attending in the trauma center shall be reimbursed:

A. At a rate of up to 60% of the reasonable compensation equivalent hourly rate for the specialty, inflated to the current year by the physician compensation component of the Medicare economic index as designated by the Centers for Medicare and Medicaid Services; and

B. When a post–graduate resident is authorized to be in the trauma center, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for Level I trauma centers or pediatric trauma centers;

4. The cost incurred by a Maryland Trauma Specialty Referral Center to maintain trauma surgeons on–call in the specialty of the Center when a post–graduate resident is attending in the Center shall be reimbursed:

A. At a rate of up to 60% of the reasonable compensation equivalent hourly rate for the specialty, inflated to the current year by the physician compensation component of the Medicare economic index as designated by the Centers for Medicare and Medicaid Services; and

B. When a post–graduate resident is authorized to be in the Center, as specified by the Maryland Institute for Emergency Medical Services Systems in its criteria for a Maryland Trauma Specialty Referral Center; and

5. A. A Level II trauma center is eligible for a maximum of 26,280 hours of trauma on–call per year;

B. A Level III trauma center is eligible for a maximum of 35,040 hours of trauma on–call per year;

C. A Level I trauma center shall be eligible for a maximum of 4,380 hours of trauma on–call per year;

D. A pediatric trauma center shall be eligible for a maximum of 4,380 hours of trauma on–call per year; and

E. A Maryland Trauma Specialty Referral Center shall be eligible for a maximum of 2,190 hours of trauma on–call per year;

(ii) The cost of undercompensated care incurred by a trauma physician in providing trauma care to enrollees of the Maryland Medical Assistance Program who are trauma patients on the State trauma registry shall be reimbursed at a rate of up to 100% of the Medicare payment for the service, minus any amount paid by the Maryland Medical Assistance Program;

(iii) The cost of uncompensated care incurred by a trauma physician in providing trauma care to trauma patients on the State trauma registry shall be reimbursed at a rate of 100% of the Medicare payment for the service, minus any recoveries made by the trauma physician for the care;

(iv) The Commission, in consultation with the Health Services Cost Review Commission, may establish a payment rate for uncompensated care incurred by a trauma physician in providing trauma care to trauma patients on the State trauma registry that is above 100% of the Medicare payment for the service if:

1. The Commission determines that increasing the payment rate above 100% of the Medicare payment for the service will address an unmet need in the State trauma system; and

2. The Commission reports on its intention to increase the payment rate to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, at least 60 days before any adjustment to the rate;

(v) The Commission shall develop guidelines for the reimbursement of the documented costs of the State primary adult resource center under subsection (b)(2)(iv) of this section;

(vi) The Commission, in consultation with the Health Services Cost Review Commission, may change the percentage of the reasonable compensation equivalent paid to trauma hospitals if:

1. The Commission determines that the projected revenue to be collected in the Fund is adequate to support the proposed increase in the percentage of reasonable compensation equivalent inflated to the current year by the physician compensation component of the Medicare economic index; and

2. The Commission reports on its intention to change the percentage of reasonable compensation equivalent to be paid for on–call costs to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, at least 60 days before any adjustment to the allowable hours;

(vii) The Commission, in consultation with the Health Services Cost Review Commission, may change the number of allowable hours of trauma on–call each year if the Commission reports on its intention to change the number of allowable hours to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, at least 60 days before any adjustment to the allowable hours;

(viii) The Commission may modify the percentage paid of the reasonable compensation equivalent for on–call hours not more than once each year; and

(ix) The total reimbursement to emergency physicians from the Fund may not exceed $300,000 annually.

(5) In order to receive reimbursement, a trauma physician or trauma health care practitioner in the case of costs of uncompensated care under subsection (b)(2)(i) of this section, or a trauma center in the case of on–call costs under subsection (b)(2)(iii) of this section, shall apply to the Fund on a form and in a manner approved by the Commission and the Health Services Cost Review Commission.

(6) (i) The Commission and the Health Services Cost Review Commission shall adopt regulations that specify the information that trauma physicians, trauma health care practitioners, and trauma centers must submit to receive money from the Fund.

(ii) The information required shall include:

1. The name and federal tax identification number of the trauma physician rendering the service;

2. The date of the service;

3. Appropriate codes describing the service;

4. Any amount recovered for the service rendered;

5. The name of the trauma patient;

6. The patient's trauma registry number; and

7. Any other information the Commission and the Health Services Cost Review Commission consider necessary to disburse money from the Fund.

(iii) It is the intent of the General Assembly that trauma physicians and trauma centers shall cooperate with the Commission and the Health Services Cost Review Commission by providing information required under this paragraph in a timely and complete manner.

(e) (1) Except as provided in paragraph (2) of this subsection and notwithstanding any other provision of law, expenditures from the Fund for costs incurred in any fiscal year may not exceed revenues of the Fund.

(2) (i) The Commission, in consultation with the Health Services Cost Review Commission and the Maryland Institute for Emergency Medical Services Systems, shall develop a process for the award of grants to Level I, Level II, and Level III trauma centers in the delivery of trauma care.

(ii) 1. The Commission shall issue grants under this paragraph from any balance carried over to the Fund from prior fiscal years.

2. The total amount of grants awarded under this paragraph in a fiscal year may not reduce the balance remaining in the Fund at the end of the fiscal year to less than 15% of the revenue collected in that fiscal year.

(iii) The process developed by the Commission for the award of grants under this paragraph shall include:

1. Grant applications and review and selection criteria for the award of grants;

2. Review by the Commission, if necessary, for any project that exceeds certificate of need thresholds; and

3. Any other procedure determined necessary by the Commission.

(iv) Before awarding grants under this subsection in a fiscal year, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the process that the Commission has developed for awarding grants in that fiscal year.

(f) On or before November 1 of each year, the Commission and the Health Services Cost Review Commission shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(1) The amount of money in the Fund on the last day of the previous fiscal year;

(2) The amount of money applied for by trauma physicians, trauma health care practitioners, and trauma centers during the previous fiscal year;

(3) The amount of money distributed in the form of trauma physician, trauma health care practitioner, and trauma center reimbursements during the previous fiscal year;

(4) Any recommendations for altering the manner in which trauma physicians, trauma health care practitioners, and trauma centers are reimbursed from the Fund;

(5) The costs incurred in administering the Fund during the previous fiscal year;

(6) The amount that each hospital that participates in the Maryland trauma system and that has a trauma center contributes toward the subsidization of trauma–related costs for its trauma center;

(7) The costs that hospitals reported to the Health Services Cost Review Commission and are accounted for in the global budgets of the hospitals for each of the following:

(i) Trauma standby;

(ii) Allowable trauma center costs for reimbursing the trauma director and trauma staff;

(iii) Maintaining Maryland Institute for Emergency Medical Services Systems trauma protocols;

(iv) Maintaining specialized trauma staff;

(v) Procuring specialized trauma equipment; and

(vi) Providing trauma education and training; and

(8) Any improvements made by trauma centers as a result of an increase in funding.

(g) The Commission shall award an annual grant from the Fund in the amount up to $1,800,000 to Level I pediatric trauma centers as follows:

(1) Up to $900,000 to Johns Hopkins Children's Center; and

(2) Up to $900,000 to Children's National Medical Center.

§19–132.

(a) In this Part III of this subtitle the following words have the meanings indicated.

(b) "Ambulatory surgical facility" has the meaning stated in § 19–3B–01 of this title.

(c) "Carrier" means:

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

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

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

(e) (1) "Health benefit plan" means a hospital or medical policy, contract, or certificate issued by a carrier.

(2) "Health benefit plan" does not include:

(i) Coverage for accident or disability income insurance;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile or property medical payment insurance;

(vi) Credit–only insurance;

(vii) Coverage for on–site medical clinics;

(viii) Dental or vision insurance;

(ix) Long–term care insurance or benefits for nursing home care, home health care, community–based care, or any combination of these;

(x) Coverage only for a specified disease or illness;

(xi) Hospital indemnity or other fixed indemnity insurance; or

(xii) The following benefits if offered as a separate insurance policy:

1. Medicare supplemental health insurance, as defined in § 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; or

3. Similar supplemental coverage provided to coverage under an employer sponsored plan.

(f) "Health care practitioner" means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(g) (1) "Health care provider" means:

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

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

1. A facility, as defined in § 10–101(g) of this article;

2. A hospital, as defined in § 19–301 of this title;

3. A related institution, as defined in § 19–301 of this title;

4. A health maintenance organization, as defined in § 19–701(g) of this title;

5. An outpatient clinic; and

6. A medical laboratory.

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

(h) "Health care service" means any health or medical care procedure or service rendered by a health care practitioner that:

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

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

(i) "Hospital" has the meaning stated in § 19–301 of this title.

(j) (1) "Mandated health insurance service" means a legislative proposal or statute that would require a particular health care service to be provided or offered in a health benefit plan, by a carrier or other organization authorized to provide health benefit plans in the State.

(2) "Mandated health insurance service", as applicable to all carriers, does not include services enumerated to describe a health maintenance organization under § 19–701(g)(2) of this title.

(k) "Nursing facility" has the meaning stated in § 19–1401 of this title.

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

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

(i) Ambulatory surgery;

(ii) Radiological or diagnostic imagery; or

(iii) Laboratory services.

(3) "Office facility" does not include any office, facility, or service operated by a hospital and regulated under Part II of this subtitle.

(m) "Payor" means:

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

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

(3) For the purposes of this Part III of this subtitle only, a person that is registered as an administrator under Title 8, Subtitle 3 of the Insurance Article.

§19–133.

(a) In this section, "code" means:

(1) The applicable Current Procedural Terminology (CPT) code as adopted by the American Medical Association; or

(2) If a CPT code is not available, the applicable code under an appropriate uniform coding scheme approved by the Commission.

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

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

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

(i) The demographic characteristics of the patient;

(ii) The principal diagnosis;

(iii) The procedure performed;

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

(v) The charge for the procedure;

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

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

(viii) If the health care practitioner rendering the service is a certified registered nurse anesthetist or certified nurse midwife, identification modifiers for the certified registered nurse anesthetist or certified nurse midwife;

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

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

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

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

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

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

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

(f) Until the provisions of § 19–134 of this subtitle are fully implemented, where appropriate, the Commission may limit the data collection under this section.

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

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

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

(2) (i) On an annual basis, the Commission shall publish:

1. The total reimbursement for all health care services over a 12–month period;

2. The total reimbursement for each health care specialty over a 12–month period;

3. The total reimbursement for each code over a 12–month period; and

4. The annual rate of change in reimbursement for health services by health care specialties and by code.

(ii) In addition to the information required under subparagraph (i) of this paragraph, the Commission may publish any other information that the Commission deems appropriate, including information on capitated health care services.

(h) In developing the medical care data base, the Commission shall consult with representatives of the Health Services Cost Review Commission, health care practitioners, payors, and hospitals to ensure that the medical care data base is compatible with information collected by the Health Services Cost Review Commission.

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

§19–134.

(a) (1) In order to more efficiently establish a medical care data base under § 19–133 of this subtitle, the Commission shall establish standards for the operation of one or more medical care electronic claims clearinghouses in Maryland and may license those clearinghouses meeting those standards.

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

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

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

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

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

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

(b) The Commission may collect the medical care claims information submitted to any licensed claims clearinghouse for use in the data base established under § 19–133 of this subtitle.

(c) (1) The Commission shall:

(i) Establish and implement a system to comparatively evaluate the quality of care and performance of categories of health benefit plans as determined by the Commission on an objective basis; and

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

(2) The purpose of the evaluation system established under this subsection is to assist carriers to improve care by establishing a common set of quality and performance measurements and disseminating the findings to carriers and other interested parties.

(3) The system, where appropriate, shall:

(i) Solicit performance information from enrollees of health benefit plans;

(ii) Establish and incorporate a standard set of measures regarding racial and ethnic variations in quality and outcomes; and

(iii) Include information on the actions taken by carriers to track and reduce health disparities, including whether the health benefit plan provides culturally appropriate educational materials for its members.

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

(ii) Before adopting regulations to implement an evaluation system under this subsection, the Commission shall consider recommendations of nationally recognized organizations that are involved in quality of care and performance measurement.

(iii) In implementing paragraph (3)(ii) and (iii) of this subsection, the Commission shall consult with appropriate stakeholders, including at least one representative of a carrier that does business predominantly in the State and a carrier that does business in the State and nationally, to determine national standards for evaluating the effectiveness of carriers in addressing health disparities and to fulfill the purposes of paragraph (3)(ii) and (iii) of this subsection in a manner that can be easily replicated in other states.

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

(6) The annual evaluation summary required under paragraph (1) of this subsection shall include to the extent feasible information on racial and ethnic variations.

(d) (1) The Commission, in consultation with the Maryland Department of Health and the Department of Aging, shall:

(i) On or before July 1, 2001, develop and implement a system to comparatively evaluate the quality of care and performance of nursing facilities on an objective basis; and

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

(2) (i) The purpose of the comparative evaluation system established under this subsection is to improve the quality of care provided by nursing facilities by establishing a common set of performance measures and disseminating the findings of the comparative evaluation to nursing facilities, consumers, and other interested parties.

(ii) In developing the comparative evaluation system, the Commission shall consider the health status of the population served.

(3) (i) The system, as appropriate, shall solicit performance information from consumers and their families.

(ii) On or before October 1, 2007, to the extent feasible, the system shall incorporate racial and ethnic variations.

(4) The Commission may adopt regulations to establish the comparative evaluation system provided under this subsection.

(e) (1) The Commission may:

(i) On or before July 1, 2001, develop and implement a system to comparatively evaluate the quality of care outcomes and performance measurements of hospitals and ambulatory surgical facilities on an objective basis; and

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

(2) (i) The purpose of a comparable performance measurement system established under this subsection is to improve the quality of care provided by hospitals and ambulatory surgical facilities by establishing a common set of performance measurements and disseminating the findings of the performance measurements to hospitals, ambulatory surgical facilities, consumers, and interested parties.

(ii) In developing the performance measurement system, the Commission shall consider the geographic location, urban or rural orientation, and teaching or nonteaching status of the hospital and the ambulatory surgical facilities, and the health status of the population served.

(3) (i) The system, where appropriate, shall solicit performance information from consumers.

(ii) On or before October 1, 2007, to the extent feasible, the system shall incorporate racial and ethnic variations.

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

(ii) Before adopting regulations to implement an evaluation system under this subsection, the Commission shall:

1. Consider the performance measurements of appropriate accreditation organizations, State licensure regulations, Medicare certification regulations, the quality indicator project of the Association of Maryland Hospitals and Health Systems, and any other relevant performance measurements; and

2. Evaluate the desirability and feasibility of developing a consumer clearinghouse on health care information using existing available data.

(5) The Commission may contract with a private entity to implement the system required under this subsection provided that the entity is not a hospital or an ambulatory surgical facility.

(6) (i) The comparable evaluation system established under this subsection shall include health care–associated infection information from hospitals.

(ii) The comparable evaluation system shall adhere, to the extent possible, to the current recommendations of the federal Centers for Disease Control and Prevention (CDC) and the CDC Healthcare Infection Control Practices Advisory Committee regarding public reporting of health care–associated infections.

(f) (1) The Commission shall compile data on:

(i) Racial and ethnic disparities in insurance coverage for low–income, nonelderly individuals;

(ii) The racial and ethnic composition of the physician population compared to the racial and ethnic composition of the State's population; and

(iii) Morbidity and mortality rates based on race and ethnicity for cardiovascular disease, cancer, diabetes, HIV/AIDS, infant mortality, asthma, and other diseases the Commission identifies.

(2) The Commission shall:

(i) Provide the racial and ethnic information compiled under this subsection to the Office of Minority Health and Health Disparities; and

(ii) Analyze the information jointly with the Office of Minority Health and Health Disparities for publication in the "Health Care Disparities Policy Report Card" required under § 20–1006(b)(2) of this article.

(3) (i) The Commission shall evaluate the feasibility of obtaining information from urban and rural populations in order to identify geographic disparities.

(ii) If the Commission is able to obtain the information described in subparagraph (i) of this paragraph, the Commission shall provide the information to the Office of Minority Health and Health Disparities.

(g) For purposes of this section, the Commission shall collect racial and ethnic information and data that is reasonably collectable from any national, State, or county source that is reasonably available.

§19–135.

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

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

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

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

§19–136.

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

(1) Hold a public hearing;

(2) Conduct an investigation; or

(3) Require the filing of any reasonable information.

§19–137.

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

§19–142.

(a) In this Part IV of this subtitle the following words have the meanings indicated.

(b) "Carrier" means:

(1) An insurer;

(2) A nonprofit health service plan;

(3) A health maintenance organization; or

(4) Any other person that provides health benefit plans subject to regulation by the State.

(c) "Electronic health record" means an electronic record of health–related information on an individual that:

(1) Includes patient demographic and clinical health information; and

(2) Has the capacity to:

(i) Provide clinical decision support;

(ii) Support physician order entry;

(iii) Capture and query information relevant to health care quality; and

(iv) Exchange electronic health information with and integrate the information from other sources.

(d) (1) "Health benefit plan" means a hospital or medical policy, contract, or certificate issued by a carrier.

(2) "Health benefit plan" does not include:

(i) Coverage for accident or disability income insurance;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile or property medical payment insurance;

(vi) Credit–only insurance;

(vii) Coverage for on–site medical clinics;

(viii) Dental or vision insurance;

(ix) Long–term care insurance or benefits for nursing home care, home health care, community–based care, or any combination of these;

(x) Coverage only for a specified disease or illness;

(xi) Hospital indemnity or other fixed indemnity insurance; or

(xii) The following benefits if offered as a separate insurance policy:

1. Medicare supplemental health insurance, as defined in § 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, U.S.C.; or

3. Similar supplemental coverage provided to coverage under an employer–sponsored plan.

(e) (1) "Health care provider" means:

(i) A person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care in the ordinary course of

business or practice of a profession or in an approved education or training program; or

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

1. A facility, as defined in § 10–101(g) of this article;

2. A hospital, as defined in § 19–301 of this title;

3. A related institution, as defined in § 19–301 of this title;

4. An outpatient clinic;

5. A freestanding medical facility, as defined in § 19–3A–01 of this title;

6. An ambulatory surgical facility, as defined in § 19–3B–01 of this title; and

7. A nursing home, as defined in § 19–1401 of this title.

(2) "Health care provider" does not include a health maintenance organization as defined in § 19–701 of this title.

(f) "Health information exchange" has the meaning stated in § 4–301 of this article.

(g) "Management service organization" means an organization that offers one or more hosted electronic health record solutions and other management services to multiple health care providers.

(h) "State–designated health information exchange" means the health information exchange designated by the Maryland Health Care Commission and the Health Services Cost Review Commission under § 19–143 of this subtitle.

(i) (1) "State–regulated payor" means a carrier issuing or delivering health benefit plans in the State.

(2) "State–regulated payor" does not include a managed care organization as defined in Title 15, Subtitle 1 of this article.

§19–143.

(a) (1) On or before October 1, 2009, the Commission and the Health Services Cost Review Commission shall designate a health information exchange for the State.

(2) The Secretary, to align funding opportunities with the purposes of this section and the development and effective operation of the State–designated health information exchange, may provide grants to the State–designated health information exchange.

(b) (1) On or before September 1, 2011, the Commission, in consultation with the Department, payors, and health care providers, shall adopt regulations that require State–regulated payors to provide incentives to health care providers to promote the adoption and meaningful use of electronic health records.

(2) Incentives required under the regulations:

(i) Shall have monetary value;

(ii) Shall facilitate the use of electronic health records by health care providers in the State;

(iii) To the extent feasible, shall recognize and be consistent with existing payor incentives that promote the adoption and meaningful use of electronic health records;

(iv) Shall take into account:

1. Incentives provided to health care providers under Medicare and Medicaid; and

2. Any grants or loans that are available to health care providers from the federal government;

(v) May include:

1. Increased reimbursement for specific services;

2. Lump sum payments;

3. Gain–sharing arrangements;

4. Rewards for quality and efficiency;

5. In–kind payments; and

6. Other items or services to which a specific monetary value can be assigned; and

(vi) Shall be paid in cash, unless the State–regulated payor and the health care provider agree on an incentive of equivalent value.

(3) The regulations need not require incentives for the adoption and meaningful use of electronic health records for each type of health care provider listed in § 19–142(e) of this subtitle.

(4) If federal law is amended to allow the State to regulate payments made by entities that self–insure their health benefit plans, regulations adopted under this section shall apply to those entities to the same extent to which they apply to State–regulated payors.

(5) Regulations adopted under this subsection:

(i) May not require a group model health maintenance organization, as defined in § 19–713.6 of this title, to provide an incentive to a health care provider who is employed by the multispecialty group of physicians under contract with the group model health maintenance organization; and

(ii) Shall allow a State–regulated payor to:

1. Request information from a health care provider to validate the health care provider's incentive claim; and

2. If the State–regulated payor determines that a duplicate incentive payment or an overpayment has been made, reduce the incentive amount.

(6) The Commission may:

(i) Audit the State–regulated payor or the health care provider for compliance with the regulations adopted under this subsection; and

(ii) If it finds noncompliance, request corrective action.

(7) It is the intent of the General Assembly that the State Employee and Retiree Health and Welfare Benefits Program support the incentives provided under this subsection through contracts between the Program and the third party

administrators arranging for the delivery of health care services to members covered under the Program.

(c) The Health Services Cost Review Commission, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services, shall take the actions necessary to:

(1) Assure that hospitals in the State receive the payments provided under § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations; and

(2) Implement any changes in hospital rates required by the federal Centers for Medicare and Medicaid Services to ensure compliance with § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(d) The Department, in consultation with the Commission, shall develop a mechanism to assure that health care providers that participate in the Maryland Medical Assistance Program receive the payments provided for adoption and use of electronic health records technology under § 4201 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(e) (1) On or before October 1, 2012, the Commission shall designate one or more management service organizations to offer services throughout the State.

(2) The Commission may use federal grants and loans to help subsidize the use of the designated management service organizations by health care providers.

(f) On and after the later of January 1, 2015, or the date established for the imposition of penalties under § 4102 of the federal American Recovery and Reinvestment Act of 2009:

(1) Each health care provider using an electronic health record that seeks payment from a State–regulated payor shall use electronic health records that are:

(i) Certified by a national certification organization designated by the Commission; and

(ii) Capable of connecting to and exchanging data with the State–designated health information exchange; and

(2) The incentives required under subsection (b) of this section may include reductions in payments to a health care provider that does not use electronic health records that meet the requirements of paragraph (1) of this subsection.

§19–144.

(a) To facilitate the use of Web–based technology for electronic advance directives, the Maryland Health Care Commission shall develop criteria for recognizing electronic advance directives services that are authorized to connect to the State–designated health information exchange.

(b) To be authorized to connect to the State–designated health information exchange, an electronic advance directives service shall:

(1) Be recognized by the Maryland Health Care Commission;

(2) Be responsible for all costs associated with connecting to the State–designated health information exchange; and

(3) Store electronic advance directives that are received by facsimile or other electronic means.

(c) The State–designated health information exchange may charge electronic advance directives services recognized by the Maryland Health Care Commission a fee for connecting to the State–designated health information exchange.

(d) The State–designated health information exchange shall ensure that electronic advance directives services do not have access to information stored on the State–designated health information exchange.

§19–145.

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

(2) "Dispenser" means a person authorized by law to dispense, as defined in § 12–101 of the Health Occupations Article, a prescription drug to a patient or the patient's agent in the State.

(3) "Noncontrolled prescription drug" means a prescription drug, as defined in § 21–201 of this article, that is not a controlled dangerous substance designated under Title 5, Subtitle 4 of the Criminal Law Article.

(4) "State–designated health information exchange" has the meaning stated in § 4–301 of this article.

(b) The State–designated health information exchange shall operate as a health data utility for the State.

(c) The purposes of the health data utility include:

(1) The collection, aggregation, and analysis of clinical information, public health data, and health administrative and operations data to assist the Department, local health departments, the Commission, and the Health Services Cost Review Commission in the evaluation of public health interventions and health equity;

(2) The communication of data between public health officials and health care providers to advance disease control and health equity; and

(3) The enhancement and acceleration of the interoperability of health information throughout the State.

(d) Dispensers shall provide data to the State–designated health information exchange.

(e) (1) The purpose of this subsection is to:

(i) Authorize individuals and organizations involved in the treatment and care coordination of patients to access, as legally authorized, a patient's medication history, including medications prescribed for the patient; and

(ii) Assist health care providers, care managers, the Department, and local health departments to understand and promote matters of health equity and treatment efficacy.

(2) After dispensing a noncontrolled prescription drug, a dispenser shall submit prescription information to the State–designated health information exchange.

(3) The prescription information shall be submitted:

(i) By electronic means;

(ii) Without unduly increasing the workload and expense on a dispenser;

(iii) In a manner that minimizes burden and duplication by being as compatible as possible with existing federal standards for data submission practices, including technology software of dispensers; and

(iv) As otherwise required by regulations adopted by the Commission.

(4) The State–designated health information exchange may not impose any fees or other assessments on dispensers to support the operation of the exchange.

(5) The State–designated health information exchange shall make prescription information submitted under this subsection available for purposes of treatment and care coordination of a patient.

(f) The State–designated health information exchange may provide data, as allowed by law, for public health purposes that may include:

(1) Improving health equity through access to prescription medications, including for the treatment of infectious disease;

(2) Assisting programs led by health care providers and the Department, local health departments, the Commission, and the Health Services Cost Review Commission to identify opportunities for quality improvement, including for stewardship of antibiotic medications; and

(3) Conducting case investigations and related activities.

(g) Information submitted to the State–designated health information exchange or provided by the State–designated health information exchange under this section shall be submitted or provided, to the extent practicable, in as near to real time as possible.

(h) (1) The Commission, in consultation with appropriate stakeholders, shall adopt regulations to carry out this section.

(2) The regulations shall take into account consumer perspective and include:

(i) The specific data required to be provided under subsection (d) of this section;

(ii) The specific prescription information required to be submitted under subsection (e) of this section;

(iii) The time frame for submitting prescription information under subsection (e) of this section;

(iv) The electronic means and manner by which prescription information is to be submitted under subsection (e) of this section;

(v) Prescription information submission requirements that align with the data submission requirements on dispensers of monitored prescription drugs under Title 21, Subtitle 2A of this article; and

(vi) Identification and necessary suppression of information related to providers or medications that are determined to have significant potential to cause harm.

(i) (1) The State–designated health information exchange shall establish a consumer advisory council to bring the perspectives of individuals and organizations with an interest in protecting consumers into the delivery of services provided by the State–designated health information exchange.

(2) In selecting members, the State–designated health information exchange shall consider diversity of experience.

(3) The consumer advisory council established under paragraph (1) of this subsection shall:

(i) Consist of a minimum of six members, including at least four consumer representatives and two staff representatives, and maintain a ratio of consumer representatives to nonconsumer representatives of at least two to one;

(ii) Identify and report consumer privacy concerns to senior leadership of the State–designated health information exchange;

(iii) Advise on efforts to educate consumers on data exchange policies, including options for consumers to opt out of disclosure of protected health information;

(iv) Meet at least 3 times each year; and

(v) Adopt and maintain a charter to be posted online that includes the purpose, members, and meeting schedule of the consumer advisory council.

§19–145.1.

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

(2) (i) "Advance care planning document" means a document that indicates an individual's preferences for the receipt of health care.

(ii) "Advance care planning document" includes:

1. An advance directive; and

2. A Medical Orders for Life–Sustaining Treatment form.

(3) "Carrier" means:

(i) An insurer;

(ii) A nonprofit health service plan; and

(iii) A health maintenance organization.

(4) "Electronic advance care planning document" means an electronic version of an advance care planning document that is able to be uploaded or saved to the electronic platform developed under subsection (b)(2)(i) of this section.

(5) "Health care provider" means:

(i) A health care practitioner who is licensed or certified under the Health Occupations Article to provide health care in the ordinary course of business;

(ii) A set of health care practitioners, as defined in § 15–113 of this article;

(iii) A health care facility as defined in § 19–114 of this subtitle;

(iv) A nursing facility, as defined in § 19–301 of this title; or

(v) An assisted living program, as defined in § 19–1801 of this title.

(b) (1) The Commission shall coordinate the accessibility of electronic advance care planning documents in the State.

(2) The coordination provided by the Commission under this subsection shall include:

(i) Collaboration with the State–designated health information exchange to develop an electronic platform through which:

1. Individuals can upload or save advance care planning documents;

2. Individuals can update electronic advance care planning documents; and

3. Health care providers can access electronic advance care planning documents as appropriate;

(ii) Identification of options meeting federal, State, and industry cybersecurity standards that may be taken by carriers, managed care organizations, and health care providers to:

1. Encourage members, enrollees, and patients to create, upload or save, and update advance care planning documents; and

2. Make tools, which may include electronic advance directives services recognized by the Commission under § 19–144 of this subtitle, accessible to members, enrollees, and patients that allow them to create, upload or save, and update electronic advance care planning documents;

(iii) Development and implementation of quality measures endorsed or designated for testing by a national quality measurement organization to measure the effectiveness of the options identified under item (ii) of this paragraph; and

(iv) Inclusion of a distinct tab on the State–designated health information exchange website that provides:

1. Access to the advance directive information sheet developed under § 5–615 of this article;

2. The electronic means to create, execute, and store an advance directive or health care designation; and

3. The capability to upload or save an advance care planning document to the electronic platform developed in accordance with item (i) of this paragraph and update existing electronic advance care planning documents.

(3) As the Commission identifies options under paragraph (2)(ii) of this subsection, the Commission may explore whether carriers, managed care organizations, and health care providers with secure member authentication websites can link between the website of the carrier, managed care organization, or health care provider and the State–designated health information exchange website.

(4) In developing the electronic platform in accordance with paragraph (2)(i) of this subsection, the Commission and the State–designated health information exchange:

(i) Shall consult with other State agencies and stakeholders, as appropriate; and

(ii) Subject to available funds, may contract with a third–party vendor, as appropriate.

(5) The electronic platform developed in accordance with paragraph (2)(i) of this subsection shall:

(i) Provide an individual with disabilities with nonvisual access in a way that is fully and equally accessible to and independently usable by the individual with disabilities so that the individual is able to acquire the same information, engage in the same interactions, and enjoy the same services as users without disabilities, with substantially equivalent ease of use; and

(ii) Be consistent with the standards of § 508 of the federal Rehabilitation Act of 1973.

(c) As an option under subsection (b)(2)(ii) of this section, a carrier, managed care organization, or health care provider may contract with an electronic advance directives service if the service:

(1) Is approved by the Maryland Health Care Commission under § 19–144 of this subtitle; and

(2) Meets the technology, security, and privacy standards set by the Commission.

(d) The Commission may adopt regulations to carry out this section.

§19–146.

(a) In this Part V of this subtitle the following words have the meanings indicated.

(b) "Carrier" has the meaning stated in § 15–1301 of the Insurance Article.

(c) "Enrollee" means an individual entitled to health benefits from a carrier.

(d) "Physician rating system" has the meaning stated in § 15–1701 of the Insurance Article.

(e) "Ratings examiner" means an independent entity that is approved by the Commission to review physician rating systems.

§19–147.

(a) The Commission shall approve an entity that meets the requirements of this section to be a ratings examiner.

(b) To be approved by the Commission as a ratings examiner, an entity examining a physician rating system shall require a physician rating system to:

(1) Use only quality of performance and cost efficiency as measurement categories;

(2) Calculate and disclose separately measures of cost efficiency and quality of performance;

(3) Disclose clearly to physicians and enrollees the proportion of the component score for cost efficiency and quality of performance in each combined score;

(4) In determining quality of performance, use measures:

(i) That are based on nationally recognized, evidence–based or consensus–based clinical recommendations or guidelines; or

(ii) When available, that are endorsed by entities whose work in physician quality of performance is generally accepted in the health care system;

(5) Disclose to physicians who are subject to the physician rating system:

(i) The measurements for each criterion and the relative weight of each criterion and measurement in the overall rating of the physician;

(ii) 1. The basis for the carrier's quality of performance ratings;

2. The data used to determine the quality of performance ratings; and

3. The relative weight or relevance of quality of performance to the overall rating of a physician in the physician rating system;

(iii) The basis for determining whether there is a sufficient number of patients and episodes of care for a given disease state and specialty to generate reliable ratings for a physician; and

(iv) The methodology used to determine how data is attributed to a physician;

(6) Use appropriate risk adjustments to account for the characteristics of the patient population seen by a physician in determining the quality of performance and cost efficiency of the physician;

(7) In measuring the cost efficiency of the performance of a physician:

(i) Compare physicians within the same specialty within the appropriate geographical market; and

(ii) Use appropriate and comprehensive episode of care computer software to evaluate the cost efficiency of the performance of a physician;

(8) (i) Include an appeals process that a physician subject to the physician rating system may use to appeal the rating received under the physician rating system; and

(ii) Based on the outcome of an appeal, make any necessary corrections to the data used to rate the physician in the physician rating system; and

(9) Disclose to physicians and enrollees how the perspectives of enrollees, consumer advocates, employers, labor unions, and physicians were incorporated into the development of the physician rating system.

(c) Notwithstanding subsection (b) of this section, an entity that has a physician performance rating certification program approved after August 1, 2008, by a national consortium of employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information:

(1) Is deemed to be a ratings examiner under this part; and

(2) Is deemed to meet the requirements of subsection (b) of this section.

§19–1B–01.

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

(b) "Advisory body" means the Community Integrated Medical Home Program advisory body.

(c) "Carrier" has the meaning stated in § 15–1801 of the Insurance Article.

(d) "Commission" means the Maryland Health Care Commission.

(e) "Community integrated medical home" means a certified participating patient centered medical home integrated with community–based services and supports provided by certified entities to address social as well as medical determinants of health.

(f) "Managed care organization" has the meaning stated in § 15–101 of this article.

(g) "Patient centered medical home" means a primary care practice organized to provide a first, coordinated, ongoing, and comprehensive source of care to patients to:

(1) Foster a partnership with a qualifying individual;

(2) Coordinate health care services for a qualifying individual; and

(3) Exchange medical information with carriers, other providers, and qualifying individuals.

§19–1B–02.

(a) There is a Community Integrated Medical Home Program.

(b) The mission of the Community Integrated Medical Home Program is to:

(1) Keep Maryland families healthy through the use of innovative mapping tools that allow better targeting of resources to those in need;

(2) Coordinate comprehensive services provided by a participating patient centered medical home with public health resources in local communities across the State; and

(3) Provide complementary support for qualified individuals between office visits.

(c) The Community Integrated Medical Home Program shall be administered jointly by the Commission and the Department.

§19–1B–03.

(a) There is a Community Integrated Medical Home Program advisory body.

(b) The advisory body shall make recommendations concerning:

(1) The model, standards, and scope of services for the Community Integrated Medical Home Program;

(2) The essential elements for implementing the Community Integrated Medical Home Program, including those necessary to attract patient centered medical homes, carriers, managed care organizations, and other payors to participate in the Program;

(3) The extent and nature of the relationship between the Community Integrated Medical Home Program and patient centered medical homes, carriers, managed care organizations, and other payors; and

(4) How the Community Integrated Medical Home Program can be financially self–sustaining.

(c) The advisory body shall include interested stakeholders representing health care provider organizations, consumer advocacy organizations, health professional associations, health occupations boards, carriers, and managed care organizations.

(d) The Commission and the Secretary, in consultation, shall:

(1) Appoint the members of the advisory body; and

(2) Determine the frequency and location of meetings of the advisory body.

§19–1C–01.

(a) Before the Department approves the operation of a facility under this title, including by granting a license to the facility, the Department shall require the facility to establish and implement:

(1) A safety plan for the safety of the individuals served by the facility; and

(2) A community relations plan, if the facility is:

(i) Accredited by an accreditation organization, as defined in § 19–2301 of this title; and

(ii) Required by the accreditation organization to establish and implement a community relations plan.

(b) The Department may authorize a facility to satisfy the requirement under:

(1) Subsection (a)(1) of this section by implementing a safety plan established for the facility for another purpose, including an emergency plan; and

(2) Subsection (a)(2) of this section by implementing the community relations plan required by the accreditation organization.

(c) A facility in operation on or before September 30, 2021, shall submit a safety plan on or before October 1, 2023, in accordance with this section.

(d) Each facility shall revise its safety plan not less than every 5 years.

(e) A facility may satisfy the requirement under subsection (c) of this section by implementing a safety or emergency plan established for the facility for another purpose.

§19–201.

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

(b) "All–payer model contract" means the payment model demonstration agreement authorized under § 1115A of the Social Security Act, including any amendments to the agreement, between the State and the federal Center for Medicare and Medicaid Innovation.

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

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

(1) Any hospital; or

(2) Any related institution.

(e) (1) "Hospital services" means:

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

(ii) Emergency services, including services provided at a freestanding medical facility licensed under Subtitle 3A of this title;

(iii) Outpatient services provided at a hospital;

(iv) Outpatient services, as specified by the Commission in regulation, provided at a freestanding medical facility licensed under Subtitle 3A of this title that has received:

1. A certificate of need under § 19–120(o)(1) of this title; or

2. An exemption from obtaining a certificate of need under § 19–120(o)(3) of this title; and

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

(2) "Hospital services" includes a hospital outpatient service:

(i) Of a hospital that, on or before June 1, 2015, is under a merged asset hospital system;

(ii) That is designated as a part of another hospital under the same merged asset hospital system to make it possible for the hospital outpatient service to participate in the 340B Program under the federal Public Health Service Act; and

(iii) That complies with all federal requirements for the 340B Program and applicable provisions of 42 C.F.R. § 413.65.

(3) "Hospital services" does not include:

(i) Outpatient renal dialysis services; or

(ii) Outpatient services provided at a limited service hospital as defined in § 19–301 of this title, except for emergency services.

(f) (1) "Related institution" means an institution that is licensed by the Department as:

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

(ii) An intermediate care facility–intellectual disability.

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

§19–202.

There is a State Health Services Cost Review Commission. The Commission is an independent commission that functions in the Department.

§19–203.

(a) (1) The Commission consists of 7 members appointed by the Governor with the advice and consent of the Senate.

(2) Of the 7 members, 4 shall be individuals who do not have any connection with the management or policy of any facility.

(b) Each member shall be interested in problems of health care.

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

(2) The terms of members are staggered as required by the terms provided for members of the Commission on July 1, 1982. The terms of those members end as follows:

(i) 2 in 1983;

(ii) 1 in 1984;

(iii) 2 in 1985; and

(iv) 2 in 1986.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) A member who serves 2 consecutive full 4-year terms may not be reappointed for 4 years after completion of those terms.

(6) When appointing a member to fill a vacancy due to the expiration of a member's term, the Governor shall give consideration to, and make appointments when appropriate, that would promote the racial, gender, and geographic diversity of the Commission.

§19–204.

Annually, from among the members of the Commission:

(1) The Governor shall appoint a chairman; and

(2) The chairman shall appoint a vice chairman.

§19–205.

(a) With the approval of the Governor, the Commission shall appoint an Executive Director, who is the chief administrative officer of the Commission.

(b) The Executive Director serves at the pleasure of the Commission.

(c) Under the direction of the Commission, the Executive Director shall perform any duty or function that the Commission requires.

§19–206.

(a) A majority of the full authorized membership of the Commission is a quorum. However, the Commission may not act on any matter unless at least 4 members in attendance concur.

(b) The Commission shall meet at least 6 times a year, at the times and places that it determines.

(c) Each member of the Commission is entitled to:

(1) Compensation in accordance with the State budget; and

(2) Reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) (1) The Commission may employ a staff in accordance with the State budget.

(2) The Commission, in consultation with the Secretary, may set the compensation of a Commission employee in a position that:

(i) Is unique to the Commission;

(ii) Requires specific skills or experience to perform the duties of the position; and

(iii) Does not require the employee to perform functions that are comparable to functions performed in other units of the Executive Branch of State government.

(3) The Secretary of Budget and Management, in consultation with the Commission, shall determine the positions for which the Commission may set compensation under paragraph (2) of this subsection.

(4) The Deputy Director and each principal section chief of the Commission serve at the pleasure of the Commission.

(5) The Commission, in consultation with the Secretary, may determine the appropriate job classifications for the Executive Director, Deputy Director, and each principal section chief of the Commission.

§19–207.

(a) In addition to the powers set forth elsewhere in this subtitle, the Commission may:

(1) Adopt rules and regulations to carry out the provisions of this subtitle;

(2) Create committees from among its members;

(3) Appoint advisory committees, which may include individuals and representatives of interested public or private organizations;

(4) Apply for and accept any funds, property, or services from any person or government agency;

(5) Make agreements with a grantor or payor of funds, property, or services, including an agreement to make any study, plan, demonstration, or project;

(6) Publish and give out any information that relates to the financial aspects of health care and is considered desirable in the public interest; and

(7) Subject to the limitations of this subtitle, exercise any other power that is reasonably necessary to carry out the purposes of this subtitle.

(b) In addition to the duties set forth elsewhere in this subtitle, the Commission shall:

(1) Adopt rules and regulations that relate to its meetings, minutes, and transactions;

(2) Keep minutes of each meeting;

(3) Prepare annually a budget proposal that includes the estimated income of the Commission and proposed expenses for its administration and operation;

(4) Within a reasonable time after the end of each facility's fiscal year or more often as the Commission determines, prepare from the information filed with the Commission any summary, compilation, or other supplementary report that will advance the purposes of this subtitle;

(5) Periodically participate in or do analyses and studies that relate to:

(i) Health care costs;

(ii) The financial status of any facility; or

(iii) Any other appropriate matter;

(6) On or before May 1 of each year, submit to the Governor, to the Secretary, and, subject to § 2–1257 of the State Government Article, to the General Assembly an annual report on the operations and activities of the Commission during the preceding fiscal year, including:

(i) A copy of each summary, compilation, and supplementary report required by this subtitle;

(ii) Budget information regarding the Health Services Cost Review Commission Fund, including:

1. Any balance remaining in the Fund at the end of the previous fiscal year; and

2. The percentage of the total annual costs of the Commission that is represented by the balance remaining in the Fund at the end of the previous fiscal year;

(iii) A summary of the Commission's role in hospital quality of care activities, including information about the status of any pay for performance initiatives;

(iv) An update on the status of the State's compliance with the provisions of the all–payer model contract that includes:

1. Performance in limiting inpatient and outpatient hospital per capita cost growth for all payers;

2. Annual progress toward achieving the State's financial targets established by the all–payer model contract;

3. A summary of the work conducted, recommendations made, including recommendations made by workgroups created to provide technical input and advice, and Commission action on activities related to the all–payer model contract;

4. Actions approved by the Commission to promote alternative methods of rate determination and payment of an experimental nature, as authorized under § 19–219(c)(2) of this subtitle;

5. Reports submitted to the federal Center for Medicare and Medicaid Innovation relating to the all–payer model contract;

6. Any known adverse consequences in implementing the all–payer model contract, as reported to the federal Center for Medicare and Medicaid Innovation, that may negatively impact quality of or access to care, and the actions taken by the Commission to mitigate the consequences; and

7. Annual progress made in the development of public and private partnerships between hospitals and other entities, including community–based physicians, community–based organizations, and other post–acute care providers, to achieve the population health goals established with the federal Center for Medicare and Medicaid Innovation; and

(v) Any other fact, suggestion, or policy recommendation that the Commission considers necessary;

(7) Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Maryland Health Care Commission; and

(8) If the Centers for Medicare and Medicaid Services issues a warning notice related to a "triggering event" as described in the all–payer model contract, provide written notification to the Governor, the Secretary, and, subject to § 2–1257 of the State Government Article, the General Assembly within 15 days after the issuance of the notice.

(c) (1) The Commission shall set deadlines for the filing of reports required under this subtitle.

(2) The Commission may adopt rules or regulations that impose penalties for failure to file a report as required.

(3) The amount of any penalty under paragraph (2) of this subsection may not be included in the costs of a facility in regulating its rates.

(d) Except for privileged medical information, the Commission shall make:

(1) Each report filed and each summary, compilation, and report required under this subtitle available for public inspection at the office of the Commission during regular business hours; and

(2) Each summary, compilation, and report available to any agency on request.

(e) (1) The Commission may contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Commission.

(2) Unless permission is granted specifically by the Commission, a third party hired by the Commission may not release, publish, or otherwise use any information to which the third party has access under its contract.

§19–208.

(a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that the Commission makes under authority specifically delegated by law to the Commission.

(b) (1) The power of the Secretary to transfer by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Commission.

(2) The Secretary may assess an administrative charge on the Commission to fund services provided to the Commission by the Department.

(3) The amount to be paid by the Commission to the Department for administrative costs, not to exceed 30.5% of the salaries of the Commission, shall be based on indirect costs or services benefiting the Commission, less overhead costs paid directly by the Commission.

(c) (1) The power of the Secretary over the procurement procedure for units in the Department does not apply to the procurement procedure for the Commission.

(2) Subject to the provisions of paragraph (1) of this subsection, any procurement for services to be performed or for supplies to be delivered to the Commission is subject to the purposes and requirements of the State Finance and Procurement Article.

§19–210.

(a) In this section, "Fund" means the Maternal and Child Health Population Health Improvement Fund.

(b) There is a Maternal and Child Health Population Health Improvement Fund.

(c) The purpose of the Fund is to invest in maternal and child population health improvements through the Medical Care Programs Administration and the Prevention and Health Promotion Administration.

(d) The Department and the Commission shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) A uniform, broad–based assessment of a reasonable amount in hospital rates in order to invest in maternal and child population health improvements under § 19–207 of this subtitle;

(2) Interest earnings; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used only for expenses associated with maternal and child health population health improvements through December 31, 2027.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(i) Expenditures from the Fund may be made only:

(1) In accordance with the State budget; and

(2) After the approval of a majority of the members of the Commission.

(j) Money expended from the Fund is supplemental to and is not intended to take the place of funding that would otherwise be appropriated for the Maryland Medical Assistance Program.

(k) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

§19–211.

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

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

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

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

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

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

(c) The Commission shall set rates for hospital services provided at:

(1) A freestanding medical facility pilot project authorized under Subtitle 3A of this title prior to January 1, 2008; and

(2) A freestanding medical facility licensed under Subtitle 3A of this title.

§19–212.

The Commission shall:

(1) Require each facility to disclose publicly:

(i) Its financial position; and

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

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

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

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

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

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

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

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

(6) Develop guidelines for the establishment of global budgets for each facility under Maryland's all–payer model contract, including guidelines to prevent facilities from taking actions to meet a budget that the Commission determines would have adverse consequences for recipients or purchasers of services;

(7) Receive confirmation from Commission staff that facility global budget agreements, as they are developed, are consistent with the guidelines; and

(8) After review by the Commission for compliance with the guidelines, post each executed global budget agreement on the Commission's website.

§19–213.

(a) In this section, "facilities" means hospitals and related institutions whose rates have been approved by the Commission.

(b) The Commission shall assess and collect user fees on facilities as defined in this section.

(c) (1) The total fees assessed by the Commission may not exceed the greater of:

(i) 0.1% of the immediately preceding fiscal year's budgeted, regulated, gross hospital revenue; or

(ii) The largest amount determined under this paragraph for a fiscal year during the immediately preceding 5 fiscal years.

(2) The total user fees assessed by the Commission may not exceed the Special Fund appropriation for the Commission by more than 20%.

(3) The user fees assessed by the Commission shall be used exclusively to cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle and any administrative costs for services to the Commission provided by the Department.

(4) The Commission shall pay all funds collected from fees assessed in accordance with this section into the Health Services Cost Review Commission Fund.

(5) The user fees assessed by the Commission may be expended only for purposes authorized by the provisions of this subtitle.

(6) The amount specified in paragraph (1) of this subsection limits only the total user fees the Commission may assess in a fiscal year.

(d) (1) There is a Health Services Cost Review Commission Fund.

(2) The Fund is a special continuing, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The Treasurer shall separately hold, and the Comptroller shall account for, the Fund.

(4) The Fund shall be invested and reinvested in the same manner as other State funds.

(5) Any investment earnings shall be retained to the credit of the Fund.

(6) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2–1220 of the State Government Article.

(7) This section may not be construed to prohibit the Fund from receiving funds from any other source.

(8) (i) The Fund shall be used only to provide funding for the Commission and for the purposes authorized under this subtitle.

(ii) The costs of the Commission include the administrative costs incurred by the Department on behalf of the Commission.

(e) The Commission shall:

(1) Assess user fees for each facility equal to the sum of:

(i) The amount equal to one half of the total user fees times the ratio of admissions of the facility to total admissions of all facilities; and

(ii) The amount equal to one half of the total user fees times the ratio of gross operating revenue of each facility to total gross operating revenues of all facilities;

(2) Establish minimum and maximum assessments; and

(3) Assess each facility on or before June 30 of each year.

(f) (1) On or before September 1 of each year, each facility assessed under this section shall make payment to the Commission.

(2) The Commission shall make provision for partial payments.

(g) Any bill not paid within 30 days of an agreed payment date may be subject to an interest penalty to be determined by the Commission.

(h) (1) This section shall terminate and be of no effect on the first day of July following the cessation of a waiver by law or agreement for Medicare and Medicaid between the State of Maryland and the federal government.

(2) (i) If notice of intent to terminate is made by the federal government to this State before the first day of an intervening session of the Maryland General Assembly, this section shall expire June 30 of the following calendar year.

(ii) Under no circumstances shall less than 7 calendar months occur between notice of termination and expiration of this section.

§19–214.

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

(1) Reduce uncompensated care; and

(2) Assure the integrity of the payment system.

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

(1) Are in the public interest;

(2) Will equitably distribute the reasonable costs of uncompensated care and the disproportionate share hospital payment;

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

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

(5) Will not result in significantly increasing costs to Medicare or termination of the all–payer model contract.

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

(d) (1) Each year, the Commission shall assess a uniform, broad–based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly.

(2) (i) 1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue.

2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15–701 of this article.

(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.

(3) (i) Funds generated from the assessment under this subsection may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008.

(ii) Any funds remaining after the expenditure of funds under subparagraph (i) of this paragraph has been made may be used for the general operations of the Medicaid program.

§19–214.1.

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

(2) "Financial hardship" means medical debt, incurred by a family over a 12–month period, that exceeds 25% of family income.

(3) "Medical debt" means out–of–pocket expenses, including co–payments, coinsurance, and deductibles, for medical costs.

(4) "Medically necessary care" means care that is:

(i) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(ii) Consistent with accepted standards of good medical practice; and

(iii) Not primarily for the convenience of the patient, the patient's family, or the provider.

(b) (1) The Commission shall require each acute care hospital and each chronic care hospital in the State under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced–cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

(2) The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 200% of the federal poverty level, calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided;

(ii) Reduced–cost medically necessary care to low–income patients with family income above 200% of the federal poverty level, calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided;

(iii) A description of the availability of the payment plan required under § 19–214.2(d) of this subtitle; and

(iv) A mechanism for a patient to request the hospital to reconsider the denial of free or reduced–cost care that includes in the request:

1. The Health Education and Advocacy Unit is available to assist the patient or the patient's authorized representative in filing and mediating a reconsideration request; and

2. The address, phone number, facsimile number, e–mail address, mailing address, and website of the Health Education and Advocacy Unit.

(3) (i) The Commission by regulation may establish income thresholds higher than those under paragraphs (2) and (4) of this subsection.

(ii) In establishing income thresholds that are higher than those under paragraph (2) of this subsection for a hospital, the Commission shall take into account:

1. The patient mix of the hospital;

2. The financial condition of the hospital;

3. The level of bad debt experienced by the hospital; and

4. The amount of charity care provided by the hospital.

(4) Subject to income thresholds set under paragraph (3) of this subsection, the financial assistance policy required under this subsection shall provide reduced–cost medically necessary care to patients with family income below 500% of the federal poverty level who have a financial hardship.

(5) (i) If a patient is eligible for reduced–cost medically necessary care under paragraph (2)(ii) of this subsection, the hospital shall, at a minimum, reduce the patient's out–of–pocket expenses for the regulated hospital service:

1. For a patient with family income of at least 201% but not more than 250% of the federal poverty level, by 75%; and

2. For a patient with family income of more than 250% but not more than 300% of the federal poverty level, by 60%.

(ii) If a patient is eligible for reduced–cost medically necessary care under paragraph (4) of this subsection, the hospital shall, at a minimum, reduce the patient's out–of–pocket expenses for the regulated hospital service:

1. For a patient with family income of at least 201% but not more than 250% of the federal poverty level, by 75%;

2. For a patient with family income of more than 250% but not more than 300% of the federal poverty level, by 60%;

3. For a patient with family income of more than 300% but not more than 350% of the federal poverty level, by 50%;

4. For a patient with family income of more than 350% but not more than 400% of the federal poverty level, by 45%;

5. For a patient with family income of more than 400% but not more than 450% of the federal poverty level, by 40%; and

6. For a patient with family income of more than 450% but not more than 500% of the federal poverty level, by 35%.

(6) If a patient has received reduced–cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced–cost medically necessary care when seeking subsequent care at the same hospital during the 12–month period beginning on the date on which the reduced–cost medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced–cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced–cost medically necessary care.

(7) The financial assistance policy required under this subsection shall provide presumptive eligibility for free medically necessary care to a patient who is not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program and:

(i) Lives in a household with a child who is enrolled in the free and reduced–cost meal program and is eligible for the program based on the household's income;

(ii) Receives benefits through the federal Supplemental Nutrition Assistance Program;

(iii) Receives benefits through the State's Energy Assistance Program;

(iv) Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or

(v) Receives benefits from any other social service program as determined by the Department and the Commission.

(8) (i) A hospital may consider only household monetary assets in excess of $100,000 when determining eligibility for free and reduced–cost care under the hospital's financial assistance policy.

(ii) If a hospital considers household monetary assets under subparagraph (i) of this paragraph, retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans shall be excluded.

(9) (i) In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

1. A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

2. Biological children, adopted children, or stepchildren; and

3. Anyone for whom the patient claims a personal exemption in a federal or State tax return.

(ii) For a patient who is a child, the household size shall consist of the child and the following individuals:

1. Biological parents, adopted parents, or stepparents or guardians;

2. Biological siblings, adopted siblings, or stepsiblings; and

3. Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

(10) (i) A hospital shall provide notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill.

(ii) The notice required under subparagraph (i) of this paragraph shall state that the patient has up to 240 days after the day the patient receives the initial hospital bill to apply for financial assistance from the hospital.

(iii) 1. The hospital shall obtain documentation ensuring that the patient or the patient's authorized representative acknowledges the patient's receipt of the notice before discharging the patient.

2. If a patient chooses not to apply for financial assistance, the patient's documented acknowledgment shall indicate that the patient is not applying on the day of the acknowledgment but may apply within 240 days immediately following the patient's receipt of the initial hospital bill.

(11) The hospital shall consider any change in the patient's financial circumstance that occurs during the 240–day period following the patient's receipt of the initial hospital bill if the patient informs the hospital of the change in financial circumstance on or before the conclusion of the 240–day period.

(c) (1) A hospital shall post a notice in conspicuous places throughout the hospital, including the billing office, informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(2) The notice required under paragraph (1) of this subsection shall:

(i) Be in simplified language in at least 10 point type; and

(ii) Be provided in the patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5% of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(d) The Commission shall:

(1) Develop a uniform financial assistance application; and

(2) Require each hospital to use the uniform financial assistance application to determine eligibility for free and reduced–cost care under the hospital's financial assistance policy.

(e) The uniform financial assistance application:

(1) Shall be written in simplified language; and

(2) May not require documentation that presents an undue barrier to a patient's receipt of financial assistance.

(f) (1) Each hospital shall develop an information sheet that:

(i) Describes the hospital's financial assistance policy and includes a section that allows for a patient to initial that the patient has been made aware of the financial assistance policy;

(ii) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(iii) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

1. The patient's hospital bill;

2. The patient's rights and obligations with regard to the hospital bill;

3. How to apply for free and reduced–cost care; and

4. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(iv) Provides contact information for the Maryland Medical Assistance Program;

(v) Includes a statement that physician charges are not included in the hospital bill and are billed separately; and

(vi) Informs patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.

(2) The information sheet shall:

(i) Be in simplified language in at least 10 point type; and

(ii) Be in the patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5% of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(3) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(i) Before discharge;

(ii) With the hospital bill;

(iii) On request; and

(iv) In each written communication to the patient regarding collection of the hospital bill.

(4) The hospital bill shall include a reference to the information sheet.

(5) The Commission shall:

(i) Establish uniform requirements for the information sheet; and

(ii) Review each hospital's implementation of and compliance with the requirements of this subsection.

(g) Each hospital shall ensure the availability of staff who are trained to work with the patient, the patient's family, and the patient's authorized representative in order to understand:

(1) The patient's hospital bill;

(2) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced–cost medically necessary care due to a financial hardship;

(3) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the hospital bill; and

(4) How to contact the hospital for additional assistance.

(h) Each hospital shall develop a procedure to determine a patient's eligibility under the hospital's financial assistance policy in which the hospital:

(1) Determines whether the patient has health insurance;

(2) Determines whether the patient is presumptively eligible for free or reduced–cost care under subsection (b)(7) of this section;

(3) Determines whether uninsured patients are eligible for public or private health insurance;

(4) To the extent practicable, offers assistance to uninsured patients if the patient chooses to apply for public or private health insurance;

(5) To the extent practicable, determines whether the patient is eligible for other public programs that may assist with health care costs;

(6) Uses information in the possession of the hospital, if available, to determine whether the patient is qualified for free or reduced–cost care under the hospital's financial assistance policy; and

(7) When a patient submits a completed application for financial assistance, determines the patient's eligibility under the hospital's financial assistance policy within 14 days after the patient applies for financial assistance and suspends any billing or collections actions while eligibility is being determined.

(i) A hospital may not:

(1) Use a patient's citizenship or immigration status as an eligibility requirement for financial assistance; or

(2) Withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

(j) Each hospital shall submit to the Commission annually at times prescribed by the Commission:

(1) The hospital's financial assistance policy developed under this section; and

(2) An annual report on the hospital's financial assistance policy that includes:

(i) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(ii) The total number of inpatients and outpatients who received:

1. Free care during the immediately preceding year; and

2. Reduced–cost care for the prior year;

(iii) The total number of patients who received financial assistance during the immediately preceding year by race or ethnicity and gender;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year by race or ethnicity and gender;

(v) The total amount of the costs of hospital services provided to patients who received free care; and

(vi) The total amount of the costs of hospital services provided to patients who received reduced–cost care that was either covered by the hospital as financial assistance or that the hospital charged to the patient.

(k) (1) The Commission shall post on its website each hospital's financial assistance policy and annual report.

(2) The Commission shall compile the reports required under subsection (j) of this section and issue a hospital financial assistance report.

(3) The hospital financial assistance report required under paragraph (2) of this subsection shall be made available to the public free of charge.

(4) On or before December 1 each year, the Commission shall submit a copy of the annual hospital financial assistance report issued under paragraph (2) of this subsection, in accordance with § 2–1257 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee.

§19–214.2. IN EFFECT

(a) (1) Each hospital annually shall submit to the Commission:

(i) At times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients; and

(ii) A report including:

1. The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital, or a debt collector used by the hospital, filed an action to collect a debt owed on a hospital bill;

2. The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom the hospital has and has not reported or classified a bad debt;

3. The total dollar amount of the charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out–of–pocket costs for patients covered by insurance, and patients without insurance; and

4. For hospital debts owed by patients of the hospital that the hospital sold to a governmental unit, contractor, or nonprofit organization under subsection (l) of this section:

A. The total dollar amount of the debt sold by the hospital for the reporting year;

B. The total dollar amount paid to the hospital by the unit, contractor, or nonprofit organization who purchased the debt; and

C. The total number of patients whose debt was sold, in full or in part, to the unit, contractor, or nonprofit organization who purchased the debt.

(2) The Commission shall post the information submitted under paragraph (1) of this subsection on its website.

(b) The policy submitted under subsection (a)(1) of this section shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Except as provided in subsection (l) of this section, prohibit the hospital from selling any debt;

(3) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(4) Prohibit the hospital from reporting adverse information to a consumer reporting agency;

(5) Prohibit the hospital from filing a civil action to collect a debt within 240 days after the initial bill is provided;

(6) Prohibit the hospital from filing a civil action to collect a debt against a patient whose outstanding debt is at or below $500;

(7) Describe the hospital's procedures for collecting a debt;

(8) Describe the circumstances in which the hospital will seek a judgment against a patient;

(9) In accordance with subsection (c) of this section, provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care within 240 days after the initial bill was provided;

(10) If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care within 240 days after the initial bill was provided for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacate the judgment or strike the adverse information;

(11) Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced–cost care;

(ii) File with the hospital a complaint against the hospital or a debt collector used by the hospital regarding the handling of the patient's bill; and

(iii) Allow the patient and the hospital to mutually agree to modify the terms of a payment plan offered under subsection (d) of this section or entered into with the patient;

(12) For a patient who is eligible for free or reduced–cost care under the hospital's financial assistance policy, prohibit the hospital from:

(i) Charging interest on the debt owed on a bill for the patient before a court judgment is obtained; or

(ii) Collecting fees or any other amount that exceeds the approved charge for the hospital service as established by the Commission;

(13) Require the hospital to dismiss actions pending against a patient for collection of debt that was sold under subsection (l) of this section;

(14) Prohibit the hospital from:

(i) Engaging in collection activities on 100% of the outstanding amount of the Commission–set charge for debt sold under subsection (l) of this section; and

(ii) Collecting on judgments entered into on patient debt that was sold under subsection (l) of this section; and

(15) Comply with § 24–2502 of this article.

(c) (1) (i) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who was found to be eligible for free care within 240 days after the initial bill is provided to the patient.

(ii) The hospital shall provide the refund to the patient not later than 30 days after determining that the patient was eligible for free care.

(2) If a patient is enrolled in a means–tested government health care plan that requires the patient to pay out–of–pocket for hospital services, a hospital's

refund policy shall provide for a refund that complies with the terms of the patient's plan.

(d) (1) Subject to paragraph (2) of this subsection, a hospital shall provide in writing to each patient who incurs medical debt information about the availability of an installment payment plan for the debt.

(2) A hospital shall provide the information under paragraph (1) of this subsection to the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(i) Before the patient is discharged;

(ii) With the hospital bill;

(iii) On request; and

(iv) In each written communication to the patient regarding collection of hospital debt.

(3) (i) The Commission shall develop guidelines, with input from stakeholders, for an income–based payment plan offered under this subsection that includes:

1. The amount of medical debt owed to the hospital;

2. The duration of the payment plan based on a patient's annual gross income;

3. Guidelines for requiring appropriate documentation of income level;

4. Guidelines for the payment amount that:

A. May not exceed 5% of the patient's federal or State adjusted gross monthly household income that takes into consideration all individuals on the same federal or State tax return; and

B. Shall consider financial hardship, as defined in § 19–214.1(a) of this subtitle;

5. Guidelines for:

A. The determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 240 days after the initial bill is provided; and

B. A prohibition on interest payments for patients who qualify for free or reduced–cost care as required under subsection (b)(12) of this section;

6. Guidelines for modification of a payment plan that does not create a greater financial burden on the patient; and

7. A prohibition on penalties or fees for prepayment or early payment.

(ii) A hospital may not seek legal action against a patient on a debt owed until the hospital has established and implemented a payment plan policy that complies with the guidelines developed under subparagraph (i) of this paragraph.

(4) (i) A patient shall be deemed to be compliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12–month period.

(ii) If a patient misses a scheduled monthly payment, the patient shall contact the health care facility and identify a plan to make up the missed payment within 1 year after the date of the missed payment.

(iii) The health care facility may, but may not be required to, waive any additional missed payments that occur within a 12–month period and allow the patient to continue to participate in the income–based payment plan and not refer the outstanding balance owed to a collection agency or for legal action.

(5) (i) A hospital shall demonstrate that it attempted in good faith to meet the requirements of this subsection and the guidelines developed by the Commission under paragraph (3) of this subsection before the hospital:

1. Files an action to collect a debt owed on a hospital bill by a patient; or

2. Delegates collection activity to a debt collector for a debt owed on a hospital bill by a patient.

(ii) Subparagraph (i) of this paragraph does not prohibit a hospital from using an eligibility vendor to provide outreach to a patient for purposes of assisting the patient in qualifying for financial assistance.

(e) (1) A hospital shall comply with § 24–2502 of this article.

(2) For at least 240 days after the initial patient bill was provided, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment.

(3) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient, including if the debt was sold under subsection (l) of this section.

(4) A hospital may not commence a civil action against a patient for nonpayment, or delegate collection activity to a debt collector:

(i) If the hospital was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days;

(ii) If the hospital is processing a requested reconsideration of the denial of free or reduced–cost care that was appropriately completed by the patient or has completed the reconsideration within the immediately preceding 60 days; or

(iii) If the hospital sold the debt under subsection (l) of this section.

(5) By November 1, 2025, a hospital that had reported adverse information about a patient to a consumer reporting agency shall instruct the consumer reporting agency to delete the adverse information about the patient.

(f) (1) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill.

(2) A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill.

(3) (i) A hospital may not give notice to a patient under subsection (h) of this section until after 240 days after the initial bill was provided.

(ii) If a hospital files an action to collect the debt owed on a hospital bill, the hospital may not request the issuance of or otherwise knowingly take action that would cause a court to issue:

1. A body attachment against a patient; or

2. An arrest warrant against a patient.

(4) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect debt owed on a hospital bill if the patient is eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

(5) (i) A hospital may not make a claim against the estate of a deceased patient to collect a debt owed on a hospital bill if the deceased patient was known by the hospital to be eligible for free care under § 19–214.1 of this subtitle or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed.

(ii) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(6) A hospital may not file an action to collect a debt owed on a hospital bill by a patient until the hospital determines whether the patient is eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

(g) (1) Except as provided in paragraph (2) of this subsection, a spouse or another individual may not be held liable for the debt owed on a hospital bill of an individual who is at least 18 years old.

(2) An individual may voluntarily consent to assume liability for the debt owed on a hospital bill of any other individual if the consent is:

(i) Made on a separate document signed by the individual;

(ii) Not solicited in an emergency room or during an emergency situation; and

(iii) Not required as a condition of providing any emergency or nonemergency health care services.

(h) (1) Subject to paragraph (2) of this subsection, at least 45 days before filing an action against a patient to collect on the debt owed on a hospital bill, a hospital shall send written notice of the intent to file an action to the patient.

(2) The notice required under paragraph (1) of this subsection shall:

(i) Be sent to the patient by certified mail and first–class mail;

(ii) Be in simplified language and in at least 10 point type;

(iii) Include:

1. The name and telephone number of:

A. The hospital;

B. If applicable, the debt collector; and

C. An agent of the hospital authorized to modify the terms of the payment plan, if any;

2. The amount required to cure the nonpayment of debt, including past due payments, interest, penalties, and fees;

3. A statement recommending that the patient seek debt counseling services;

4. Telephone numbers and Internet addresses of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt;

5. An explanation of the hospital's financial assistance policy; and

6. Any other relevant information prescribed by the Commission; and

(iv) Be provided in the patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5% of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census.

(3) The notice required under this subsection shall be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for

financial assistance, and the telephone number to call to confirm receipt of the application;

(ii) The availability of an income–based payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(iii) The information sheet required under § 19–214.1(f) of this subtitle.

(i) A complaint by a hospital in an action to collect a debt owed on a hospital bill by a patient shall:

(1) Include an affidavit stating:

(i) The date on which the 240–day period required under subsection (f)(3) of this section elapsed and the nature of the nonpayment;

(ii) That a notice of intent to file an action under subsection (h) of this section:

1. Was sent to the patient and the date on which the notice was sent; and

2. Accurately reflected the contents required to be included in the notice;

(iii) That the hospital provided:

1. The patient with a copy of the information sheet on the financial assistance policy in accordance with subsection (h)(3)(ii) of this section; and

2. Notice of the financial assistance policy as documented under § 19–214.1(f) of this subtitle;

(iv) That the hospital made a determination regarding whether the patient is eligible for the hospital's financial assistance policy in accordance with § 19–214.1 of this subtitle; and

(v) That the hospital made a good–faith effort to meet the requirements of subsection (d) of this section; and

(2) Be accompanied by:

(i) The original or a certified copy of the hospital bill;

(ii) A statement of the remaining due and payable debt supported by an affidavit of the plaintiff, the hospital, or the agent or attorney of the plaintiff or hospital;

(iii) A copy of the most recent hospital bill sent to the patient;

(iv) If the defendant is eligible for federal Service Members Civil Relief Act benefits, an affidavit that the hospital is in compliance with the Act;

(v) A copy of the notice of intent to file an action on a hospital bill; and

(vi) A copy of the patient's signed certified mail acknowledgment of receipt of the written notice of intent to file an action, if received by the hospital.

(j) If a hospital delegates collection activity to a debt collector, the hospital shall:

(1) Specify the collection activity to be performed by the debt collector through an explicit authorization or contract;

(2) Require the debt collector to abide by the hospital's credit and collection policy;

(3) Specify procedures the debt collector must follow if a patient appears to qualify for financial assistance; and

(4) Require the debt collector to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the debt collector regarding the handling of the patient's bill;

(ii) Forward the complaint to the hospital if a patient files a complaint with the debt collector; and

(iii) Along with the hospital, be jointly and severally responsible for meeting the requirements of this section.

(k) (1) The board of directors of each hospital shall review and approve the hospital's financial assistance policy required under § 19–214.1 of this subtitle and debt collection policy required under this section at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

(l) (1) (i) Subject to paragraph (2) of this subsection, a hospital may sell debt owed to the hospital by a patient for hospital services to a governmental unit or an entity that is under contract with the unit or to a nonprofit organization that is exempt from taxation under § 501(c)(3) of the Internal Revenue Code for the sole purpose of canceling the debt.

(ii) The contract between the hospital and the governmental unit, contractor, or nonprofit organization purchasing the debt under this subsection shall state that the sole purpose of the sale of the debt is to cancel the debt.

(iii) The patient is not responsible to the hospital, the governmental unit, the contractor, or the nonprofit organization for any amount of the debt that is sold under this subsection or any interest, fees, or costs associated with the debt or the sale.

(2) Debt sold under this subsection:

(i) Must be for hospital services provided at least 2 years before the date of the sale;

(ii) May not be expected to yield additional reimbursements from a third–party payor;

(iii) May not be subject to an open appeal with an insurance company; and

(iv) Must be for an individual whose family income is at or below 500% of the federal poverty level or who has medical debt exceeding 5% of the individual's family income, as determined by the governmental unit, contractor, or nonprofit organization purchasing the debt.

(3) Debt sold under this subsection may be sold with a reduction of Commission charges.

(4) The Commission shall treat the amount of payments to hospitals under this subsection as an offset to uncompensated care amounts reported by hospitals.

(5) The purchaser of the debt shall:

(i) Notify the patient that the debt has been canceled; and

(ii) If the hospital obtained a judgment against the patient or reported adverse information to a consumer reporting agency about the patient, seek to vacate the judgment or strike the adverse information.

(m) The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section.

(n) (1) On or before February 1 each year, beginning in 2023, the Commission shall compile the information required under subsection (a) of this section and prepare a medical debt collection report based on the compiled information.

(2) The report required under paragraph (1) of this subsection shall be:

(i) Made available to the public free of charge; and

(ii) Submitted to the Senate Finance Committee and the House Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

§19–214.2. // EFFECTIVE JUNE 30, 2028 PER CHAPTER 750 OF 2025 //

(a) (1) Each hospital annually shall submit to the Commission:

(i) At times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients; and

(ii) A report including:

1. The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital, or a debt collector used by the hospital, filed an action to collect a debt owed on a hospital bill;

2. The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom the hospital has and has not reported or classified a bad debt; and

3. The total dollar amount of the charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out–of–pocket costs for patients covered by insurance, and patients without insurance.

(2) The Commission shall post the information submitted under paragraph (1) of this subsection on its website.

(b) The policy submitted under subsection (a)(1) of this section shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Prohibit the hospital from selling any debt;

(3) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(4) Prohibit the hospital from reporting adverse information to a consumer reporting agency;

(5) Prohibit the hospital from filing a civil action to collect a debt within 240 days after the initial bill is provided;

(6) Prohibit the hospital from filing a civil action to collect a debt against a patient whose outstanding debt is at or below $500;

(7) Describe the hospital's procedures for collecting a debt;

(8) Describe the circumstances in which the hospital will seek a judgment against a patient;

(9) In accordance with subsection (c) of this section, provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care within 240 days after the initial bill was provided;

(10) If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care within 240 days after the initial bill was provided for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacate the judgment or strike the adverse information;

(11) Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced–cost care;

(ii) File with the hospital a complaint against the hospital or a debt collector used by the hospital regarding the handling of the patient's bill; and

(iii) Allow the patient and the hospital to mutually agree to modify the terms of a payment plan offered under subsection (d) of this section or entered into with the patient;

(12) For a patient who is eligible for free or reduced–cost care under the hospital's financial assistance policy, prohibit the hospital from:

(i) Charging interest on the debt owed on a bill for the patient before a court judgment is obtained; or

(ii) Collecting fees or any other amount that exceeds the approved charge for the hospital service as established by the Commission; and

(13) Comply with § 24–2502 of this article.

(c) (1) (i) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who was found to be eligible for free care within 240 days after the initial bill is provided to the patient.

(ii) The hospital shall provide the refund to the patient not later than 30 days after determining that the patient was eligible for free care.

(2) If a patient is enrolled in a means–tested government health care plan that requires the patient to pay out–of–pocket for hospital services, a hospital's refund policy shall provide for a refund that complies with the terms of the patient's plan.

(d) (1) Subject to paragraph (2) of this subsection, a hospital shall provide in writing to each patient who incurs medical debt information about the availability of an installment payment plan for the debt.

(2) A hospital shall provide the information under paragraph (1) of this subsection to the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(i) Before the patient is discharged;

(ii) With the hospital bill;

(iii) On request; and

(iv) In each written communication to the patient regarding collection of hospital debt.

(3) (i) The Commission shall develop guidelines, with input from stakeholders, for an income–based payment plan offered under this subsection that includes:

1. The amount of medical debt owed to the hospital;

2. The duration of the payment plan based on a patient's annual gross income;

3. Guidelines for requiring appropriate documentation of income level;

4. Guidelines for the payment amount that:

A. May not exceed 5% of the patient's federal or State adjusted gross monthly household income that takes into consideration all individuals on the same federal or State tax return; and

B. Shall consider financial hardship, as defined in § 19–214.1(a) of this subtitle;

5. Guidelines for:

A. The determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 240 days after the initial bill is provided; and

B. A prohibition on interest payments for patients who qualify for free or reduced–cost care as required under subsection (b)(12) of this section;

6. Guidelines for modification of a payment plan that does not create a greater financial burden on the patient; and

7. A prohibition on penalties or fees for prepayment or early payment.

(ii) A hospital may not seek legal action against a patient on a debt owed until the hospital has established and implemented a payment plan policy that complies with the guidelines developed under subparagraph (i) of this paragraph.

(4) (i) A patient shall be deemed to be compliant with a payment plan if the patient makes at least 11 scheduled monthly payments within a 12–month period.

(ii) If a patient misses a scheduled monthly payment, the patient shall contact the health care facility and identify a plan to make up the missed payment within 1 year after the date of the missed payment.

(iii) The health care facility may, but may not be required to, waive any additional missed payments that occur within a 12–month period and allow the patient to continue to participate in the income–based payment plan and not refer the outstanding balance owed to a collection agency or for legal action.

(5) (i) A hospital shall demonstrate that it attempted in good faith to meet the requirements of this subsection and the guidelines developed by the Commission under paragraph (3) of this subsection before the hospital:

1. Files an action to collect a debt owed on a hospital bill by a patient; or

2. Delegates collection activity to a debt collector for a debt owed on a hospital bill by a patient.

(ii) Subparagraph (i) of this paragraph does not prohibit a hospital from using an eligibility vendor to provide outreach to a patient for purposes of assisting the patient in qualifying for financial assistance.

(e) (1) A hospital shall comply with § 24–2502 of this article.

(2) For at least 240 days after issuing an initial patient bill, a hospital may not commence civil action against a patient for nonpayment.

(3) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(4) A hospital may not commence a civil action against a patient for nonpayment, or delegate collection activity to a debt collector:

(i) If the hospital was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days; or

(ii) If the hospital has completed a requested reconsideration of the denial of free or reduced–cost care that was appropriately completed by the patient within the immediately preceding 60 days.

(5) By November 1, 2025, a hospital that had reported adverse information about a patient to a consumer reporting agency shall instruct the consumer reporting agency to delete the adverse information about the patient.

(f) (1) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill.

(2) A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill.

(3) (i) A hospital may not give notice to a patient under subsection (h) of this section until after 240 days after the initial bill was provided.

(ii) If a hospital files an action to collect the debt owed on a hospital bill, the hospital may not request the issuance of or otherwise knowingly take action that would cause a court to issue:

1. A body attachment against a patient; or

2. An arrest warrant against a patient.

(4) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect debt owed on a hospital bill if the patient is eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

(5) (i) A hospital may not make a claim against the estate of a deceased patient to collect a debt owed on a hospital bill if the deceased patient was known by the hospital to be eligible for free care under § 19–214.1 of this subtitle or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed.

(ii) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(6) A hospital may not file an action to collect a debt owed on a hospital bill by a patient until the hospital determines whether the patient is eligible for free or reduced–cost care under § 19–214.1 of this subtitle.

(g) (1) Except as provided in paragraph (2) of this subsection, a spouse or another individual may not be held liable for the debt owed on a hospital bill of an individual who is at least 18 years old.

(2) An individual may voluntarily consent to assume liability for the debt owed on a hospital bill of any other individual if the consent is:

(i) Made on a separate document signed by the individual;

(ii) Not solicited in an emergency room or during an emergency situation; and

(iii) Not required as a condition of providing any emergency or nonemergency health care services.

(h) (1) Subject to paragraph (2) of this subsection, at least 45 days before filing an action against a patient to collect on the debt owed on a hospital bill, a hospital shall send written notice of the intent to file an action to the patient.

(2) The notice required under paragraph (1) of this subsection shall:

(i) Be sent to the patient by certified mail and first–class mail;

(ii) Be in simplified language and in at least 10 point type;

(iii) Include:

1. The name and telephone number of:

A. The hospital;

B. If applicable, the debt collector; and

C. An agent of the hospital authorized to modify the terms of the payment plan, if any;

2. The amount required to cure the nonpayment of debt, including past due payments, interest, penalties, and fees;

3. A statement recommending that the patient seek debt counseling services;

4. Telephone numbers and Internet addresses of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt;

5. An explanation of the hospital's financial assistance policy; and

6. Any other relevant information prescribed by the Commission; and

(iv) Be provided in the patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5% of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census.

(3) The notice required under this subsection shall be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance, and the telephone number to call to confirm receipt of the application;

(ii) The availability of an income–based payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(iii) The information sheet required under § 19–214.1(f) of this subtitle.

(i) A complaint by a hospital in an action to collect a debt owed on a hospital bill by a patient shall:

(1) Include an affidavit stating:

(i) The date on which the 240–day period required under subsection (f)(3) of this section elapsed and the nature of the nonpayment;

(ii) That a notice of intent to file an action under subsection (h) of this section:

1. Was sent to the patient and the date on which the notice was sent; and

2. Accurately reflected the contents required to be included in the notice;

(iii) That the hospital provided:

1. The patient with a copy of the information sheet on the financial assistance policy in accordance with subsection (h)(3)(ii) of this section; and

2. Notice of the financial assistance policy as documented under § 19–214.1(f) of this subtitle;

(iv) That the hospital made a determination regarding whether the patient is eligible for the hospital's financial assistance policy in accordance with § 19–214.1 of this subtitle; and

(v) That the hospital made a good–faith effort to meet the requirements of subsection (d) of this section; and

(2) Be accompanied by:

(i) The original or a certified copy of the hospital bill;

(ii) A statement of the remaining due and payable debt supported by an affidavit of the plaintiff, the hospital, or the agent or attorney of the plaintiff or hospital;

(iii) A copy of the most recent hospital bill sent to the patient;

(iv) If the defendant is eligible for federal Service Members Civil Relief Act benefits, an affidavit that the hospital is in compliance with the Act;

(v) A copy of the notice of intent to file an action on a hospital bill; and

(vi) A copy of the patient's signed certified mail acknowledgment of receipt of the written notice of intent to file an action, if received by the hospital.

(j) If a hospital delegates collection activity to a debt collector, the hospital shall:

(1) Specify the collection activity to be performed by the debt collector through an explicit authorization or contract;

(2) Require the debt collector to abide by the hospital's credit and collection policy;

(3) Specify procedures the debt collector must follow if a patient appears to qualify for financial assistance; and

(4) Require the debt collector to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the debt collector regarding the handling of the patient's bill;

(ii) Forward the complaint to the hospital if a patient files a complaint with the debt collector; and

(iii) Along with the hospital, be jointly and severally responsible for meeting the requirements of this section.

(k) (1) The board of directors of each hospital shall review and approve the hospital's financial assistance policy required under § 19–214.1 of this subtitle and debt collection policy required under this section at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

(l) The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section.

(m) (1) On or before February 1 each year, beginning in 2023, the Commission shall compile the information required under subsection (a) of this section and prepare a medical debt collection report based on the compiled information.

(2) The report required under paragraph (1) of this subsection shall be:

(i) Made available to the public free of charge; and

(ii) Submitted to the Senate Finance Committee and the House Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

§19–214.3.

(a) (1) (i) The Commission shall establish a process for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of § 19–214.1 or § 19–214.2 of this subtitle.

(ii) The process established under subparagraph (i) of this paragraph shall:

1. Include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit; and

2. Provide the patient or the patient's authorized representative with the following information:

A. The Health Education and Advocacy Unit is available to assist the patient or the patient's authorized representative in filing and mediating a reconsideration request; and

B. The address, phone number, facsimile number, e–mail address, mailing address, and website of the Health Education and Advocacy Unit.

(2) (i) Subject to subparagraph (ii) of this paragraph, a complaint filed with the Commission is a public record and is subject to reasonable inspection.

(ii) The Commission shall deny inspection of the complainant's name, address, or any other personal identifying information.

(3) The filing of a complaint under this subsection does not prevent an individual from:

(i) Exercising any right or seeking any remedy to which the individual may otherwise be entitled; or

(ii) Filing a complaint with any other agency or a court.

(b) (1) The remedies authorized under this section are in addition to any other statutory, legal, or equitable remedies that may be available and are not intended to be a prerequisite to, or exclusive of, any other remedy.

(2) An individual or a governmental unit is not required to exhaust the administrative remedy authorized under this subtitle before filing suit.

(c) (1) A waiver by any patient or other individual of any protection provided by § 19–214.1, § 19–214.2, or § 19–214.4 of this subtitle or any regulation adopted under this subtitle is null and void as being against the public policy of the State.

(2) Except as prohibited by federal law, a provision in a hospital's financial assistance policy or agreement between the patient and a hospital that waives any substantive or procedural right or remedy related to conduct prohibited by § 19–214.1, § 19–214.2, or § 19–214.4 of this subtitle or any regulation adopted under this subtitle is null and void as being against the public policy of the State.

(d) (1) If a hospital knowingly violates any provision of § 19–214.1 or § 19–214.2 of this subtitle or any regulation adopted under this subtitle, the Commission may impose a fine not to exceed $50,000 per violation.

(2) Before imposing a fine, the Commission shall consider the appropriateness of the fine in relation to the severity of the violation.

(3) A violation by a hospital or an outside collection agency of § 19–214.1 or § 19–214.2 of this subtitle or any regulation adopted under this subtitle is an unfair, abusive, and deceptive trade practice under the Maryland Consumer Protection Act.

§19–214.4. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2025 PER CHAPTER 683 OF 2022 //

(a) The Commission, in coordination with the Department, the Department of Human Services, the Office of the Comptroller, the State Department of Education, the Health Education and Advocacy Unit, and the Maryland Hospital Association, shall develop a process that:

(1) Identifies the patients who paid more than $25 for hospital services who may have qualified for free care under § 19–214.1 of this subtitle on the date the hospital service was provided during calendar years 2017 through 2021;

(2) Provides reimbursement to the patients identified under item (1) of this subsection, which may be applied incrementally;

(3) Ensures that a patient's alternate address is used if the patient requested an alternate address for safety reasons; and

(4) Determines how the Commission, the Department, the Department of Human Services, the Office of the Comptroller, and the State Department of Education should share with or disclose relevant information, including tax information, to the minimum extent necessary, to the hospital and in accordance with federal and State confidentiality laws for the purpose of carrying out the process developed under this subsection.

(b) The Health Education Advocacy Unit in the Office of the Attorney General shall assist patients identified under subsection (a) of this section in obtaining reimbursement under this section.

(c) (1) The process developed under subsection (a) of this section:

(i) Shall require each hospital to consider:

1. Tax data from the Office of the Comptroller as de facto evidence of a patient's income; and

2. Data from the Department, the Department of Human Services, and the State Department of Education as de facto evidence of a patient's presumptive eligibility for free care;

(ii) Shall require each hospital to provide refunds to patients who qualify under subsection (g)(2) of this section; and

(iii) May not require a hospital to provide a patient with a refund if the patient previously was denied free care because of a failed asset test for the identified date of service.

(2) Each hospital shall create a webpage that includes:

(i) Information about the reimbursement provided in accordance with this section, including the process to be followed by a patient and relevant timelines; and

(ii) A telephone number and e–mail address that a patient may use to submit questions about the reimbursement process developed under this section.

(3) If a patient is entitled to a single refund per year under subsection (a) of this section in an amount of $25 or less, the hospital may but is not required to provide the reimbursement.

(d) (1) The Commission may modify the process developed under subsection (a) of this section as necessary.

(2) If reimbursements are provided incrementally and less than 5% of the estimated reimbursements are made each year during the first increment, the Commission is not required to implement additional increments of the process.

(e) The Department, the Department of Human Services, the Office of the Comptroller, the State Department of Education, and each hospital shall report information on the process developed under this section to the Commission, in the time and manner determined by the Commission.

(f) (1) Notwithstanding any other provision of law, the Commission, the Department, the Department of Human Services, the Office of the Comptroller, the State Department of Education, and each hospital shall disclose to:

(i) Each other, to the minimum extent necessary, relevant information, including tax information, necessary for implementation of the process developed under subsection (a) of this section; and

(ii) The Health Education and Advocacy Unit relevant information necessary for the Health Education and Advocacy Unit to assist patients in obtaining reimbursement under subsection (a) of this section, on receipt of the patient's executed authorization for release of medical information form provided by the Health Education and Advocacy Unit or other authorization form required by the Department of Human Services, the Office of the Comptroller, or the State Department of Education.

(2) If the Health Education and Advocacy Unit requests information from the Commission, the Department, the Department of Human Services, the Office of the Comptroller, the State Department of Education, or a hospital to assist a patient in obtaining reimbursement under subsection (a) of this section, the Commission, the Department, the Department of Human Services, the Office of the Comptroller, the State Department of Education, or the hospital shall provide the information to the Health Education and Advocacy Unit within 10 business days after the date of the receipt of the request.

(3) This section may not be construed to make a hospital responsible for the confidentiality of the information in possession of each State entity listed in paragraph (1) of this subsection.

(g) (1) (i) On or before January 1, 2023, and October 1, 2024, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the development and implementation by hospitals of the process required under subsection (a) of this section.

(ii) If the process developed under subsection (a) of this section requires legislation for implementation, the Commission shall include the legislative recommendations in the report required on or before January 1, 2023, under subparagraph (i) of this paragraph.

(iii) If the process established under subsection (a) of this section does not require legislation, each hospital shall implement the process developed under subsection (a) of this section on or before January 1, 2023.

(2) (i) Subject to subparagraph (ii) of this paragraph, each hospital the Commission, the Office of the Comptroller, the Department, the Department of Human Services, and the State Department of Education shall implement Option 3 from the "Free Hospital Care Refund Process" report submitted by the Commission in December 2022 as required under paragraph (1)(i) of this subsection and in accordance with this section and § 13–203(c) of the Tax – General Article.

(ii) Under the process required under subparagraph (i) of this paragraph, a patient shall qualify for refunds who paid an out–of–pocket expense for services based on the following:

1. The Office of the Comptroller determining that the patient's family income was at or below 200% of the federal poverty level during the year of service date or dates; or

2. The Department of Human Services, the Department, or the State Department of Education determining that during the year of service date or dates, the patient:

A. Received benefits through the federal Supplemental Nutrition Assistance Program;

B. Received benefits through the State's Energy Assistance Program;

C. Received benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or

D. Lived in a household with children enrolled in the free and reduced–cost meal program.

(3) The Office of the Comptroller, the Department of Human Services, the Department, the State Department of Education, the Commission, and each hospital may not implement the alternative approach included with Option 3 in the report identified under paragraph (2)(i) of this subsection.

(h) (1) Each hospital shall reimburse the Commission, the Office of the Comptroller, the Department, the Department of Human Services, the State Department of Education, and the Health Education Advocacy Unit in the Office of the Attorney General for the costs incurred by each State entity in complying with this section.

(2) (i) Reimbursement required under paragraph (1) of this subsection shall be based on the hospital's proportion of the total number of patients who were identified by the State entity as potentially eligible for reimbursement in a designated year, as determined by the Commission.

(ii) For the purpose of determining the reimbursement due under subparagraph (i) of this paragraph, the State entities identified under paragraph (1) of this subsection shall provide quarterly cost information to the Commission.

(3) The Commission shall provide each hospital with the reimbursement amount due to the appropriate State entity based on the costs incurred by the entity in complying with this section.

(i) (1) (i) If a hospital fails to provide refunds to patients who qualify under subsection (g)(2) of this section as required, the Commission may impose a fine not exceeding $50,000 per violation.

(ii) In determining the amount of a fine to be imposed under subparagraph (i) of this paragraph, the Commission shall consider the appropriateness of the fine in relation to the severity of the violation.

(2) A violation of this section by a hospital is:

(i) An unfair, abusive, or deceptive trade practice, as defined under Title 13 of the Commercial Law Article; and

(ii) Subject to enforcement and penalty provisions of Title 13 of the Commercial Law Article.

§19–215.

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

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

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

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

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

§19–216.

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

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

(2) A statement of income and expenses;

(3) The most recent Form 990 that the facility filed with the Internal Revenue Service; and

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

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

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

(ii) Conform to the uniform accounting and financial reporting system adopted under this subtitle; and

(iii) Be certified by the facility's certified public accountant.

(2) If the Commission requires, responsible officials of a facility also shall attest that, to the best of their knowledge and belief, the report has been prepared in conformity with the uniform accounting and financial reporting system adopted under § 19–211 of this subtitle.

§19–217.

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

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

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

(3) Result in more than 50% of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

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

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

§19–218.

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

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

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

(3) Includes the effect of any proposal made, under Subtitle 1 of this title, on comprehensive health planning; and

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

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

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

(2) The Medical and Chirurgical Faculty of the State of Maryland;

(3) The State Board of Physicians;

(4) The Office of Health Care Quality in the Department;

(5) The Maryland Health Care Commission; or

(6) An investigatory body under the State or federal government.

§19–219. ** CONTINGENCY – IN EFFECT – CHAPTERS 244 AND 245 OF 2008 **

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

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

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

(3) Except as provided in § 19–214.2(l) of this subtitle, the rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

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

(2) A facility shall:

(i) Charge for services only at a rate set in accordance with this subtitle; and

(ii) Comply with the applicable terms and conditions of the all–payer model contract.

(3) Consistent with the all–payer model contract, in determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(c) Consistent with the all–payer model contract, and notwithstanding any other provision of this subtitle, the Commission may:

(1) Establish hospital rate levels and rate increases in the aggregate or on a hospital–specific basis;

(2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all–payer model contract; and

(3) On request of the Secretary, assist in the implementation of federally approved model programs.

§19–219. ** CONTINGENCY – NOT IN EFFECT – CHAPTERS 244 AND 245 OF 2008 **

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

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

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

(3) Except as provided in § 19–214.2(l) of this subtitle, the rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

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

(2) A facility shall:

(i) Charge for services only at a rate set in accordance with this subtitle; and

(ii) Comply with the applicable terms and conditions of the all–payer model contract.

(3) Consistent with the all–payer model contract, in determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(c) Consistent with the all–payer model contract, and notwithstanding any other provision of this subtitle, the Commission may:

(1) Establish hospital rate levels and rate increases in the aggregate or on a hospital–specific basis;

(2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all–payer model contract; and

(3) On request of the Secretary, assist in the implementation of federally approved model programs.

(d) (1) In this subsection, "base hospital rate" means the aggregate value to participating commercial health insurance carriers of the substantial, available, and affordable coverage purchaser differential as determined by the Commission for the calendar year 2002.

(2) The Commission, in accordance with this subsection, shall calculate the amount of funds necessary to operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.

(3) (i) The Commission shall determine the percentage of total net patient revenue received in calendar year 2002 by all hospitals for which the Commission approved hospital rates that is represented by the base hospital rate.

(ii) The percentage under subparagraph (i) of this paragraph shall be determined by dividing the base hospital rate by the total net patient revenue received in calendar year 2002 by all hospitals for which the Commission approved hospital rates.

(4) On or before May 1 of each year, the Commission shall:

(i) Determine the amount of funding to allocate to the Maryland Health Insurance Plan by multiplying the percentage determined under paragraph (3) of this subsection by the value of the total net patient revenues received in the immediately preceding State fiscal year by all hospitals for which rates were approved by the Commission; and

(ii) Determine the share of total funding owed by each hospital for which rates have been approved by the Commission proportionate to the percentage of the base hospital rate attributable to each hospital.

(5) Each hospital shall remit monthly one–twelfth of the amount determined under paragraph (4)(ii) of this subsection to the Maryland Health Insurance Plan Fund.

(e) (1) The Commission shall adjust hospital rates to ensure that the assessment collected under subsection (d) of this section is revenue neutral to each hospital.

(2) The Commission may not consider the assessment required under subsection (d) of this section in determining:

(i) The reasonableness of rates under this section; or

(ii) Hospital financial performance.

§19–219. ** CONTINGENCY – IN EFFECT – CHAPTERS 244 AND 245 OF 2008 **

// EFFECTIVE UNTIL JUNE 30, 2028 PER CHAPTER 750 OF 2028 //

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

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

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

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

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

(2) A facility shall:

(i) Charge for services only at a rate set in accordance with this subtitle; and

(ii) Comply with the applicable terms and conditions of the all–payer model contract.

(3) Consistent with the all–payer model contract, in determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(c) Consistent with the all–payer model contract, and notwithstanding any other provision of this subtitle, the Commission may:

(1) Establish hospital rate levels and rate increases in the aggregate or on a hospital–specific basis;

(2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all–payer model contract; and

(3) On request of the Secretary, assist in the implementation of federally approved model programs.

§19–219. // EFFECTIVE JULY 1, 2028 PER CHAPTER 750 OF 2025 //

** CONTINGENCY – NOT IN EFFECT – CHAPTERS 244 AND 245 OF 2008 **

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

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

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

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

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

(2) A facility shall:

(i) Charge for services only at a rate set in accordance with this subtitle; and

(ii) Comply with the applicable terms and conditions of the all–payer model contract.

(3) Consistent with the all–payer model contract, in determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(c) Consistent with the all–payer model contract, and notwithstanding any other provision of this subtitle, the Commission may:

(1) Establish hospital rate levels and rate increases in the aggregate or on a hospital–specific basis;

(2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all–payer model contract; and

(3) On request of the Secretary, assist in the implementation of federally approved model programs.

(d) (1) In this subsection, "base hospital rate" means the aggregate value to participating commercial health insurance carriers of the substantial, available,

and affordable coverage purchaser differential as determined by the Commission for the calendar year 2002.

(2) The Commission, in accordance with this subsection, shall calculate the amount of funds necessary to operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.

(3) (i) The Commission shall determine the percentage of total net patient revenue received in calendar year 2002 by all hospitals for which the Commission approved hospital rates that is represented by the base hospital rate.

(ii) The percentage under subparagraph (i) of this paragraph shall be determined by dividing the base hospital rate by the total net patient revenue received in calendar year 2002 by all hospitals for which the Commission approved hospital rates.

(4) On or before May 1 of each year, the Commission shall:

(i) Determine the amount of funding to allocate to the Maryland Health Insurance Plan by multiplying the percentage determined under paragraph (3) of this subsection by the value of the total net patient revenues received in the immediately preceding State fiscal year by all hospitals for which rates were approved by the Commission; and

(ii) Determine the share of total funding owed by each hospital for which rates have been approved by the Commission proportionate to the percentage of the base hospital rate attributable to each hospital.

(5) Each hospital shall remit monthly one–twelfth of the amount determined under paragraph (4)(ii) of this subsection to the Maryland Health Insurance Plan Fund.

(e) (1) The Commission shall adjust hospital rates to ensure that the assessment collected under subsection (d) of this section is revenue neutral to each hospital.

(2) The Commission may not consider the assessment required under subsection (d) of this section in determining:

(i) The reasonableness of rates under this section; or

(ii) Hospital financial performance.

§19–220.

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

(2) The information shall include:

(i) Necessary operating expenses;

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

(iii) Incurred interest charges; and

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

(b) The Commission shall define, by regulation, the types and classes of charges that may not be changed, except as specified in § 19-222 of this subtitle.

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

(d) Consistent with the all–payer model contract approved by the federal Center for Medicare and Medicaid Innovation, the Commission shall:

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

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

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

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

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

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

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

§19–221.

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

§19–222.

(a) (1) A facility may not change any rate schedule or charge of any type or class defined under § 19-220(b) of this subtitle, unless the facility files with the Commission a written notice of the proposed change that is supported by any information that the facility considers appropriate.

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

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

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

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

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

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

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

(5) The Commission:

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

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

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

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

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

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

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

(2) Accept any benefits under that decision.

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

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

(i) Funds received because of the change; and

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

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

(i) To refund the funds with interest; or

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

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

(g) (1) The State Health Services Cost Review Commission shall provide incentives for merger, consolidation, and conversion and for the implementation of the institution–specific plan developed in accordance with § 19–119 of this title.

(2) Notwithstanding any of the provisions in this section, on notification of a merger or consolidation by 2 or more hospitals, the Commission shall review the rates of those hospitals that are directly involved in the merger or consolidation in accordance with the rate review and approval procedures provided in § 19–220 of this subtitle and the regulations of the Commission.

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

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

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

(iii) Any other closure costs as defined in § 10–340 of the Economic Development Article; or

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

§19–223.

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

(1) To the extent provided for in Title 10, Subtitle 3, Part IV of the Economic Development Article, the amounts required by § 10–350 of the Economic Development Article with respect to public obligations or closure costs of a closed or delicensed hospital; and

(2) Funding the Hospital Employees Retraining Fund.

§19–224.

(a) This section applies to each person that is concurrently:

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

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

(i) A partnership;

(ii) A firm;

(iii) A corporation; or

(iv) Any other business entity.

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

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

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

(c) A report under this section shall be:

(1) Signed and verified; and

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

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

§19–225.

(a) In any matter that relates to a facility's cost of services and consistent with the all–payer model contract, the Commission may:

(1) Hold a public hearing;

(2) Conduct an investigation;

(3) Require the filing of any information; or

(4) Subpoena any witness or evidence.

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

§19–226.

(a) If the Commission considers a further investigation necessary or desirable to authenticate information in a report that a facility files under this subtitle, consistent with the all–payer model contract, the Commission may make any necessary further examination of the records or accounts of the facility, in accordance with the rules or regulations of the Commission.

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

(1) Provided by the facility; or

(2) Performed by:

(i) The staff of the Commission;

(ii) A third party for the Commission; or

(iii) The Legislative Auditor.

§19–227.

(a) (1) Any person aggrieved by a final decision of the Commission under this subtitle may take a direct judicial appeal.

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

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

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

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

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

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

§19–301.

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

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

(c) "Accredited residential treatment center" means a residential treatment center that is accredited by:

(1) The Joint Commission on Accreditation of Healthcare Organizations;

(2) The Commission on Accreditation of Rehabilitation Facilities; or

(3) The Council on Accreditation.

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

(1) 2 or more rooms;

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

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

(4) At least the following facilities for cooking:

(i) Storage space for food and utensils;

(ii) A refrigerator;

(iii) A cook top; and

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

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

(2) "Domiciliary care" includes:

(i) Shelter;

(ii) Housekeeping services;

(iii) Board;

(iv) Facilities and resources for daily living; and

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

(f) "Hospital" means an institution that:

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

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

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

(g) "License" means a license issued by the Secretary:

(1) To operate a hospital in this State;

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

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

(h) "Limited service hospital" means a health care facility that:

(1) Is licensed as a hospital on or after January 1, 1999;

(2) Changes the type or scope of health care services offered by eliminating the facility's capability to admit or retain patients for overnight hospitalization;

(3) Retains an emergency or urgent care center; and

(4) Complies with the regulations adopted by the Secretary under § 19-307.1 of this subtitle.

(i) "Nonaccredited hospital" means a hospital not accredited by the Joint Commission on Accreditation of Healthcare Organizations.

(j) "Nonaccredited residential treatment center" means a residential treatment center that is not accredited by:

(1) The Joint Commission on Accreditation of Healthcare Organizations;

(2) The Commission on Accreditation of Rehabilitation Facilities; or

(3) The Council on Accreditation.

(k) "Nursing care" means service for a patient that is:

(1) Ordered by a physician; and

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

(l) "Nursing facility" means a related institution that provides nursing care for 2 or more unrelated individuals.

(m) "Person" includes this State or a county or municipal corporation.

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

(2) "Personal care" includes:

(i) Help in walking;

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

(iii) Help in bathing;

(iv) Help in dressing;

(v) Help in feeding; and

(vi) General supervision and help in daily living.

(o) (1) "Related institution" means an organized institution, environment, or home that:

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

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

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

(p) "Residential treatment center" means a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting.

(q) "Unrelated individual" means anyone who is not:

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

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

§19–302.

(a) This subtitle does not apply to a dispensary or first aid treatment facility that is maintained only to provide services for:

(1) Employees of a commercial or industrial plant;

(2) Employees or students of an educational institution; or

(3) Individuals in a convent, county home, motel, hotel, apartment, or facility, if the individuals are able to live independently.

(b) This subtitle applies to the provision of home health care services by a hospital or related institution to 2 or more unrelated individuals, whether the services are provided directly or under contract with a home health agency.

§19–303.

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

(2) "Commission" means the Health Services Cost Review Commission.

(3) (i) "Community benefit" means a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.

(ii) "Community benefit" may include:

1. A community health service;

2. Health professional education;

3. Research;

4. A financial contribution;

5. A community–building activity, including partnerships with community–based organizations;

6. Charity care;

7. An activity described under subparagraph (i) of this paragraph that is funded by a foundation;

8. A mission–driven health service;

9. An operation related to an activity described under subparagraph (i) of this paragraph;

10. Financial or in–kind support of the Maryland Behavioral Health Crisis Response System; and

11. A community health worker workforce program established in accordance with § 19–303.1 of this subtitle.

(4) "Community Benefit Reporting Workgroup" means the Community Benefit Reporting Workgroup established in accordance with subsection (b) of this section.

(5) "Community health needs assessment" means the process required by the Affordable Care Act by which unmet community health care needs and priorities are identified by a nonprofit hospital in accordance with § 501(r)(3) of the Internal Revenue Code.

(b) (1) The Commission shall establish a Community Benefit Reporting Workgroup.

(2) The Community Benefit Reporting Workgroup shall be composed of individuals and stakeholder groups that have knowledge of and are impacted by hospital community benefit spending.

(c) The Commission shall adopt regulations to implement the recommendations of the Community Benefit Reporting Workgroup, that:

(1) Establish a standard format for reporting the information required under this subsection;

(2) Specify the date by which each nonprofit hospital is required to submit the annual community benefit report;

(3) Require each nonprofit hospital to solicit and take into account input received from individuals who represent the broad interests of that community, including individuals with special knowledge of or expertise in public and behavioral health in accordance with § 501(r)(3) of the Internal Revenue Code;

(4) Require each nonprofit hospital to conduct its community health needs assessment in consultation with community members as recommended by the Community Benefit Reporting Workgroup and to submit an annual community benefits report to the Commission detailing the community benefits provided by the hospital during the preceding year that includes:

(i) The mission statement of the hospital;

(ii) A list of the activities that were undertaken by the hospital to address the identified community health needs within the hospital's community;

(iii) The cost to the hospital of each community benefit activity;

(iv) A description of how each of the listed activities addresses the community health needs of the hospital's community;

(v) A description of efforts taken to evaluate the effectiveness of each community benefit activity;

(vi) A description of gaps in the availability of providers to serve the community;

(vii) A description of the hospital's efforts to track and reduce health disparities in the community that the hospital serves;

(viii) A list of the unmet community health needs identified in the most recent community health needs assessment; and

(ix) A list of tax exemptions the hospital claimed during the immediately preceding taxable year, in accordance with State law.

(d) The Commission shall establish a method through which State and local governing bodies are made aware of the meetings of the Community Benefit Reporting Workgroup.

§19–303.1.

(a) In this section, "community health worker" has the meaning stated in § 13–3701 of this article.

(b) (1) A community benefit under § 19–303 of this subtitle may include a partnership between a nonprofit hospital and a community–based organization to establish a community health worker workforce program.

(2) The primary purpose of a community health worker workforce program shall be to provide services to patients of a nonprofit hospital that are intended to improve health outcomes and address social determinants of health.

(c) (1) A partnership established under this section may be executed through a memorandum of understanding between a nonprofit hospital and a community–based organization.

(2) The memorandum of understanding shall include:

(i) The program design;

(ii) Goals for patient health outcomes;

(iii) Implementation procedures;

(iv) Criteria for evaluation and impact measurement;

(v) Data collection, management, and reporting standards and protocols that are in accordance with applicable federal and State laws and regulations, including the federal Health Insurance Portability and Accountability Act; and

(vi) An agreement between the nonprofit hospital and the community–based organization identifying which party will be responsible for:

1. Recruiting and employing the community health worker workforce;

2. Supervising the workforce in the settings in which the community health workers will provide services to patients;

3. Training the workforce; and

4. Providing employer–sponsored health insurance coverage to each community health worker.

(d) A partnership established under this section may provide health insurance coverage to each community health worker for the duration of the program if the individual does not have health insurance coverage and requests coverage.

(e) A nonprofit hospital and a community–based organization may collaborate to identify financial resources to address costs associated with increasing administrative capacity within the community–based organization necessary to participate in the partnership.

(f) Subject to other provisions of law governing community benefits and on the agreement of the parties, a nonprofit hospital may provide financial support to a community–based organization to cover the costs associated with increasing administrative capacity within the community–based organization necessary to participate in the partnership.

§19–304.

(a) A hospital or related institution shall:

(1) Report an unexpected occurrence related to an individual's medical treatment that results in death or serious disability that is not related to the natural course of the individual's illness or underlying disease condition; and

(2) Submit the report to the Department within 5 days of the hospital's or related institution's knowledge of the occurrence.

(b) A hospital or related institution may report to the Department an unexpected occurrence or other incident related to an individual's medical treatment that does not result in death or serious disability.

(c) A hospital or related institution shall:

(1) Conduct a root cause analysis of an occurrence required to be reported under subsection (a) of this section; and

(2) Unless the Department approves a longer time period, submit the root cause analysis to the Department within 60 days of the hospital's or related institution's knowledge of the occurrence.

(d) If a hospital or related institution fails to comply with subsection (a) or (c) of this section, the Secretary may impose a fine of $500 per day for each day the violation continues.

(e) The Secretary shall adopt regulations to implement this section.

§19–305.

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

(2) "Adverse event" means an unexpected occurrence that:

(i) Is related to a resident's medical or behavioral treatment; and

(ii) Is not related to the natural course of the resident's illness or underlying disease condition.

(3) "Change in condition" means a significant change in a resident's physical, mental, or psychological status including:

(i) Life-threatening conditions;

(ii) Clinical complications including significant somatic symptoms that require the assessment of or treatment by qualified medical personnel;

(iii) The need to discontinue a medication or treatment because of:

1. Adverse consequences; or

2. The need to begin a new form of treatment;

(iv) Evaluation at or admission to a hospital;

(v) Injuries that require the assessment of or treatment by qualified medical personnel;

(vi) The use of restraint or seclusion; and

(vii) Suicide attempts.

(b) (1) Within 24 hours, in accordance with State and federal confidentiality laws, a residential treatment center shall attempt to notify a resident and a resident's representative, family member, legal guardian, or custodian of:

(i) A change in condition;

(ii) An adverse event; and

(iii) Corrective action, if appropriate.

(2) If a residential treatment center sends a notice to an individual under paragraph (1) of this subsection, the individual may send a written response to the residential treatment center instructing the residential treatment center that:

(i) The individual waives the notification required under paragraph (1) of this subsection; or

(ii) The individual requires notification only in the circumstances specified in writing by the individual.

(c) A residential treatment center shall document the notification required under subsection (b)(1) of this section and the response of the resident and the resident's representative, family member, legal guardian, or custodian in the resident's medical record.

(d) If the Department determines that a residential treatment center failed to notify a resident and a resident's representative, family member, legal guardian, or custodian under subsection (b)(1) of this section, the Department shall require the residential treatment center, as part of a plan of correction, to notify the resident and the resident's representative, family member, legal guardian, or custodian as soon as possible.

§19–306.

A hospital shall:

(1) Adopt a policy describing the protocol of the hospital when there is an immigration enforcement action at the hospital consistent with the guidance of the Attorney General issued under § 6–111 of the State Government Article;

(2) Make the hospital's immigration enforcement action policy available to all hospital staff members; and

(3) Provide annual training to all hospital staff members to ensure the staff's knowledge and understanding of the immigration enforcement action policy.

§19–307.

(a) (1) A hospital shall be classified:

(i) As a general hospital if the hospital at least has the facilities and provides the services that are necessary for the general medical and surgical care of patients;

(ii) As a special hospital if the hospital:

1. Defines a program of specialized services, such as obstetrics, mental health, tuberculosis, orthopedy, chronic disease, or communicable disease;

2. Admits only patients with medical or surgical needs within the program; and

3. Has the facilities for and provides those specialized services;

(iii) As a special rehabilitation hospital if the hospital meets the requirements of this subtitle and Subtitle 12 of this title; or

(iv) As a limited service hospital if the health care facility:

1. Is licensed as a hospital on or after January 1, 1999;

2. Changes the type or scope of services offered by eliminating the capability to admit or retain individuals for overnight hospitalization;

3. Retains an emergency or urgent care center; and

4. Complies with the regulations adopted by the Secretary under § 19-307.1 of this subtitle.

(2) The Secretary may set, by rule or regulation, other reasonable classifications for hospitals.

(b) A related institution shall be classified:

(1) As a care home if the related institution provides care to individuals who, because of advanced age or physical or mental disability, require domiciliary care or personal care in a protective environment; or

(2) As a nursing home if the related institution:

(i) Provides nursing care for chronically ill or convalescent patients; or

(ii) Offers to provide 24-hour a day nursing care of patients in a home-type facility such as:

1. A convalescent home;

2. A nursing unit of a home for the aged;

3. A psychiatric nursing home;

4. A nursing facility for individuals with disabilities;

5. A home for alcoholics; or

6. A halfway house.

§19–307.1.

The Department shall adopt regulations for a limited service hospital that include the following standards:

(1) The limited service hospital shall be open 24 hours a day, 7 days a week;

(2) There shall be at least one physician credentialed in emergency medicine at the limited service hospital at all times;

(3) A sufficient number of registered nurses and other health professionals shall be available at the limited service hospital to provide advanced life support;

(4) Basic X–ray and laboratory facilities shall be available at the limited service hospital and operable at all times by one radiology technician and one laboratory technician;

(5) Resuscitation equipment, including monitor, defibrillator, cardiac medications, intubation equipment, and intravenous line equipment shall be available at the limited service hospital and operable at all times;

(6) Standard procedures in accordance with the State Emergency Medical Services Plan shall exist for the immediate transport of individuals in need of hospitalization or other more definitive care;

(7) A specific defined role in the Emergency Medical Services System with appropriate telephone communication shall exist;

(8) Emergency services shall be available to all persons regardless of ability to pay;

(9) Adoption, implementation, and enforcement of a policy shall exist that requires, except in an emergency life–threatening situation where it is not feasible or practicable, compliance by all employees and medical staff involved in patient care services with the Centers for Disease Control and Prevention's guidelines on universal precautions; and

(10) Any other standard that the Secretary deems necessary to ensure the quality of the services provided by a limited service hospital.

§19–307.2.

(a) For a hospital classified as a general hospital, the Secretary shall annually calculate the hospital's licensed bed capacity.

(b) The annual licensed bed calculation for each hospital shall equal 140 percent of the average daily census for the 12-month period immediately preceding the calculation.

(c) If necessary to adequately meet demand for services, a hospital may exceed its licensed bed capacity if:

(1) On average for the 12-month period, the hospital does not exceed its licensed bed capacity based on the annual calculation; and

(2) The hospital includes in its monthly report to the Health Services Cost Review Commission the following information:

(i) The number of days in the month the hospital exceeded its licensed bed capacity; and

(ii) The number of beds that were in excess on each of those days.

(d) Before July 1, 2000 and each July 1 thereafter, the Secretary shall delicense any licensed hospital beds determined to be excess bed capacity under subsection (b) of this section.

§19–308.

(a) The Secretary shall adopt reasonable rules and regulations that set standards of services for related institutions, accredited hospitals, nonaccredited hospitals, accredited residential treatment centers, and nonaccredited residential treatment centers in the following areas:

(1) The care of patients;

(2) The medical supervision of patients;

(3) The physical environment;

(4) Disease control;

(5) Sanitation;

(6) Safety; and

(7) Dietary matters.

(b) (1) To assure compliance with the standards adopted under this subtitle, the Secretary shall have an inspection made:

(i) Of each related institution, each accredited hospital or nonaccredited hospital, and each accredited residential treatment center or nonaccredited residential treatment center for which a license is sought; and

(ii) Periodically of each related institution, each accredited hospital or nonaccredited hospital, and each accredited residential treatment center or nonaccredited residential treatment center for which a license has been issued.

(2) At least 2 inspections a year of each related institution shall be unannounced.

(3) The part of a building that contains part of a hospital, residential treatment center, or related institution and any outbuilding are considered part of the facility and are subject to inspection to determine occupancy status for licensing purposes.

(4) Subject to § 2–1257 of the State Government Article, during each regular session of the General Assembly, the Department shall submit to the General Assembly a report on the inspections.

(5) (i) An employee of the Department may not inform a hospital, residential treatment center, or related institution of any proposed inspection activity, unless the chief of the employee's division directs the employee to do so.

(ii) An employee who violates any provision of this paragraph is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

§19–308.1.

(a) (1) In this section, "patient care personnel" means an individual whom a related institution employs to provide health related or personal care services.

(2) "Patient care personnel" does not include an individual who provides general administrative, nonmedical supervisory, or record keeping services in a related institution.

(b) The Secretary may adopt reasonable rules and regulations that set minimum qualifications for patient care personnel who are not licensed under the Health Occupations Article.

§19–308.2.

(a) (1) Subsection (b)(1) of this section is not intended to preempt the requirements of § 10-625 of this article.

(2) The Department shall adopt guidelines, after consultation with the Maryland Hospital Association, Inc., governing the transfer of patients between hospitals to ensure that transfers of patients between hospitals are accomplished in a medically appropriate manner and in accordance with the health care policies of the State that, at a minimum, require:

(i) Notification to the receiving hospital before the transfer and confirmation by that hospital that the patient meets that hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;

(ii) The use of medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer;

(iii) The provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer; and

(iv) The transfer of all necessary records for continuing the care for the patient.

(b) (1) The Department shall adopt regulations providing for penalties for hospitals that violate provisions of subsection (a) of this section.

(2) A penalty not exceeding $1,000 may be imposed per violation.

§19–308.3.

(a) In this section "facility" means a related institution that, under the regulations of the Department, is a comprehensive care facility or an extended care facility.

(b) Before a facility may use an application or contract for admission the administrator of the facility shall submit the application or contract for admission to the Department.

(c) Before a facility may make any substantive change in an application or contract for admission that has been submitted under subsection (b) of this section, the administrator of the facility shall submit the proposed change to the Department.

(d) The Department, after consulting with the Department of Aging, shall review the applications and contracts to assure:

(1) That the rights, responsibilities, and duties of the parties are set forth clearly and legibly;

(2) That they comply with applicable federal and State laws, including the patient's bill of rights; and

(3) That they do not contain provisions which are unenforceable because of public policy.

(e) (1) Any application or contract for admission submitted by a facility to the Department for review and approval in accordance with the provisions of this section shall be deemed approved if the Department fails to make a decision on the proposed application or contract for admission within 30 days of its submission.

(2) Any substantive change in an application or contract for admission submitted by a facility to the Department for review and approval in accordance with the provisions of this section shall be deemed approved if the Department fails to make a decision on the proposed substantive change within 15 days of its submission.

(3) Any decision disapproving any provision of any application or contract shall clearly and with particularity state the grounds for such disapproval.

(f) The Department shall adopt regulations to implement the provisions of this section.

§19–308.4.

(a) Each hospital or nursing facility in the State shall ensure that its employees and any other individuals who provide a health care service within or on the premises of the hospital or nursing facility wear a personal identification tag, except where inappropriate for medical reasons, that indicates in readable text:

(1) The first name, nickname, last name, or full name of the individual that is commonly used in the hospital or nursing facility; and

(2) The professional or other title of the individual.

(b) The Secretary may impose a fine not to exceed $25 per violation of this section.

§19–308.5.

(a) Each hospital that provides obstetrical services shall establish a universal newborn hearing screening program to ensure that:

(1) (i) All newborns born in the hospital are screened for hearing loss before discharge; and

(ii) The results are reported as required under § 13–605 of this article; and

(2) Before discharge and to the extent practicable, the hospital provides to the parent or legal guardian of a newborn identified as having a hearing loss under item (1)(i) of this subsection a list of resources available for parents of children with hearing loss, including:

(i) Locations for subsequent testing; and

(ii) Resources on language and communication mode options for communicating with their child.

(b) The universal newborn hearing screening program established under this section shall consist of at least one of the following screening tests:

(1) Auditory brain stem response;

(2) Otoacoustic emissions; or

(3) Another appropriate screening test recommended by the Advisory Council and approved by the Secretary.

§19–308.6.

(a) The Secretary, in consultation with the Association of Maryland Hospitals and Health Systems and the Maryland Association of Hospital Security and Safety Directors, shall develop a uniform set of emergency security codes for hospitals.

(b) The Secretary shall adopt regulations to implement the uniform set of emergency security codes.

(c) Each hospital in Maryland shall implement the provisions of the uniform set of emergency security codes for hospitals within 2 years of the adoption of the regulations by the Secretary.

§19–308.7.

(a) Unless it is medically inadvisable, each hospital shall allow a pregnant patient to arrange for the donation of the blood extracted from the umbilical cord of the patient's newborn child to a certified public cord blood bank.

(b) A patient who agrees to donate cord blood to a public cord blood bank may not be charged for the costs of collecting, storing, or transporting the cord blood.

(c) A hospital is not required to collect cord blood if in the professional judgment of a licensed physician the collection of the cord blood would threaten the health of the mother or newborn child.

(d) A hospital or hospital employee, including a physician, nurse, or other medical staff, may not be required to collect cord blood if the collection of cord blood conflicts with the bona fide religious practices and beliefs of the hospital or hospital employee.

(e) This section may not be construed to require a hospital to arrange for the donation of blood extracted from umbilical cords.

(f) (1) The Department, in consultation with obstetricians, the Maryland Hospital Association, and interested groups, shall develop educational materials concerning the values, uses, and donation of umbilical cord blood for the purposes of paragraph (2) of this subsection.

(2) Each obstetrician and hospital that provides obstetrical services shall distribute the educational materials described in paragraph (1) of this subsection to pregnant patients.

§19–308.8.

(a) A hospital may discharge a patient:

(1) Entirely;

(2) To another level of care, treatment, or services;

(3) To different health professionals; or

(4) To settings for continued services.

(b) A hospital's process for transfer or discharge shall be based on a patient's assessed needs.

(c) To facilitate discharge or transfer, the hospital shall:

(1) Assess a patient's needs;

(2) Plan for discharge or transfer;

(3) Facilitate the discharge or transfer process;

(4) Give the patient or person responsible for providing continuing care to the patient written discharge instructions in a form the patient can understand; and

(5) Help to ensure that continuity of care, treatment, and services is maintained.

(d) If a hospital fails to comply with the requirements of this section, the Secretary may impose a civil money penalty not to exceed $10,000 for each failure to comply.

(e) A hospital may appeal a civil money penalty imposed under subsection (c) of this section in accordance with Title 10, Subtitle 2 of the State Government Article.

§19–308.9.

(a) Except as provided in subsection (c) of this section, if an individual is treated at a hospital and the hospital conducts a urine drug screening to assist in diagnosing the individual's condition, the hospital shall include testing for fentanyl in the individual's urine drug screening.

(b) If the urine drug screening conducted in accordance with subsection (a) of this section detects fentanyl, the hospital shall report the test results, which shall be deidentified, to the Department through the State–designated health information exchange.

(c) This section does not apply to a hospital that does not have chemical analyzer equipment.

(d) This section does not affect any State law providing civil or criminal immunity to an individual who is in need of medical assistance after ingesting or using alcohol or drugs, or to an individual who in good faith assists another individual who is in need of medical assistance after ingesting or using alcohol or drugs.

§19–308.10.

(a) In this section, "safe sleep environment" means, as described in the most recent American Academy of Pediatrics policy statements, an environment in which a newborn may sleep that reduces the risk of sleep–related infant deaths, including through:

(1) The use of supine positioning;

(2) The use of a firm, flat sleep surface;

(3) The use of room sharing without bed sharing;

(4) The avoidance of soft bedding and overheating; and

(5) The avoidance of exposure to smoke.

(b) (1) As soon as practicable before a hospital discharges an infant after the birth of the infant, the hospital shall provide oral and written educational resources to the parent or legal guardian on how to provide a safe sleep environment.

(2) The oral and written educational resources required under paragraph (1) of this subsection may be supplemented by an educational video.

(c) (1) As soon as practicable before discharging an infant after the birth of the infant, a hospital shall:

(i) Ask the infant's parent or legal guardian to describe the sleep environment that the parent or legal guardian will provide at home;

(ii) Inform the parent or legal guardian of the importance of ensuring that the infant has a safe sleep environment and the risks of suffocation and sudden infant death in unsafe sleep environments; and

(iii) Document that the educational resources described under subsection (b) of this section and the information described under item (ii) of this paragraph were provided to the parent or legal guardian.

(2) The hospital shall provide a list of resources available for the parent or legal guardian to obtain the items necessary to provide a safe sleep environment for the infant.

(d) On or before January 1, 2025, each hospital shall establish a process for:

(1) Providing each parent or legal guardian with:

(i) Oral and written educational resources as required under subsection (b) of this section; and

(ii) The information described under subsection (c)(1)(ii) of this section;

(2) A parent or legal guardian to confirm the receipt of the educational resources provided under subsection (b) of this section; and

(3) Maintaining records of confirmations made under item (2) of this subsection.

(e) (1) On or before January 1, 2025, the Department, in consultation with local health officers, shall develop for distribution to birthing parents and legal guardians a list of resources available by county to obtain the items necessary to provide a safe sleep environment for an infant.

(2) Each local health department shall provide an updated list of resources to the Department each year to assist the Department in developing the list of resources required under paragraph (1) of this subsection.

§19–308.11.

(a) In this section, "medication for opioid use disorder":

(1) Means a drug approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder; and

(2) Does not include a drug administered to mitigate opioid–related overdose symptoms.

(b) Each hospital shall establish and maintain, as part of its emergency services, protocols and capacity to:

(1) Provide to a patient before discharging the patient appropriate, evidence–based interventions that reduce the risk of subsequent harm and fatality following an opioid–related overdose or a visit for an opioid–related emergency medical condition;

(2) Possess at least one formulation of each U.S. Food and Drug Administration–approved full opioid agonist and partial opioid agonist used for the treatment of opioid use disorder; and

(3) Treat a patient who presents in a hospital emergency department for care and treatment of an opioid–related overdose or opioid–related emergency medical condition with a medication for opioid use disorder if the treatment:

(i) Occurs as recommended by the treating health care practitioner; and

(ii) Is voluntarily agreed to by the patient.

(c) A protocol established by a hospital under this section shall include:

(1) Any requirement by the Department regarding prescribing opioid agonist treatment;

(2) Uniform practices for screening and diagnosing individuals who present with an opioid–related overdose or opioid–related emergency medical condition for an opioid use disorder based on the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;

(3) Uniform practices for offering and administering opioid agonist medication to treat an opioid–related overdose or opioid use disorder; and

(4) Uniform practices to identify community–based treatment services that are appropriate for:

(i) Treating opioid use disorders; and

(ii) Assisting patients to voluntarily access ongoing community–based treatment at discharge.

(d) Before discharging a patient who is diagnosed with an opioid use disorder or administered or prescribed medication for opioid use disorder, a hospital shall:

(1) Make a referral of the patient to an appropriate provider or facility for a timely appointment, when possible, to voluntarily continue treatment in the community; and

(2) Work with peer support professionals, as available, or other resources to assist the patient in accessing the identified treatment services.

§19–309.

(a) Notwithstanding any other provisions of this subtitle, each hospital or residential treatment center shall be open to inspections by the Department to investigate and resolve any complaint concerning patient care, safety, medical and nursing supervision, physical environment, sanitation or dietary matters.

(b) (1) To resolve expeditiously a complaint that alleges the existence of any nonlife-threatening deficiency, the Department may refer the complaint directly to the hospital or residential treatment center.

(2) If appropriate, issues relating to the practice of medicine or the licensure or conduct of a health professional shall be referred to the hospital or the residential treatment center and may be referred to the appropriate licensure board for resolution.

(3) If the Department determines that the hospital or residential treatment center has not satisfactorily addressed the referred complaint or where the complaint alleges the existence of a life-threatening deficiency, the Department shall conduct an independent investigation.

§19–310.

(a) (1) In this subsection, "designated requestor" means a hospital employee who has completed a course offered by an organ, tissue, or eye recovery agency on how to approach potential donor families and request organ or tissue donation.

(2) (i) On or before the occurrence of each death in a hospital, the hospital shall contact an appropriate organ, tissue, or eye recovery agency in order to determine the patient's suitability for organ, tissue, or eye donation.

(ii) The contact and its disposition shall be noted in the patient's medical record.

(3) (i) The appropriate organ, tissue, or eye recovery agency, in consultation with the patient's attending physician or the physician's designee, shall determine the patient's suitability for organ, tissue, or eye donation.

(ii) If the organ, tissue, or eye recovery agency, in consultation with the patient's attending physician or the physician's designee, determines that donation is not appropriate based on established medical criteria, this determination shall be noted by hospital personnel in the patient's medical record and no further action is necessary.

(iii) If the organ, tissue, or eye recovery agency, in consultation with the patient's attending physician or the physician's designee, determines that the patient is a suitable candidate for organ, tissue, or eye donation, a representative of the appropriate organ, tissue, or eye recovery agency or a designated requestor shall initiate a request under paragraph (4) of this subsection, if applicable.

(4) (i) Except as provided in the Maryland Revised Uniform Anatomical Gift Act, when an individual dies in a hospital in accordance with § 5–202 of this article, a representative of the appropriate organ, tissue, or eye recovery agency or a designated requestor shall request, with sensitivity and in compliance with § 4–507 of the Estates and Trusts Article, that the individual's representative consent to the donation of all or any of the decedent's organs or tissues as an anatomical donation if suitable.

(ii) Directions given by a person authorized under § 4–503 of the Estates and Trusts Article to make, amend, revoke, or refuse to make an anatomical gift of a decedent's body or parts shall be recorded in the decedent's medical record.

(iii) The representative of the appropriate organ, tissue, or eye recovery agency or the designated requestor and the representative of the deceased patient are entitled to protection from civil and criminal liability as provided in § 4–514 of the Estates and Trusts Article.

(5) In all discussions concerning donations of organs and tissues, the representative of the appropriate organ, tissue, or eye recovery agency or the designated requestor shall show reasonable discretion and sensitivity:

(i) To the circumstances of the family of the decedent;

(ii) To the religious beliefs of the decedent; and

(iii) To the nonsuitability for organ or tissue donation of the decedent.

(6) (i) When a representative of the appropriate organ, tissue, or eye recovery agency or a designated requestor makes a request under paragraph (4)(i) of this subsection, the representative or designated requestor shall document the request and its disposition as required by § 4–508 of the Estates and Trusts Article.

(ii) Hospital personnel shall note the request and its disposition in the decedent's medical record or death certificate.

(7) A hospital may not bill the estate of the decedent, a surviving spouse or domestic partner of the decedent, any heirs of the decedent, or an insurer of the decedent for the costs associated with the removal of all or any of the decedent's organs or tissues for the purpose of an anatomical donation.

(8) After consultation with the Maryland Hospital Association, Inc., the Medical and Chirurgical Faculty of the State of Maryland, Living Legacy Foundation, the Washington Regional Transplant Community, the Medical Eye Bank of Maryland, the Health Facilities Association of Maryland, and Tissue Banks International, the Secretary shall publish guidelines designed to implement this subsection, including guidelines:

(i) Requiring that, at or near the time of each individual death in a hospital, the hospital contact by telephone an appropriate organ, tissue, or eye recovery agency to determine the suitability of the individual for organ, tissue, and eye donation;

(ii) Requiring that each hospital designate a person to make the contact; and

(iii) Identifying the information that the person designated by the hospital shall have available before making the contact.

(9) The provisions of this subsection shall in no way interfere with the duties of the office of the Chief Medical Examiner. In sudden deaths under the jurisdiction of the office of the Chief Medical Examiner as provided in § 5–309 of this article, notification will be made to the office of the Chief Medical Examiner prior to organ removal.

(10) The consent of the decedent's representative is not necessary and the provisions of paragraph (4) of this subsection do not apply if § 4–506 of the Estates

and Trusts Article precludes the decedent's representative from making an anatomical gift.

(11) A person who acts in good faith to recover organs or tissues in accordance with a notation on the decedent's driver's license or identification card that the decedent is an organ donor, a gift made in accordance with § 5–604.1 of this article or Title 4, Subtitle 5 of the Estates and Trusts Article, or a gift made in accordance with the anatomical gift laws of another state or country is immune from criminal prosecution and liability for damages in any cause of action related to the recovery and donation of the decedent's organs or tissues.

(12) The Department shall conduct annual death record reviews at each hospital to determine the hospital's compliance with the provisions of this subsection. The Department may delegate its duty to conduct annual death record reviews to the appropriate organ, tissue, or eye recovery agency serving the region in which a particular hospital is located.

(b) (1) Subject to paragraph (2) of this subsection and notwithstanding any other provision of law, a hospital offering bone marrow transplant services shall allow an individual to donate bone marrow to any individual.

(2) An individual may donate bone marrow to another individual if a licensed physician determines, based on the physician's medical judgment, that the donation of the bone marrow is in the best interests of the donee and there is no substantial risk of medical injury to the donor.

§19–310.1.

(a) (1) This section applies to a nursing facility, as defined in § 19–301 of this subtitle, that:

(i) Has 45 or more beds; and

(ii) Operates in the State.

(2) This section does not apply to a nursing home bed in a continuing care retirement community that has obtained a certificate of registration to provide continuing care under Title 10, Subtitle 4 of the Human Services Article.

(b) (1) The Department may impose a quality assessment on each freestanding nursing facility subject to this section.

(2) The amount assessed in the aggregate on all nursing facilities may not exceed 6.0% of the operating revenue for all nursing facilities subject to this section for the previous fiscal quarter.

(3) The assessment authorized by this section shall be paid by each nursing facility in accordance with this section.

(c) (1) On or before the 60th day after each quarter of the State fiscal year, each nursing facility subject to this section shall pay to the Comptroller an amount determined by the Department based on an amount per non–Medicare day of service for the previous fiscal quarter.

(2) The assessment shall be based on an amount per patient day, not including Medicare days.

(d) (1) All amounts collected by the State Comptroller under this section shall be distributed to a special fund, to be used by the Department only to fund reimbursements to nursing facilities under the Medicaid program.

(2) At least 65% of the funds allocated by the Department as reimbursements to nursing facilities under this section shall be in addition to and may not supplant funds already appropriated for this purpose.

(e) The Department shall adopt regulations to implement this section.

(f) On or before September 1, 2015, and each year thereafter, the Department shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the implementation of this section, including:

(1) The percentage and amount of the assessment charged to each nursing facility subject to this section;

(2) The number of nursing facilities subject to this section with a net loss; and

(3) A comparison of the total amount provided in the Medicaid budget for nursing home reimbursement in the current fiscal year to the actual amount received in the immediately prior fiscal year.

§19–310.2.

On or before July 1, 2014, each hospital that provides emergency medical services shall have a protocol to provide timely access to a sexual assault medical

forensic examination by a forensic nurse examiner or a physician to a victim of an alleged rape or sexual offense who arrives at the hospital for treatment.

§19–310.3.

(a) On or before January 1, 2018, each hospital shall have a protocol for discharging a patient who was treated by the hospital for a drug overdose or was identified as having a substance use disorder.

(b) The protocol:

(1) May include:

(i) Coordination with peer recovery counselors who can conduct a screening, a brief intervention, and referral to treatment and connection of the patient with community services; and

(ii) Prescribing opioid overdose reversal drugs approved by the federal Food and Drug Administration for the patient; and

(2) On or before June 30, 2023, shall require offering opioid overdose reversal drugs approved by the federal Food and Drug Administration, free of charge, to a patient who received treatment for a substance use disorder, opioid use disorder, or nonfatal drug overdose event.

§19–310.4.

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

(2) "Committee" means the review committee established in accordance with subsection (e) of this section.

(3) "Program" means the Private Hospital Grant Program.

(b) Except as provided in subsection (f) of this section, this section may not be construed to prohibit an organization from receiving funds from a government source other than the Private Hospital Grant Program.

(c) There is a Private Hospital Grant Program.

(d) The purpose of the Program is to make recommendations to the Governor for funding in the annual State budget for capital projects at private hospitals in the State.

(e) (1) The Maryland Hospital Association shall establish a review committee to:

(i) Develop the process for hospitals in the State to submit requests for funding in the annual budget;

(ii) Establish eligibility criteria for a hospital to submit a request for funding under the Program;

(iii) Establish criteria for projects eligible to receive funding under the Program;

(iv) Establish deadlines for the submission of requests for funding and the determination of projects recommended for funding;

(v) Develop project scoring and selection criteria guidelines;

(vi) Review eligible requests for funding; and

(vii) Make final recommendations for projects to be funded in the annual State budget.

(2) To the extent practicable, the membership of the committee established under paragraph (1) of this subsection shall reflect the geographic diversity of hospitals in the State.

(3) The committee shall consult with the Department of Budget and Management and the Department of Legislative Services in:

(i) Establishing the project funding request process under paragraph (1) of this subsection; and

(ii) Making recommendations for funding requests.

(f) In consultation with the Department of Budget and Management, the committee may establish conditions under which a request for funding may be rejected for consideration.

(g) The Maryland Hospital Association shall submit the recommendations of the committee to the Governor and the Secretary of Budget and Management.

(h) For fiscal year 2026 and each fiscal year thereafter, the Governor may include in the capital or operating budget bill an appropriation of $20,000,000 for the Private Hospital Grant Program.

§19–310.5. NOT IN EFFECT

** TAKES EFFECT JULY 1, 2025 PER CHAPTERS 798 AND 799 OF 2024 **

(a) If a newborn is delivered in a hospital following a high–risk pregnancy, the hospital shall:

(1) Complete a postpartum infant and maternal referral form and submit the form to the local health department for the county in which the birthing parent resides;

(2) Provide to the birthing parent resources and information specific to the circumstances of the birthing parent, including information regarding the risks, signs, preventive measures, and treatment needs for postpartum complications, including cardiovascular conditions, chronic disease, substance misuse, and mental health conditions; and

(3) Call the birthing parent at least 24, but not later than 48, hours after discharging the parent to evaluate the parent's status and, as necessary, provide information about postpartum complications.

(b) On or before October 1 each year, each local health department shall submit to the Department a report that includes the number and type of referrals made based on the referral forms submitted to the local health department in accordance with subsection (a)(1) of this section.

§19–310.6.

(a) (1) Subject to paragraphs (2) and (3) of this subsection, on or before January 1, 2025, each hospital and urgent care center in the State shall implement an evidence–based protocol for the early recognition and treatment of a patient with sepsis, severe sepsis, or septic shock that is based on generally acceptable standards of care.

(2) The evidence–based protocol implemented for hospitals under paragraph (1) of this subsection shall comply with the Centers for Disease Control and Prevention sepsis guidelines.

(3) A hospital that is a specialty psychiatric hospital shall establish a process for the screening and early recognition of a patient with sepsis, severe sepsis, or septic shock, and procedures to transfer the patient to the appropriate setting.

(b) A hospital that submits sepsis data to the Centers for Medicare and Medicaid Services Hospital Inpatient Quality Reporting Program is presumed to meet the requirements of subsection (a) of this section.

(c) Each hospital and urgent care center shall:

(1) Require periodic training in the implementation of the sepsis protocol required under subsection (a) of this section for professional staff with direct patient care responsibilities and, as appropriate, for staff with indirect patient care responsibilities, including laboratory and pharmacy staff; and

(2) Ensure that the staff receive updated training if the hospital or urgent care center makes a substantive change to the sepsis protocol.

§19–310.7.

(a) In this section, "health system" has the meaning stated in § 15–112(y) of the Insurance Article.

(b) A health system shall comply with § 15–112(y) of the Insurance Article.

§19–311.

A person shall have the approval of the Secretary before the person may:

(1) Build a hospital or related institution; or

(2) Make any conversion, alteration, or addition to the plant or building that will affect the functional structure or normal bed capacity of a hospital or related institution.

§19–312.

To qualify for approval under Part II of this subtitle, the applicant shall satisfy the Secretary that the hospital or related institution will meet the requirements that the Secretary adopts under this subtitle.

§19–313.

An applicant for approval under Part II of this subtitle shall submit to the Secretary:

(1) A written application on the form that the Secretary requires; and

(2) The documents, drawings, and other information that the Secretary requires.

§19–314.

(a) (1) The Secretary promptly shall:

(i) Review each application and the information submitted under Part II of this subtitle; and

(ii) Investigate the proposed new hospital or related institution or proposed conversion, alteration, or addition.

(2) Within 30 days after the application is submitted, the Secretary shall give the applicant:

(i) Notice of approval or disapproval; and

(ii) In case of disapproval, each reason for the disapproval.

(b) The Secretary shall grant approval under Part II of this subtitle if the hospital or related institution will meet the requirements of this subtitle.

§19–315.

The Maryland Health and Higher Educational Facilities Authority Act provides means to enlarge and establish hospitals and related health care facilities.

§19–318.

(a) A person shall be licensed by the Secretary before the person may operate a hospital or related institution in this State.

(b) A hospital shall be classified as a special rehabilitation hospital before the hospital may provide or hold itself out as providing comprehensive physical rehabilitation services, as defined in § 19-1201 of this title.

§19–319.

(a) To qualify for a license, an applicant and the hospital or related institution to be operated shall meet the requirements of this section.

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

(1) At least 18 years old; and

(2) Of reputable and responsible character.

(c) (1) The applicant shall have a certificate of need, as required under Subtitle 1 of this title, for the hospital, residential treatment center, or related institution to be operated.

(2) The hospital, residential treatment center, or related institution to be operated shall meet the requirements that the Secretary adopts under this subtitle and Subtitle 12 of this title.

(d) (1) As a condition of licensure, each hospital shall establish a utilization review program for all patients admitted to the hospital. The utilization review program:

(i) May be conducted by an independent, nonhospital-affiliated review agent;

(ii) Shall be performed by registered nurses, medical records technicians, or similar qualified personnel supported and supervised by physicians as may be required;

(iii) Shall be certified by the Secretary if the program meets the minimum standards established under paragraph (4) of this subsection; and

(iv) Shall be recertified by the Secretary if the hospital makes any changes to the program after the initial certification.

(2) Any change made to a certified utilization review program shall be reported to the Secretary by the hospital within 30 days of the date the change was made.

(3) If a hospital fails to provide the utilization review program required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of hospital; or

(ii) $500 per day for each day the violation continues.

(4) The Secretary shall, by regulation and in consultation with health care providers and payors, establish minimum standards for a utilization review

program, directed at appropriateness and quality of inpatient care, as enumerated in the following items:

(i) Preadmission review of elective admissions;

(ii) Postadmission review of emergency admissions;

(iii) Concurrent or retrospective review of all admissions as appropriate;

(iv) Preauthorization of certain selected procedures if proposed to be performed on an inpatient basis;

(v) Continued stay review based on recognized objective criteria;

(vi) Discharge planning review; and

(vii) Readmission review.

(5) A patient may not be charged for any days disallowed as a result of retrospective review under paragraph (4) of this subsection unless the patient refuses to leave the hospital when it is medically appropriate to do so and the disallowed days occur:

(i) After the hospital has notified the patient in writing of the potential disallowance; or

(ii) As a direct result of the noncompliance by the patient to treatment or hospital regulations.

(6) A hospital shall be exempt from requiring a utilization review program for a patient if:

(i) 1. The patient is insured by a third-party payor; and

2. The third-party payor has a utilization review program for its subscribers or beneficiaries which meets the minimum standards as adopted in paragraph (4) of this subsection; or

(ii) The patient is a subscriber or member of a health maintenance organization as defined in § 19-701 of this title.

(7) Where federal regulations or guidelines for a federally mandated utilization review program for federally insured patients differ from standards established under paragraph (4) of this subsection, the Secretary may waive a specific standard if the program achieves the same objectives as the standards established by the Secretary.

(8) The Secretary may establish record keeping and reporting requirements:

(i) To evaluate the effectiveness of hospitals' utilization review programs; and

(ii) To determine if the utilization review programs are in compliance with the provisions of this section and regulations adopted by the Secretary to administer this section.

(e) (1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Telemedicine" means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

2. "Telemedicine" does not include:

A. An audio–only telephone conversation between a physician and a patient;

B. An electronic mail message between a physician and a patient; or

C. A facsimile transmission between a physician and a patient.

(iii) "Uniform standard credentialing form" means:

1. The form designated by the Secretary through regulation for credentialing physicians who seek to be employed by or have staff privileges at a hospital; or

2. The uniform credentialing form that the Insurance Commissioner designates under § 15–112.1 of the Insurance Article.

(2) As a condition of licensure, each hospital shall:

(i) Establish a credentialing process for the physicians who are employed by or who have staff privileges at the hospital; and

(ii) Use the uniform standard credentialing form as the initial application of a physician seeking to be credentialed.

(3) Use of the uniform standard credentialing form does not preclude a hospital from requiring supplemental or additional information as part of the hospital's credentialing process.

(4) (i) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar, establish minimum standards for a credentialing process which shall include:

1. A formal written appointment process documenting the physician's education, clinical expertise, licensure history, insurance history, medical history, claims history, and professional experience;

2. A requirement that an initial appointment to staff not be complete until the physician has successfully completed a probationary period; and

3. Subject to subparagraph (ii) of this paragraph, a formal, written reappointment process to be conducted in accordance with standards of the accreditiation body that accredits a hospital.

(ii) The reappointment process established under subparagraph (i)3 of this paragraph shall document the physician's pattern of performance by analyzing:

1. Claims filed against the physician;

2. Data dealing with utilization, quality, and risk;

3. Clinical skills;

4. Adherence to hospital bylaws, policies, and procedures;

5. Compliance with continuing education requirements;

6. Mental and physical status; and

7. The results of the practitioner performance evaluation process under subsection (i) of this section.

(5) If requested by the Department, a hospital shall provide documentation that, prior to employing or granting privileges to a physician, the hospital has complied with the requirements of this subsection and that, prior to renewing employment or privileges, the hospital has complied with the requirements of this subsection.

(6) Notwithstanding any other provision of this subsection, in its credentialing and privileging process for a physician who provides medical services to patients at the hospital only through telemedicine from a distant–site hospital or distant–site telemedicine entity, a hospital may rely on the credentialing and privileging decisions made for the physician by the distant–site hospital or distant–site telemedicine entity, as authorized under 42 C.F.R. Part 482, if:

(i) The physician who provides medical services through telemedicine holds a license to practice medicine in the State issued under Title 14 of the Health Occupations Article; and

(ii) The credentialing and privileging decisions with respect to the physician who provides medical services through telemedicine are:

1. Approved by the medical staff of the hospital; and

2. Recommended by the medical staff of the hospital to the hospital's governing body.

(7) If a hospital fails to establish or maintain a credentialing process required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of the hospital; or

(ii) $500 per day for each day the violation continues.

(f) As a condition of licensure, each accredited and nonaccredited hospital shall develop a protocol for the procurement of organs and tissues.

(g) (1) As a condition of licensure, each hospital shall establish a risk management program.

(2) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar establish minimum standards for a risk management program which shall include:

(i) A board policy statement indicating commitment to the risk management program;

(ii) A requirement that one person be assigned the responsibility for coordinating the program;

(iii) An internal staff committee structure to conduct ongoing review and evaluation of risk management activities;

(iv) A formal written program for addressing patient complaints;

(v) A documented facility-wide risk reporting system;

(vi) Ongoing risk management education programs for all staff; and

(vii) Documentation that the risk management and quality assurance programs share relevant information.

(3) If a hospital fails to establish or maintain a risk management program required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of the hospital; or

(ii) $500 per day for each day the violation continues.

(h) (1) As a condition of licensure, each hospital and related institution shall:

(i) Adopt, implement, and enforce a policy that requires, except in an emergency life-threatening situation where it is not feasible or practicable, all employees and medical staff involved in patient care services to comply with the Centers for Disease Control and Prevention guidelines on universal precautions; and

(ii) Display the notice developed under § 1-207 of the Health Occupations Article at the entrance to the hospital or related institution.

(2) If a hospital or related institution fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to $500 per day per violation for each day a violation continues.

(i) (1) As a condition of licensure, each hospital shall establish a practitioner performance evaluation process that objectively evaluates the performance of each member of the medical staff at the hospital.

(2) The practitioner performance evaluation process shall include a review of care provided to patients at the hospital by the members of the medical staff.

(3) The review of care shall:

(i) Be undertaken for cases chosen at random and for cases with unexpected adverse outcomes;

(ii) Be based on objective review standards;

(iii) Include a review of the appropriateness of the plan of care for the patient, particularly any medical procedures performed on the patient, in relation to the patient's condition; and

(iv) Be conducted by members of the medical staff or, at the discretion of the hospital, external reviewers, who:

1. Are of the same specialty as the member of the medical staff under review;

2. Have been trained to perform practitioner performance evaluation; and

3. Are not otherwise associated with the case under review.

(4) A hospital shall take into account the results of the practitioner performance evaluation process for a member of the medical staff in the reappointment process established under subsection (e) of this section.

(5) If a hospital fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to $500 per day per violation for each day a violation continues.

(j) (1) The Department, in coordination with the Maryland Institute for Emergency Medical Services Systems, shall adopt regulations establishing minimum perinatal care standards that meet or exceed the Maryland Perinatal System Standards for each hospital that provides obstetrical services.

(2) Each hospital that provides obstetrical services shall comply with the perinatal care standards established by the regulations adopted under paragraph (1) of this subsection as a condition of licensure.

§19–319.1.

As a prerequisite to the licensing of related institutions and each year after the license is issued, the Department shall require each related institution that provides long–term care and programs for patients with Alzheimer's disease and related disorders to have an in–service education program that includes instruction on dementia and the techniques necessary to manage dementia patients with regard to their physical, intellectual, and behavioral manifestations.

§19–319.2.

(a) In this section, "facility" means a special psychiatric hospital or an acute general care hospital with separately identified inpatient psychiatric service.

(b) (1) As a condition of licensure, each facility shall adopt written policies and procedures to implement the requirements of §§ 10-701 through 10-709 of this article. The policies and procedures:

(i) May expand the rights provided in §§ 10-701 through 10-709 of this article;

(ii) Shall provide for a mechanism for patients and others to report suspected violations of §§ 10-701 through 10-709 of this article to a designated official of the hospital;

(iii) Shall provide a system for investigating suspected violations; and

(iv) Shall ensure that there is a timely appropriate response to any suspected violation.

(2) The Secretary may inspect any document necessary to ensure compliance with this subsection and §§ 10-701 through 10-709 of this article.

(3) If a hospital that is a facility fails to adopt and implement the policies and procedures required by this subsection or maintains a continuing pattern of conditions or practices in knowing violation of §§ 10-701 through 10-709 of this article, the Secretary may impose the following penalties, but only after the Secretary has satisfied the conditions in § 19-360 of this subtitle:

(i) Delicensure of the specialty psychiatric hospital;

(ii) Delicensure of the separately identified psychiatric service of the acute general care hospital; or

(iii) A fine not to exceed $500 per day for each day the violation continues.

§19–320.

(a) An applicant for a license shall submit an application to the Secretary.

(b) The application:

(1) Shall be on the form that the Secretary requires;

(2) Shall be signed and verified as follows:

(i) If the application is made for an individual, by the individual; or

(ii) If the application is made for a corporation, association, or government agency, by 2 officers of the organization; and

(3) Shall include:

(i) The name of the applicant;

(ii) A statement that the applicant meets the requirements of this subtitle;

(iii) The class of the proposed hospital or related institution;

(iv) The location of the proposed hospital or related institution;

(v) The name of the individual who is to be the administrative head of the proposed hospital or related institution; and

(vi) Any other information that the Secretary requires.

§19–321.

(a) The Secretary shall issue a license to any applicant if the applicant and the hospital or related institution to be operated meet the requirements of this subtitle.

(b) The Secretary shall include on each license that the Secretary issues:

(1) The name of the hospital or related institution; and

(2) The classification of the hospital or related institution.

§19–322.

While it is effective, a license authorizes the licensee to operate the hospital or related institution named in the license under the classification set forth in the license.

§19–324.

A license issued under this subtitle is not transferable.

§19–325.

(a) If voluntary efforts to reduce excess capacity prove insufficient, as a last resort the Maryland Health Care Commission and the Health Services Cost Review Commission may petition the Secretary to delicense any hospital or part of a hospital or hospital service based on a finding after a public hearing that the delicensure is consistent with the State health plan or institution–specific plan. The petition shall specify in detail all efforts made by the petitioner to encourage the hospital:

(1) To reduce its underutilized capacity;

(2) To merge or consolidate;

(3) To become more efficient and effective; and

(4) To convert from acute capacity to alternative uses, where appropriate.

(b) On petition by the Maryland Health Care Commission and the Health Services Cost Review Commission, the Secretary may order that a hospital or part of a hospital or hospital service be delicensed if:

(1) The Secretary determines that delicensure is the last resort and a hospital or hospital services are excessive or inefficient, which determination is based on and is not inconsistent with the State health plan or institution–specific plan;

(2) An opportunity for notice and hearing in accordance with the Administrative Procedure Act has been given to the affected hospital, and in the affected political subdivision notice shall be given to the elected public officials and for at least 2 consecutive weeks in a newspaper of general circulation; and

(3) The hospital is not the sole provider of hospital services in a county for which the Commission and Health Services Cost Review Commission have petitioned for all of the beds of the hospital to be delicensed.

(c) The Maryland Health Care Commission and the Health Services Cost Review Commission are necessary parties to any proceeding in accordance with this section.

(d) Any person who is aggrieved by a final decision of the Secretary under this section may take a direct judicial appeal.

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

(f) The Secretary may participate in any appeal of a decision made in accordance with this section.

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

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

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

§19–326.

If a hospital voluntarily closes, merges, or is delicensed under § 19–325 of this subtitle, the Department of Commerce, in cooperation with the Maryland Health Care Commission, shall assist the hospital and local community in identifying alternative uses for the hospital buildings or sites.

§19–326.1.

If a hospital voluntarily closes, merges, or is delicensed under § 19–325 of this subtitle and workers are displaced:

(1) Each hospital shall pay a fee directly to the Maryland Department of Labor. The fee shall not exceed 0.01 percent of the gross operating revenue for the fiscal year immediately preceding the closure or delicensing of the hospital. A fee shall only be assessed once for each voluntary closure, merger, or delicensure.

(2) The Secretary of Labor shall pay the fees received under this section into the Hospital Employees Training Fund established under § 11–201 of the Labor and Employment Article.

§19–327.

(a) (1) The Secretary shall deny a license to any applicant or revoke a license if the applicant or licensee has been convicted of a felony that relates to Medicaid or to a nursing home.

(2) The Secretary may deny a license to an applicant or revoke a license if the applicant or licensee does not meet the requirements of this subtitle or any rule or regulation that the Secretary adopts under this subtitle.

(b) The Secretary may deny a license to an applicant or revoke a license if the applicant or licensee violates Title 6.5 of the State Government Article.

(c) (1) Before any action is taken under this section, the Secretary shall give the applicant or licensee an opportunity for a hearing.

(2) The hearing notice to be given to the applicant or licensee shall be sent at least 10 days before the hearing.

(3) The applicant or licensee is entitled to be represented by counsel at the hearing.

§19–328.

(a) (1) If the Secretary determines that a life-threatening, health or fire safety deficiency exists in a related institution, the Secretary immediately may restrict new admissions to the related institution for not more than a 30-day period.

(2) Within 7 days after a request by an aggrieved party, a hearing shall be held to determine the appropriateness of the admissions restriction.

(3) Within 21 days after admissions are restricted, the related institution shall take steps to correct the deficiency.

(b) (1) Unless the Secretary lifts the admissions restriction, within 30 days after admissions are restricted, a hearing shall be held to determine whether the related institution has taken enough steps to correct the deficiency.

(2) If the Secretary finds that the deficiency still exists, the Secretary may:

(i) Continue to restrict admissions for not more than 3 consecutive 30-day periods; or

(ii) Revoke the license of the related institution and move its residents to an appropriate, licensed facility.

(3) An aggrieved party is entitled to a hearing on each continuation of the admissions restriction. Within 7 days after a request by an aggrieved party, a hearing shall be held to determine the appropriateness of the admissions restriction.

§19–329.

(a) (1) If, under a Montgomery or Prince George's county ordinance for licensing related institutions, the county licensing authority proposes to suspend or revoke the county license of a related institution, that authority shall give the Secretary notice of the proposed suspension or revocation and the reasons for it before the authority notifies the related institution.

(2) If, within 14 days after the Secretary receives the notice, the Secretary disapproves the proposed suspension or revocation, the county licensing authority may not proceed with the action. Otherwise the county licensing authority may proceed with the action.

(3) If the Secretary disapproves the proposed suspension or revocation, the Secretary shall state, in writing, the reasons for the disapproval.

(b) (1) If the Montgomery or Prince George's county licensing authority proposes to restrict new admissions to a related institution, that authority shall give the Secretary as much prior notice of the proposed restriction as possible, so that State and county action may be coordinated.

(2) The Secretary may become a party to any county administrative or judicial proceeding on the restriction.

§19–330.

(a) Except as provided in this section for an action under § 19–329(a) of this subtitle, any person aggrieved by a final decision of the Secretary in a contested case, as defined in the Administrative Procedure Act, may petition for judicial review as allowed by the Administrative Procedure Act.

(b) A person aggrieved by a final decision of the Secretary under § 19–329(a) of this subtitle may not appeal.

§19–333.

(a) In Part V of this subtitle the following words have the meanings indicated.

(b) "Affiliate" means:

(1) Each partner of a partnership;

(2) Each officer, director, and stockholder who has direct or indirect ownership or control of 10 percent or more of the stock of a corporation; or

(3) Each individual who has direct or indirect ownership of 10 percent or more of a nursing home or community program.

(c) "Community program" means:

(1) A program which provides residential services and is an alcohol abuse and drug abuse treatment program as defined in § 8-403(a) of this article;

(2) A program which provides residential services for individuals with a developmental disability as defined in § 7-101(d) and (h) of this article;

(3) A private group home required to be licensed by the Secretary under § 10-517 of this article;

(4) A private therapeutic group home for children and adolescents as defined under § 10-920 of this article;

(5) A private residential treatment center for children and adolescents licensed under § 19-307 of this subtitle;

(6) A private facility operating living units that house less than 4 persons per unit under § 10-902 of this article;

(7) A program which provides day habilitation, vocational, or community supported living arrangements services required to be licensed under § 7-903 of this article; or

(8) A private program that provides outpatient services as set forth in § 10-902 of this article.

(d) "Individual" means a person who is a resident of a nursing home or a community residential program or a person enrolled in a day habilitation or vocational program.

(e) "Nursing home" means a related institution that is classified as a nursing home.

§19–334.

(a) In addition to any other power set forth in this article or the Health Occupations Article, the Secretary may file a petition for appointment of a receiver for a nursing home or community program defined in this subtitle if, after investigation of the Secretary or after investigation at the request of the Secretary of Aging, the Secretary reasonably believes that:

(1) A person is operating the nursing home or community program without a license for it;

(2) The nursing home or community program will be closed within 30 days and arrangements to relocate its residents have not been approved by the Secretary;

(3) The nursing home or community program or its residents have been abandoned; or

(4) A situation, physical condition, practice, or method of operation presents an imminent danger of death or serious mental or physical harm to the individuals.

(b) A petition under this section shall be filed with the circuit court for the county where the nursing home or community program is located.

§19–335.

(a) (1) Except as otherwise provided in subsection (b) of this section, the court shall hold a hearing on a petition under Part V of this subtitle within 10 days after the petition is filed.

(2) The owner of the nursing home or entity operating the community program shall be given notice of the hearing:

(i) At least 5 days before the hearing; or

(ii) At least 3 days before the hearing, by a notice posted conspicuously inside or on the front door of the nursing home or site of the community program, if the Secretary files a statement that:

1. Is signed and verified by the Secretary;

2. States that the owner or operating entity cannot be found; and

3. Sets forth a substantial account of reasonable, good faith efforts to find the owner or operating entity and serve process.

(3) The owner of the nursing home or operating entity of a community service is entitled to offer evidence at the hearing.

(b) (1) A court may appoint a receiver for a nursing home or community program if, from the petition, affidavits, and any evidence offered ex parte, the court finds probable cause to believe that a situation, physical condition, practice, or method of operation presents an imminent danger of death or serious mental or physical harm to the residents and must be remedied immediately to insure their health, safety, and welfare.

(2) The owner or person then in charge of the nursing home or community program shall be given notice of the appointment of a receiver:

(i) By service of the notice, within 24 hours after the appointment; or

(ii) By posting the notice conspicuously inside or on the front door of the nursing home or site of the community program, if the Secretary files a statement that:

1. Is signed and verified by the Secretary;

2. States that the owner and the person in charge of the nursing home or community program cannot be found; and

3. Sets forth a substantial account of reasonable, good faith efforts to find the owner and the person in charge and serve process.

(3) Unless the owner of the nursing home or entity operating the community program consents to a later date, the court shall hold a hearing on the appointment of the receiver within 5 days after service of process.

§19–336.

(a) After the hearing under § 19-335 of this subtitle, the court may appoint a receiver for the nursing home or community program or continue the appointment of the receiver made ex parte, if the court finds:

(1) A person is operating the nursing home or community program without a license for it;

(2) The nursing home or community program will be closed within 30 days and arrangements to relocate its residents have not been approved by the Secretary;

(3) The nursing home or community program or its residents have been abandoned; or

(4) A situation, physical condition, practice, or method of operation presents an imminent danger of death or serious mental or physical harm to the individuals.

(b) The court may appoint as receiver any responsible individual other than:

(1) A State employee;

(2) An employee of a local government; or

(3) The owner or administrator of or other individual with a financial interest in the nursing home or community program or agent of any of those individuals.

(c) (1) Before the receiver takes charge of the nursing home or community program, the receiver shall file a bond with the court.

(2) The bond:

(i) May not exceed the value of the nursing home or community program and its assets; and

(ii) Shall run to this State for benefit of all persons interested in the faithful performance of the receiver including the individuals.

(3) Unless the court directs otherwise, the receiver may pay the premium of the bond from the income of the nursing home or community program.

(d) The Secretary may petition the court to appoint a substitute for a receiver who:

(1) Dies;

(2) Has a disability;

(3) Has an adverse interest; or

(4) Does not make reasonable progress in carrying out the receivership.

§19–337.

(a) (1) Except as expressly provided otherwise in this section, each receiver who is appointed under Part V of this subtitle has all of the powers of a receiver who is appointed under § 3-414 of the Corporations and Associations Article.

(2) The receiver shall perform all acts that are necessary and exercise the powers of the receiver to:

(i) Correct each condition on which the appointment of the receiver was based;

(ii) Ensure adequate care for each individual in the nursing home or community program; and

(iii) Preserve the property of the owner of the nursing home or community program.

(b) The receiver shall report to the court as the court requires.

(c) The receiver of a nursing home or community program shall:

(1) Give each individual and interested parties with respect to each individual notice of the receivership;

(2) Preserve all property of and records that relate to an individual and are in the custody of the receiver or the owner or operating entity;

(3) If an individual is to be discharged or transferred:

(i) Explain to the individual or guardian of the individual the alternative placements that are available;

(ii) Help the individual or guardian of the individual to find an alternative placement;

(iii) Give information about the alternative placement chosen;

(iv) Transport the individual to the alternative placement; and

(v) Transfer all property of and records on the individual, including all necessary medical information, to the individual or the alternative placement.

(d) The receiver may use:

(1) Any private or third-party reimbursements to the nursing home, including any Medicaid or Medicare payments; and

(2) With the approval of the court, money from the fund established under § 19-338 of this subtitle.

(e) If the structure or furnishings of a nursing home or site of the community program violate State or federal law, the receiver may correct the violation:

(1) Without the consent of the court, if the cost of the correction does not exceed $3,000; or

(2) On petition to and with the consent of the court, if the cost of the correction is more than $3,000.

(f) (1) The receiver shall pay the principal of and interest on a mortgage or secured transaction unless the holder of the mortgage or the secured party is the owner or an affiliate of the owner.

(2) On petition of a receiver, the court may:

(i) Allow the receiver to avoid a lease, mortgage, secured transaction, or other contract that the owner or operating entity made if:

1. The person seeking payment under the contract is, or at the time the contract was made was, the owner or an affiliate of the owner; and

2. The contract provides for a rent or interest rate substantially exceeding the rent or interest rate that was reasonable when the contract was made; and

(ii) If the receiver is allowed to avoid the contract, set a reasonable rent or interest rate to be paid on any property that is subject to the contract and is needed to continue operation of the nursing home or community program.

(3) The court shall hold a hearing on a petition under this subsection within 15 days after the petition is filed.

(4) Notice of the petition shall be given to all known owners of property that the petition affects:

(i) By the receiver, at least 10 days before the hearing; or

(ii) By publication, if the receiver files with the court a statement that:

1. Is signed and verified by the receiver;

2. States that the owner of the property cannot be found; and

3. Sets forth a substantial account of reasonable, good faith efforts to find the owner and serve process.

(5) The court shall set a rent under this subsection in an amount that is not less than the total current payments of principal and interest required on all mortgages and secured transactions that:

(i) Affect the property under the contract to be avoided; and

(ii) Cannot be avoided under this subsection.

(6) Payment of the rent or interest rate that a court sets under this subsection is a defense in any action against the receiver for payment or for possession of the property. However, the payment does not relieve the owner or operating entity of any liability for the difference between the amount that the receiver pays and the amount that is due under the contract.

(g) (1) A receiver is not liable for an injury to person or property that results from the condition of the nursing home or site of the community program.

(2) A receiver only is liable for any act or omission that constitutes negligence in the fulfillment of the duties as receiver.

(h) A receiver is entitled to the fee that the court finds reasonable.

§19–338.

(a) The Secretary shall determine whether the receivership can be funded by State funds previously designated for the community program. In the event that previously designated funds are available, these funds shall be used for the operation of the receivership.

(b) In the event that there are insufficient funds to operate the receivership, the Secretary may petition the Board of Public Works for sufficient funds to operate the receivership.

(c) (1) State funds used to operate a receivership under this section shall be a lien on the community program and its assets if the receiver files a notice of the lien that contains:

(i) The amount of the lien;

(ii) The name of the community program to which the lien attaches; and

(iii) A description of the assets of the community program that are affected by the lien.

(2) The receiver shall file the notice of lien with:

(i) The land and chattel records of the county where the sites operated by the community program are located; and

(ii) The Department of Assessments and Taxation.

(3) A lien under this subsection:

(i) Extends to the property of the community program that is described in the notice of lien; and

(ii) Has priority over any lien or other interest that attaches after the date of the completion of the filings required under this subsection.

§19–339.

(a) (1) The owner or operating entity or receiver of a nursing home or community program may petition the court to terminate the receivership.

(2) The court shall terminate the receivership, if the court finds:

(i) The grounds for appointment of the receiver under Part V of this subtitle no longer exist; or

(ii) The nursing home or community program is ready to be closed because all residents have been moved.

(b) A receivership ends automatically 1 year after the court appoints the receiver, unless the court:

(1) Terminates the receivership sooner; or

(2) On petition of the Secretary, extends the receivership for an additional 1-year period because the court finds that the grounds for appointment of a receiver under Part V of this subtitle still exist.

(c) The sale of a nursing home or site for a community program or any of its assets does not terminate a receivership of the nursing home or community program.

§19–342.

(a) In this section, "patient" includes an inpatient, an outpatient, and an emergency services patient.

(b) The General Assembly intends to promote the health, safety, and well–being of patients and to foster better communication between patients and health care providers in hospitals through the use of a patient's bill of rights that specifies the ethical and humane treatment the patient has a right to expect.

(c) Each administrator of a hospital shall:

(1) Provide to each patient in the hospital a written copy of the patient's bill of rights that:

(i) The hospital adopts under Joint Commission guidelines or guidelines issued by a nationally recognized hospital accreditation organization approved by the Centers for Medicare and Medicaid Services conditions of participation; and

(ii) Complies with subsection (d) of this section;

(2) If a patient does not speak English or requires the patient's bill of rights in an alternative format, provide a translator, an interpreter, or another accommodation to assist the patient in understanding and exercising the rights included in the patient's bill of rights;

(3) Conspicuously post copies of the patient's bill of rights on the hospital's website and in areas that are accessible to patients and visitors, which may include admitting offices, patient floors, patient rooms, the outpatient department, and emergency services waiting areas; and

(4) Provide annual training to all patient care staff members to ensure the staff's knowledge and understanding of the patient's bill of rights.

(d) The patient's bill of rights shall at a minimum include a statement, in plain language, that a patient has a right to:

(1) Receive considerate, respectful, and compassionate care;

(2) Be provided care in a safe environment free from all forms of abuse and neglect, including verbal, mental, physical, and sexual abuse;

(3) Have a medical screening exam and be provided stabilizing treatment for emergency medical conditions and labor;

(4) Be free from restraints and seclusion unless needed for safety;

(5) Be told the names and jobs of the health care team members involved in the patient's care if staff safety is not a concern;

(6) Have respect shown for the patient's personal values, beliefs, and wishes;

(7) Be treated without discrimination based on race, color, national origin, ethnicity, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, language, or ability to pay;

(8) Be provided a list of protective and advocacy services when needed;

(9) Receive information about the patient's hospital and physician charges and ask for an estimate of hospital charges before care is provided and as long as patient care is not impeded;

(10) Receive information in a manner that is understandable by the patient, which may include:

(i) Sign and foreign language interpreters;

(ii) Alternative formats, including large print, braille, audio recordings, and computer files; and

(iii) Vision, speech, hearing, and other temporary aids as needed, without charge;

(11) Receive information from the patient's doctor or other health care practitioners about the patient's diagnosis, prognosis, test results, possible outcomes of care, and unanticipated outcomes of care;

(12) Access the patient's medical records in accordance with HIPAA Notice of Privacy Practices;

(13) Be involved in the patient's plan of care;

(14) Be screened, assessed, and treated for pain;

(15) Refuse care;

(16) In accordance with hospital visitation policies, have an individual of the patient's choice remain with the patient for emotional support during the patient's hospital stay, choose the individuals who may visit the patient, and change the patient's mind about the individuals who may visit;

(17) Appoint an individual of the patient's choice to make health care decisions for the patient, if the patient is unable to do so;

(18) Make or change an advance directive;

(19) Give informed consent before any nonemergency care is provided, including the benefits and risks of the care, alternatives to the care, and the benefits and risks of the alternatives to the care;

(20) Agree or refuse to take part in medical research studies, without the agreement or refusal affecting the patient's care;

(21) Allow or refuse to allow pictures of the patient for purposes other than the patient's care;

(22) Expect privacy and confidentiality in care discussions and treatments;

(23) Be provided a copy of the Health Insurance Portability and Accountability Act Notice of Privacy Practices; and

(24) File a complaint about care and have the complaint reviewed without the complaint affecting the patient's care.

(e) The Office of Health Care Quality shall monitor the compliance of each hospital with the requirements of this section.

§19–342.1.

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

(2) "Emergency pregnancy–related medical condition" means a medical condition that presents in a pregnant patient through acute symptoms of sufficient severity and for which the absence of immediate medical attention could be reasonably expected to result in:

(i) Placing the health of the patient in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or body part.

(3) "Stabilize" means, for an emergency pregnancy–related medical condition, to provide the medical treatment necessary to alleviate the condition or ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from the facility.

(b) This section applies only to a hospital with an emergency department.

(c) If a hospital determines that a patient has an emergency pregnancy–related medical condition, the hospital shall:

(1) Using the staff and facilities available to the hospital, provide further examination and the treatment required to stabilize the emergency pregnancy–related medical condition, including the termination of a pregnancy when the termination is medically necessary to stabilize the patient; or

(2) Transfer the patient to another medical facility.

(d) A hospital shall allow the termination of a pregnancy at the hospital if the patient's treating health care practitioner determines termination is medically necessary to stabilize a patient.

(e) (1) A hospital is considered to have met the requirements of this section if, after offering further examination and treatment or transfer to the patient or the patient's representative and informing the patient or patient's representative of the risks and benefits of further examination and treatment or transfer:

(i) A patient or the patient's representative refuses to consent to further examination and treatment; or

(ii) A patient or the patient's representative refuses to consent to a transfer to another medical facility.

(2) A hospital shall take reasonable steps to secure written informed consent to the refusal of an examination or treatment or transfer under this subsection from the patient or the patient's representative.

(f) If a patient has an emergency pregnancy–related medical condition that has not been stabilized, the hospital may not transfer the patient unless the transfer is done consistent with 42 U.S.C. § 1395dd.

(g) A hospital may not penalize or take other adverse action, including an action related to discharge, promotion, demotion, suspension, compensation, training opportunities, staff privileges, or admitting privileges, against:

(1) A treating health care provider if the provider refuses to authorize the transfer of a patient with an emergency pregnancy–related medical condition that has not been stabilized;

(2) A treating health care provider if the provider's treatment of the patient is consistent with the medical standards of care that, in the provider's clinical judgment, were necessary to stabilize the patient; or

(3) A hospital employee if the employee reports a violation of this section.

(h) A hospital that negligently violates this section is subject to a civil penalty of:

(1) For a hospital with 100 or more beds, not more than $50,000 for each violation; or

(2) For a hospital with fewer than 100 beds, not more than $25,000 for each violation.

(i) (1) The Department shall stay a final decision on a potential violation if there is an ongoing federal investigation under 42 U.S.C. § 1395dd regarding the same incident.

(2) If a federal investigation under 42 U.S.C. § 1395dd results in a fine being imposed for the same incident, the Department shall subtract the amount of the federal fine from the maximum potential fine under this section for the same incident.

(3) (i) Subject to subparagraph (ii) of this paragraph, if a federal investigation under 42 U.S.C. § 1395dd results in a fine being imposed for the same incident within 2 years after the Department imposes a fine under this section, the Department shall refund the hospital an amount equal to the amount of the federal fine.

(ii) The amount refunded under subparagraph (i) of this paragraph may not exceed the amount of the fine imposed by the Department for the same incident.

§19–343.

(a) In this section and §§ 19–344, 19–345, 19–345.1, 19–345.2, and 19–345.3 of this subtitle, "facility" means a related institution that, under the rules and regulations of the Department, is a comprehensive care facility or an extended care facility.

(b) (1) The General Assembly intends to promote the interests and well–being of each resident of a facility.

(2) It is the policy of this State that, in addition to any other rights, each resident of a facility has the following basic rights:

(i) The right to be treated with consideration, respect, and full recognition of human dignity and individuality;

(ii) The right to receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State and federal laws, rules, and regulations;

(iii) The right to privacy;

(iv) The right to be free from mental and physical abuse;

(v) The right to notice, procedural fairness, and humane treatment when being transferred or discharged from a facility;

(vi) The right to participate in decision making regarding transitions in care, including a transfer or discharge from a facility;

(vii) The right to expect and receive appropriate assessment, management, and treatment of pain as an integral component of the patient's care;

(viii) The right to be free from physical and chemical restraints, except for restraints that a physician authorizes for a clearly indicated medical need;

(ix) The right to receive respect and privacy in a medical care program; and

(x) The right to manage personal financial affairs.

(c) Each facility shall:

(1) Post, conspicuously in a public place, the policy set forth in subsection (b) of this section and the provisions in §§ 19–344(b) through (m), 19–345, and 19–346(i)(2) of this subtitle;

(2) Give a copy of the policy and those provisions:

(i) On admission, to the resident;

(ii) To the guardian, next of kin, or sponsoring agency of the resident; and

(iii) To a representative payee of the resident;

(3) Keep a receipt for the copy that is signed by the person who received the copy; and

(4) Provide appropriate staff training to carry out the policy and those provisions.

§19–344.

(a) To carry out the policy set forth in § 19-343 of this subtitle, the following procedures are required for all services provided to a resident of a facility.

(b) (1) A facility may not require or solicit, as a condition of admission into the facility, the signature of another person, other than the applicant, on the application or contract for admission to the facility, unless:

(i) The applicant is adjudicated disabled under Title 13, Subtitle 7 of the Estates and Trusts Article; or

(ii) 1. The applicant's physician determines that the applicant is incapable of understanding or exercising the applicant's rights and responsibilities; and

2. The applicant's physician records, in the applicant's facility record, the specific reasons for the determination.

(2) If, in addition to the signature of an applicant, a facility requires the signature of another person on the application or contract for admission to the facility in accordance with the provisions of paragraph (1) of this subsection, the facility shall provide a written statement to be included in the document of the rights, duties, and liabilities of the signer of the document.

(3) (i) A facility may request an applicant for whom a second signature cannot be required or solicited under paragraph (1) of this subsection to execute valid durable powers of attorney designating an attorney in fact to make financial, medical, funeral, and burial decisions in the event of the applicant's disability.

(ii) A facility may not require the execution of a durable power of attorney as a condition or requirement of admission to the facility.

(c) (1) In this subsection, "agent" means a person who manages, uses, or controls the funds or assets that legally may be used to pay the applicant's or resident's share of costs or other charges for the facility's services.

(2) Except as provided by the Department, a facility may not charge an applicant or resident who is a medical assistance beneficiary, or the applicant's or resident's agent, any amount in addition to the amounts determined by the medical assistance program for services that are covered by medical assistance.

(3) Unless otherwise agreed, the financial obligation of the applicant's or resident's agent is limited to the amount of the applicant's or resident's funds that are considered available to the agent by the medical assistance program.

(4) (i) A facility may require an applicant, a resident, or the agent of an applicant or resident to agree to distribute any funds, including income or assets of the applicant or resident, which the medical assistance program has determined to be available to pay for the cost of the applicant's or resident's care, to the facility, promptly when due, for the cost of the applicant's or resident's care.

(ii) For the purpose of this section, funds of the applicant or resident include funds of the applicant or resident that are under the use, ownership, management, or control of the agent.

(iii) A resident or agent of the resident who has not paid a current obligation for the resident's care may apply to the medical assistance program for a determination of the funds available to pay for the cost of the resident's care.

(iv) If a request for a determination is made under subparagraph (iii) of this paragraph, the medical assistance program shall make the determination.

(v) If a resident or agent of a resident who has not paid a current obligation for the resident's care fails to request a determination under subparagraph (iii) of this paragraph, the facility may, without requesting the appointment of a guardian, petition the appropriate circuit court for an order or

injunction directing the resident or agent of the resident to request and pursue the determination with due diligence or granting other appropriate relief to enforce the obligations under this section.

(vi) If a resident or agent of the resident fails to pay for the cost of the resident's care from funds that the medical assistance program has determined to be available to pay for that care, the facility may, without requesting the appointment of a guardian, petition the appropriate circuit court for an order directing the resident or agent of the resident to pay the facility from the funds determined by the medical assistance program to be available.

(5) (i) An applicant, a resident, or the agent of an applicant or resident shall seek and pursue with due diligence, on behalf of the applicant or resident, all assistance from the medical assistance program which may be available to the applicant or resident.

(ii) The facility shall cooperate with and assist the agent in seeking assistance from the medical assistance program on behalf of the applicant or resident.

(iii) If a resident or the agent of a resident fails to seek assistance from the medical assistance program or to cooperate fully in the eligibility determination process, a facility providing care to the resident may, without requesting the appointment of a guardian, petition the appropriate circuit court for an order or injunction requiring the resident or agent of the resident to seek assistance from the medical assistance program or to cooperate in the eligibility determination process with due diligence or granting other appropriate relief to enforce the obligations under this section.

(6) (i) Any agent who willfully or with gross negligence violates the requirements of paragraph (4) of this subsection regarding the distribution of the applicant's or resident's funds is subject to a civil penalty not less than the amount of funds subject to the violation.

(ii) Any agent who willfully or with gross negligence violates the requirements of paragraph (5) of this subsection regarding an application for medical assistance by or on behalf of an applicant or resident is subject to a civil penalty not exceeding $10,000.

(iii) The Attorney General is responsible for the enforcement and prosecution of violations of the provisions of paragraphs (4) and (5) of this subsection.

(7) Nothing in this subsection may be construed to prohibit any person from knowingly and voluntarily agreeing to guarantee payment for the cost of an applicant's care.

(d) Each facility shall:

(1) On or before admission of an individual, give the individual a written statement of:

(i) The services of the facility, including each service that is required to be offered on an as-needed basis; and

(ii) Related charges, including any charges for services that are not covered by Medicare, Medicaid, or the basic rate of the facility; and

(2) Keep a written receipt for the statement that is signed by the individual.

(e) Unless it is medically inadvisable, the resident physician of a facility or attending physician of its resident shall give the resident information about the diagnosis, treatment, and prognosis of the resident that is complete and current and is stated in language that the resident reasonably can be expected to understand.

(f) (1) A resident of a facility:

(i) Shall participate in the planning of the medical treatment;

(ii) May refuse medication or treatment; and

(iii) May know the medical consequences of these actions.

(2) The facility shall:

(i) Have the informed consent of a resident before the resident participates in any experimental research; and

(ii) Keep the resident's written acknowledgment of that consent.

(3) The resident shall receive information about the relationship of the facility to other health care institutions if the information relates to the care of the resident.

(4) The resident shall receive reasonable continuity of care, including information as to the availability of physicians and times for medical appointments.

(g) (1) Any case discussion, consultation, examination, or treatment of a resident of a facility:

(i) Is confidential;

(ii) Is to be done discreetly; and

(iii) Is not open to an individual who is not involved directly in the care of the resident unless the resident permits the individual to be present.

(2) Except as necessary for the transfer of a resident from the facility to another health care institution or as required by law or a third-party payment contract, the personal and medical records of a resident are confidential and may not be released without the consent of the resident to any individual who:

(i) Is not associated with the facility; or

(ii) Is associated with the facility, but does not have a demonstrated need for the information.

(h) If it is feasible to do so and not medically contraindicated, spouses or domestic partners who are both residents of the facility shall be given the opportunity to share a room.

(i) A resident of a facility alone or with other individuals is entitled to present any grievance or recommend a change in a policy or service to the staff or administrator of the facility, the Department of Aging, or any other person, without fear of reprisal, restraint, interference, coercion, or discrimination.

(j) (1) Each facility shall place at the bedside of each resident the name, address, and telephone number of a physician who is responsible for the resident's care.

(2) A resident shall have access at any reasonable time to a telephone where the resident may speak privately.

(3) A resident shall have access to writing instruments, stationery, and postage.

(4) The correspondence of a resident shall be sent to the addressee without delay and without being opened.

(5) Every patient and resident may associate and communicate privately and without restriction with persons and groups of his choice on his own or their initiative at any reasonable hour.

(k) (1) Each married resident of a facility shall have privacy during a visit by the spouse.

(2) Each resident of a facility who has a domestic partner shall have privacy during a visit by the other domestic partner.

(l) To a reasonable extent, a resident of a facility shall have the right to possess and use clothing and other personal effects and to have security for those effects.

(m) A resident of a facility may not be assigned to do any work for the facility without personal consent and without written approval of the attending physician of the resident.

(n) A resident of a facility shall receive a reasonable response from an administrator or staff to a personal request of the resident.

(o) (1) A resident of a facility shall enjoy privacy in the room of the resident.

(2) Unless the staff member knows that the resident is asleep, the member shall knock on the door before the member enters the room of the resident.

(p) The administrator of a facility is responsible for carrying out this section.

(q) (1) A resident of a facility or the next of kin or domestic partner or guardian of the person of a resident may file a complaint about an alleged violation of this section.

(2) The complaint may be filed with the Department of Aging or the Department.

(3) The Secretary of Aging shall:

(i) Investigate the complaint; and

(ii) After the investigation, report the findings to the complainant.

(4) After receipt of the report, the complainant shall be given an opportunity for a hearing before the Department in accordance with the rules and regulations that the Department adopts.

(5) The Secretary of Aging or the Secretary's designee may request a hearing and act as a representative of the resident at the hearing under paragraph (4) of this subsection when:

(i) There is no guardian able and available or family member able, willing, and available; and

(ii) The resident consents.

(6) The Secretary of Aging or the Secretary's designee may, in any hearing under paragraph (4) of this subsection to which it is not a party under paragraph (5) of this subsection, take part as an interested party.

(r) If a resident is adjudicated a disabled person, is found to be medically incompetent by the attending physician of the resident, or is unable to communicate with others, the rights of the resident may be exercised by:

(1) The next of kin of the resident;

(2) The guardian of the person of the resident;

(3) The sponsoring agency of the resident; or

(4) Unless the facility is the representative payee, the representative payee that the Social Security Administration designates for the resident.

§19–345.

(a) A resident of a facility may not be transferred or discharged from the facility involuntarily except for the following reasons:

(1) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(2) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility;

(3) The health or safety of an individual in a facility is endangered;

(4) The resident has failed, after reasonable and appropriate notice, to pay for, or under Medicare or Medicaid or otherwise, to have paid for a stay at the facility; or

(5) The facility ceases to operate.

(b) A resident of a facility that is transferred or discharged from the facility involuntarily may not be transferred or discharged:

(1) To a location other than the location identified in the notice required under § 19–345.1(b)(3) of this subtitle, such as a hotel, shelter, or other temporary housing;

(2) Before the facility to which the resident is to be transferred has confirmed that:

(i) The resident may be transferred to the facility; and

(ii) The facility is prepared to accept the resident.

(c) (1) A Medicaid certified facility may not:

(i) Include in the admission contract of a resident any requirement that, to stay at the facility, the resident will be required to pay for any period of time or amount of money as a private pay resident for any period when the resident is eligible for Medicaid benefits; or

(ii) Transfer or discharge a resident involuntarily because the resident is a Medicaid benefits recipient.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, a Medicaid certified facility is presumed to be transferring or discharging a resident in violation of this subsection, if the resident is or becomes eligible for Medicaid benefits.

(ii) A Medicaid certified facility is not presumed to be transferring or discharging a resident in violation of this subsection for transferring or discharging a resident for nonpayment for services while the resident was ineligible for assistance under the medical assistance program.

§19–345.1.

(a) (1) A facility shall provide the resident with written notice of:

(i) Any proposed discharge or transfer; and

(ii) The opportunity for a hearing in accordance with the provisions of this section before the discharge or transfer.

(2) The notice required under paragraph (1) of this subsection shall include, at a minimum, the information listed under subsection (b) of this section.

(b) The Department shall prepare and provide each facility with a standardized form that provides, in clear and simple language, at least the following information:

(1) Notice of the intended discharge or transfer of the resident, including the proposed date of the intended discharge or transfer, which may change as a result of an appeal or the discharge planning process;

(2) Each reason for the discharge or transfer;

(3) The location to which the resident will be discharged or transferred, which may change as a result of an appeal or the discharge planning process;

(4) The name of the social worker or other professionally qualified staff, which may change during the discharge planning process, who:

(i) Is designated to provide social services and discharge planning services to the resident in connection with the discharge or transfer; and

(ii) Will be responsible for the development of the post discharge plan of care under subsection (g) of this section;

(5) A proposed date within 10 days after the date of the notice for a meeting between the resident, the resident's representative, and facility staff to develop the post discharge plan of care under subsection (g) of this section;

(6) (i) The right of the resident to request a hearing;

(ii) The name, mailing address, e–mail address, and telephone number of the entity to which the resident must submit a request for a hearing; and

(iii) Instructions for obtaining, completing, and submitting a request for a hearing;

(7) The right of the resident to consult with any lawyer the resident chooses;

(8) The availability of the services of Maryland Legal Aid, the Older American Act Senior Legal Assistance Programs, and other agencies that may provide assistance to individuals who need legal counsel;

(9) (i) The availability of the Long–Term Care Ombudsman Program to assist the resident; and

(ii) The mailing address, e–mail address, and telephone number of the Long–Term Care Ombudsman Program;

(10) The mailing address, e–mail address, and telephone number of Disability Rights Maryland; and

(11) The provisions of this section.

(c) Except as otherwise provided in this section, at least 30 days before the facility involuntarily transfers or discharges a resident, the facility shall:

(1) Provide to the resident the written notice required under subsection (a) of this section; and

(2) Provide the written notice required under subsection (a) of this section to:

(i) The resident;

(ii) The next of kin, guardian, or any other individual known to have acted as the resident's representative, if any;

(iii) The Long–Term Care Ombudsman; and

(iv) The Department.

(d) (1) (i) In accordance with regulations adopted by the Secretary, the facility shall provide the resident with an opportunity for a hearing on the proposed transfer or discharge.

(ii) The regulations adopted by the Secretary may provide for the establishment of an escrow account when:

1. The basis for the discharge is nonpayment; and

2. The resident continues to reside in the facility while the appeal is pending.

(2) Except as otherwise provided in this subsection, hearings on proposed transfers or discharges shall be conducted in accordance with the provisions of Title 10, Subtitle 2 of the State Government Article and the Medicaid Fair Hearing Procedures.

(3) Any hearing on a proposed discharge or transfer of a resident:

(i) Is not a contested case as defined in § 10–202 of the State Government Article; and

(ii) May not include the Secretary as a party.

(4) A decision by an administrative law judge on a proposed discharge or transfer of a resident:

(i) Is not a decision of the Secretary;

(ii) Unless appealed, is final and binding on the parties; and

(iii) May be appealed in accordance with § 10–222 of the State Government Article as if it were a contested case but the appeal does not automatically stay the decision of the administrative law judge.

(e) The facility shall provide the written notice required in subsection (a) of this section as soon as practicable before discharge or transfer if an emergency exists and health or safety of the resident or other residents would be placed in imminent and serious jeopardy if the resident were not transferred or discharged from the facility as soon as possible.

(f) (1) If the information in the notice provided under subsection (c) of this section changes before the discharge or transfer, the facility shall provide the changes to the recipients of the notice as soon as practicable after the new information becomes available.

(2) If a new notice is provided under paragraph (1) of this subsection, the following time requirements apply to the discharge or transfer of the resident:

(i) The resident may not be discharged or transferred for at least 30 days after the new notice has been provided to the resident if the new notice is provided before:

1. The expiration of the time period required under subsection (c) of this section; or

2. The date of an order of discharge issued by an administrative law judge under subsection (d) of this section; and

(ii) If the new notice is provided after a date described under item (i) of this paragraph:

1. If the original notice indicated a discharge location that was a licensed skilled nursing facility and the new notice changes the date of discharge or transfer only, the resident may be discharged on the earliest date that a bed is available at the facility;

2. If the new notice changes the location of discharge or transfer from a licensed skilled nursing facility to a different licensed skilled nursing facility, the resident may not be discharged or transferred for at least 7 days after the new notice has been provided to the resident; and

3. If the new notice changes the location of discharge or transfer from a licensed skilled nursing facility to a location that is not a licensed skilled nursing facility but is otherwise determined to be a safe discharge location under an appropriate clinical evaluation and as set forth in the post discharge plan of care, the resident may not be discharged or transferred for at least 30 days after the new notice has been provided to the resident.

(3) A new notice provided under this subsection shall:

(i) Indicate any differences between the prior notice and the new notice; and

(ii) Include a notice of the right to appeal the new notice:

1. For any discharge or transfer described under paragraph (2)(i) of this subsection; or

2. For a discharge or transfer described under paragraph (2)(ii)3 of this subsection, if the underlying basis of the original notice has changed.

(4) For a discharge or transfer described under paragraph (2)(ii)1 or 2 of this subsection, a new notice is not required to include a notice of the right to appeal the new notice.

(g) (1) Before any discharge or transfer and subject to paragraphs (4) and (5) of this subsection, a facility shall develop a post discharge plan of care for the resident to assist the resident with adjusting to the resident's new living environment and that:

(i) Addresses the resident's post discharge goals of care and treatment preferences;

(ii) Identifies each of the resident's reasonably anticipated medical and basic needs after discharge or transfer and establishes a plan for meeting those needs;

(iii) Identifies the address at which the resident will reside post discharge; and

(iv) In accordance with regulations adopted by the Secretary, provides a safe, secure, and sustainable environment for the resident.

(2) The facility shall designate a social worker or other professionally qualified staff member to coordinate the development of the resident's post discharge plan of care.

(3) The facility shall, if possible, meet with the resident and, with the resident's consent, the resident's representative within 10 days after providing the notice required under subsection (a) of this section to discuss the post discharge plan of care for the resident.

(4) (i) The resident's post discharge plan of care shall be developed with the participation of the resident and, with the resident's consent, the resident's representative.

(ii) If the post discharge plan of care was developed without the participation of the resident or the resident's representative, the facility shall include in the resident's medical record an explanation of why the resident or the resident's representative did not participate.

(5) The resident's post discharge plan of care shall be developed in consultation with:

(i) The resident's attending physician;

(ii) A registered nurse responsible for the care of the resident; and

(iii) Any other appropriate staff or professional involved with meeting the resident's medical needs.

§19–345.2.

(a) In addition to the provisions of §§ 19–345 and 19–345.1 of this subtitle, a facility may not involuntarily discharge or transfer a resident unless, within 48 hours before the discharge or transfer, the facility has:

(1) Provided or obtained:

(i) A comprehensive medical assessment and evaluation of the resident, including a physical examination, that is documented in the resident's medical record;

(ii) A post discharge plan of care for the resident that is developed, if possible, with the participation of the resident's next of kin, guardian, or legal representative in accordance with § 19–345.1 of this subtitle; and

(iii) Written documentation from the resident's attending physician indicating that the transfer or discharge is in accordance with the post discharge plan of care and is not contraindicated by the resident's medical condition; and

(2) Provided information to the resident concerning the resident's rights to make decisions concerning health care, including:

(i) The right to accept or refuse medical treatment;

(ii) The right to make an advance directive, including the right to make a living will and the right to appoint an agent to make health care decisions; and

(iii) The right to revoke an advance directive.

(b) Except as provided in subsection (d)(3) of this section, and at least 24 hours before discharge or transfer, the facility shall provide the resident and the resident's next of kin, guardian, or legal representative with:

(1) The written statement of the medical assessment and evaluation and written documentation from the resident's attending physician required under subsection (a) of this section;

(2) The post discharge plan of care developed under § 19–345.1 of this subtitle;

(3) The information necessary to assist the resident and the resident's next of kin, guardian, or legal representative in obtaining additional prescriptions for necessary medication through consultation with the resident's treating physician; and

(4) A written statement containing the date, time, method, mode, and destination of discharge.

(c) To the extent authorized under State and federal law, a facility shall provide at least a 3–day supply of medications currently being taken by the resident at the time of discharge or transfer.

(d) (1) Except as provided in paragraphs (2) and (3) of this subsection, a facility may not discharge or transfer a resident unless the resident is capable of and has consented in writing to the discharge or transfer.

(2) A facility may discharge or transfer a resident without obtaining the written consent of the resident for one of the reasons listed in § 19–345(a) of this subtitle if the discharge or transfer:

(i) Is in accordance with a post discharge plan of care developed under § 19–345.1 of this subtitle;

(ii) Is to the community in which the resident resided before becoming a resident of the facility unless the facility documents why it is in the best interest of the resident to be discharged to another location;

(iii) Is to another licensed provider, unless:

1. The resident is being discharged or transferred because the resident's health has improved sufficiently and the resident no longer needs the services provided by the facility;

2. The resident has no pending application to the medical assistance program or is ineligible for the medical assistance program and is being discharged or transferred for nonpayment under § 19–345(a)(4) of this subtitle; or

3. If the resident is or may be eligible for the medical assistance program:

A. The facility has fulfilled its obligation under § 19–344(c) of this subtitle to cooperate with and assist the resident or the resident's representative in seeking assistance from the medical assistance program and has documented the cooperation and assistance;

B. The resident or resident's representative has refused to apply for or seek assistance from the medical assistance program or has repeatedly failed, despite the facility's documented assistance, to make good–faith efforts to supply information or materials necessary for the medical assistance program to enroll the resident; and

C. The resident is being discharged for nonpayment under § 19–345(a)(4) of this subtitle; and

(iv) Is to a safe and secure environment.

(3) A facility that is certified as a continuing care provider under Title 10, Subtitle 4 of the Human Services Article is not subject to the provisions of subsection (b) of this section if:

(i) The facility transfers a resident to a lesser level of care within the same facility in accordance with a contractual agreement between the facility and the resident; and

(ii) The transfer is approved by the attending physician.

(e) (1) If the requirements of §§ 19–345 and 19–345.1 of this subtitle and subsections (a) and (b) of this section have been met, the resident's next of kin or legal representative shall cooperate and assist in the discharge planning process, including:

(i) Contacting, cooperating with, and assisting other facilities considering admitting the resident; and

(ii) Cooperating with governmental agencies, including meeting the requirements of § 19–344(c) of this subtitle to seek and pursue with due diligence assistance from the medical assistance program.

(2) A facility may, without requesting the appointment of a guardian, petition the appropriate circuit court for an order or injunction directed at the resident or agent of the resident for appropriate relief to enforce this subsection.

(f) If requested by any person during the process of transferring or discharging a resident or on its own initiative, the Office of the Attorney General may

investigate whether an abuse of funds under § 19–346 of this subtitle contributed to the decision to transfer or discharge the resident and may make appropriate referrals of the matter to other government agencies.

§19–345.3.

(a) The Secretary may impose a civil money penalty not to exceed $10,000 for:

(1) Each violation by a facility of § 19–345, § 19–345.1, or § 19–345.2 of this subtitle; or

(2) Each willful or grossly negligent violation by a resident's agent or legal representative of § 19–345, § 19–345.1, or § 19–345.2 of this subtitle.

(b) If a civil money penalty is imposed under this section, the facility or agent or legal representative of the resident shall have the right to appeal from an order imposing the civil money penalty in accordance with Title 10, Subtitle 2 of the State Government Article.

(c) (1) A resident, resident's agent, or resident's attorney, or the Attorney General on behalf of the resident, who believes that an involuntary discharge or transfer that violates the requirements of § 19–345, § 19–345.1, or § 19–345.2 of this subtitle is imminent or has taken place may request injunctive relief from a circuit court.

(2) To prevent irreparable harm to residents in a facility, the Attorney General may seek injunctive relief on behalf of the State on the basis of an imminent or ongoing violation of a basic right of residents of facilities provided under § 19–343(b)(2)(ii), (iv), (v), (viii), or (x) of this subtitle.

(3) In an action brought by the Attorney General under this subsection, the Attorney General may request that the court impose a civil penalty not to exceed $100,000 for each violation by a facility of § 19–345, § 19–345.1, or § 19–345.2 of this subtitle.

(4) In exercising the authority granted under paragraphs (2) and (3) of this subsection, the Attorney General may not duplicate any corrective action imposed by the Department for the same violation.

§19–346.

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

(2) "Abuse of funds" means using the assets or income of a resident:

(i) Against the express wish of the resident, if the expenditure was not necessary for the direct and immediate benefit and welfare of the resident; or

(ii) For the use or benefit of a person other than the resident if the expenditure is not also for the direct and immediate benefit of the resident or consistent with an express wish and past behavior of the resident.

(3) "Bank" means a bank, trust company, savings bank, or savings and loan association that:

(i) Is authorized to do business in this State; and

(ii) Is insured by the Federal Deposit Insurance Corporation, Federal Savings and Loan Insurance Corporation, or the State of Maryland Deposit Insurance Fund Corporation.

(4) "Facility" means:

(i) A hospital that is classified as a special hospital; or

(ii) A related institution.

(b) This section provides rights and remedies in addition to, and not in derogation of, any right or remedy that a resident of a facility has under any other law.

(c) Each resident of a facility may:

(1) Keep control over personal financial transactions unless:

(i) A court adjudicates the resident as a disabled person, in accordance with Title 13 of the Estates and Trusts Article; or

(ii) The Social Security Administration designates a representative payee to receive the Social Security funds for the use and benefit of the resident; and

(2) Choose any person, including the administrator of the facility or a designee of the administrator, to handle the financial transactions.

(d) (1) Each facility shall have adequate safeguards for property of a resident that is entrusted to the facility.

(2) (i) A facility to which money is entrusted shall deposit the money in an account if the facility cannot keep the money safely.

(ii) If the facility is operated by a State, county, or municipal agency and one resident entrusts more than $300 to the facility, the facility shall deposit the amount in excess of $300.

(iii) If the facility is operated by a person other than a State, county, or municipal agency and one resident entrusts more than $100 to the facility, the facility shall deposit the amount in excess of $100.

(iv) If the total amount of money that is entrusted to the facility by its residents exceeds $50 per resident, the facility shall deposit the amount in excess of $50 per resident or $1,000, whichever is less.

(3) A facility that is a related institution caring for individuals and whose administrator or bookkeeper has control over or access to the funds of a resident of the facility shall provide, as determined by the Department, either:

(i) A bond in an amount the Department requires;

(ii) A letter of credit equal to 3 times the average yearly balance of funds of all residents of the facility; or

(iii) Self–insurance if the net worth of the facility is at least 3 times the average yearly balance of funds of all residents of the facility.

(e) (1) A facility shall keep the accounts of its residents separate from the accounts of the facility.

(2) A facility that is operated by a person other than a State, county, or municipal agency shall:

(i) Establish a separate account with a bank in the name of each resident who entrusts more than $100 to the facility; and

(ii) Deposit other money that the facility is required to deposit, in either:

1. A separate account in the name of the resident; or

2. An account that is designated "General Fund of the Participating Residents of the (name of facility)".

(3) If the facility is operated by a State, county, or municipal agency, the facility may establish any required accounts with a bank or with the State, county, or municipal treasurer.

(f) (1) The accounts established by facilities shall be interest bearing accounts.

(2) All interest on money of a resident shall be credited to the resident.

(3) The State Treasurer or a county or municipal treasurer shall:

(i) Credit interest to the total account at a rate that equals the average interest rate on short term investments of the government; and

(ii) Allocate the interest among each resident participating in the account in proportion to the resident's participation in the total account.

(g) (1) A resident may get money as follows:

(i) If the facility has the money in possession, during the business hours of the facility; or

(ii) If a bank or the State or a county or municipal treasurer holds the money, within 3 banking days.

(2) A resident may give a licensed employee of the facility a limited power of attorney for the account of the resident. The Department shall prescribe the form to be used for this limited power of attorney.

(h) A facility may:

(1) Include in its operating costs the cost of establishing and servicing accounts for private, State, and federally funded residents; and

(2) Recover the cost through a daily or monthly charge for care or as provided in rules or regulations that the Secretary of Health and Human Services adopts under the Social Security Act.

(i) (1) A facility:

(i) Shall make an accounting of money of a resident to the resident or personal representative of the resident; and

(ii) In accordance with Department rules and regulations:

1. Shall keep, at the facility, records of all transactions with money of residents; and

2. Shall be subject to audit.

(2) Each facility that, under the rules and regulations of the Department, is a comprehensive care facility or an extended care facility shall:

(i) Have a monthly accounting available for inspection; and

(ii) Provide a quarterly statement on money of a resident:

1. To the resident; or

2. To a person exercising the right of the resident under § 19–344(r) of this subtitle.

(j) (1) If a facility discharges a resident, the facility shall:

(i) Return, on demand, the money of the resident that the facility has in possession to the resident or a designee of the resident if the resident or designee signs a receipt; and

(ii) Make the money of the resident in an account with a bank or the State, county, or municipal treasurer available to the resident or designee within 3 banking days.

(2) (i) This paragraph does not apply to a resident who is transferred temporarily to an acute care facility.

(ii) If a facility discharges a resident and the facility is the representative payee of the resident, the facility shall:

1. Promptly seek designation of a new representative payee; and

2. Transfer all money of the resident to the new representative payee.

(k) (1) If a resident has been absent from a facility for 1 year, the facility shall make reasonable attempts to find the resident or the personal representative or heirs of the resident to turn over the property of the resident unless the resident or the attending physician of the resident gives the facility written notice that the resident:

(i) Is expected to be readmitted to the facility; and

(ii) Wants the facility to continue to hold the property.

(2) All property and any income from property that a facility holds for a discharged or deceased resident are presumed abandoned in accordance with Title 17 of the Commercial Law Article, if the property and income are not claimed by the resident, personal representative, or heir within 1 year.

(l) (1) If the ownership of a facility changes, the transferor shall give the transferee a certified written audit of all funds that residents have entrusted to the facility.

(2) The transferee shall give to the transferor a signed receipt acknowledging the receipt of the accounts.

(m) A resident is not liable for any act or omission of the facility concerning the finances of the facility or the resident.

(n) (1) A person, including the legal representative of the resident, may not use the assets or income of a resident for any purpose that is not authorized by the resident, a designee, or a legal representative, including a representative payee of the resident.

(2) (i) A person may make a written or oral complaint if the person believes that there has been an abuse of funds.

(ii) The complaint shall set forth each reason for the belief that there has been an abuse of funds and any facts that the complainant has to support the complaint.

(iii) The complaint shall be made:

1. To the local department of social services for the county where the facility is located; or

2. If the patient is 65 years old or older, to the Secretary of Aging.

(3) The recipient of the complaint shall:

(i) Immediately give the administrator of the facility written notice of the complaint, unless the administrator is the alleged abuser and the recipient believes that the notice would affect an investigation adversely;

(ii) Investigate the complaint, as appropriate; and

(iii) Give the alleged abuser specific notice of the alleged abuse and an opportunity to reply to the charges stated in the complaint.

(4) On request of the Secretary of Aging or the local department of social services, a State's Attorney shall help in the investigation.

(5) If, after the completion of an investigation, there is probable cause to believe that there has been an abuse of funds, the Secretary of Aging or the local department of social services may:

(i) Refer the matter to the State's Attorney for appropriate action; and

(ii) On behalf of the resident, bring suit to recover the misused money, costs, and attorney's fees.

(6) A person who acts in good faith is not civilly or criminally liable for:

(i) Making a complaint under this subsection;

(ii) Participating in an investigation arising out of a complaint under this subsection; or

(iii) Participating in a judicial proceeding arising out of a report under this subsection.

(o) (1) If there is an abuse of funds, a person who misused the money is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000.

(2) Any person who violates another provision of this section is subject to a fine of $10,000.

§19–347.

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

(2) (i) "Abuse" means the non–therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce or resulting in mental or emotional distress.

(ii) "Abuse" does not include the performance of an accepted medical procedure that a physician orders.

(3) "Law enforcement agency" means the Department of State Police or a police agency of a county or municipal corporation.

(b) (1) A person who believes that a resident of a related institution has been abused shall report promptly the alleged abuse to an appropriate law enforcement agency and the Office of Health Care Quality in the Department.

(2) A report:

(i) May be oral or written; and

(ii) Shall contain as much information as the reporter is able to provide.

(3) (i) Unless the administrator is the alleged abuser, a recipient of a report promptly shall notify, to the extent allowed by federal and State law, the administrator of the related institution.

(ii) If the Office of Health Care Quality receives a report under paragraph (1) of this subsection, the Office promptly shall notify the Long–Term Care Ombudsman Program established under § 10–902 of the Human Services Article.

(c) Any employee of a related institution who is required to report alleged abuse under subsection (b) of this section, and who fails to report the alleged abuse within 3 days after learning of the alleged abuse, is liable for a civil penalty of not more than $1,000.

(d) (1) Unless otherwise provided, the law enforcement agency, with the assistance of the Secretary, shall:

(i) Investigate thoroughly each report of an alleged abuse; and

(ii) Attempt to ensure the protection of the alleged victim.

(2) The investigation shall include:

(i) A determination of the nature, extent, and cause of the abuse;

(ii) The identity of the alleged abuser; and

(iii) Any other pertinent fact or matter.

(3) Within 10 working days after the completion of the investigation, the law enforcement agency shall submit a written report of its findings to:

(i) The State's Attorney;

(ii) The Secretary;

(iii) The local long–term care ombudsman entity, as defined in § 10–901 of the Human Services Article;

(iv) Unless the administrator is the alleged abuser, the administrator of the related institution; and

(v) The Office of Health Care Quality of the Maryland Department of Health.

(e) The law enforcement agency:

(1) Shall refer to the Secretary for investigation reported instances of abuse involving any persistent course of conduct intended to produce or resulting in mental or emotional distress; and

(2) May refer to the Secretary for investigation reported instances of patient–to–patient abuse.

(f) Within 10 working days after the completion of an investigation under subsection (d) of this section, the Secretary shall submit a written report of its findings to:

(1) The State's Attorney;

(2) The local long–term care ombudsman entity, as defined in § 10–901 of the Human Services Article; and

(3) Unless the administrator is the alleged abuser, the administrator of the related institution.

(g) A person shall have the immunity from liability described under § 5–631 of the Courts and Judicial Proceedings Article for:

(1) Making a report under this section;

(2) Participating in an investigation arising out of a report under this section;

(3) Participating in a judicial proceeding arising out of a report under this section; or

(4) Participating in transferring, suspending, or terminating the employment of any individual who is believed to have abused or aided in abusing a resident under this section.

(h) (1) The Department shall provide each related institution with signs that set forth the reporting requirements under this section.

(2) The related institution shall post the signs conspicuously in the employee and public areas of the related institution.

§19–347.1.

(a) In this section, "inappropriate sexual behavior" has the meaning stated in COMAR 10.01.18.02.

(b) A privately owned and operated residential treatment center shall be subject to the reporting requirements established by the Department under COMAR 10.01.18.05 that apply when a staff member observes, receives a complaint regarding, or otherwise has reason to believe that an individual has been subjected to inappropriate sexual behavior.

§19–348.

(a) (1) Each hospital shall offer to each adult female inpatient of the hospital a Papanicolaou smear for detection of cervical cancer unless:

(i) The attending physician orders otherwise; or

(ii) The patient has had the examination within the preceding year.

(2) A patient may refuse the examination.

(b) (1) Each hospital shall offer mammography educational materials to each female patient when medically appropriate for the patient.

(2) The Department, in collaboration with the Maryland Hospital Association, the Medical and Chirurgical Faculty of Maryland, and appropriate advocacy groups, shall select and approve, or develop and print, and update as necessary, mammography educational materials for the purposes of paragraph (1) of this subsection.

§19–349.

At least 45 days before a related institution increases any fee or charge for a service of the related institution, the related institution shall give each resident or the authorized representative of the resident written notice of the amount of the increase.

§19–349.1.

(a) A hospital shall provide oral and written notice to a patient of the patient's outpatient status, the billing implications of the outpatient status, and the impact of the outpatient status on the patient's eligibility for Medicare rehabilitation services if:

(1) The patient receives on–site services from the hospital for more than 23 consecutive hours;

(2) The on–site services received by the patient include a hospital bed and meals that have been provided in an area of the hospital other than the emergency room; and

(3) The patient is classified as an outpatient at the hospital for observation rather than an admitted inpatient.

(b) The Department, in consultation with hospitals in the State, shall adopt by regulation standardized elements to be included in the written notice required under subsection (a) of this section.

§19–349.2.

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

(2) "Electronically" means a secure digital or electronic transmission in compliance with federal and State law, including by:

(i) Patient Internet portal;

(ii) Encrypted e–mail; or

(iii) Text message with a link to an encrypted notice.

(3) (i) "Outpatient facility fee" means a hospital outpatient charge approved by the Commission for an outpatient clinic service, supply, or equipment, including the service of a nonphysician clinician.

(ii) "Outpatient facility fee" does not include:

1. A charge billed for services delivered in an emergency department; or

2. A physician fee billed for professional services provided at the hospital.

(4) (i) "Patient" means an individual who receives health care.

(ii) "Patient" includes:

1. A person authorized to consent to health care for an individual consistent with the authority granted, including a guardian, surrogate, or person with a medical power of attorney;

2. An individual who is a minor, if the minor seeks treatment to which the minor has the right to consent and has consented under Title 20, Subtitle 1 of this article;

3. A parent, guardian, custodian, or representative of an individual who is a minor; and

4. A person authorized to consent to health care for an individual who is a minor consistent with the authority granted.

(b) Subject to subsections (c), (d), (e), and (f) of this section, if a hospital charges an outpatient facility fee, the hospital shall provide the patient with a written notice, separate from any other forms or notices, in the following form or a substantially similar form:

IMPORTANT FINANCIAL INFORMATION

(Patient Name)_____ Appointment Date:_____

Notice Of Hospital Outpatient Facility Fee And Billing Disclosure

a. Your appointment with (provider, practice, or outpatient facility name) will take place in an outpatient department of (hospital name).

b. (Hospital name) will charge an outpatient facility fee that is separate from and in addition to the bill you will receive from (provider).

c. You will receive two charges for your visit:

1. a provider services bill from (provider); and

2. a hospital facility bill from (hospital name).

Expected Fee

(if known) The amount of the facility fee that will be charged by (hospital name) for your appointment is $ _____. or

(if unknown) (Hospital name's) facility fee is likely to range from $_____ to $_____. and

(if unknown) Based on appointments like the one you are scheduled for, we estimate the facility fee to be $_____. and

(if unknown) We are providing you with a range of fees and an estimate because the actual amount of the facility fee will depend on the hospital services that are actually provided. The fee could be higher if you require services during your appointment that we cannot reasonably predict today.

Financial help for your portion of the outpatient facility fee bill may be available. If you need financial help with the outpatient facility bill, please contact (hospital financial assistance office, with telephone number and direct website address).

Receiving services here may result in greater financial liability than receiving services at a location where a facility fee may not be charged.

(if applicable) No Facility Fee Location

You can see (provider) at another location that does not charge a facility fee.

(address and contact information)

Contact your insurance carrier to see if (provider) is a participating provider and in–network at the (address of alternative location) location.

Insurance Information

(1) The amount of the facility fee that you will be responsible for paying will depend on your insurance coverage.

(2) Insurance companies could impose deductibles or higher copayment or coinsurance amounts for services provided in hospital outpatient departments.

(3) If you have insurance, you should contact your carrier to determine your insurance coverage and your estimated financial responsibility for the facility fee, including copayments, coinsurance, and deductible amounts for the outpatient facility fee.

Facility Fee Complaints

If you have a complaint about an outpatient facility fee charge, please first contact the hospital, (hospital billing office contact information).

If the complaint is unresolved, you may then file the complaint with the Health Services Cost Review Commission, (contact information).

If you need additional information regarding your facility fee charges or if you need assistance mediating a facility fee complaint against a hospital, contact the Health Education and Advocacy Unit of the Office of the Attorney General, 1–877–261–8807 | Heau@oag.state.md.us | www.MarylandCares.org.

Acknowledgment

(1) I understand that I will be billed a hospital facility fee and a provider fee.

(2) (Hospital name) provided me with information on the facility fees that will be billed for my appointment.

(3) I understand that the fee could vary based on conditions and services provided to me that the hospital cannot reasonably predict today.

(4) I understand that my out–of–pocket costs will depend on my insurance coverage.

_____(initial here) – by initialing here, I confirm that I received the facility fee information at the time I made my appointment with (provider).

By signing this form, I acknowledge that I have received this information before receiving services today.

_____ _____

Signature Date

To request this notice in an alternative format, please call (contact information) or e–mail (contact information).

(Same sentence in Spanish).

(c) If a patient does not speak English or requires the notice required under subsection (b) of this section to be in an alternative format, the hospital shall, to the extent practicable, provide the notice in a language or format that is understood by the patient.

(d) (1) A hospital shall determine the range of hospital outpatient facility fees and fee estimates, based on typical or average facility fees for the same or similar appointments, to be provided in the notice required under this section, consistent with the hospital's most recent rate order as approved by the Commission.

(2) Each hospital that charges an outpatient facility fee shall use the range of hospital outpatient facility fees and fee estimates determined under paragraph (1) of this subsection.

(e) (1) For an appointment made in person or by telephone:

(i) Oral notice of all the information that would be provided in the form required under subsection (b) of this section shall be given at the time the appointment is made; and

(ii) Except as provided in paragraph (3) of this subsection, the written notice required under subsection (b) of this section shall be sent to the patient electronically at the time the appointment is made.

(2) For an appointment made electronically or using a website, the written notice required under subsection (b) of this section shall be:

(i) Provided at the time the appointment is made; and

(ii) Sent to the patient electronically at the time the appointment is made.

(3) If the patient refuses electronic communication under paragraph (1)(ii) of this subsection, the written notice shall be sent to the patient by first–class mail at the time the appointment is made.

(f) Before professional medical services are provided on the date of the appointment, the patient shall acknowledge in writing that the notice required under this section was provided at the time the appointment was made.

(g) A hospital may not charge, bill, or attempt to collect an outpatient facility fee unless the patient was given notice in accordance with this section.

(h) (1) On or before January 31 each year, beginning in 2022, each hospital shall report to the Health Services Cost Review Commission a list of the hospital–based, rate–regulated outpatient services provided by the hospital.

(2) On or before February 28 each year, beginning in 2022, the Health Services Cost Review Commission annually shall:

(i) Post on its website the list of the hospital–based, rate–regulated outpatient services reported by each hospital under paragraph (1) of this subsection; and

(ii) Provide the list of the hospital–based, rate–regulated outpatient services reported by each hospital to the Maryland Insurance Administration and the Health Education and Advocacy Unit in the Office of the Attorney General.

(3) When lack of notice in accordance with this section is alleged in a consumer complaint, the Commission shall give consideration in its investigatory and audit procedures as to whether notice was not feasible due to circumstances beyond the hospital's control.

§19–350.

(a) (1) This section applies only to:

(i) Related institutions as defined in § 19–301 of this subtitle; and

(ii) Hospitals as defined in § 19–301 of this subtitle.

(2) Nothing in this section shall apply to charges for services that are set pursuant to § 16–201 of this article.

(b) (1) (i) On request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

(ii) The written estimate shall state clearly that it is only an estimate and actual charges could vary.

(iii) A hospital may restrict the availability of a written estimate to normal business office hours.

(iv) This paragraph does not apply to emergency services.

(2) Within 30 days after discharge of an individual from a hospital, the hospital shall give the individual a summary financial statement that clearly describes:

(i) The total charges incurred;

(ii) If readily ascertainable, a summary of the total charges under the major services categories, including:

1. Room and board;

2. Diagnostic services;

3. Therapeutic services;

4. Emergency room services;

5. Drugs and IV solutions; and

6. Miscellaneous other supplies and services;

(iii) If applicable, the name of the primary and secondary insurer to which a claim has been or will be filed on the individual's behalf;

(iv) That charges for services provided by a physician are not included in the total hospital charges and are billed separately; and

(v) The individual's right to request an itemized statement of the account within 1 year of receipt of the summary statement.

(3) Within 30 days after an individual's request as provided under paragraph (2)(v) of this subsection, the hospital shall provide the individual a statement of the account that:

(i) Is itemized; and

(ii) Describes briefly but clearly each item and the amount charged for it.

(c) (1) Unless a related institution contracts with its residents to provide care for an all–inclusive preestablished fee, on demand made within 90 days after service is provided to a resident, the related institution shall give the resident or representative of the resident a financial statement that:

(i) Is itemized;

(ii) Describes briefly but clearly each item and the amount charged for it; and

(iii) Identifies the payor to whom a claim has been forwarded.

(2) A related institution may not be required to give a resident more than 1 itemized statement in any 90–day period.

(d) (1) On demand made within 30 days after payment of any charge for an individual, a hospital or related institution shall give the individual or representative of the individual a financial statement that:

(i) Is itemized; and

(ii) Describes briefly but clearly each item and the amount charged for it.

(2) A hospital or related institution is subject to a fine of $300 if it fails to:

(i) Comply with this subsection; or

(ii) Give the individual or representative a reasonable written explanation for any delay in complying with this subsection.

(e) A hospital or related institution may not demand or accept final payment or recover for money unless the hospital or related institution has given the financial statements required under this section.

§19–350.1.

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

(2) "Third party payor" means any person that administers or provides reimbursement for hospital benefits on an expense incurred basis including:

(i) A health maintenance organization issued a certificate of authority in accordance with Subtitle 7 of this title;

(ii) A health insurer or nonprofit health service plan authorized to offer health insurance policies or contracts in this State in accordance with the Insurance Article; or

(iii) A third party administrator registered under the Insurance Article.

(3) "Uniform claims form" means the claim or billing form for reimbursement of hospital services adopted by the Insurance Commissioner under § 15-1003 of the Insurance Article.

(b) When submitting a claim or bill for reimbursement to a third party payor, a hospital shall use the uniform claims form.

(c) The uniform claims form submitted under this section:

(1) Shall be properly completed; and

(2) May be submitted by electronic transfer.

(d) The Secretary may impose a penalty not to exceed $500 on any hospital that violates the provisions of this section.

§19–351.

(a) Except as provided in subsections (b) and (d) of this section, this subtitle does not affect the right of a hospital or related institution to employ or appoint staff.

(b) (1) A hospital or related institution that provides services that licensed podiatrists are authorized to perform under Title 16 of the Health Occupations Article, other than incidental care, shall include, in its bylaws, rules, or regulations, provisions for use of facilities by and staff privileges for qualified podiatrists.

(2) The hospital or related institution may restrict use of facilities and staff privileges by podiatrists to those podiatrists who meet the qualifications that the hospital or related institution sets for granting those privileges.

(3) The qualifications that the hospital or related institution sets for granting privileges for services that licensed podiatrists are authorized to perform under Title 16 of the Health Occupations Article shall include consideration of the training, education, and experience of the podiatrist.

(c) (1) A hospital or related institution shall include in its bylaws, rules, or regulations provisions for use of facilities by and staff privileges for qualified dentists.

(2) The hospital or related institution may restrict use of facilities and staff privileges by dentists to those dentists who meet the qualifications that the hospital or related institution sets for granting those privileges.

(d) (1) A hospital or related institution that provides services of the type that licensed psychologists are permitted to perform under Title 18 of the Health Occupations Article shall include in its bylaws, rules, or regulations, provisions for use of facilities by and staff privileges for qualified psychologists.

(2) The hospital or related institution may restrict use of facilities and staff privileges by psychologists to those psychologists who meet the qualifications that the hospital or related institution sets for granting those privileges.

(3) (i) Nothing in this subsection shall be construed to require a hospital to:

1. Grant admitting privileges to a psychologist; or

2. Permit the exercise of those privileges granted by the hospital board of trustees to psychologists without appropriate collaboration with the physician who has privileges to admit and attend patients in the unit of the facility where the patient is being treated and who has ongoing responsibility for the patient.

(ii) In the event of a disagreement between the psychologist and the physician concerning the patient's treatment, the decision of the physician who has ongoing responsibility for the patient shall govern.

§19–352.

(a) In this section, "nursing home" means a related institution that is classified as a nursing home.

(b) A nursing home may not assess an interest penalty on charges for services provided to a resident until, whichever is later in time:

(1) 45 days after the nursing home mails an itemized statement of the charges to the person responsible for payment of the charges; or

(2) 30 days after the end of the period for which the itemized statement of the charges covers.

(c) The nursing home shall include on the itemized statement of charges a statement in bold and conspicuous print as to when interest may be assessed consistent with the provisions of subsection (b) of this section.

§19–353.

A health care facility that is not covered under § 19-342 or § 19-343 of this subtitle shall include in a patient's bill of rights or similar document that is provided to the patient or resident a statement that a patient or resident has the right to expect and receive appropriate assessment, management, and treatment of pain as an integral component of that patient's or resident's care.

§19–354.

A hospital or related institution that is a charitable institution shall have the immunity from liability described under § 5-632 of the Courts and Judicial Proceedings Article.

§19–355.

(a) In this section, "gender identity" and "sexual orientation" have the meanings stated in § 20–101 of the State Government Article.

(b) This section does not prohibit a hospital or related institution that is licensed or otherwise regulated by the Department or a unit of the Department from refusing, withholding from, or denying any person services for failure to conform to

the usual and regular requirements, standards, and regulations imposed by the licensed or regulated hospital or related institution, unless the refusal, withholding, or denial is based on discrimination on the grounds of race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability.

(c) A hospital or related institution may not discriminate against any individual with respect to the individual's medical care because of the race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability of the individual.

(d) The Commission on Civil Rights shall enforce this section as provided in Title 20 of the State Government Article.

§19–356.

(a) A hospital or related institution may not grant a discount to or receive a discount from any medical referral service or in any manner split fees with a medical referral service.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 for the first offense and not exceeding $500 for each subsequent conviction for a violation of the same provision.

§19–357.

(a) A person who operates a hospital or related institution may not ask for or receive any rebate, commission, or other consideration from a pharmacy or other provider of drugs, prescriptions, or pharmaceutical services.

(b) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 and is subject to suspension or revocation of the license.

(c) In addition to the penalties provided in subsection (b) of this section, the Department may declare a person who violates this section to be ineligible to participate in the Maryland Medical Assistance Program.

§19–358.

(a) A person may not operate a hospital or related institution unless issued a registration permit or licensed by the Secretary.

(b) A hospital may not provide or hold itself out as providing comprehensive physical rehabilitation services, as defined in § 19-1201 of this title, or operate as a special rehabilitation hospital unless the hospital is classified as a special rehabilitation hospital by the Secretary.

(c) Unless a health care facility is classified as a special rehabilitation hospital by the Secretary, a health care facility may only offer those physical rehabilitation services which are appropriate and necessary to the care, treatment, or support of the acute, chronic disease, or long-term care patient.

(d) (1) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for the first offense and not exceeding $10,000 for each subsequent conviction for a violation of the same provision. Each day a violation is continued after the first conviction is a subsequent offense.

(2) The Secretary may impose a civil money penalty not to exceed $10,000 for each offense under this section.

§19–359.

(a) A person who operates a related institution in violation of the rules and regulations that the Secretary adopts for related institutions is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000. Each day a violation is continued after the first conviction is a separate offense.

(b) The Secretary may impose a civil money penalty not to exceed $10,000 for each offense under this section.

(c) (1) If a civil money penalty is imposed under this section or under § 19-358 of this subtitle, the Secretary shall issue an order which shall state the basis on which the order is made, the amount of the civil money penalty imposed, and the manner in which the amount of the civil money penalty was calculated.

(2) The operator of an unlicensed hospital or an unlicensed or unregistered related institution shall have the right to appeal from the order imposing the civil money penalty in accordance with Title 10, Subtitle 2 of the State Government Article (Administrative Procedure Act - Contested Cases).

§19–360.

(a) This section applies to:

(1) Nonaccredited hospitals found in violation of the standards adopted under this subtitle;

(2) Accredited hospitals:

(i) Found deficient as a result of the complaint review process; or

(ii) Subject to inspection by the Department under § 19–2302(e) of this title as a result of a serious or life–threatening patient care deficiency identified by the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare and Medicaid Services, or the Department;

(3) Accredited residential treatment centers subject to inspection by the Department under § 19–2302(e) of this title as a result of a serious or life–threatening patient care deficiency identified by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, the Centers for Medicare and Medicaid Services, or the Department; and

(4) Health care facilities that fail to achieve substantial compliance with the standards of an approved accreditation organization under § 19–2302(c)(2) of this title.

(b) (1) If conditions are found to be detrimental to patient health, safety, or welfare, the Department shall allow the hospital, residential treatment center, or health care facility 30 days to address the deficiencies in other than serious or life-threatening situations.

(2) If corrections cannot be completed within the 30-day period, the Department may accept a plan of correction from the hospital, residential treatment center, or health care facility based upon evidence that corrective action has been undertaken by the hospital or residential treatment center.

(3) Periodic updates of the plan of correction from the hospital, residential treatment center, or health care facility may be requested by the Department.

(c) If a serious or life-threatening condition is found to exist, the Department may order the hospital, residential treatment center, or health care facility to initiate immediate corrective action, and the hospital or residential treatment center shall be subject to inspection by the Department under § 19-308 of this subtitle.

(d) If the Secretary determines that a serious or life-threatening patient care deficiency exists and the hospital, residential treatment center, or health care facility fails to correct the deficiency through implementation of immediate corrective action, the Secretary may:

(1) For an accredited hospital or accredited residential treatment center:

(i) Revoke or restrict the licensure entitlement of § 19-319(c)(2) of this subtitle;

(ii) Impose a civil monetary penalty of not more than $10,000 per instance or per day;

(iii) Impose a directed plan of correction; and

(iv) Impose appropriate operating conditions.

(2) For an unaccredited hospital or health care facility:

(i) Revoke or restrict the license to operate;

(ii) Impose a civil monetary penalty of not more than $10,000 per instance or per day;

(iii) Impose a directed plan of correction; and

(iv) Impose appropriate operating conditions.

(e) In determining the action to be taken under subsection (d) of this section, the Secretary shall consider the following factors:

(1) The number, nature, and seriousness of the patient care deficiencies;

(2) The extent to which the patient care deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;

(3) The degree of risk to the health, life, or safety of the patients of the hospital, residential treatment center, or health care facility caused by the patient care deficiency or deficiencies;

(4) The efforts made by, and the ability of, the hospital, residential treatment center, or health care facility to correct the patient care deficiency or deficiencies through implementation of immediate corrective action; and

(5) The hospital's, residential treatment center's, or health care facility's history of compliance.

(f) The remedies provided by this section are in addition to any other remedies available to the Department at law or equity.

§19–361.

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

(b) "Hazardous condition" means a condition existing in a related institution that does not constitute a life-threatening, health, or fire safety deficiency, as described in § 19-328 of this subtitle, but which is a violation of departmental regulations which is likely to endanger the health, life, or safety of patients.

(c) "Intermediate sanction" means the establishment of an escrow account by a related institution.

§19–362.

(a) (1) An intermediate sanction may be imposed consistent with this section when a hazardous condition exists in a related institution and that condition is not remedied pursuant to the following sections.

(2) In determining whether a hazardous condition exists, the following factors shall be considered:

(i) The potential impact of the condition on the health, life, or safety of patients;

(ii) The period of time during which the condition has existed;

(iii) The frequency of occurrence of the condition; and

(iv) The efforts made by the related institution to correct the condition.

(3) Upon determination by the Department that a hazardous condition exists, the Department will notify the facility that a hazardous condition exists which may subject the facility to a sanction.

(b) (1) The Department shall order that a plan of correction which is acceptable to the Department be submitted within 10 working days.

(2) The Department shall notify the related institution within 3 working days of receipt of the plan of correction as to whether it is or is not acceptable.

(3) If the Department determines that the plan is not acceptable, the related institution will resubmit a revised plan within 5 working days of such notification.

(4) The Department will schedule reinspections of the facility based on time frames established in the plan of correction.

(c) (1) If the Department determines that an acceptable plan of correction has not been submitted, that the hazardous condition has not been corrected, or that progress satisfactory to the Department has not been accomplished, the Department shall order the facility ownership and appropriate administrative personnel to appear before a representative of the Department.

(2) Following the appearance, or if the facility ownership fails to appear, a decision may be issued which:

(i) Extends the time frame in which the hazardous condition must be corrected; or

(ii) Proposes the imposition of the sanction.

(d) (1) If a sanction is proposed, or if at the end of the extended time frame the hazardous condition has not been corrected, the Secretary may issue a sanction order.

(2) The sanction order shall state the number of days within which the hazardous condition must be corrected and shall require the related institution to establish an escrow account in accordance with § 19-363 of this subtitle.

§19–363.

(a) The funds in the escrow account shall be used only for the purposes of remedying the hazardous condition.

(b) The amount of the escrow account shall be the estimated cost of correcting the hazardous condition or $5,000 whichever is greater.

(c) The escrow account is to be established by the related institution at an authorized financial institution selected by the related institution.

(d) Current operating funds may not be used to establish the escrow account.

§19–364.

(a) The related institution shall have the right to appeal from the order within 5 working days from the receipt of the order.

(b) The appeal shall be heard by the hearings office of the Department, which shall render the final agency decision for purposes of judicial review.

(c) Imposition of the sanction shall be stayed until the final decision is issued pursuant to subsection (m) of this section.

(d) A hearing on the sanction shall be held within 10 working days of the request for hearing.

(e) The parties to the hearing shall be the aggrieved related institution and the Secretary.

(f) The parties are entitled to be represented by counsel.

(g) The hearings office may permit, modify, or deny a timely request by the related institution for prehearing discovery.

(h) The hearings office, upon its own motion or upon motion of either party, may subpoena any person or evidence, administer oaths, and take depositions and other testimony.

(i) The hearing shall inquire fully into all of the matters at issue and shall receive into evidence the testimony of witnesses and any documents which are relevant and material to such matters.

(j) The parties shall have the right to present evidence and testimony and to cross-examine that presented by the opposing party.

(k) The purpose of the hearing is to consider and render a decision on the following matters:

(1) The existence of a hazardous condition;

(2) If a hazardous condition exists, the amount of money to be placed into the escrow account; and

(3) The length of time in which the hazardous condition must be corrected.

(l) The burdens of proof are as follows:

(1) The related institution has the burden of proof with respect to establishing the lack of the cited deficiency or deficiencies; and

(2) The Secretary has the burden of proof with respect to the establishment of a deficiency or deficiencies as constituting a hazardous condition.

(m) A decision shall be rendered by the hearings office within 7 days of the hearing. The decision shall be the final agency decision of the Department, subject to appeal pursuant to § 19-367 of this part.

§19–365.

(a) Escrowed funds may be released by the escrow agent:

(1) If the related institution can present specific bills (vouchers) for correcting the hazardous condition which have been certified by the Secretary as appropriate; and

(2) In the absence of bills or vouchers, the related institution has received written approval from the Secretary that the expenditure is appropriate for correcting the hazardous condition.

(b) The escrow is terminated and the balance, if any, in the account is returned to the related institution when:

(1) The Secretary certifies that the hazardous condition is corrected;

(2) After the time period set by the Secretary, the Secretary certifies that adequate progress has been made toward correcting the hazardous condition; or

(3) The related institution changes ownership.

§19–366.

(a) If the related institution fails to establish the escrow account as ordered, the Secretary may petition the appropriate circuit court to require compliance with the sanction order.

(b) If the hazardous condition is not corrected or progress acceptable to the Secretary is not made within the time frame set by the sanction order, the Secretary may:

(1) Petition the appropriate circuit court to require the related institution to comply with the sanction order; or

(2) Order the forfeiture of the escrowed funds and/or remove all patients and initiate procedures to revoke the related institution's licensure in accordance with § 19–327 of this subtitle.

(c) Upon petition to the circuit court under subsection (b)(1) of this section, and following notification to the Secretary by the circuit court that the related institution has failed to comply with a court order, the Secretary may impose further sanctions in accordance with subsection (b)(2) of this section. This sanction is in addition to all remedies otherwise available to the circuit court for enforcement of a court order.

§19–367.

(a) Either party aggrieved by the decision of the hearings office shall have the right to appeal that decision.

(b) A related institution subject to a sanction shall have the right to appeal a decision by the Secretary that the hazardous condition has not been corrected or that inadequate progress has been made toward correcting the hazardous condition.

(c) Such appeal shall be filed within 30 days of the action to be appealed.

(d) The appeal shall be taken directly to the circuit court of the jurisdiction in which the related institution is located.

(e) Appeal to the circuit court does not stay the imposition of the sanction.

§19–370.

(a) In this Part IX of this subtitle the following words have the meanings indicated.

(b) "Advice" means the recommendations of the advisory committee.

(c) "Advisory committee" means a patient care advisory committee.

(d) "Petitioner" means one of the following individuals who is responsible for making a decision with a medical consequence for a patient:

(1) A patient;

(2) A physician;

(3) A registered nurse;

(4) A social worker;

(5) A family member;

(6) A guardian;

(7) An individual with a power of attorney to make a decision with a medical consequence for a patient; or

(8) Any other health care practitioner directly involved in the care of the patient.

(e) "Related institution" does not include a domiciliary care home that is operated independent of any other related institution.

§19–371.

(a) Each hospital and each related institution shall establish:

(1) An advisory committee as provided in this Part IX of this subtitle; and

(2) A written procedure by which the advisory committee shall be convened.

(b) An advisory committee at a related institution may function:

(1) Solely at that related institution;

(2) Jointly with a hospital advisory committee; or

(3) Jointly with an advisory committee representing no more than 30 other related institutions.

§19–372.

(a) (1) Each advisory committee shall consist of at least 4 members, including:

(i) A physician not directly involved with the care of the patient in question;

(ii) A registered nurse not directly involved with the care of the patient in question;

(iii) A social worker; and

(iv) The chief executive officer or a designee from each hospital and each related institution represented on that advisory committee.

(2) The advisory committee may consist of as many other individuals as each represented hospital and related institution may choose, including:

(i) Representatives of the community; and

(ii) Ethical advisors or clergy.

(3) As part of the advisory committee's deliberations, the advisory committee, in appropriate cases, shall consult:

(i) All members of the patient's treatment team;

(ii) The patient;

(iii) The patient's family; and

(iv) In a case involving the options for medical care and treatment of a child with a life-threatening condition, a medical professional familiar with pediatric end-of-life care, if a medical professional with this expertise is not already a member of the committee.

(b) The petitioner may be accompanied by any persons the petitioner desires.

§19–373.

(a) In addition to any other duties or responsibilities, and on the request of a petitioner, the advisory committee shall offer advice in cases involving individuals with life-threatening conditions.

(b) In addition to any other duties or responsibilities, the advisory committee may:

(1) Educate represented hospital and related institution personnel, patients, and patients' families concerning medical decision-making; and

(2) Review and recommend institutional policies and guidelines concerning the withholding of medical treatment.

§19–374.

(a) On the request of a petitioner, an advisory committee shall give advice concerning the options for medical care and treatment of an individual with a life-threatening condition.

(b) (1) The advisory committee shall make a good faith effort to notify a patient, a patient's immediate family members, a patient's guardians, and an individual with a power of attorney to make a decision with a medical consequence for a patient, of the individual's right:

(i) To be a petitioner;

(ii) To meet with the advisory committee concerning the options for medical care and treatment; and

(iii) To receive an explanation of the basis of the advisory committee's advice.

(2) Any information or document that indicates the wishes of the patient shall take precedence in the deliberations of the advisory committee.

(c) An advisory committee or a member of an advisory committee who gives advice in good faith may not be held liable in court for the advice given.

(d) A person that assists one or more hospitals or related institutions in the establishment of an advisory committee may not be held liable in court for any advice given in good faith by that person, the related institution, the advisory committee, or any member of the advisory committee and the committee and its members may not be held liable for any advice given in good faith.

(e) (1) The proceedings and deliberations of an advisory committee are confidential as provided in § 1-401 of the Health Occupations Article.

(2) The advice of an advisory committee concerning a patient's medical care and treatment shall become part of the patient's medical record and is confidential under §§ 4-301 and 4-302 of this article.

(f) A hospital or related institution may not be held liable in a civil action for failing to carry out the advice of an advisory committee concerning a patient's medical care if the advice given is inconsistent with the written policies of the hospital or related institution.

§19–377.

(a) In this section, "safe patient lifting" means the use of mechanical lifting devices by hospital employees, instead of manual lifting, to lift, transfer, and reposition patients.

(b) On or before December 1, 2007, each hospital shall establish a safe patient lifting committee with equal membership from management and employees.

(c) (1) On or before July 1, 2008, the safe patient lifting committee shall develop a safe patient lifting policy for the hospital.

(2) The goal of the policy shall be to reduce employee injuries associated with patient lifting.

(d) While developing a safe patient lifting policy, the committee shall consider, based on the patient population of that hospital, the appropriateness and effectiveness of:

(1) Developing or enhancing patient handling hazard assessment processes;

(2) Enhanced use of mechanical lifting devices;

(3) Developing specialized lift teams;

(4) Training programs for safe patient lifting required for all patient care personnel at the hospital;

(5) Incorporating physical space and construction design for mechanical lifting devices in any architectural plans for hospital construction or renovation; and

(6) Developing an evaluation process to determine the effectiveness of the policy.

§19–380.

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

(b) (1) "Aftercare" means any assistance provided by a lay caregiver to a patient after discharge of the patient.

(2) "Aftercare" includes tasks that are limited to the patient's condition at the time of discharge that do not require a licensed professional.

(c) "Discharge" means the exit or release of a patient from inpatient care in a hospital to the residence of the patient.

(d) "Lay caregiver" means an individual who:

(1) Is an adult;

(2) Is designated as a lay caregiver by a patient or the legal guardian of a patient under this part; and

(3) Performs aftercare for the patient at the residence of the patient.

(e) (1) "Residence" means a dwelling that a patient considers to be home.

(2) "Residence" does not include:

(i) A rehabilitation facility;

(ii) A hospital;

(iii) A nursing home;

(iv) An assisted living facility; or

(v) A group home licensed by the State.

§19–381.

(a) A hospital shall provide a patient or the legal guardian of a patient with an opportunity to designate one lay caregiver before discharge of the patient.

(b) If a patient or the legal guardian of a patient declines to designate a lay caregiver:

(1) The hospital shall document the decision in the patient's medical record; and

(2) The hospital shall be deemed to be in compliance with the provisions of this part.

(c) If a patient or the legal guardian of a patient designates a lay caregiver, the hospital shall:

(1) Record in the patient's medical record:

(i) The designation of the lay caregiver;

(ii) The relationship of the lay caregiver to the patient; and

(iii) The name, telephone number, and address of the lay caregiver; and

(2) Request the written consent of the patient or the legal guardian of the patient to release medical information to the lay caregiver in accordance with:

(i) The procedures of the hospital for releasing personal health information; and

(ii) All applicable federal and State laws.

(d) If a patient or the legal guardian of a patient declines to consent to the release of medical information to the lay caregiver, the hospital is not required to:

(1) Provide to the lay caregiver the notice required under § 19–382 of this part; or

(2) Consult with the lay caregiver or provide to the lay caregiver information contained in the discharge plan issued under § 19–383 of this part.

(e) A patient or the legal guardian of a patient may change the designation of a lay caregiver in the event the lay caregiver becomes incapacitated.

(f) A designation of a lay caregiver by a patient or the legal guardian of a patient under this section does not obligate an individual to perform any aftercare for the patient.

(g) This section may not be construed to require a patient or the legal guardian of a patient to designate a lay caregiver.

§19–382.

If a patient or the legal guardian of a patient has designated a lay caregiver under § 19–381 of this part, the hospital shall notify the lay caregiver of the discharge of the patient or the transfer of the patient to another hospital or facility licensed by the State as soon as practicable.

§19–383.

(a) As soon as practicable before discharge of a patient, a hospital shall attempt to:

(1) Consult with the patient's lay caregiver to prepare the lay caregiver for aftercare; and

(2) Issue a discharge plan that describes the aftercare needs of the patient.

(b) The inability of a hospital to consult with a patient's designated lay caregiver may not interfere with, delay, or otherwise affect the medical care provided to the patient or the patient's discharge.

§19–384.

A hospital's discharge process may incorporate established evidence–based practices, including those described in:

(1) Standards for accreditation adopted by The Joint Commission or another nationally recognized hospital accreditation organization; and

(2) The Conditions of Participation for hospitals adopted by the Centers for Medicare and Medicaid Services.

§19–385.

(a) This part may not be construed to:

(1) Affect the rights of an agent to make health care decisions under Title 5, Subtitle 6 of this article; or

(2) Create a private right of action against a hospital, a hospital employee, or a duly authorized agent of a hospital, or otherwise supersede or replace existing rights or remedies under any other State or federal law.

(b) No federal or State:

(1) Funds may be used for payment of a lay caregiver; and

(2) Program funding may be impacted by this part.

§19–388.

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

(b) "Coordinators" means the pediatric overstay coordinator in the Department and the pediatric overstay coordinator in the Department of Human Services.

(c) "Pediatric hospital overstay patient" means a patient under the age of 22 years who remains in an inpatient unit or emergency department of a hospital for more than 48 hours after being medically cleared for discharge or transfer.

§19–389.

(a) (1) Except as provided in paragraph (2) of this subsection, the Department shall ensure that a pediatric hospital overstay patient is transferred to and treated in the least restrictive setting when clinically indicated and when possible.

(2) The Department of Human Services, in coordination with the Department, shall ensure that a pediatric hospital overstay patient who is a child committed to the care and custody of the Department of Human Services is transferred to and treated in the least restrictive setting when clinically indicated and when possible.

(b) If a pediatric hospital overstay patient remains in the hospital for more than 48 hours and the registry established under § 7.5–802 of this article indicates that an appropriate inpatient bed is available, the hospital shall seek the transfer to maintain the clinical stability of the patient.

(c) Notwithstanding any other provision of law, to ensure that a pediatric hospital overstay patient is treated in the least restrictive setting, a hospital may concurrently explore in–State and out–of–state placement options.

§19–390. IN EFFECT

(a) The Department and the Department of Human Services shall establish a pediatric hospital overstay coordinator within each department.

(b) The coordinators shall act in the best interest of a pediatric overstay patient by coordinating between hospitals, relevant State agencies and programs, and providers of mental health and substance use disorder services.

(c) The coordinators shall:

(1) Advocate on behalf of pediatric hospital overstay patients while maintaining appropriate patient confidentiality;

(2) Review policies and procedures of relevant State agencies and make recommendations for necessary changes to the policies and procedures to better serve pediatric hospital overstay patients;

(3) Maintain data on each pediatric hospital overstay patient, including:

(i) Patient's length of stay;

(ii) The responsible State agency, if applicable;

(iii) Services needed;

(iv) Placement options being sought by the patient;

(v) Information regarding previous hospital admissions for a behavioral health diagnosis;

(vi) Information regarding whether the admission was based on an emergency petition and, if so, whether the emergency petition was executed in a school; and

(vii) Any other relevant data; and

(4) Provide monthly reports on the data collected under this subsection to the Secretary, the Secretary of Human Services, and the Child and Youth Placement Review Panel in the Governor's Office for Children.

(5) A hospital immediately shall notify the coordinators, through a system designated by the Department, about a pediatric hospital overstay patient.

§19–390. // EFFECTIVE SEPTEMBER 30, 2029 PER CHAPTER 160 OF 2026 //

(a) The Department and the Department of Human Services shall establish a pediatric hospital overstay coordinator within each department.

(b) The coordinators shall act in the best interest of a pediatric overstay patient by coordinating between hospitals, relevant State agencies and programs, and providers of mental health and substance use disorder services.

(c) The coordinators shall:

(1) Advocate on behalf of pediatric hospital overstay patients while maintaining appropriate patient confidentiality;

(2) Review policies and procedures of relevant State agencies and make recommendations for necessary changes to the policies and procedures to better serve pediatric hospital overstay patients;

(3) Maintain data on each pediatric hospital overstay patient, including:

(i) Patient's length of stay;

(ii) The responsible State agency, if applicable;

(iii) Services needed;

(iv) Placement options being sought by the patient;

(v) Information regarding previous hospital admissions for a behavioral health diagnosis; and

(vi) Any other relevant data; and

(4) Report on the data collected under this subsection to the Secretary and the Secretary of Human Services.

§19–393.

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

(b) "Clinical staffing committee" means a committee established by a hospital in accordance with § 19–394(c) of this subtitle.

(c) "Clinical staffing plan" means a plan developed under § 19–394(d) of this subtitle.

§19–394.

(a) This part does not apply to State hospitals.

(b) (1) Each hospital licensed under this title shall comply with the staffing standards of:

(i) The accreditation body that accredits the hospital; and

(ii) The federal Centers for Medicare and Medicaid Services conditions of participation.

(2) A clinical staffing plan developed under this part shall comply with this subsection.

(c) (1) Each hospital licensed under this title shall establish and maintain a clinical staffing committee that:

(i) If the hospital has 150 or fewer licensed beds, has 3 managers and 2 employees; or

(ii) If the hospital has 151 or more licensed beds, has 5 managers and 4 employees.

(2) Each clinical staffing committee established under this part may include:

(i) A certified nursing assistant;

(ii) A dietary aide;

(iii) A licensed nurse;

(iv) An environmental service worker;

(v) A medical resident, if the committee is in a teaching hospital;

(vi) A staff physician who is not a hospital employee or administrator;

(vii) A technician; or

(viii) An employee whose duties include patient advocacy.

(d) (1) The chief nurse executive of each hospital shall produce a draft clinical staffing plan and submit it to the clinical staffing committee of the hospital.

(2) Each clinical staffing committee shall finalize a clinical staffing plan that meets patient needs using the plan submitted under paragraph (1) of this subsection.

(e) When finalizing a clinical staffing plan, the clinical staffing committee shall consider:

(1) Existing staffing levels;

(2) Methods to secure coverage needs as necessary;

(3) Existing gaps in staffing and how to address the gaps;

(4) Any available evidence–based staffing standards;

(5) A schedule for periodic review of the staffing plan;

(6) Appropriate skill mix and competency of staff;

(7) Standards required by:

(i) The Centers for Medicare and Medicaid Services conditions of participation; and

(ii) The accreditation body that accredits the hospital;

(8) The average number of patients of the hospital during the immediately preceding year and relevant information regarding patient discharges, potential admissions, and transfers;

(9) The average level of acuity for patients of the hospital during the immediately preceding year and the corresponding level of nursing care required; and

(10) An estimate of the appropriate combination of skill, experience level, and specialty certification or training of staff that is required to adequately provide care to patients of the hospital.

§19–395.

On or before July 1 each year, beginning in 2028, each hospital shall:

(1) Implement the clinical staffing plan finalized under § 19–394 of this subtitle; and

(2) Assign personnel to each patient care unit in accordance with the clinical staffing plan.

§19–396.

Each hospital shall provide the clinical staffing plan to staff on request.

§19–397.

This part may not be construed to require a hospital to take actions that are inconsistent with the Centers for Medicare and Medicaid Services conditions of participation or the accreditation standards of the accreditation body that accredits the hospital.

§19–3A–01.

In this subtitle, "freestanding medical facility" means a facility:

(1) In which medical and health services are provided;

(2) That, except for a freestanding medical facility established as a result of a conversion of a licensed general hospital under § 19–120(o)(3) of this title, is physically separate from a hospital or hospital grounds;

(3) That is an administrative part of a hospital, as defined in § 19–301 of this title; and

(4) That meets the requirements for provider–based status under the certification for an affiliated hospital as set forth by the Centers for Medicare and Medicaid Services in 42 C.F.R. § 413.65.

§19–3A–02.

(a) On or before January 1, 2006, the Department shall adopt regulations for licensing a freestanding medical facility that uses in its title or advertising the word "emergency" or other language indicating to the public that medical treatment for immediately life-threatening medical conditions is available at that freestanding medical facility.

(b) The regulations shall require the freestanding medical facility to:

(1) Be open 24 hours a day, 7 days a week;

(2) Have available at all times:

(i) At least 1 physician who is credentialed in emergency medicine by the hospital of which the freestanding medical facility is an administrative part;

(ii) A sufficient number of registered nurses and other health care professionals to provide advanced life support;

(iii) Basic diagnostic and laboratory facilities and technicians;

(iv) Resuscitation supplies and equipment, including monitors, defibrillators, cardiac medications, intubation equipment, and intravenous line equipment;

(v) A commercial ambulance for transport of individuals in need of hospitalization or other emergency care; and

(vi) Emergency services to all individuals, regardless of ability to pay;

(3) Comply with all Maryland Institute for Emergency Medical Services Systems emergency transport protocols established for the freestanding medical facility;

(4) (i) Comply, except in a life–threatening emergency in which compliance is not feasible or practicable, with the federal Centers for Disease Control and Prevention guidelines on universal precautions; and

(ii) Display the notice developed under § 1–207 of the Health Occupations Article that explains the federal Centers for Disease Control and

Prevention's guidelines on universal precautions at the entrance to the freestanding medical facility;

(5) Refrain from use of the words "emergency department", "emergency room", or "hospital"; and

(6) Meet any other standard that the Secretary deems necessary to ensure the quality and safety of services provided by a freestanding medical facility.

§19–3A–03.

(a) The Department shall issue a license to a freestanding medical facility that:

(1) Meets the licensure requirements under this subtitle; and

(2) Receives a certificate of need or an exemption from obtaining a certificate of need from the Maryland Health Care Commission under § 19–120 of this title.

(b) A freestanding medical facility that uses in its title or advertising the word "emergency" or other language indicating to the public that medical treatment for immediately life–threatening medical conditions exist at that facility shall be licensed by the Department before it may operate in this State.

(c) Notwithstanding subsection (a)(2) of this section, the Department may not require a freestanding medical facility pilot project to be approved by the Maryland Health Care Commission as a condition of licensure.

§19–3A–04.

The governing body of any county may adopt rules and regulations governing freestanding medical facilities more restrictive than the regulations adopted by the Department.

§19–3A–05.

(a) Except as provided in subsection (b) of this section, a person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000 or imprisonment not exceeding 1 year or both.

(b) (1) In addition to other penalties available under law, the Department may impose sanctions against a freestanding medical facility that fails to comply with this subtitle or regulations adopted under this subtitle.

(2) The sanctions imposed by the Department under paragraph (1) of this subsection include:

(i) A civil penalty not to exceed $10,000;

(ii) Restrictions on the operation of the freestanding medical facility;

(iii) A directed plan of correction; and

(iv) Suspension or revocation of the freestanding medical facility's license.

(c) (1) Except as otherwise provided under the Administrative Procedure Act, before the Department may impose sanctions under subsection (b)(2)(i), (ii), or (iv) of this section, the Department shall give the freestanding medical facility notice and the opportunity for a hearing and judicial review under the Administrative Procedure Act, as provided in Title 10, Subtitle 2 of the State Government Article.

(2) Before the Department may impose a directed plan of correction, the Department shall give the freestanding medical facility notice and the opportunity for a prompt informal hearing with the Director of the Office of Health Care Quality.

§19–3A–06.

The circuit court for a county in which a person is operating a freestanding medical facility in violation of a provision of this subtitle may enjoin further operation of the freestanding medical facility that violates this subtitle.

§19–3A–07.

(a) There are two freestanding medical facility pilot projects that shall operate in two jurisdictions in the State.

(b) The Department shall issue a freestanding medical facility license to:

(1) One freestanding medical facility pilot project if:

(i) The freestanding medical facility pilot project is established by, and will operate administratively as part of, an acute care general hospital;

(ii) The acute care general hospital is part of a merged asset system with all of its existing Maryland acute care general hospitals located in a single jurisdiction;

(iii) There are not more than 5 acute care general hospitals in the jurisdiction;

(iv) One or more of the existing acute care general hospitals in the merged asset system has an emergency department volume of 75,000 or more visits for the 12 months ending June 30, 2004;

(v) The freestanding medical facility pilot project will operate in Montgomery County;

(vi) The capital expenditure to implement the freestanding medical facility pilot project otherwise meets the requirements of § 19–120(k)(6)(viii) of this title; and

(vii) The freestanding medical facility pilot project meets the requirements under § 19–3A–02(b) of this subtitle; and

(2) One freestanding medical facility pilot project if:

(i) The freestanding medical facility pilot project is established by, and will operate administratively as part of, an acute care general hospital located in Talbot County;

(ii) The freestanding medical facility pilot project will operate in Queen Anne's County;

(iii) The capital expenditure to implement the freestanding medical facility pilot project otherwise meets the requirements of § 19–120(k)(6)(viii) of this title; and

(iv) The freestanding medical facility pilot project meets the requirements under § 19–3A–02(b) of this subtitle.

(c) (1) A freestanding medical facility pilot project shall provide to the Maryland Health Care Commission information, as specified by the Commission, on the configuration, location, operation, and utilization, including patient–level utilization, of the pilot project.

(2) A certificate of need is not required for a freestanding medical facility pilot project.

(d) The provisions of §§ 19–3A–01 through 19–3A–06 of this subtitle shall apply to a freestanding medical facility pilot project.

§19–3A–08.

(a) This section applies to all payors subject to the rate–setting authority of the Health Services Cost Review Commission, including:

(1) Insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery individual, group, or blanket health insurance policies and contracts in the State;

(2) Managed care organizations, as defined in § 15–101 of this article; and

(3) The Maryland Medical Assistance Program established under Title 15, Subtitle 1 of this article.

(b) A payor subject to this section shall pay rates set by the Health Services Cost Review Commission under Subtitle 2 of this title for hospital services provided at:

(1) A freestanding medical facility pilot project authorized under this subtitle prior to January 1, 2008; and

(2) A freestanding medical facility licensed under § 19–3A–03 of this subtitle.

§19–3B–01.

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

(b) (1) "Ambulatory surgical facility" means any center, service, office facility, or other entity that:

(i) Operates exclusively for the purpose of providing surgical services to patients requiring a period of postoperative observation but not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission; and

(ii) Seeks reimbursement from payors as an ambulatory surgery center.

(2) "Ambulatory surgical facility" does not include:

(i) The office of one or more health care practitioners seeking only professional reimbursement for the provisions of medical services, unless:

1. The office operates under contract or other agreement with a payor as an ambulatory surgical facility regardless of whether it is paid a technical or facility fee; or

2. The office is designated to receive ambulatory surgical referrals in accordance with utilization review or other policies adopted by a payor;

(ii) Any facility or service owned or operated by a hospital and regulated under Subtitle 2 of this title;

(iii) The office of a health care practitioner with not more than one operating room if:

1. The office does not receive a technical or facility fee; and

2. The operating room is used exclusively by the health care practitioner for patients of the health care practitioner;

(iv) The office of a group of health care practitioners with not more than one operating room if:

1. The office does not receive a technical or facility fee; and

2. The operating room is used exclusively by members of the group practice for patients of the group practice; or

(v) An office owned or operated by one or more dentists licensed under the Health Occupations Article.

(c) "Freestanding ambulatory care facility" means:

(1) An ambulatory surgical facility;

(2) A freestanding endoscopy facility;

(3) A freestanding facility utilizing major medical equipment;

(4) A kidney dialysis center; or

(5) A freestanding birthing center.

(d) (1) "Freestanding birthing center" means a facility that provides nurse midwife services under Title 8, Subtitle 6 of the Health Occupations Article.

(2) "Freestanding birthing center" does not include:

(i) A hospital regulated under Subtitle 2 of this title; or

(ii) The private residence of the mother.

(e) (1) "Freestanding endoscopy facility" means a facility:

(i) For the testing, diagnosis, or treatment of a medical disorder in conjunction with the use of microscopic, endoscopic, or laparoscopic equipment that is inserted in a naturally occurring orifice of the body; and

(ii) That seeks reimbursement as a freestanding endoscopy facility from payors or Medicare.

(2) "Freestanding endoscopy facility" does not include:

(i) The office of one or more health care practitioners unless:

1. The office operates under a contract or other agreement with a payor as a freestanding endoscopy facility regardless of whether it is paid a technical or facility fee; or

2. The office is designated to receive endoscopic referrals in accordance with utilization review or other policies adopted by a payor; or

(ii) Any facility or service operated by a hospital and regulated under Subtitle 2 of this title.

(f) (1) "Freestanding facility operating major medical equipment" means a facility using major medical equipment.

(2) "Freestanding facility operating major medical equipment" does not include any facility or service owned or operated by a hospital and regulated under Subtitle 2 of this title.

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

(h) (1) "Kidney dialysis center" means a facility that provides hemodialysis or chronic peritoneal dialysis.

(2) "Kidney dialysis center" does not include any facility or service owned or operated by a hospital and regulated under Subtitle 2 of this title.

(i) "License" means a license issued by the Secretary under this subtitle.

(j) "Major medical equipment" means:

(1) Cardiac catheterization equipment;

(2) A computer tomography (CT) scanner;

(3) A lithotripter;

(4) Radiation therapy equipment, including a linear accelerator; or

(5) A magnetic resonance imager (MRI).

(k) "Nonsterile procedure room" means a room:

(1) In which minor surgical procedures are performed, including endoscopy and endoscopic procedures requiring deep sedation;

(2) That can only be accessed from a semi–restricted corridor or an unrestricted corridor;

(3) That is not used for open surgical procedures that:

(i) Enter the thorax, abdomen, pelvis, cranium, or spine; or

(ii) Routinely require induction of deep sedation or general anesthesia for the entirety of the surgical procedure; and

(4) In which deep sedation or general anesthesia may be induced if:

(i) Warranted by the clinical situation; and

(ii) The room is equipped to safely conduct the required level of anesthesia.

(l) "Payor" means:

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

(2) A third party administrator or any other entity under contract with a Maryland business to administer health benefits; or

(3) A self–insured group.

(m) "Sterile operating room" means a room in a surgical suite that meets the requirements of a restricted area and is designated and equipped for performing surgical operations or other invasive procedures that may require an aseptic field.

(n) "Surgical services" has the meaning incorporated in the Centers for Medicare and Medicaid Services State Operations Manual – Guidance for Surveyors: Ambulatory Surgical Centers.

§19–3B–02.

(a) A freestanding ambulatory care facility may not operate in the State unless the Secretary has granted the facility a license.

(b) The Secretary shall issue a license to an applicant that meets the requirements of this subtitle and all applicable regulations adopted by the Secretary.

(c) A license issued under this subtitle is not transferable.

§19–3B–03.

(a) (1) After consultation with representatives of payors, health care practitioners, and freestanding ambulatory care facilities, the Secretary shall by regulation establish:

(i) Procedures to implement the provisions of this subtitle; and

(ii) Standards to ensure quality of care and patient safety that shall include:

1. Procedures for credentialing and practitioner performance evaluation;

2. Qualifications of health care practitioners and support personnel;

3. Procedures to be followed in the event of an emergency, including a requirement that in the event of an emergency the patient be transported to the nearest appropriate emergency care facility;

4. Procedures for quality control of any biomedical equipment;

5. Procedures for postoperative recovery;

6. Procedures for discharge;

7. Procedures for ensuring that an anesthesia practitioner is not precluded from providing the highest level of anesthesia support that may be required to safely treat patients undergoing procedures in a freestanding ambulatory surgical facility performed in a nonsterile procedure room or a sterile operating room;

8. The use of ultrasound imaging in a freestanding birthing center;

9. Minimum perinatal care standards for a freestanding birthing center that meet or exceed the Maryland Perinatal System Standards that a freestanding birthing center shall meet as a condition of licensure; and

10. Any other procedures that the Secretary considers necessary for quality of care and patient safety.

(2) The procedures for practitioner performance evaluation required under paragraph (1)(ii)1 of this subsection shall include a review of care provided to patients at the freestanding ambulatory care facility by members of the medical staff.

(3) The review of care shall:

(i) Be undertaken for cases chosen at random and for cases with unexpected adverse outcomes;

(ii) Be based on objective review standards;

(iii) Include a review of the appropriateness of the plan of care for the patient, particularly any medical procedures performed on the patient, in relation to the patient's condition; and

(iv) Except as provided in paragraph (4) of this subsection, be conducted by at least two members of the medical staff who:

1. As appropriate, are of the same specialty as the member of the medical staff under review; and

2. Have been trained in the freestanding ambulatory care facility's policies and procedures regarding practitioner performance evaluation.

(4) A review of the care provided by a member of the medical staff who is a solo practitioner shall be conducted by an external reviewer.

(5) A freestanding ambulatory care facility shall take into account the results of the practitioner performance evaluation process for a member of the medical staff in the reappointment process.

(b) If appropriate certification by Medicare is available, obtaining the certification shall be a condition of licensure for:

(1) An ambulatory surgical facility; and

(2) A kidney dialysis center.

(c) Each freestanding ambulatory care facility shall provide assurances satisfactory to the Secretary that the freestanding ambulatory care facility does not discriminate against patients, including discrimination based on ability to pay for nonelective procedures.

(d) The Secretary may delegate to the Kidney Disease Commission the Secretary's authority under § 19–3B–07 of this subtitle to inspect kidney dialysis centers.

(e) (1) Except as provided in paragraph (2) of this subsection, the Department shall survey freestanding ambulatory care facilities in accordance with federal regulations.

(2) The Department shall survey each freestanding birthing center at least once per calendar year.

§19–3B–03.1.

(a) If a newborn is delivered in a freestanding birthing center following a high–risk pregnancy, the freestanding birthing center shall:

(1) Complete a postpartum infant and maternal referral form and submit the form to the local health department for the county in which the birthing parent resides;

(2) Provide to the birthing parent resources and information specific to the circumstances of the birthing parent, including information regarding the risks, signs, preventive measures, and treatment needs for postpartum complications, including cardiovascular conditions, chronic disease, substance misuse, and mental health conditions; and

(3) Call the birthing parent at least 24, but not later than 48, hours after discharging the parent to evaluate the parent's status and, as necessary, provide information about postpartum complications.

(b) On or before October 1 each year, each local health department shall submit to the Department a report that includes the number and type of referrals made based on the referral forms submitted to the local health department in accordance with subsection (a)(1) of this section.

§19–3B–04.

(a) An applicant for a license shall submit an application to the Secretary.

(b) The application shall:

(1) Be on a form and accompanied by any supporting information that the Secretary requires, including documentation that the Maryland Health Care Commission has determined that the freestanding ambulatory care facility either received a certificate of need or is exempt from certificate of need requirements; and

(2) Be signed and verified by the applicant.

§19–3B–05.

A license does not entitle the licensee to an exemption from other provisions of law relating to:

(1) The review and approval of hospital rates and charges by the Health Services Cost Review Commission; or

(2) The review and approval of new services or facilities by the Maryland Health Care Commission.

§19–3B–06.

The Secretary, by regulation, may encourage the joint acquisition, purchase, or operation of major medical equipment by two or more health care practitioners, despite the fact that such joint acquisition, purchase, or operation may limit free economic competition.

§19–3B–07.

(a) The Secretary may investigate complaints concerning the conformance of a freestanding ambulatory care facility to the requirements of this subtitle or to the regulations adopted under this subtitle.

(b) If the complaint concerns health care practitioner performance or standards of medical practice, the complaint shall be referred to the board that licenses, certifies, or otherwise authorizes the health care practitioner under the Health Occupations Article to provide medical services.

§19–3B–08.

(a) (1) The Secretary may deny a license to any applicant, or suspend, restrict, or revoke a license if the applicant has been convicted of:

(i) A felony that relates to Medicaid; or

(ii) A crime involving moral turpitude.

(2) The Secretary may deny a license to any applicant or may restrict, suspend, or revoke any license if the applicant does not meet the requirements of this subtitle or any regulation that the Secretary adopts under this subtitle.

(b) (1) Before denying, suspending, restricting, or revoking a license or a provisional license under this section, the Secretary shall provide the applicant an opportunity for a hearing.

(2) The Secretary shall send a hearing notice to any applicant by certified mail, return receipt requested, at least 30 days before the hearing.

§19–3B–09.

(a) A person who violates any provision of this subtitle or any regulation adopted under this subtitle is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding $1,000 or imprisonment not exceeding 1 year or both. Each day a violation is continued after the first conviction is a separate offense.

(b) (1) In addition to the provisions of subsection (a) of this section, the Secretary may impose an administrative penalty of up to $1,000 for a violation of any provision of this subtitle or any regulations adopted under this subtitle.

(2) The Secretary shall adopt regulations to provide standards for the imposition of an administrative penalty under paragraph (1) of this subsection.

§19–3C–01.

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

(b) (1) "Cosmetic surgical facility" means an office or a facility in which a cosmetic surgical procedure is performed.

(2) "Cosmetic surgical facility" does not include:

(i) An ambulatory surgical facility regulated under Subtitle 3B of this title;

(ii) A hospital regulated under Subtitle 3 of this title; or

(iii) An office owned or operated by one or more dentists providing services within the scope of practice of dentistry under Title 4 of the Health Occupations Article.

(c) (1) "Cosmetic surgical procedure" means the use of surgical services to reshape the structure of a human body to change the appearance of an individual.

(2) Except as provided in paragraph (3) of this subsection, "cosmetic surgical procedure" does not include:

(i) A procedure done under local anesthesia or mild sedation; or

(ii) Liposuction that removes less than 1,000 cubic centimeters of aspirate.

(3) "Cosmetic surgical procedure" includes any procedure under paragraph (2) of this subsection that, under the circumstances established by the Secretary in regulations adopted under § 19–3C–02(d) of this subtitle, is a cosmetic surgical procedure.

§19–3C–02.

(a) The Secretary may adopt regulations for cosmetic surgical facilities in the State.

(b) Regulations adopted by the Secretary under this section shall include deeming a cosmetic surgical facility to meet specified requirements, if the cosmetic surgical facility is accredited by:

(1) The American Association for Accreditation of Ambulatory Surgical Facilities;

(2) The Accreditation Association for Ambulatory Health Care;

(3) The Joint Commission; or

(4) Any other accreditation organization, as determined by the Secretary.

(c) Regulations adopted under this section may not require higher standards for cosmetic surgical facilities than the standards required for ambulatory surgical facilities under Subtitle 3B of this title.

(d) (1) The Secretary may adopt regulations that establish the circumstances under which a procedure is a "cosmetic surgical procedure" under § 19–3C–01(c)(3) of this subtitle.

(2) The regulations adopted under paragraph (1) of this subsection shall be based on a finding by the Secretary that the procedure raises substantial health and safety concerns that warrant regulation of the procedure under this subtitle.

(3) In adopting regulations under paragraph (1) of this subsection, the Secretary shall consider available studies, reports, and other literature related to:

(i) The safety or risks of the procedure;

(ii) The education and training of the health care practitioners administering anesthesia for the procedure;

(iii) The education and training of the health care practitioners performing the procedure; and

(iv) The setting in which the procedure is performed.

§19–3C–03.

(a) The Secretary may investigate complaints concerning the conformance of a cosmetic surgical facility to the requirements of regulations adopted under § 19–3C–02 of this subtitle.

(b) If the complaint concerns health care practitioner performance or standards of medical practice, the complaint shall be referred to the appropriate health occupations board that licenses, certifies, or otherwise regulates the health care practitioner under the Health Occupations Article.

§19–401.

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

(b) "Home health agency" means a health-related institution, organization, or a part of an institution that:

(1) Is owned or operated by 1 or more persons, whether or not for profit and whether as a public or private enterprise; and

(2) Directly or through a contractual arrangement, provides to a sick or disabled individual in the residence of that individual skilled nursing services, home health aid services, and at least one other home health care service that are centrally administered.

(c) (1) "Home health care" means any of the following services that are provided under the general direction of a licensed health professional practicing within the scope of their practice:

(i) Audiology and speech pathology;

(ii) Dietary and nutritional services;

(iii) Drug services;

(iv) Home health aid;

(v) Laboratory;

(vi) Medical social services;

(vii) Nursing;

(viii) Occupational therapy;

(ix) Physical therapy; or

(x) Provision of medically necessary sickroom equipment and supplies.

(2) However, the provisions of this subsection do not apply to:

(i) A nursing referral service agency that is licensed as a nursing referral service agency under the provisions of Subtitle 4B of this title; or

(ii) A home-based hospice care program that is licensed as a home-based hospice care program under the provisions of Subtitle 9 of this title.

(3) A home health agency shall also be licensed as a hospice care program if the home health agency operates a hospice care program that is distinct from its other services.

§19–402.

The purpose of home health care is:

(1) To avoid institutionalization;

(2) To shorten hospital stays;

(3) To speed recovery; and

(4) To bridge the gap in community health services for patients who otherwise could not get adequate health care.

§19–403.

This subtitle does not:

(1) Limit the right of any person to practice a health occupation that the individual is authorized to practice under the Health Occupations Article;

(2) Limit the right of any person who holds a license under this article to act as authorized by that license; or

(3) Prohibit the care of an individual who relies on treatment in accordance with the tenets and practices of a recognized church or religious denomination and, with or without compensation, is cared for in accordance with those tenets and practices.

§19–404.

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

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

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

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

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

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

(5) Establish patient care policies and personnel policies;

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

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

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

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

(i) A licensed physician;

(ii) A registered nurse; or

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

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

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

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

(i) 1 physician;

(ii) 1 registered nurse;

(iii) 1 representative of another offered service; and

(iv) 1 public member;

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

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

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

(i) A physician;

(ii) A registered nurse; or

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

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

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

§19–405.

Except as otherwise provided in this subtitle, a person shall be licensed by the Department before the person may operate a home health agency.

§19–406.

To qualify for a license, an applicant shall:

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

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

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

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

§19–407.

The Department shall:

(1) Inspect the operations of each home health agency at least every 3 years to determine whether it is meeting the requirements of this subtitle and the rules and regulations adopted under it; and

(2) Issue, deny, suspend, or revoke a home health agency license in accordance with the rules and regulations adopted under this subtitle.

§19–408.

(a) A person may not operate, attempt to operate, or hold one's self out as operating a home health agency unless licensed under this subtitle.

(b) A home health agency may not withhold any home health care services from an individual because of the individual's age, sex, sexual orientation, gender

identity, disability, race, color, creed, national origin, source of payment, or ability to pay.

§19–409.

A person who operates a home health agency without a license is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for the first offense and not exceeding $10,000 for each subsequent offense.

§19–410.

A home health agency may not hold itself out as providing a complete array of physical rehabilitation services unless the home health agency:

(1) Provides a program of coordinated interdisciplinary rehabilitative care, including at a minimum, physical and occupational therapy, speech and language therapy, audiology therapy, psychotherapy, and social work services;

(2) Holds interdisciplinary meetings with the involvement of a physician to plan and monitor patient care; and

(3) Meets any other standard that the Secretary may adopt by regulation.

§19–411. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2022 PER CHAPTERS 29 AND 31 OF THE 2021 SPECIAL SESSION //

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

(2) "COVID–19" means, interchangeably and collectively, the coronavirus known as COVID–19 or 2019–nCoV and the SARS–CoV–2 virus.

(3) "COVID–19 test" means an in vitro diagnostic test for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, as described in § 3201 of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

(b) For calendar years 2021 and 2022, a home health agency shall adopt and implement a COVID–19 infection control and prevention plan for patients and staff who provide home health care services to patients of the home health agency.

(c) (1) The plan required under subsection (b) of this section shall:

(i) Be adopted and implemented in accordance with any applicable federal orders and guidance; and

(ii) Ensure that patients and staff who provide home health care services to patients of the home health agency are screened for COVID–19 on a regular basis and tested or referred for testing for COVID–19, if required or recommended under applicable federal orders or guidance, to control and prevent the spread of COVID–19 among staff and patients of the home health agency.

(2) The screening required under paragraph (1) of this subsection shall include reporting to the home health agency of any:

(i) Symptoms related to COVID–19 experienced by patients and staff; and

(ii) Known exposures of patients and staff to individuals who have been diagnosed with COVID–19.

(d) A home health agency shall provide the plan required under subsection (b) of this section to:

(1) Patients and staff; and

(2) Members of the public on request.

§19–4A–01.

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

(b) "Home health care" includes any of the following services:

(1) Audiology and speech pathology;

(2) Dietary and nutritional services;

(3) Drug services;

(4) Home health aide;

(5) Laboratory;

(6) Medical social services;

(7) Nursing;

(8) Occupational therapy;

(9) Physical therapy;

(10) Provision of invasive medical equipment; and

(11) Home medical equipment services.

(c) "Home medical equipment services" means the delivery, installation, maintenance, or replacement of, or instruction in the use of, medical equipment used by a sick or disabled individual to allow the individual to be maintained in a noninstitutional environment.

(d) "Medical equipment" means technologically sophisticated medical devices including:

(1) Oxygen and oxygen delivery systems;

(2) Ventilators;

(3) Respiratory disease management devices;

(4) Electronic and computer driven wheelchairs and seating systems;

(5) Apnea monitors;

(6) Transcutaneous electrical nerve stimulator (T.E.N.S.) units;

(7) Low air loss cutaneous pressure management devices;

(8) Sequential compression devices;

(9) Neonatal home phototherapy devices;

(10) Feeding pumps; and

(11) Other similar equipment as defined in regulations established by the Secretary.

(e) "Personal care aide" means an individual who provides personal care as defined in § 19–301 of this title.

(f) (1) "Residential service agency" means any person that is engaged in a nongovernmental business of employing or contracting with individuals to provide home health care for compensation to an unrelated sick or disabled individual in the residence of that individual.

(2) "Residential service agency" includes any agency that employs or contracts with individuals directly for hire as home health care providers.

(3) "Residential service agency" does not include:

(i) A home health agency that is licensed under the provisions of Subtitle 4 of this title;

(ii) A person required to be licensed as a home health agency under the provisions of Subtitle 4 of this title;

(iii) A home–based hospice care program that is licensed under the provisions of Subtitle 9 of this title;

(iv) A hospital that is licensed under the provisions of Subtitle 3 of this title;

(v) A related institution that is licensed under the provisions of Subtitle 3 of this title;

(vi) Personal care providers under the Medical Assistance Personal Care Program;

(vii) Any person practicing a health occupation that the person is authorized to practice under the Health Occupations Article;

(viii) A nursing referral service agency that is licensed under Subtitle 4B of this title;

(ix) A group of persons licensed under the same title of the Health Occupations Article practicing as a business; or

(x) Residential rehabilitation services providers approved under regulations adopted by the State mental health authority.

§19–4A–02.

This subtitle does not:

(1) Limit the right of any person who holds a license under this article to act as authorized by that license; or

(2) Prohibit the care of an individual who relies on treatment in accordance with the tenets and practices of a recognized church or religious denomination and, with or without compensation, is provided care in accordance with those tenets and practices.

§19–4A–03.

(a) The Department shall adopt regulations that set standards for the care, treatment, health, safety, welfare, and comfort of individuals who receive home health care services through a residential service agency.

(b) The regulations shall provide for the licensing of residential service agencies.

(c) The regulations shall include provisions that:

(1) Provide for the establishment of residential service agencies;

(2) Establish qualifications for licensure;

(3) Set minimum standards for individuals who provide home health care services through a residential service agency;

(4) Require the residential service agency to screen and verify the character references of all home health care providers that are employed by the residential service agency; and

(5) Authorize a residential service agency to provide training to a licensed nurse after hire in accordance with § 19–4A–03.2 of this subtitle.

§19–4A–03.1.

(a) In this section, "supervisory staff" means an individual who supervises direct care staff in the individual's clinical role.

(b) This section does not apply to a residential service agency that only provides durable medical equipment.

(c) (1) Except as provided in subsection (d) of this section, beginning July 1, 2022, each residential service agency shall ensure that:

(i) Within 45 days after an individual's start of employment as part of the residential service agency's direct care or supervisory staff, the individual is trained to provide the care required by the clients of the residential service agency by, at a minimum, providing 3 hours of online or in–person training regarding dementia, including training regarding:

1. An overview of Alzheimer's disease and dementia;

2. Person–centered care;

3. An understanding of the assessment and care planning process;

4. Activities of daily living; and

5. Alzheimer's disease and dementia–related behaviors and communication; and

(ii) Each member of the residential service agency's direct care or supervisory staff receives 2 hours of online or in–person continuing education training regarding Alzheimer's disease and dementia each calendar year.

(2) The training required under paragraph (1) of this subsection may be provided by a supervisory staff member who is responsible for developing an individual's plan of care and assigning appropriate personnel.

(d) A residential service agency is not required to provide the training:

(1) Described under subsection (c)(1)(i) of this section if the individual has:

(i) Provided Alzheimer's disease or dementia–related direct care or supervisory services for at least 24 consecutive months before beginning employment with the residential service agency; and

(ii) Received from a residential service agency or other entity a certificate of completion issued under subsection (e) of this section; or

(2) Described under subsection (c)(1)(ii) of this section if the individual has completed the training described under subsection (c)(1)(ii) of this section in the immediately preceding 12 months.

(e) A person providing the training described under subsection (c) of this section shall issue a certificate of completion to each individual who completes the training.

(f) Each residential service agency shall maintain records that indicate the type of training received by each individual who has received a certificate of completion issued under subsection (e) of this section while employed by the residential service agency.

§19–4A–03.2.

(a) A residential service agency that provides private duty nursing services may employ a licensed nurse who does not meet the clinical experience requirements established by the Department if the residential service agency provides training and a competency evaluation in accordance with this section.

(b) A residential service agency that seeks to employ a nurse described under subsection (a) of this section shall:

(1) Establish and implement a training program designed to ensure safe and competent care based on patient needs;

(2) Ensure the nurse receives clinical supervision by a registered nurse qualified in private duty nursing services;

(3) Assign the nurse to a qualified preceptor or clinical supervisor until competency is demonstrated;

(4) Document satisfactory completion of required competency standards in the nurse's personnel file; and

(5) Conduct competency evaluations of the nurse:

(i) Annually; or

(ii) For disciplinary purposes, on a more frequent schedule as required by the Department.

(c) A training program and competency evaluation required under this section are subject to approval by the Department.

(d) This section may not be construed to affect requirements relating to occupational licensure, scope of practice, or standards of care.

§19–4A–04.

Except as otherwise provided in this subtitle, a person shall be licensed by the Department before the person may operate a residential service agency.

§19–4A–05.

To qualify for a license, an applicant:

(1) Shall show that the residential service agency will provide appropriate home health care providers to sick or disabled individuals who may be provided care in the individual's residence, instead of in a hospital;

(2) Shall meet any additional requirements that the Department adopts; and

(3) May not be required to meet the requirements of Subtitle 1 of this title for certificate of need.

§19–4A–06.

The Department shall:

(1) Inspect the operations of each residential service agency to determine whether the agency is meeting the requirements of this subtitle and the regulations adopted under this subtitle; and

(2) Issue, deny, suspend, or revoke a residential service agency license in accordance with the regulations adopted under this subtitle.

§19–4A–07.

A person may not operate, attempt to operate, or hold one's self out as operating a residential service agency, unless the person is licensed under this subtitle.

§19–4A–08.

A person who operates a residential service agency without a license is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for the first offense and not exceeding $10,000 for each subsequent offense.

§19–4A–09.

A person who operates a residential service agency in violation of the regulations adopted under this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000. Each day a violation is continued after the first conviction is a separate offense.

§19–4A–10.

(a) Except as provided by federal law, licensure under this subtitle does not entitle a residential service agency to reimbursement by a third party payor.

(b) The Department may reimburse a residential service agency for personal assistance services only if the personal assistance services are provided by an individual classified as an employee.

§19–4A–11.

(a) (1) On or before December 30, 2021, the Office of the Attorney General, in consultation with the Department and the Maryland Department of Labor, shall produce a guidance document concerning the application of employee protection laws in the Labor and Employment Article, to the use of personal care aides by residential service agencies.

(2) The guidance document required under paragraph (1) of this subsection shall:

(i) Describe with specific reference to the residential service care industry:

1. Relevant definitions of "employ", "employee", "employer", and "independent contractor";

2. The concept of independent contractor misclassification and the potential for legal liability including monetary damages for employees; and

3. Steps a residential service agency may take to ensure compliance with the Labor and Employment Article;

(ii) Be three pages or fewer and, to the extent feasible, written in plain language; and

(iii) Be revised and updated on an annual basis.

(b) (1) As a condition of obtaining an initial license from the Department to operate as a residential service agency and every 3 years thereafter, a residential service agency shall certify to the Department, on a form developed by the Department and through the signature of an individual with authority over the residential service agency's pay or employment practices, that:

(i) The individual has read and understood the guidance document produced under subsection (a) of this section; and

(ii) The residential service agency will comply with the relevant requirements of the Labor and Employment Article.

(2) On an annual basis, the Secretary shall provide the most current version of the guidance document to each licensed residential service agency.

(3) A form developed by the Department for use under paragraph (1) of this subsection shall include a checkbox by which a residential service agency that receives Medicaid reimbursement for the provision of home care or similar services by a personal care aide shall indicate whether the residential service agency uses personal care aides designated as independent contractors.

(c) On or before October 1 each year, each residential service agency receiving Medicaid reimbursement for the provision of home care or similar services by a personal care aide shall report to the Department, on a form or in an electronic manner developed by the Department, the number of personal care aides classified by the residential service agency as:

(1) Employees; and

(2) Independent contractors.

(d) (1) On or before July 1 each year, the Department shall use the information reported under subsection (c) of this section to create a report concerning:

(i) Medicaid reimbursement rates;

(ii) The cost of delivering services; and

(iii) Aggregated employment classifications of individuals who provide personal care.

(2) Data included in the report under this subsection:

(i) May only be in aggregate; and

(ii) May not identify a specific residential service agency.

(3) The Department shall submit each report created under paragraph (1) of this subsection to the Senate Finance Committee and the House Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

§19–4B–01.

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

(b) "Background check" has the meaning stated in § 19-1901 of this title.

(c) "Care provider" means an individual who provides health care services and assistance to a client in the activities of daily living, including:

(1) Bathing, toileting, and personal hygiene;

(2) Dressing;

(3) Meal preparation and eating;

(4) Companionship; and

(5) Assistance in physical transfer and ambulation.

(d) "Central Repository" means the Criminal Justice Information System Central Repository of the Department of Public Safety and Correctional Services.

(e) "Home health aid services" means personal and health care services delivered to a client by a care provider.

(f) "License" means a nursing referral service agency license.

(g) "Licensed health professional" means an individual who is licensed or certified under the Health Occupations Article to provide health care services.

(h) "Nursing referral service agency" means one or more individuals engaged in the business of screening and referring, directly or in accordance with contractual arrangements that may include independent contractors, licensed health professionals or care providers to clients for the provision of nursing services, home health aid services, or other home health care services at the request of the client.

(i) "Private agency" has the meaning stated in § 19-1901 of this title.

§19–4B–02.

This subtitle does not limit the right of any person who holds a license under this article to act as authorized by that license.

§19–4B–03.

(a) (1) A nursing referral service agency may receive a fee or other compensation for providing its services.

(2) A contractual arrangement may provide that a nursing referral service agency is not responsible for paying any part of the compensation to the licensed health care professionals or care providers that the nursing referral service agency screens or refers to clients.

(3) A nursing referral service agency may provide administrative assistance.

(b) A nursing referral service agency shall:

(1) Obtain a license from the Department prior to operating as a nursing referral service agency;

(2) Develop and implement a procedure to screen licensed health professionals and care providers that includes the following:

(i) In accordance with subsection (c) of this section:

1. A State criminal history records check; or

2. A private agency background check;

(ii) Verification of current licensure or certification under the Health Occupations Article;

(iii) A basic health screening, including a tuberculosis screening;

(iv) Verification of references;

(v) Verification of employment history;

(vi) Completion of I-9 forms; and

(vii) An in-person interview of a licensed health professional and care provider before any referral of the individual is made to a client;

(3) Institute an internal client complaint investigation process that includes:

(i) Notice to the client or client's representative of the complaint process; and

(ii) Protocols to investigate complaints;

(4) Provide notice to clients of the Department's complaint hotline number for complaints about the services provided by an individual referred by the nursing referral service agency; and

(5) Allow clients to accept or reject, at their discretion, any licensed health professional or care provider referred by the nursing referral service agency.

(c) (1) For each licensed health professional and care provider, a nursing referral service agency shall:

(i) Apply to the Central Repository for a State criminal history records check; or

(ii) Request a private agency to conduct a background check.

(2) (i) As part of the application for a criminal history records check, the nursing referral service agency shall submit to the Central Repository:

1. Two complete sets of legible fingerprints of the licensed health professional or care provider taken on forms approved by the Director of the Central Repository; and

2. The fee authorized under § 10-221(b)(7) of the Criminal Procedure Article for access to Maryland criminal history records.

(ii) In accordance with §§ 10-201 through 10-228 of the Criminal Procedure Article, the Central Repository shall forward to the licensed health professional or care provider and the nursing referral service agency a printed statement listing the criminal convictions of the licensed health professional or care provider.

(iii) Information obtained from the Central Repository under this subsection:

1. Is confidential and may not be redisseminated; and

2. May be used only for the screening purpose authorized by this subsection.

(iv) The subject of a criminal history records check under this subsection may contest the contents of the printed statement issued by the Central Repository as provided in § 10-223 of the Criminal Procedure Article.

(3) If a nursing referral service agency requests a private agency to conduct a background check:

(i) The private agency shall:

1. Conduct a background check in each state in which the nursing referral service agency knows or has reason to know the licensed health professional or care provider worked or resided during the past 7 years; and

2. Issue a statement of its findings to:

A. On request, the licensed health professional or care provider; and

B. The nursing referral service agency; and

(ii) The licensed health professional or care provider shall have an opportunity to contest the findings.

§19–4B–04.

(a) (1) The Department shall adopt regulations to implement the requirements of this subtitle.

(2) The regulations may not preclude a nursing referral service agency from operating with independent contractors.

(b) The Department shall issue a license to a nursing referral service agency after the nursing referral service agency completes an application for licensure.

(c) The Department may suspend or revoke a license issued under this section if the nursing referral service agency is operating in violation of the requirements of this subtitle.

§19–4B–05.

(a) An individual may not operate or engage in, or attempt to operate or engage in, or hold one's self out as operating or engaging in the business of a nursing referral service agency unless the individual is licensed under this subtitle.

(b) (1) An individual who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for the first offense and not exceeding $10,000 for any subsequent offense.

(2) Each day a violation is continued after the first conviction is a separate offense.

§19–4B–06.

For the purposes of any other provision of law, the granting of a license under this subtitle does not constitute a finding of any fact on which the granting of the license was based and may not give rise to any presumption regarding the existence of any fact on which the granting of the license was based.

§19–501.

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

(b) "Board" means a citizens' advisory board for a center.

(c) "Center" means a chronic disease center.

§19–502.

(a) There are chronic disease centers in the State for individuals who:

(1) Need constant medical and nursing care by reason of chronic illness or infirmity; or

(2) Have a chronic disability amenable to rehabilitation.

(b) One center shall be located in each of the following places:

(1) The Eastern Shore; and

(2) The western part of this State.

(c) The Secretary also shall operate any other centers established by law and placed under the jurisdiction of the Secretary for the care of individuals who have chronic diseases.

§19–503.

The Secretary shall adopt rules and regulations that set:

(1) The services to be provided by centers; and

(2) The qualifications and standards for admission to and discharge from the centers.

§19–504.

Each center may:

(1) Establish any outpatient clinic for preadmission evaluation, aftercare, or other home health care service;

(2) Further medical knowledge by having a facility to explore new ways of treating problems peculiar to chronically ill and disabled individuals;

(3) Conduct any educational and training program to improve the knowledge and skills of physicians and ancillary professional, scientific, and other staff of the center and other treatment facilities and, thus, to improve a high standard of patient care; and

(4) Add a unit to treat chronic diseases of children.

§19–505.

(a) Admission of an individual to a center shall be based on:

(1) The statement of a physician who, after an examination of the individual, finds that the individual needs care at a center; and

(2) The review and approval of an application for admission of the individual by the center.

(b) If an individual cannot be placed in a special facility in this State that can treat the condition of the individual, the individual may be admitted to a center.

(c) A center may not admit an individual who has:

(1) A mental disorder of the type that requires care in a mental health facility; or

(2) An orthopedic disease for which medical treatment is available in a special orthopedic hospital.

(d) (1) The centers shall be operated primarily for residents of this State.

(2) A center may admit an individual who is not a resident of this State if:

(i) The individual is admitted and discharged in accordance with a specific regional health program or specific demonstration or study project approved by the Department; and

(ii) This State is reimbursed for the full cost of services to the individual.

§19–506.

(a) If the medical staff of a center determines that an individual cannot receive any further benefit at the center, the individual shall be discharged on the written order of a medical staff member.

(b) If, after a competent authority directs a discharged individual to leave the center, the individual fails to do so, the administrative head of the center may take any legal step needed to remove the individual from the center, under an adequate plan for treatment and care.

§19–507.

(a) If this State is paying any of the costs of an individual at a center, the individual may be transferred to another facility that is approved under a federal program.

(b) If the individual refuses to apply for assistance from any applicable State, federal, or local program, the administrative head of the center or the designee of the administrative head may apply for the assistance and transfer the individual to another facility.

§19–508.

There is a citizens' advisory board for each center.

§19–509.

(a) (1) Each board consists of 7 members appointed by the Governor.

(2) The Governor shall appoint the members from a list of qualified individuals submitted to the Governor by the Secretary.

(b) Each member of the board for a center:

(1) Shall be a citizen of this State;

(2) Shall be a resident of a county that the center serves;

(3) Shall be representative of the community; and

(4) Shall be known for an interest in civic and public affairs and for concern about the care of chronically ill individuals.

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

(2) The terms of members are staggered as required by the terms provided for members of each board on July 1, 1982. The terms of those members end as follows:

(i) 1 in 1983.

(ii) 4 in 1984.

(iii) 1 in 1985.

(iv) 1 in 1986.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) A member who serves 2 consecutive full 4-year terms may not be reappointed for 4 years after completion of those terms.

§19–510.

(a) From among its members, each board shall elect a chairman and other officers that the board considers necessary.

(b) The manner of election of officers and their terms of office shall be as the board determines.

§19–511.

(a) Each board shall meet at least 4 times a year, at the times and places that the board determines.

(b) A member of a board may not receive compensation.

§19–512.

(a) Each board may adopt rules and regulations for the conduct of its meetings.

(b) (1) Each board serves in an advisory capacity.

(2) Each board shall:

(i) Submit to the Secretary an annual report on:

1. The needs of chronically ill individuals; and

2. The extent to which its center meets these needs;

(ii) Advise the administrative head of the center on its facilities, goals, programs, and policies;

(iii) Help in evaluating the degree to which these goals are achieved;

(iv) Review and make recommendations about the annual budget of the center;

(v) Assume leadership in developing community understanding of the needs of chronically ill individuals; and

(vi) Carry out any other responsibility that the administrative head of the center requests.

§19–513.

(a) Except with the approval of the administrative head of a center, a person other than an employee of the center may not bring any alcoholic beverage into any area of the center that is used by individuals under treatment in the center.

(b) An employee of the center may not:

(1) Drink any alcoholic beverage while on duty; or

(2) Give any alcoholic beverage to an individual who is under treatment in the center.

(c) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding $100 or imprisonment not exceeding 60 days or both.

§19–701.

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

(b) "Benefit package" means a set of health care services to be provided to a member of a health maintenance organization under a contract that entitles the member to the health care services, whether the services are provided:

(1) Directly by a health maintenance organization; or

(2) Through a contract or arrangement with another person.

(c) "Commissioner" means the State Insurance Commissioner.

(d) "Covered service" means a health care service included in the benefit package of the health maintenance organization and rendered to a member or subscriber of the health maintenance organization by:

(1) A provider under contract with the health maintenance organization, when the service is obtained in accordance with the terms of the benefit contract of the member or subscriber; or

(2) A noncontracting provider under § 19–710.1 of this subtitle, when the service is:

(i) Obtained in accordance with the terms of the benefit contract of the member or subscriber;

(ii) Obtained pursuant to a verbal or written referral by:

1. The health maintenance organization of the member or subscriber; or

2. A provider under written contract with the health maintenance organization of the member or subscriber; or

(iii) Preauthorized or otherwise approved either verbally or in writing by:

1. The health maintenance organization of the member or subscriber; or

2. A provider under written contract with the health maintenance organization of the member or subscriber.

(e) "Emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in a condition described in § 1867(e)(1) of the Social Security Act.

(e–1) (1) "Emergency services" means, with respect to an emergency medical condition:

(i) A medical screening examination that is within the capability of the emergency department of a hospital or freestanding medical facility, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition;

(ii) Any other examination or treatment within the capabilities of the staff and facilities available at the hospital or freestanding medical facility that is necessary to stabilize the patient, regardless of the department of the hospital in which the examination or treatment is furnished; or

(iii) Except as provided in paragraph (3) of this subsection, additional covered items and services furnished by a health care provider of emergency services that does not have a contractual relationship with the carrier after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in items (i) and (ii) of this paragraph are furnished.

(2) "Emergency services" includes services described in paragraph (1) of this subsection that are provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services.

(3) Subject to § 19–710(p) of this subtitle and § 14–205.2 of the Insurance Article, "emergency services" does not include items and services described in paragraph (1)(iii) of this subsection if all of the conditions in 45 C.F.R. § 149.410(b) are met.

(f) (1) "Health care services" means services, medical equipment, and supplies that are provided by a provider.

(2) "Health care services" includes:

(i) Ambulance services;

(ii) Appliances, drugs, medicines, and supplies;

(iii) Chiropractic care and services;

(iv) Convalescent institutional care;

(v) Dental care and services;

(vi) Extended care;

(vii) Family planning or infertility services;

(viii) Health education services;

(ix) Home health care or medical social services;

(x) Inpatient hospital services;

(xi) Laboratory, radiological, or other diagnostic services;

(xii) Medical care and services;

(xiii) Mental health services;

(xiv) Nursing care and services;

(xv) Nursing home care;

(xvi) Optical care and services;

(xvii) Optometric care and services;

(xviii) Osteopathic care and services;

(xix) Outpatient services;

(xx) Pharmaceutical services;

(xxi) Physical therapy care and services;

(xxii) Podiatric care and services;

(xxiii) Preventive medical services;

(xxiv) Psychological care and services;

(xxv) Rehabilitative services;

(xxvi) Surgical care and services;

(xxvii) Treatment for alcoholism or drug abuse; and

(xxviii) Any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well–being of human beings.

(g) "Health maintenance organization" means any person, including a profit or nonprofit corporation organized under the laws of any state or country, that:

(1) Operates or proposes to operate in this State;

(2) Except as provided in § 19–703(b) and (e) of this subtitle, provides or otherwise makes available to its members health care services that include at least physician, hospitalization, laboratory, X–ray, emergency, and preventive services, out–of–area coverage, and any other health care services that the Commissioner

determines to be available generally on an insured or prepaid basis in the area serviced by the health maintenance organization, and, at the option of the health maintenance organization, may provide additional coverage;

(3) Except for any copayment or deductible arrangement, is compensated only on a predetermined periodic rate basis for providing to members the minimum services that are specified in item (2) of this subsection;

(4) Assures its subscribers and members, the Commissioner, and the Department that one clearly specified legal and administrative focal point or element of the health maintenance organization has the responsibility of providing the availability, accessibility, quality, and effective use of comprehensive health care services; and

(5) Primarily provides services of physicians:

(i) Directly through physicians who are either employees or partners of the health maintenance organization; or

(ii) Under arrangements with one or more groups of physicians, who are organized on a group practice or individual practice basis, under which each group:

1. Is compensated for its services primarily on the basis of an aggregate fixed sum or on a per capita basis; and

2. Is provided with an effective incentive to avoid unnecessary inpatient use, whether the individual physician members of the group are paid on a fee–for–service or other basis.

(h) "Member" means a person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services.

(i) "Provider" means any person, including a physician or hospital, who is licensed or otherwise authorized in this State to provide health care services.

(j) "Subscriber" means a person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services.

§19–702.

(a) In adopting this subtitle, the General Assembly intends to:

(1) Provide alternative methods for the delivery of health care services to residents of this State, with a view toward achieving greater efficiency and economy in providing these services;

(2) Encourage the formation of health maintenance organizations that provide health care services to subscribers or groups of subscribers who contract for these services under a system of prepayments; and

(3) Encourage the formation of health maintenance organizations by such diverse groups as:

(i) Nonprofit health service plans;

(ii) Medical health service plans;

(iii) Medical care foundations;

(iv) Groups of professionals, either in the form of partnerships or professional corporations;

(v) Consumer sponsored organizations; or

(vi) Business or legal entities.

(b) To carry out the intent of subsection (a) of this section, the policy of this State is to:

(1) Provide one overall State law that:

(i) Regulates health maintenance organizations;

(ii) Allows flexibility for the many forms these health maintenance organizations may take; and

(iii) Facilitates public understanding and uniform administration of the rules and regulations that are adopted under this subtitle;

(2) Eliminate legal barriers to the organization, promotion, and expansion of health maintenance organizations;

(3) Provide for regulation of:

(i) The quality of health care, by the Department and by professional standards review organizations where appropriate; and

(ii) All other matters covered under this subtitle, by the Commissioner; and

(4) Exempt health maintenance organizations from the insurance laws of this State, except as set forth in this subtitle.

§19–703.

(a) This subtitle does not:

(1) Authorize any person to engage directly or indirectly in the practice of any health occupation except as otherwise authorized by law;

(2) Authorize any person to regulate, interfere, or intervene in the relationship between any provider of health care services and the patients of the provider; or

(3) Prohibit any health maintenance organization from meeting the requirements of any federal law that authorizes the health maintenance organization to:

(i) Receive federal financial assistance; or

(ii) Enroll beneficiaries assisted by federal funds.

(b) A health maintenance organization or a part of it that is also a community health center organized under the federal Public Health Service Act and receives federal funds under 42 U.S.C. § 254c is not required to provide hospitalization for individuals for whom services are provided by those funds.

(c) Health maintenance organizations shall offer as an option to all of their members or subscribers benefits for hospice services provided by a hospice care program, as defined in § 19–901(c) of this title.

(d) Health maintenance organizations shall provide continuation coverage required under §§ 15–407 through 15–409 of the Insurance Article.

(e) Notwithstanding any other provision of this subtitle, a health maintenance organization may provide a limited set of health benefits if the limited set of health benefits is for subscribers or members who are enrolled in a county program to provide health care services for low–income individuals.

(f) (1) In addition to the requirements of § 15–10B–09 of the Insurance Article, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, a health maintenance organization shall provide as part of its hospitalization services provided to members and subscribers payment for the cost of additional hospitalization for the newborn for up to 4 days.

(2) The attending physician or certified nurse midwife of the mother, or the designee of the attending physician or certified nurse midwife, shall provide notice to the mother of the provisions of paragraph (1) of this subsection.

§19–704.

A health maintenance organization may operate as authorized by this subtitle notwithstanding any prohibition against the corporate practice of medicine.

§19–705.

(a) (1) The Secretary may adopt rules, regulations, and standards for the quality of health care services provided by a health maintenance organization through its benefit packages.

(2) With the advice of the Department, the Commissioner shall adopt reasonable rules and regulations as necessary to carry out any other provisions of this subtitle.

(b) (1) The Commissioner and the Department shall adopt joint internal procedures to help them work together to carry out their duties under this subtitle.

(2) The joint internal procedures shall establish means by which the Commissioner and the Department may inform each other promptly on matters that affect any health maintenance organization, including:

(i) Any important action, change, or rearrangement that a health maintenance organization may undertake; and

(ii) Any regulatory problem.

§19–705.1.

(a) The Secretary shall adopt regulations that set out reasonable standards of quality of care that a health maintenance organization shall provide to its members.

(b) (1) The standards of quality of care shall include:

(i) A requirement that a health maintenance organization shall provide for regular hours during which a member may receive services, including providing for services to a member in a timely manner that takes into account the immediacy of need for services;

(ii) A requirement that a health maintenance organization shall have a system for providing a member with 24–hour access to a physician in cases where there is an immediate need for medical services, and for promoting timely access to and continuity of health care services for members, including:

1. Providing 24–hour access by telephone to a person who is able to appropriately respond to calls from members and providers concerning after–hours care; and

2. Providing a 24–hour toll free telephone access system for use in hospital emergency departments in accordance with § 19–705.7 of this subtitle;

(iii) A requirement that any nonparticipating provider shall submit to the health maintenance organization the appropriate documentation of the medical complaint of the member and the services rendered;

(iv) A requirement that a health maintenance organization shall have a physician available at all times to provide diagnostic and treatment services;

(v) A requirement that a health maintenance organization shall ensure that:

1. Each member who is seen for a medical complaint is evaluated under the direction of a physician; and

2. Each member who receives diagnostic evaluation or treatment is under the medical management of a health maintenance organization physician who provides continuing medical management;

(vi) A requirement that each member shall have an opportunity to select a primary physician, a physician assistant, a certified nurse–midwife, a licensed certified midwife, or a certified nurse practitioner from among those available to the health maintenance organization; and

(vii) A requirement that a health maintenance organization print, in any directory of participating providers or hospitals, in a conspicuous manner, the address, telephone number, and facsimile number of the State agency that members, enrollees, and insureds may call to discuss quality of care issues, life and health insurance complaints, and assistance in resolving billing and payment disputes with the health plan or health care provider, as follows:

1. For quality of care issues and life and health care insurance complaints, the Maryland Insurance Administration; and

2. For assistance in resolving a billing or payment dispute with the health plan or a health care provider, the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General.

(2) This subsection may not be construed to require that a health maintenance organization include certified nurse practitioners on the health maintenance organization's provider panel as primary care providers.

(c) (1) The health maintenance organization shall make available and encourage appropriate history and baseline examinations for each member within a reasonable time of enrollment set by it.

(2) Medical problems that are a potential hazard to the person's health shall be identified and a course of action to alleviate these problems outlined.

(3) Progress notes indicating success or failure of the course of action shall be recorded.

(4) The health maintenance organization shall:

(i) Offer or arrange for preventive services that include health education and counseling, early disease detection, immunization, and hearing loss screening of newborns provided by a hospital before discharge;

(ii) Develop or arrange for periodic health education on subjects which impact on the health status of a member population; and

(iii) Notify every member in writing of the availability of these and other preventive services.

(5) The health maintenance organization shall offer services to prevent a disease if:

(i) The disease produces death or disability and exists in the member population;

(ii) The etiology of the disease is known or the disease can be detected at an early stage; and

(iii) Any elimination of factors leading to the disease or immunization has been proven to prevent its occurrence, or early disease detection followed by behavior modification, environmental modification, or medical intervention has been proven to prevent death or disability.

(d) (1) To implement these standards of quality of care, a health maintenance organization shall have a written plan that is updated and reviewed at least every 3 years.

(2) The plan shall include the following information:

(i) Statistics on age, sex, and other general demographic data used to determine the health care needs of its population;

(ii) Identification of the major health problems in the member population;

(iii) Identification of any special groups of members that have unique health problems, such as the poor, the elderly, the mentally ill, and educationally disadvantaged; and

(iv) A description of community health resources and how they will be used.

(3) The health maintenance organization shall state its priorities and objectives in writing, describing how the priorities and objectives relating to the health problems and needs of the member population will be provided for.

(4) (i) The health maintenance organization shall provide at the time membership is solicited a general description of the benefits and services available to its members, including benefit limitations and exclusions, location of facilities or providers, and procedures to obtain medical services.

(ii) The health maintenance organization shall place the following statement, in bold print, on every enrollment card or application: "If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card".

(5) The plan shall contain evidence that:

(i) The programs and services offered are based on the health problems of and the community health services available to its member population;

(ii) There is an active program for preventing illness, disability, and hospitalization among its members; and

(iii) The services designed to prevent the major health problems identified among child and adult members and to improve their general health are provided by the health maintenance organization.

(e) (1) The health maintenance organization shall have an internal peer review system that will evaluate the utilizational services and the quality of health care provided to its members.

(2) The review system shall:

(i) Provide for review by appropriate health professionals of the process followed in the provision of health services;

(ii) Use systematic data collection of performances and patient results;

(iii) Provide interpretation of this data to the practitioners;

(iv) Review and update continuing education programs for health professionals providing services to its members;

(v) Identify needed change and proposed modifications to implement the change; and

(vi) Maintain written records of the internal peer review process.

(f) (1) Except as provided in paragraph (5) of this subsection, the Department shall conduct an annual external review of the quality of the health services of the health maintenance organization in a manner that the Department considers to be appropriate.

(2) The external review shall be conducted by:

(i) A panel of physicians and other health professionals that consists of persons who:

1. Have been approved by the Department;

2. Have substantial experience in the delivery of health care in a health maintenance organization setting, but who are not members of the health maintenance organization staff or performing professional services for the health maintenance organization; and

3. Reside outside the area serviced by the health maintenance organization; or

(ii) The Department.

(3) The final decision on the type of external review that is to be employed rests solely with the Secretary.

(4) The external review shall consist of a review and evaluation of:

(i) An internal peer review system and reports;

(ii) The program plan of the health maintenance organization to determine if it is adequate and being followed;

(iii) The professional standards and practices of the health maintenance organization in every area of services provided;

(iv) The grievances relating specifically to the delivery of medical care, including their final disposition;

(v) The physical facilities and equipment; and

(vi) A statistically representative sample of member records.

(5) A health maintenance organization accredited by an accreditation organization approved by the Secretary in accordance with § 19–2302 of this title shall be exempt from the external review.

§19–705.2.

(a) With the advice of the Secretary, the Commissioner shall adopt regulations to establish a system for the receipt and timely investigation of

complaints of members and subscribers of health maintenance organizations concerning the operation of any health maintenance organization in this State.

(b) The complaint system shall include:

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

(2) Criteria that the Secretary shall adopt by regulation for determining the appropriate level of investigation for a complaint concerning quality of care, including:

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

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

(3) A procedure for the referral of quality of care complaints to the Secretary for an appropriate investigation.

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

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

(e) For quality of care complaints referred to the Secretary for investigation under subsection (b)(3) of this section, the Secretary shall report to the Commissioner in a timely manner on the results and findings of each investigation.

§19–705.3.

(a) In this section, "health maintenance organization" means a health maintenance organization where health care services are delivered by health care providers to subscribers at a central facility or centralized system of facilities operated by the health maintenance organization.

(b) The Department shall adopt regulations to require health maintenance organizations to:

(1) Adopt, implement, and enforce a policy that requires, except in an emergency life–threatening situation where it is not feasible or practicable, all employees and medical staff involved in patient care services to comply with the Centers for Disease Control and Prevention's guidelines on universal precautions; and

(2) Display the notice developed under § 1–207 of the Health Occupations Article at the entrance to the health maintenance organization.

(c) If the health maintenance organization fails to comply with the requirements of this section the Secretary may impose a penalty of up to $500 per day per violation for each day a violation continues.

§19–705.4.

(a) Any limitation imposed by a health maintenance organization on the receipt of covered services provided to a member or subscriber by a physical therapist licensed under Title 13 of the Health Occupations Article may only be imposed per incident or per injury within a contract period.

(b) This subsection may not be construed to prohibit a health maintenance organization from imposing any limitations on the number of visits permitted for a member or subscriber.

§19–705.5.

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

(2) (i) "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry.

(ii) "Inherited metabolic disease" includes a disease for which the State screens newborn babies.

(3) (i) "Low protein modified food product" means a food product that is:

1. Specially formulated to have less than 1 gram of protein per serving; and

2. Intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

(ii) "Low protein modified food product" does not include a natural food that is naturally low in protein.

(4) "Medical food" means a food that is:

(i) Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

(ii) Formulated to be consumed or administered enterally under the direction of a physician.

(b) A health maintenance organization shall include as part of its benefit package of health care services to be provided to members and subscribers coverage for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods and low protein modified food products are:

(1) Prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases; and

(2) Administered under the direction of a physician.

§19–705.6.

(a) If it is necessary to provide emergency services, authorization shall be presumed for utilizing the medical or surgical provider on call for unassigned patients or the appropriate specialist on call for the hospital on that date if:

(1) A telephone access system is not operational at the time of the call; or

(2) A member's primary care provider or the specialist needed by a member cannot be determined within a reasonable time, as determined by the treating emergency physician but not to exceed 30 minutes after the initial documented call to the telephone access system.

(b) This section may not be construed to require a health maintenance organization to have contracted specialist providers at hospitals outside of the service area of the health maintenance organization.

§19–705.7.

The 24-hour toll free telephone access system provided by each health maintenance organization shall:

(1) Enable members and providers to determine, with one telephone call, the primary care provider assigned to a member; and

(2) Enable providers to determine, with one telephone call, the names of three contracted specialist providers for the health maintenance organization who also have staff privileges at a particular hospital in the State.

§19–705.8.

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

(2) "HMO Quality Assurance Unit" means the Health Maintenance Organization (HMO) Quality Assurance Unit in the Department.

(3) "Quality Assurance Medical Director" means the Medical Director of the HMO Quality Assurance Unit.

(b) There is a Health Maintenance Organization (HMO) Quality Assurance Unit in the Department.

(c) (1) The Secretary shall appoint the Quality Assurance Medical Director.

(2) The Quality Assurance Medical Director shall:

(i) Be a physician who is licensed in the State;

(ii) Be board certified in at least one specialty;

(iii) Have experience in primary care and administrative medicine; and

(iv) Have broad knowledge of health maintenance organizations and managed care organizations.

(3) The Quality Assurance Medical Director is entitled to the compensation provided in the State budget.

(4) Subject to the authority vested in the Secretary by law, the Quality Assurance Medical Director is in charge of and responsible for the clinical operations of the HMO Quality Assurance Unit.

(5) In accordance with the State budget the Secretary may employ staff for the HMO Quality Assurance Unit.

(d) The HMO Quality Assurance Unit shall:

(1) Enforce all requirements established under §§ 19-705 and 19-705.1 of this subtitle and the regulations adopted under these provisions regarding the quality of health care provided by a health maintenance organization; and

(2) Investigate quality of care complaints referred to the Secretary under § 19-705.2(b)(3) of this subtitle.

(e) The Quality Assurance Medical Director shall:

(1) Determine whether a health maintenance organization meets the requirements established under §§ 19-705 and 19-705.1 of this subtitle and the regulations adopted under these provisions regarding the quality of health care provided by a health maintenance organization; and

(2) Make recommendations to the Secretary for corrective action necessary to meet these requirements.

(f) If the Secretary agrees with a determination made by the Quality Assurance Medical Director that a health maintenance organization does not meet the requirements established under §§ 19-705 and 19-705.1 of this subtitle or the regulations adopted under these provisions regarding the quality of health care provided by a health maintenance organization, the Secretary may issue an order under § 19-731 of this subtitle.

§19–706.

(a) Each health maintenance organization that is issued a certificate of authority by the Commissioner shall be regulated under this subtitle.

(b) (1) Any health maintenance organization that is regulated by Title 14, Subtitle 1 of the Insurance Article is subject also to this subtitle.

(2) This subsection applies to a corporation described in Title 14, Subtitle 1 of the Insurance Article, but only if it is a health maintenance organization.

(c) Except as otherwise provided in this subtitle or expressly provided in the Insurance Article, a health maintenance organization is not subject to the insurance laws of this State.

(d) Only the Commissioner may issue, suspend, or revoke a certificate of authority of a health maintenance organization.

(e) The provisions of Title 27, Subtitle 8 of the Insurance Article shall apply to health maintenance organizations.

(f) The provisions of Title 15, Subtitle 10B of the Insurance Article shall apply to health maintenance organizations.

(g) The provisions of Title 6.5 of the State Government Article shall apply to the acquisition of a health maintenance organization owned by a nonprofit entity.

(h) The provisions of § 27–210 of the Insurance Article apply to health maintenance organizations.

(i) The provisions of § 15–145 of this article apply to health maintenance organizations.

(j) The provisions of Title 15, Subtitle 16 of the Insurance Article apply to health maintenance organizations.

(k) The provisions of § 2–517 of the State Personnel and Pensions Article apply to health maintenance organizations.

(l) The provisions of § 15–134 of the Insurance Article apply to health maintenance organizations.

(m) The provisions of Title 4, Subtitle 5 of the Insurance Article apply to health maintenance organizations.

(n) The provisions of Title 9, Subtitle 4 of the Insurance Article apply to health maintenance organizations.

(o) The provisions of Title 33 of the Insurance Article apply to health maintenance organizations.

(p) The provisions of § 12–211 of the Insurance Article apply to health maintenance organizations.

§19–706.1.

(a) Subject to this section, the provisions of Title 9, Subtitle 2 of the Insurance Article regarding the rehabilitation and liquidation of insurers are applicable to health maintenance organizations.

(b) (1) Subject to paragraph (2) of this subsection, any rehabilitation or liquidation of a health maintenance organization shall be deemed to be the rehabilitation or liquidation of an insurer and shall be conducted under the supervision of the Commissioner under the law governing the rehabilitation or liquidation of insurers.

(2) The provisions of §§ 9-224 and 9-225 of the Insurance Article do not apply to the rehabilitation or liquidation of a health maintenance organization.

(c) The Commissioner may apply for an order directing the Commissioner to rehabilitate or liquidate a health maintenance organization:

(1) Upon any one or more grounds set out in Title 9, Subtitle 2 of the Insurance Article; or

(2) When in the Commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to its members or to the people of this State.

(d) (1) In addition to the Commissioner's authority under Title 9, Subtitle 2 of the Insurance Article, the Commissioner as a rehabilitator of a health maintenance organization may, subject to approval by a court:

(i) Change premium rates and other terms of an individual or group contract;

(ii) Terminate or change the terms of:

1. Provider contracts; or

2. Contracts with participating entities for the provision of administrative, financial, or management services; and

(iii) Negotiate and, if the assuming health maintenance organization agrees:

1. Transfer the coverage obligations of the impaired health maintenance organization to an assuming health maintenance organization; and

2. Assign the provider contracts of the impaired health maintenance organization to an assuming health maintenance organization.

(2) Before taking any action under paragraph (1)(ii) of this subsection, the Commissioner shall consider:

(i) The interests of providers and other participating entities under contract with the impaired health maintenance organizations; and

(ii) The viability of continuing the health plan.

(3) If a court under paragraph (1)(ii) of this subsection approves a change to the terms of a contract that diminishes the compensation of a provider or a participating entity providing administrative, financial, or management services, the change may not:

(i) Be effective for more than 60 days; and

(ii) Except by mutual consent, be renewed or extended.

(e) In addition to the Commissioner's authority under Title 9, Subtitle 2 of the Insurance Article, the Commissioner as a liquidator may, subject to approval by a court:

(1) Contract with a solvent health maintenance organization or other appropriate entity to operate the insolvent health maintenance organization, including the provision of medical care, on a short-term basis;

(2) Operate the insolvent health maintenance organization, which may include compensating health care providers in accordance with the terms of the health care provider's contract with the insolvent health maintenance organization;

(3) (i) Direct all other health maintenance organizations that participated in an open enrollment process with the insolvent health maintenance organization at a group's last regular open enrollment period to offer enrollees or subscribers of the insolvent health maintenance organization a 30-day open enrollment period to begin on the date of the insolvency; and

(ii) Require each health maintenance organization directed to offer enrollees or subscribers of the insolvent health maintenance organization a 30-day open enrollment period to offer the enrollees of the insolvent health maintenance organization the same coverage and rates that it offered the enrollees at the last regular open enrollment period;

(4) (i) Equitably allocate the insolvent health maintenance organization's group contracts of those groups not offered other coverage under item (3) of this subsection, among all health maintenance organizations operating within

a portion of the insolvent health maintenance organization's service area, except that before allocating the group contracts under this item, the Commissioner shall consider the health care delivery system and financial resources of all possible successor health maintenance organizations;

(ii) Require each health maintenance organization allocated a group or groups under item (i) of this item to offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rate methodology; and

(iii) Ensure that any enrollee or subscriber whose group coverage had terminated prior to the date of the insolvency and who converted their group coverage into individual conversion coverage is offered the same conversion coverage that is offered by the successor health maintenance organization to persons converting from the group of which the enrollee or subscriber had been a former member;

(5) (i) Equitably allocate the insolvent health maintenance organization's nongroup individual contracts of those nongroup individuals not offered other coverage under item (3) of this subsection, among all health maintenance organizations operating within a portion of the insolvent health maintenance organization's service area, except that before allocating the nongroup individual contract or contracts under this item, the Commissioner shall consider the health care delivery system and financial resources of all possible successor health maintenance organizations; and

(ii) Require each health maintenance organization allocated a nongroup individual or individuals under item (i) of this item to offer the nongroup individual or individuals the health maintenance organization's existing coverage which is most similar to the nongroup individual's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rate methodology; and

(6) Take any other action deemed necessary by the Commissioner.

(f) The claims and expenses of health care providers incurred by the Commissioner, as a receiver, in continuing plan benefits as provided in the insolvent health maintenance organization's plan of insolvency adopted under § 19-710(q) of this subtitle shall:

(1) Be considered expenses for the administration of the receivership; and

(2) Have priority over all other expenses.

(g) In the event of the liquidation or rehabilitation of a health maintenance organization under this section:

(1) Members of the health maintenance organization shall have the same priority of claims as provided in § 9-227(c) of the Insurance Article; and

(2) For claims for health care services rendered to members before an order of receivership has been entered, the following health care providers shall immediately follow in priority claims of the members of the health maintenance organization:

(i) Health care providers under contract with the health maintenance organization;

(ii) Health care providers that rendered health care services to members of the health maintenance organization upon referral from a health care provider under contract with the health maintenance organization; and

(iii) A hospital.

(h) (1) A health care provider may not assert a claim of subrogation against:

(i) A member of an insolvent health maintenance organization; or

(ii) Any individual, organization, or government agency which has made payments to the health maintenance organization on behalf of a member.

(2) Notwithstanding paragraph (1) of this subsection, a health care provider may assert any claim it may have against the receiver of the insolvent health maintenance organization.

§19–707.

(a) A health maintenance organization shall obtain from the Commissioner a certificate of authority to operate as a health maintenance organization before it may issue any contract or certificate to a member, provide any health care services to a member, or otherwise operate in this State.

(b) Except as permitted by the Commissioner and subject to the rules and regulations adopted under this subtitle, a health maintenance organization that does not have a certificate of authority may not contact potential members to discuss the health care services the health maintenance organization proposes to offer if a certificate of authority is granted.

§19–708.

(a) An applicant for a certificate to operate as a health maintenance organization shall submit an application to the Commissioner on the form that the Commissioner requires.

(b) The application shall include or be accompanied by:

(1) A copy of the basic health maintenance organizational document and any amendments to it that, where applicable, are certified by the Department of Assessments and Taxation;

(2) A copy of the bylaws of the health maintenance organization, if any, that are certified by the appropriate officer;

(3) A list of the individuals who are to be responsible for the conduct of the affairs of the health maintenance organization, including all members of the governing body, the officers and directors if it is a corporation, and the partners or associates if it is a partnership or association;

(4) The addresses of those individuals and their official capacity with the health maintenance organization;

(5) A statement by each individual referred to in item (3) of this subsection that fully discloses the extent and nature of any contract or arrangement between the individual and the health maintenance organization and any possible conflict of interest;

(6) A resume of the qualifications of:

(i) The administrator;

(ii) The medical director, who shall be a physician licensed in this State and certified under Title 15, Subtitle 10C of the Insurance Article;

(iii) The enrollment director; and

(iv) Any other individual who is associated with the health maintenance organization that the Commissioner and the Secretary request under their joint internal procedures;

(7) A statement that describes generally:

(i) The health maintenance organization, including:

1. Its operations;

2. Its enrollment process;

3. Its quality assurance mechanism; and

4. Its internal grievance procedures;

(ii) The methods the health maintenance organization proposes to use to offer its members and public representatives an opportunity to participate in matters of policy and operation;

(iii) The location of the facilities where health care services will be available regularly to members;

(iv) The type and specialty of physicians and health care personnel who are engaged to provide health care services;

(v) The number of physicians and personnel in each category; and

(vi) The health and medical records system to provide documentation of use by members;

(8) The form of each contract that the health maintenance organization proposes to offer to subscribers showing the benefits to which they are entitled and a table of the rates charged or proposed to be charged for each form of contract;

(9) A statement that describes with reasonable certainty each geographic area to be served by the health maintenance organization;

(10) A statement of the financial condition of the health maintenance organization, including:

(i) Sources of financial support;

(ii) A balance sheet showing assets, liabilities, and minimum tangible net worth; and

(iii) Any other financial information the Commissioner requires for adequate financial evaluation;

(11) Copies of any proposed advertising and proposed techniques and methods of selling the services of the health maintenance organization;

(12) A power of attorney that is executed by the health maintenance organization appointing the Commissioner as agent of the organization in this State to accept service of process in any action, proceeding, or cause of action arising in this State against the health maintenance organization; and

(13) Copies of the agreements proposed to be made between the health maintenance organizations and providers of health care services.

§19–709.

(a) When a health maintenance organization files its initial application for a certificate of authority to operate, it shall pay to the Commissioner a fee of $300.

(b) In addition to the fee required under subsection (a) of this section, each health maintenance organization shall pay a reasonable sum that the Commissioner finds to be the cost of the investigations made by the Commissioner and the Department as required under this subtitle.

§19–710.

(a) To qualify for a certificate of authority to operate as a health maintenance organization, an applicant shall satisfy the Commissioner that the applicant will meet the requirements of this section.

(b) The applicant shall conform to the definition of a health maintenance organization.

(c) The applicant shall establish and operate a bona fide health maintenance organization that can provide health care services in the proposed geographic area.

(d) (1) The health maintenance organization shall be actuarially sound.

(2) (i) Except as otherwise provided in this paragraph, the surplus that the health maintenance organization is required to have shall be paid in full.

(ii) The health maintenance organization licensed on or after July 1, 1989 shall have an initial surplus that exceeds the liabilities of the health maintenance organization by at least $1,500,000.

(iii) All health maintenance organizations shall maintain a surplus that exceeds the liabilities of the health maintenance organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the health maintenance organization with the Commissioner.

(iv) No health maintenance organization shall be required to maintain a surplus in excess of a value of $3,000,000.

(3) (i) For the protection of the health maintenance organization's members and creditors, the applicant shall deposit and maintain in trust with the State Treasurer $100,000 in cash or government securities of the type described in § 5–701(b) of the Insurance Article.

(ii) 1. The deposits shall be accepted and held in trust by the State Treasurer in accordance with Title 5, Subtitle 7 of the Insurance Article.

2. For the purpose of applying this subparagraph, a health maintenance organization shall be treated as an insurer.

(4) The Commissioner may waive the surplus and deposit requirements contained in this subsection if the Commissioner is satisfied that:

(i) The health maintenance organization has sufficient net worth and an adequate history of generating net income to assure financial viability for the next year;

(ii) The health maintenance organization's performance and obligations are guaranteed by another person with sufficient net worth and an adequate history of generating net income; or

(iii) The assets of the health maintenance organization or contracts with insurers, governments, providers, or other persons are sufficient to reasonably assure the performance of the health maintenance organization's obligations.

(e) The provisions of Title 4, Subtitle 3 (Risk Based Capital Standards for Insurers) and § 15–604 (Rates for Payments to Hospitals) of the Insurance Article apply to health maintenance organizations in the same manner as they apply to insurers.

(f) The terms of contracts, including any medical assistance program contracts under Title XVIII or Title XIX of the Social Security Act or Title III of the Public Health Service Act, proposed to be made or made with government or private agencies that cover all or part of the cost of subscriptions to provide health care services, facilities, appliances, medicines, or supplies shall be financially sound, based on reasonable actuarial assumptions that the health maintenance organization can meet its obligations to the agencies and their beneficiaries by reason of the health maintenance organization's net worth position, stop loss, reinsurance arrangements with authorized insurers, or other arrangements that are satisfactory to the Commissioner.

(g) (1) The terms of the contracts to be offered to subscribers shall provide that the health care services provided to members of the health maintenance organization will meet reasonable standards of quality of care that are applicable to the geographic area to be served, as approved by the Department.

(2) If a health maintenance organization offers services that are within the scope of practice of a physician and another health care practitioner who is licensed under the Health Occupations Article, the health maintenance organization shall offer those services through other licensed health care practitioners, where appropriate, as determined by the health maintenance organization.

(h) (1) The procedures for offering health care services and offering and terminating contracts to subscribers may not discriminate unfairly on the basis of age, sex, sexual orientation, gender identity, religious beliefs, disability, race, health, or economic status.

(2) The requirement under paragraph (1) of this subsection does not prohibit:

(i) Reasonable underwriting classifications for establishing contract rates; or

(ii) Experience rating.

(i) (1) The terms of the agreements between a health maintenance organization and providers of health services shall contain a "hold harmless" clause.

(2) The hold harmless clause shall provide that the provider may not, under any circumstances, including nonpayment of money due the providers by the health maintenance organization, insolvency of the health maintenance organization, or breach of the provider contract, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, member, enrollee, patient, or any persons other than the health maintenance organization acting on their behalf, for services provided in accordance with the provider contract.

(3) Collection from the subscriber or member of copayments or supplemental charges in accordance with the terms of the subscriber's contract with the health maintenance organization, or charges for services not covered under the subscriber's contract, may be excluded from the hold harmless clause.

(4) Each provider contract shall state that the hold harmless clause will survive the termination of the provider contract, regardless of the cause of termination.

(j) The health maintenance organization shall provide evidence of adequate insurance coverage or an adequate plan for self–insurance to satisfy claims for injuries that may occur from providing health care.

(k) The health maintenance organization shall provide for having its health and medical facilities and services audited and reviewed periodically:

(1) By personnel outside the health maintenance organization who:

(i) Act in a manner that is approved by the Department; and

(ii) Use methods that will assure objective evaluation and keep the identity of patients as confidential as possible;

(2) By the health maintenance organization's own internal quality of care committee audit procedures, if the Department approves the procedures; or

(3) By a professional standards review organization, as described in Title XI of the Social Security Act, that is certified by the Department of Health and Human Services as capable of serving individuals in the area where the health maintenance organization operates who are receiving benefits under Title XVIII or Title XIX of the Social Security Act or Title III of the Public Health Service Act, if the professional standards review organization is acting consistently with its certification.

(l) (1) With the approval of the Department, the health maintenance organization shall provide continuous internal peer review for monitoring and evaluating patient records for:

(i) Quality of care; and

(ii) Overuse and underuse of provider care; and

(2) The health maintenance organization shall meet the requirements of Subtitle 13 of this title and all regulations for the performance of utilization review.

(m) The health maintenance organization shall provide an internal grievance system to resolve adequately any grievances initiated by any of its members, in a manner approved by the Department on matters concerning quality of care and by the Commissioner on all other matters covered by this subtitle, under rules and regulations adopted under this subtitle.

(n) The health maintenance organization shall establish procedures to offer each member an opportunity to participate in matters of policy and operation.

(o) The health maintenance organization shall maintain a health and medical records system that:

(1) Under procedures assuring maximum confidentiality, is readily accessible to authorized persons;

(2) Can accurately document use by each member; and

(3) At a minimum:

(i) Identifies clearly each patient by:

1. Name;

2. Number;

3. Age; and

4. Sex; and

(ii) Shows clearly:

1. The services provided;

2. When the services are provided;

3. Where the services are provided;

4. By whom the services are provided;

5. The diagnosis and prognosis, if appropriate;

6. The treatment;

7. Any drug therapy; and

8. The health status of the patient, if appropriate.

(p) (1) Except as provided in paragraph (3) of this subsection, individual enrollees and subscribers of health maintenance organizations issued certificates of authority to operate in this State may not be liable to any health care provider for any covered services provided to the enrollee or subscriber.

(2) (i) A health care provider or any representative of a health care provider may not collect or attempt to collect from any subscriber or enrollee any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(ii) A health care provider or any representative of a health care provider may not maintain any action against any subscriber or enrollee to collect or attempt to collect any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(3) Notwithstanding any other provision of this subsection, a health care provider or representative of a health care provider may collect or attempt to collect from a subscriber or enrollee:

(i) Any copayment or coinsurance sums owed by the subscriber or enrollee to a health maintenance organization issued a certificate of authority to operate in this State for covered services provided by the health care provider;

(ii) If Medicare is the primary insurer and a health maintenance organization is the secondary insurer, any amount up to the Medicare approved or limiting amount, as specified under the Social Security Act, that is not owed to the health care provider by Medicare or the health maintenance organization

after coordination of benefits has been completed, for Medicare covered services provided to the subscriber or enrollee by the health care provider; or

(iii) Any payment or charges for services that are not covered services.

(q) (1) The Commissioner shall require each health maintenance organization to have an insolvency plan by January 1, 1990 which provides for:

(i) Continuation of benefits to subscribers and enrollees for the duration of the contract period for which premiums have been paid; and

(ii) Continuation of benefits to subscribers or enrollees who are admitted to an inpatient health care facility on the date of insolvency until, the earlier of:

1. The subscriber or enrollee is discharged from the inpatient health care facility; or

2. 365 days.

(2) In determining the adequacy of any insolvency plan, the Commissioner may consider:

(i) The existence of insurance to cover expenses incurred in continuing benefits after an insolvency;

(ii) Provisions in provider contracts obligating providers to continue to provide services to enrollees or subscribers:

1. For the duration of the contract period for which premiums have been made; and

2. If admitted to an inpatient health care facility, until the enrollee or subscriber is discharged or 365 days, whichever occurs first;

(iii) Reserves;

(iv) Letters of credit;

(v) Guarantees; or

(vi) Any other arrangement to assure that benefits are continued in accordance with the provisions of paragraph (1) of this subsection.

(r) Repealed.

(s) (1) In this subsection, "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning services rendered or utilized by a provider under contract with or employed by a health maintenance organization for the provision of health care services by the provider to enrollees or subscribers of the health maintenance organization.

(2) If a health maintenance organization uses a practice profile as a factor in its contract review to evaluate a provider's status on a provider panel, the health maintenance organization shall disclose at the commencement and renewal of the contract and, not more often than annually, upon the request of the provider:

(i) A description of the criteria used to compile the practice profile concerning the provider; and

(ii) The manner in which the practice profile is used to evaluate the provider.

(3) The information provided under this subsection may not be used to create a cause of action.

(4) A health maintenance organization may not terminate a provider contract or provider's employment with the health maintenance organization on the basis of a practice profile without first informing the provider of the findings of the practice profile and the provider specific data underlying those findings.

(t) A health maintenance organization may not by contract, or in any other manner, require a provider to indemnify the health maintenance organization or hold the health maintenance organization harmless from a coverage decision or negligent act of the health maintenance organization.

§19–710.1.

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

(2) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland Ambulance Information Systems form, or a medical record.

(3) "Berenson–Eggers Type of Service Code" means a code in a classification system developed by the Centers for Medicare and Medicaid Services that groups Current Procedural Terminology codes together based on clinical consistency.

(4) "Enrollee" means a subscriber or member of a health maintenance organization.

(5) "Evaluation and management service" means any service with a Berenson–Eggers Type of Service Code in the category of evaluation and management.

(6) "Institute" means the Maryland Institute for Emergency Medical Services Systems.

(7) "Medicare Economic Index" means the fixed–weight input price index that:

(i) Measures the weighted average annual price change for various inputs needed to produce physician services; and

(ii) Is used by the Centers for Medicare and Medicaid Services in the calculation of reimbursement of physician services under Title XVIII of the federal Social Security Act.

(8) "Similarly licensed provider" means:

(i) For a physician:

1. A physician who is board certified or eligible in the same practice specialty; or

2. A group physician practice that contains board certified or eligible physicians in the same practice specialty;

(ii) For a health care provider that is not a physician, a health care provider that holds the same type of license.

(9) (i) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the institute to provide care to trauma patients.

(ii) "Trauma center" includes an out–of–state pediatric facility that has entered into an agreement with the institute to provide care to trauma patients.

(10) "Trauma patient" means a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

(11) "Trauma physician" means a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

(b) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(1) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(2) Shall pay the claim submitted by:

(i) A hospital at the rate approved by the Health Services Cost Review Commission;

(ii) A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

1. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

2. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and

(iii) Any other health care provider:

1. For an evaluation and management service, no less than the greater of:

A. 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for

the same covered service, to similarly licensed providers under written contract with the health maintenance organization; or

B. 140% of the rate paid by Medicare, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; and

2. For a service that is not an evaluation and management service, no less than 125% of the average rate the health maintenance organization paid as of January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, to a similarly licensed provider under written contract with the health maintenance organization for the same covered service.

(c) For the purposes of subsection (b)(2)(iii) of this section, a health maintenance organization shall calculate the average rate paid to similarly licensed providers under written contract with the health maintenance organization for the same covered service by summing the contracted rate for all occurrences of the Current Procedural Terminology Code for that service and then dividing by the total number of occurrences of the Current Procedural Terminology Code.

(d) A health maintenance organization shall disclose, on request of a health care provider not under written contract with the health maintenance organization, the reimbursement rate required under subsection (b)(2)(ii) and (iii) of this section.

(e) (1) Subject to paragraph (2) of this subsection, a health maintenance organization may require a trauma physician not under contract with the health maintenance organization to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the health maintenance organization.

(2) If a health maintenance organization requires a trauma physician to include a provider number on the uniform claim form in accordance with paragraph (1) of this subsection, the health maintenance organization shall assign a provider number to a trauma physician not under contract with the health maintenance organization at the request of the physician.

(3) A trauma center, on request from a health maintenance organization, shall verify that a licensed physician is credentialed or otherwise designated by the trauma center to provide trauma care.

(4) Notwithstanding the provisions of § 19–701(d) of this subtitle, for trauma care rendered to a trauma patient in a trauma center by a trauma physician,

a health maintenance organization may not require a referral or preauthorization for a service to be covered.

(f) (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

(g) (1) A health care provider may enforce the provisions of this section by filing a complaint against a health maintenance organization with the Maryland Insurance Administration or by filing a civil action in a court of competent jurisdiction under § 1–501 or § 4–201 of the Courts Article.

(2) The Maryland Insurance Administration or a court shall award reasonable attorney fees if the complaint of the health care provider is sustained.

(h) The Maryland Health Care Commission annually shall review payments to health care providers to determine the compliance of health maintenance organizations with the requirements of this section and report its findings to the Maryland Insurance Administration.

(i) The Maryland Insurance Administration may take any action authorized under this subtitle or the Insurance Article, including conducting an examination under Title 2, Subtitle 2 of the Insurance Article, to investigate and enforce a violation of the provisions of this section.

(j) In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed $5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization.

(k) The Maryland Insurance Administration, in consultation with the Maryland Health Care Commission, shall adopt regulations to implement this section.

§19–710.2.

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

(2) "Carrier" means:

(i) An insurer;

(ii) A nonprofit health service plan;

(iii) A health maintenance organization;

(iv) A dental plan organization; or

(v) Any other person or organization that provides health benefit plans subject to State regulation.

(3) "Point-of-service option" means a health benefit plan that permits a member or subscriber of a health maintenance organization to receive any health care service outside the provider panel of the health maintenance organization that is covered under the member's or subscriber's contract with the health maintenance organization.

(4) "Provider panel" means those providers with which a health maintenance organization contracts to provide services to the health maintenance organization's members or subscribers under the health maintenance organization's health benefit plan.

(b) (1) If an employer, association, or other private group arrangement offers health benefit plan coverage to employees or individuals only through a health maintenance organization, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another carrier to offer, a point-of-service option to the employer, association, or other private group arrangement in conjunction with the health maintenance organization as an additional benefit for an employee or individual, at the employee's or individual's option, to accept or reject.

(2) When a health maintenance organization is the sole delivery system offered to employees by an employer, the health maintenance organization:

(i) Shall offer the employer a point-of-service option for the individual employee to accept or reject;

(ii) May not impose a minimum participation level on the point-of-service option; and

(iii) As part of the group enrollment application, shall provide to each employer a disclosure statement for each point-of-service option offered that conforms to regulations, for the point-of-service option required under paragraph (1) of this subsection, adopted by:

1. The Maryland Health Care Commission for the small group market; and

2. The Maryland Insurance Administration for the non-small group market.

(c) (1) An employer, association, or other private group arrangement may require an employee or individual that accepts the additional coverage under a point-of-service option under subsection (b) of this section to be responsible for the payment of a premium over the amount of the premium for the coverage offered by the health maintenance organization.

(2) A carrier may impose different cost-sharing provisions for the point-of-service option based on whether the service is provided through the provider panel of the health maintenance organization or outside the provider panel of the health maintenance organization.

§19–711.

(a) Within 90 days after the filing of an application for a certificate of authority to operate as a health maintenance organization, the Commissioner shall issue the certificate of authority to the applicant if:

(1) The application conforms with § 19-708 of this subtitle;

(2) The applicant has paid the fees required by § 19-709 of this subtitle;

(3) The Department has advised in writing that the health maintenance organization's proposed health-related services, operations, and functions that fall under the regulatory jurisdiction of the Department appear to meet its requirements or are approved by the Department; and

(4) The Commissioner is satisfied that the requirements of § 19-710 of this subtitle are met.

(b) (1) Subject to paragraph (2) of this subsection, the provisions of Title 7 of the Insurance Article apply to health maintenance organizations.

(2) Before approving a transaction under § 7-306 of the Insurance Article, the Insurance Commissioner shall consult with the Secretary.

(c) Subsection (b) of this section may not apply to any transaction preempted by federal law.

§19–711.3.

In any case where a health maintenance organization is being merged or consolidated with or acquired by another person, any current financing money provided by the health maintenance organization to a hospital, in accordance with regulations adopted by the Health Services Cost Review Commission, in return for a discount in rates charged by the hospital shall be deemed to be security for the amount of outstanding charges owed by the health maintenance organization to the hospital for bills or claims for services provided by the hospital prior to the merger, consolidation, or acquisition.

§19–712.

(a) Subject to the provisions of subsection (b) of this section, a person who holds a certificate of authority to operate a health maintenance organization under this subtitle may:

(1) Exercise the power that professional and other corporations, partnerships, associations, or other business entities have under their organizational documents and any laws of this State that do not conflict with this subtitle;

(2) Provide health care services to nonmembers who present themselves on other than a prepaid basis;

(3) Provide health care services on a prepaid basis through licensed providers of these services who are under contract with or employed by the health maintenance organization;

(4) Contract with any person to perform, on behalf of the health maintenance organization, functions such as marketing, enrollment, and administration;

(5) Contract for insurance, reinsurance, or indemnity or reimbursement against the cost of health care services provided by the health maintenance organization with:

(i) Any insurance company licensed to do health business in this State; or

(ii) Any hospital, nonprofit health service plan, medical health service, nursing service, optometric service, podiatry service, dental service, pharmaceutical service plan corporation, or similar entity authorized to do business in this State;

(6) Accept from government or private agencies payments that cover all or part of the cost of subscriptions to provide health care services, facilities, appliances, medicines, and supplies;

(7) Buy, lease, construct, renovate, operate, or maintain:

(i) A hospital, medical facility, and ancillary equipment; and

(ii) Property that is reasonably required for its principal office or for any other purpose necessary in the business of the health maintenance organization; and

(8) Offer indemnity benefits that cover out-of-area and emergency services.

(b) (1) A person who holds a certificate of authority to operate a health maintenance organization under this subtitle and who enters into any administrative service provider contract, as defined in § 19-713.2 of this subtitle, with a person or entity for the provision of health care services to subscribers shall be responsible for all claims or payments for health care services:

(i) Covered under the subscriber's contract; and

(ii) Rendered by a provider, who is not the person or entity which entered into the administrative service provider contract with the health maintenance organization, pursuant to a referral by a person or entity which entered into the administrative service provider contract with the health maintenance organization.

(2) Responsibility for claims and payments under this subsection is subject to the provisions of § 15-1005 of the Insurance Article.

(c) The responsibility of a health maintenance organization for claims or payments for health care services in accordance with subsection (b) of this section under an administrative service provider contract:

(1) Is not limited by the amount in a segregated fund established under § 19-713.2 of this subtitle;

(2) Exists irrespective of the insolvency or other inability or failure of a contracting provider, as defined in § 19-713.2 of this subtitle, to pay;

(3) Exists irrespective of the delegation or further subcontracting of health care services by a contracting provider to an external provider, as defined in § 19-713.2 of this subtitle;

(4) May not be altered by contract; and

(5) Applies to all health care services, including those provided under State and federal programs, unless preempted by federal law.

(d) Subsections (b) and (c) of this section apply to a contract between a health maintenance organization and any company affiliated with the health maintenance organization through common ownership within an insurance holding company system, that meets the definition of a contracting provider under § 19-713.2 of this subtitle.

§19–712.2.

(a) A health maintenance organization that provides pharmaceutical benefits shall notify all pharmacies under contract with the health maintenance organization in writing of changes in the pharmaceutical benefit program rules or requirements at least 30 days before the change is effective.

(b) Changes that require 30 days' advance written notice under subsection (a) of this section are:

(1) Exclusion of coverage for classes of drugs as specified by contract;

(2) Changes in prior or preauthorization procedures; and

(3) Selection of new prescription claims processors.

(c) A health maintenance organization that fails to provide advance notice as required under subsection (a) of this section shall honor and pay in full any claim under the program rules or requirements that existed before the change for 30 days after the postmarked date of the notice.

§19–712.4.

(a) In this section the terms "health care practitioner", "health care entity", and "health care service" have the same meanings as provided in § 1–301 of the Health Occupations Article.

(b) A health maintenance organization may seek repayment from a health care practitioner of any money paid for any claim, bill, or other demand or request for payment for the health care services that were determined by the appropriate regulatory licensing board to be furnished as a result of a referral prohibited by § 1–302 of the Health Occupations Article.

(c) Every contract between a health maintenance organization and its subscribers or a group of subscribers for the provision of health care services shall include a provision excluding payment of any claim, bill, or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by § 1–302 of the Health Occupations Article.

(d) A health maintenance organization subject to the provisions of this section shall report to the Commissioner and the appropriate regulatory board any pattern of claims, bills or other demands or requests for payment submitted for a health care service provided as a result of a referral prohibited by § 1–302 of the Health Occupations Article within 30 days after that health maintenance organization has knowledge of that pattern.

(e) (1) Notwithstanding the provisions of this section, a health maintenance organization reimbursing for health care services is not required to audit or investigate any claim, bill, or other demand or request for payment for the purpose of determining whether those services were the result of a prohibited referral.

(2) Any audit or investigation of any claim, bill, or other demand or request for payment for the purpose of determining whether those services were the result of the prohibited referral are not grounds to delay payment or waive the provisions of § 15–1005 of the Insurance Article.

(f) For any claim, bill, or request for payment that is paid and is subsequently determined to be the result of a prohibited referral, a health maintenance organization may seek a refund of that payment in accordance with the provisions of § 1–305 of the Health Occupations Article.

§19–712.5.

(a) A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable co–payments, for medically necessary services provided to a member or subscriber of the health maintenance

organization if the health maintenance organization authorized, directed, referred, or otherwise allowed the member or subscriber to use the emergency facility and the medically necessary services are related to the condition for which the member was allowed to use the emergency facility.

(b) A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable co–payments, for medically necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to a member or subscriber of the health maintenance organization if the health maintenance organization fails to provide 24–hour access in accordance with the standards of quality of care required under § 19–705.1(b)(1)(ii) of this subtitle.

(c) A health maintenance organization shall reimburse a hospital emergency facility and provider, less any applicable co–payments, for medical screening, assessment, and stabilization services rendered to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act.

(d) Notwithstanding any other provision of this subtitle, a provider may not be required to obtain prior authorization or approval for payment from a health maintenance organization in order to obtain reimbursement under subsection (a), (b), or (c) of this section.

(e) Notwithstanding any other provision of this article, a hospital emergency facility or provider or a health maintenance organization that has reimbursed a provider may collect or attempt to collect payment from a member or subscriber for health care services provided for a medical condition that is determined not to be an emergency as defined in § 19–701(e) of this subtitle.

(f) If a health maintenance organization authorizes, directs, refers, or otherwise allows a member or subscriber to access a hospital emergency facility or other urgent care facility for a medical condition that requires emergency surgery, the health maintenance organization:

(1) Shall reimburse the physician, oral surgeon, periodontist, or podiatrist, who performed the surgical procedure, for follow–up care that is:

(i) Medically necessary;

(ii) Directly related to the condition for which the surgical procedure was performed; and

(iii) Provided in consultation with the member's or subscriber's primary care physician; and

(2) May not impose on the member or subscriber any co–payment or other cost–sharing requirement for any follow–up care that exceeds what a member or subscriber is required to pay for services rendered by a physician, oral surgeon, periodontist, or podiatrist who is a member of the provider panel of the health maintenance organization.

§19–712.6.

(a) Whenever a subscriber or an enrollee of a health maintenance organization is a resident of a continuing care facility that is regulated under Title 10, Subtitle 4 of the Human Services Article and received health care services in an acute care health care facility, the resident's primary care physician shall refer, if medically appropriate, the resident to the skilled nursing unit at the resident's continuing care facility for the provision of health care services included in the resident's health maintenance organization Medicare contract if:

(1) The primary care physician and the resident or the designated representative of the resident do not choose an alternative course of treatment;

(2) The continuing care facility becomes a contracting provider in accordance with the health maintenance organization's standard terms and conditions for its participating providers and meets the credentialing criteria for becoming a participating provider;

(3) The continuing care facility meets all the guidelines established by the Division of Licensing and Certification of the Department, including Medicare certification; and

(4) The continuing care facility's skilled nursing unit is certified as a Medicare skilled nursing facility.

(b) (1) The continuing care facility is not obligated to accept for the provision of health care services anyone other than a resident of the continuing care facility.

(2) The health maintenance organization and the continuing care facility are not obligated to advertise in any manner that the continuing care facility is a participating provider with respect to coverage offered by the health maintenance organization for Medicare benefits or other treatment in the skilled nursing unit for anyone other than residents of the continuing care facility.

§19–712.7.

To the extent required under federal law, a health maintenance organization shall reimburse a community health resource, as defined in § 19-2101 of this title, for covered services provided to a member or subscriber of the health maintenance organization.

§19–713.

(a) (1) Each health maintenance organization shall file with the Commissioner and pay the applicable filing fee as provided in § 2–112 of the Insurance Article, before they become effective:

(i) All rates that the health maintenance organization charges subscribers or groups of subscribers; and

(ii) The form and content of each contract between the health maintenance organization and its subscribers or groups of subscribers.

(2) (i) A health maintenance organization that offers a health benefit plan, as defined in § 11–601 of the Insurance Article, is subject to Title 11, Subtitle 6 of the Insurance Article for the health benefit plan.

(ii) If the provisions of Title 11, Subtitle 6 of the Insurance Article conflict with the provisions of this section, the provisions of Title 11, Subtitle 6 of the Insurance Article shall prevail.

(b) (1) Rates of a health maintenance organization may not be excessive, inadequate, or unfairly discriminatory in relation to the services offered.

(2) A health maintenance organization that includes a subrogation provision in its contract as authorized under § 19-713.1(d) of this subtitle shall:

(i) Use in its rating methodology an adjustment that reflects the subrogation; and

(ii) Identify in its rate filing with the Maryland Insurance Administration, and annually in a form approved by the Insurance Commissioner, all amounts recovered through subrogation.

(c) (1) If, at any time, a health maintenance organization wishes to amend any contract with its subscribers or change any rate charged, the health maintenance organization shall file with the Commissioner the number of copies of the amendment or rate change that the Commissioner requires.

(2) The Commissioner shall provide the Department with the number of copies it requires.

(d) The Commissioner shall coordinate the contract and related rate filing review under this section.

(e) (1) If within 60 days after a filing made pursuant to this section, the Commissioner finds the filing does not meet the requirements of subsection (f) of this section, the filer shall be sent notice of disapproval specifying in what respects the Commissioner finds that the filing fails to meet the requirements of this section and stating that the filing shall not become effective.

(2) The Commissioner may extend the initial review period described in paragraph (1) of this subsection for up to an additional 30 days if the Commissioner gives notice to the health maintenance organization of the extension before the initial review period ends.

(3) The Commissioner may not issue a notice of disapproval of a filing under subsection (f) of this section without a statutory or regulatory basis for the disapproval and an explanation of the application of the statutory or regulatory basis which resulted in the disapproval.

(f) The Commissioner shall disapprove any form filed, or withdraw any previous approval, if the form:

(1) Is in any respect in violation or does not comply with this article or applicable regulations;

(2) Contains, or incorporates by reference, any inconsistent or inapplicable clauses, exceptions, or conditions which affect the risk purported to be assumed in the general coverage of the contract;

(3) Has any title, heading, or other indication of its provisions which is likely to mislead the subscriber or member;

(4) Includes provisions that are inequitable, or provisions that lack any substantial benefit to the subscriber or member;

(5) Is printed or otherwise reproduced in a manner as to render any provision of the form substantially illegible; or

(6) Provides benefits that are unreasonable in relation to the premium charged.

(g) (1) Except as provided in paragraph (2) of this subsection, unless the Commissioner disapproves a filing under this section, the filing becomes effective:

(i) 60 days after the office of the Commissioner receives the filing;

(ii) If the Commissioner extends the review period under subsection (e)(2) of this section, on the date specified in the notice required under subsection (e)(2) of this section; or

(iii) On any other date that the Commissioner sets.

(2) The Commissioner may adopt regulations to allow a type or kind of form to be effective upon receipt of the filing by the Commissioner.

(3) If a health maintenance organization uses a form which becomes effective in accordance with the provisions of paragraph (2) of this subsection and the form would be subject to disapproval under subsection (f) of this section, the Commissioner may:

(i) Subsequently disapprove the form; and

(ii) Find the health maintenance organization to be in violation of § 19–729 of this subtitle and impose a penalty as provided in § 19–730 of this subtitle.

(4) If a health maintenance organization files a form with the Commissioner which becomes effective in accordance with the provisions of paragraph (2) of this subsection, the health maintenance organization shall pay the applicable filing fee provided in § 2–112 of the Insurance Article.

§19–713.1.

(a) A contract between a health maintenance organization and its subscribers or a group of subscribers may contain nonduplication provisions or provisions to coordinate the coverage with subscriber contracts of other health maintenance organizations, health insurance policies, including those of nonprofit health service plans, and with other established programs under which the subscriber or member may make a claim.

(b) Notwithstanding the provisions of subsection (a) of this section, a contract between a health maintenance organization and its subscribers or a group of subscribers may not contain nonduplication provisions or provisions to coordinate coverage with any individually underwritten and issued, guaranteed renewable,

specified disease policy, as defined in § 15-109 of the Insurance Article, or intensive care policy, which does not provide benefits on an expense incurred basis.

(c) For purposes of this section, "intensive care policy" means a health insurance policy that provides benefits only when treatment is received in that specifically designated facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

(d) Notwithstanding § 19-701(g)(3) of this subtitle, a contract between a health maintenance organization and its subscribers or a group of subscribers may contain a provision allowing the health maintenance organization to be subrogated to a cause of action that a subscriber has against another person:

(1) To the extent that any actual payments made by the health maintenance organization result from the occurrence that gave rise to the cause of action; or

(2) For a nonprofit health maintenance organization that exclusively contracts with a group of physicians to provide or to arrange for the provision of health care services for its enrollees, for any service provided by the health maintenance organization as a result of the occurrence that gave rise to the cause of action, per the fee schedule established by the nonprofit health maintenance organization.

(e) (1) Subsection (d) of this section does not allow a contract between a health maintenance organization and its subscribers or a group of subscribers to contain a provision allowing the health maintenance organization to recover any payments made to a subscriber under the personal injury protection coverage of a motor vehicle liability insurance policy.

(2) A contract between a health maintenance organization and its subscribers or a group of subscribers may not contain a provision that requires personal injury protection benefits under a motor vehicle liability insurance policy to be paid before benefits under the contract.

(f) Subsection (d) of this section does not allow a health maintenance organization to recover medical expenses from a subscriber under a subrogation provision unless the subscriber recovers for medical expenses in a cause of action.

§19–713.2.

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

(2) "Administrative service provider contract" means a contract or capitation agreement between a health maintenance organization and a contracting provider which includes requirements that:

(i) The contracting provider accept payments from a health maintenance organization for health care services to be provided to members of the health maintenance organization that the contracting provider arranges to be provided by external providers; and

(ii) The contracting provider administer payments pursuant to the contract with the health maintenance organization for the health care services to the external providers.

(3) (i) "Contracting provider" means a person who enters into an administrative service provider contract with a health maintenance organization.

(ii) "Contracting provider" does not include a medical laboratory as defined in § 17–201 of this article.

(4) "External provider" means a health care provider, including a physician or hospital, who is not:

(i) A contracting provider; or

(ii) An employee, shareholder, or partner of a contracting provider.

(b) This section does not apply to a contract between a health maintenance organization and a contracting provider that is affiliated with the health maintenance organization through common ownership within an insurance holding company system, if the health maintenance organization:

(1) Files with the Commissioner consolidated financial statements that include the contracting provider; and

(2) Records a reserve for the liabilities of the contracting provider in accordance with § 5-201 of the Insurance Article.

(c) A health maintenance organization may not enter into an administrative service provider contract unless:

(1) The health maintenance organization files with the Insurance Commissioner a plan that satisfies the requirements of subsection (d) of this section; and

(2) The Insurance Commissioner does not disapprove the filing within 30 days after the plan is filed.

(d) The plan required under subsection (c) of this section shall:

(1) Require the contracting provider to provide the health maintenance organization with monthly reports, within 30 days of the end of the month reported, that identify payments made or owed to external providers in sufficient detail to determine if the payments are being made in compliance with law;

(2) Require the contracting provider to provide to the health maintenance organization a current annual financial statement of the contracting provider each year, within 90 days of the end of the year reported;

(3) Require the health maintenance organization to establish and maintain a segregated fund, in a form and an amount approved by the Commissioner, which may include withheld funds, escrow accounts, letters of credit, or similar arrangements, or require the availability of other resources that are sufficient to satisfy the contracting provider's obligations to external providers for services rendered to members of the health maintenance organization;

(4) Require the contracting provider to submit to the health maintenance organization information demonstrating that the fund established under item (3) of this subsection is sufficient to satisfy the contracting provider's obligations to external providers for services rendered to members of the health maintenance organization; and

(5) Require the health maintenance organization, at least quarterly, to review and inspect the contracting provider's books, records, and operations relevant to the provider's contract for the purpose of determining the contracting provider's compliance with the plan.

(e) In determining the sufficiency of a segregated fund, the Commissioner may consider whether external providers are owned or controlled by the contracting provider.

(f) The segregated fund or other resources established as a result of an administrative service provider contract:

(1) Shall be held in trust for payment to external providers; and

(2) May not be considered an asset or an account of the contracting provider for the purpose of determining the assets or accounts of a bankrupt contracting provider.

(g) The health maintenance organization and the contracting provider shall comply with the plan.

(h) (1) The health maintenance organization shall monitor the contracting provider to assure compliance with the plan, and the health maintenance organization shall notify the contracting provider whenever a failure to comply with the plan occurs.

(2) Upon the failure of the contracting provider to comply with the plan following notice of noncompliance, or upon termination of the administrative service provider contract for any reason, the health maintenance organization shall notify the Commissioner and shall assume the administration of any payments due from the contracting provider to external providers on behalf of the contracting provider, as required under § 19-712 of this subtitle.

(i) The health maintenance organization shall file with the Commissioner, the results of each quarterly review required under subsection (d)(5) of this section.

(j) The plan and all supporting documentation submitted in connection with the plan shall be treated as confidential and proprietary, and may not be disclosed except as otherwise required by law.

(k) A health maintenance organization and a contracting provider shall comply with the terms of an administrative service provider contract as required under this section and § 19-712 of this subtitle.

(l) If a contracting provider fails to comply with the plan or the administrative service provider contract, as required under subsections (g) and (k) of this section, the Commissioner may impose a fine not exceeding $125,000 or suspend or revoke the registration of the contracting provider under § 19-713.3 of this subtitle, or both.

§19–713.3.

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

(2) "Administrative service provider contract" has the meaning stated in § 19-713.2 of this subtitle.

(3) "Contracting provider" has the meaning stated in § 19-713.2 of this subtitle.

(b) (1) A person must register with the Commissioner before the person acts as a contracting provider in this State.

(2) A health maintenance organization may not enter into an administrative service provider contract with a contracting provider that has not registered with the Commissioner.

(c) (1) An applicant for registration shall submit an application to the Commissioner in a form approved by the Commissioner and include any information required under subsection (e) of this section.

(2) A registration under this section expires 2 years from the date the application is approved.

(d) The Commissioner may charge a registration fee sufficient to cover the cost of implementing this section.

(e) The Commissioner may adopt regulations to carry out the provisions of this section and § 19-713.2 of this subtitle.

§19–713.4.

(a) In this section, "health maintenance organization" or "HMO" includes any agent of a health maintenance organization.

(b) (1) A health maintenance organization that issues a request for proposal, including changes in terms to an existing contract to provide pharmaceutical services, shall notify the Maryland Pharmacists Association of the request for proposal to provide pharmaceutical services within 10 days after issuing that request.

(2) The Maryland Pharmacists Association may inform licensed pharmacists of the request.

(c) A health maintenance organization may not charge a fee for processing or accepting an application to provide pharmaceutical services.

(d) This section does not apply to a health maintenance organization if the health maintenance organization provides pharmaceutical services from a pharmacy that is:

(1) Located on the site of the health maintenance organization; and

(2) Wholly owned and operated by the health maintenance organization.

§19–713.5.

(a) If a health maintenance organization requires its subscribers to have a referral to receive consultation services in writing, the health maintenance organization shall use the uniform consultation referral form adopted by the Commissioner under § 15-120 of the Insurance Article as the sole instrument for referrals for consultation services.

(b) A health maintenance organization may not impose as a condition of coverage any requirement to:

(1) Modify the uniform consultation referral form; or

(2) Submit additional consultation referral forms.

(c) The uniform consultation referral form shall be properly completed by the health care provider referring the subscriber for consultation services.

§19–713.6.

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

(2) "Documented informed consent" means:

(i) A written consent form signed by a patient; or

(ii) Verbal or otherwise communicated consent signified by a notation in a patient's electronic medical record maintained by a group model health maintenance organization.

(3) "Drug therapy management" means treatment of a patient using drug therapy, laboratory tests, or medical devices under conditions or limitations set forth in a protocol specified in a physician–pharmacist agreement for the purpose of improving patient outcome.

(4) "Group model health maintenance organization" means a health maintenance organization that:

(i) Contracts with one multispecialty group of physicians who are employed by and shareholders of the multispecialty group; and

(ii) Provides and arranges for the provision of physician services to patients at medical facilities operated by the health maintenance organization.

(5) "Licensed pharmacist" means an individual who is licensed to practice pharmacy under Title 12 of the Health Occupations Article.

(6) "Licensed physician" means an individual who is licensed to practice medicine under Title 14 of the Health Occupations Article.

(7) "Patient" means:

(i) A patient who is a member of a group model health maintenance organization; or

(ii) An individual to whom the group model health maintenance organization is contractually or legally obligated to provide, or arrange to provide, health care services.

(8) "Physician–pharmacist agreement" means an agreement between a licensed physician and a licensed pharmacist that is disease–state specific and specifies the protocols that may be used.

(9) "Protocol" means a course of treatment predetermined by the licensed physician and licensed pharmacist according to generally accepted medical practice for the proper completion of a particular therapeutic or diagnostic intervention.

(b) (1) In a group model health maintenance organization, a licensed physician and a licensed pharmacist who wish to provide drug therapy management to patients shall have a physician–pharmacist agreement.

(2) Drug therapy management shall be provided under this section only:

(i) In accordance with a physician–pharmacist agreement; and

(ii) Through the internal pharmacy operations of the group model health maintenance organization.

(3) A licensed physician who has entered into a physician–pharmacist agreement shall submit to the State Board of Physicians a copy of the physician–pharmacist agreement and any subsequent modifications made to the physician–pharmacist agreement or the protocols specified in the physician–pharmacist agreement.

(4) A licensed pharmacist who has entered into a physician–pharmacist agreement shall submit to the State Board of Pharmacy a copy of the physician–pharmacist agreement and any subsequent modifications made to the physician–pharmacist agreement or the protocols specified in the physician–pharmacist agreement.

(c) A licensed pharmacist is authorized to enter into a physician–pharmacist agreement if the licensed pharmacist:

(1) Has a Doctor of Pharmacy degree or equivalent training as established in regulations adopted by the State Board of Pharmacy;

(2) Is approved by the State Board of Pharmacy to enter into a physician–pharmacist agreement with a licensed physician; and

(3) Meets any other requirements established by regulation by the State Board of Pharmacy.

(d) A physician–pharmacist agreement shall prohibit the substitution of a chemically dissimilar drug product by the pharmacist for the product prescribed by the physician, unless permitted in the protocol specified in the physician–pharmacist agreement.

(e) A patient may decline to participate or withdraw from participating in drug therapy management in a group model health maintenance organization at any time.

(f) A licensed physician or licensed pharmacist or both shall inform a patient:

(1) Regarding the procedures that will be utilized for drug therapy management under the associated protocols;

(2) That the patient may decline to participate or withdraw from participating in the drug therapy management at any time; and

(3) That neither the physician nor the pharmacist has been coerced, given economic incentives, excluding normal reimbursement for services rendered, or involuntarily required to participate.

(g) A licensed physician or a licensed pharmacist or both shall obtain documented informed consent from a patient after disclosing the information required to be disclosed under subsection (f) of this section.

§19–714.

Each marketing document that sets forth the health care services of a health maintenance organization shall describe fully and clearly:

(1) The health care services under each benefit package and every other benefit to which a member is entitled;

(2) Where and how services may be obtained;

(3) Each exclusion or limitation on any service or other benefit that it provides;

(4) Each deductible feature;

(5) Each copayment provision; and

(6) All information required by § 15-1206 of the Insurance Article.

§19–715.

Each health maintenance organization application or offer of enrollment shall contain or be accompanied by, and each form of health maintenance organization subscriber contract shall contain, a full and clear statement of:

(1) The items specified in § 19-714 of this subtitle;

(2) The rate of periodic payment;

(3) When the coverage is effective and what restrictions, if any, apply to preexisting conditions;

(4) All standards for cancellation of enrollment or denial of reenrollment; and

(5) Service priorities, if any, in epidemic or other emergency or catastrophic conditions that may cause an unusually high demand for medical services.

§19–716.

Annually, each health maintenance organization shall provide to its members and make available to the general public, in clear, readable, and concise form:

(1) A summary of the most recent financial report that the health maintenance organization submits to the Commissioner under § 19-717 of this subtitle;

(2) A description of the benefit packages available and the nongroup rates required by the Commissioner;

(3) A description of the accessibility and availability of services, including where and how to obtain them;

(4) A statement of the potential responsibility of a member for payment for services the member seeks to obtain from a provider, including a physician or hospital, that does not have a written contract with the health maintenance organization;

(5) A description of procedures to be followed for emergency services, including:

(i) The appropriate use of hospital emergency facilities;

(ii) The appropriate use, location, and hours of operation of any urgent care facilities operated by the health maintenance organization; and

(iii) The potential responsibility of subscribers and enrollees for payment for emergency services or nonemergency services rendered in a hospital emergency facility;

(6) A statement that shows, by category, the percentage of members assisted by public funds;

(7) The information required to be disclosed by § 15-1206 of the Insurance Article; and

(8) Any other information that the Commissioner or the Department requires by rule or regulation.

§19–717.

(a) Except as provided in subsections (b) and (c) of this section and unless, for good cause shown, the Commissioner extends the time for a reasonable period:

(1) On or before March 1 of each year, each health maintenance organization shall file with the Commissioner a report that shows the financial condition of the health maintenance organization on the last day of the preceding calendar year and any other information that the Commissioner requires by rule or regulation; and

(2) On or before June 1 of each year, each health maintenance organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(b) A health maintenance organization that has a fiscal year other than the calendar year may request permission to file both the annual report required under subsection (a)(1) of this section and the audited financial report required under subsection (a)(2) of this section at the end of its fiscal year rather than the preceding calendar year. If the Commissioner grants this permission, the health maintenance organization shall file the annual report with the Commissioner within 60 days after the end of its fiscal year, and the health maintenance organization shall file the audited financial report with the Commissioner within 150 days after the end of its fiscal year.

(c) With 90 days' advance notice, the Commissioner may require a health maintenance organization to file an audited financial report earlier than the date specified in subsection (a) of this section.

(d) The annual report shall:

(1) Be on the forms that the Commissioner requires; and

(2) Include a description of any changes in the information submitted under § 19–708 of this subtitle.

(e) The audited financial report shall:

(1) Be on the forms that the Commissioner requires; and

(2) Be certified by an audit of a certified public accounting firm.

(f) Each financial report filed under this section is a public record.

§19–719.

Under rules, regulations, and procedures that the Secretary approves and using methods that keep the identity of patients as confidential as possible, assure objective evaluation, and are consistent with § 19-710 of this subtitle, the Department may do periodic examinations to:

(1) Determine the quality of health care services being provided by health maintenance organizations; and

(2) Develop statistical information.

§19–720.

(a) The State Health Services Cost Review Commission promptly shall give the Commissioner and the Secretary any financial information that the Commission acquires about each facility that is:

(1) Under the jurisdiction of the Commission; and

(2) Subject to this subtitle.

(b) If requested by the Commissioner or the Secretary, the State Health Services Cost Review Commission shall provide any other information that the Commission is authorized to acquire about health maintenance organizations regulated under this subtitle.

§19–721.

(a) Unless previously suspended or revoked, each original and renewal certificate of authority issued under this subtitle to a health maintenance organization expires at midnight on the November 30 after its effective date.

(b) On payment of an annual renewal fee of $25 by the health maintenance organization before the expiration date of its certificate of authority, its certificate remains in effect until a new certificate of authority is issued or specifically refused.

§19–722.

(a) The Commissioner may refuse to renew a certificate of authority for any reason for which the Commissioner may:

(1) Refuse to issue an original certificate; or

(2) Suspend or revoke an existing certificate.

(b) If the Commissioner refuses to renew a certificate of authority, the applicant has the same administrative and legal remedies as those provided under this subtitle for the suspension or revocation of a certificate of authority.

§19–723.

(a) At all times, each health maintenance organization is subject to the supervision of the Commissioner and the Department as provided in this subtitle.

(b) Any health maintenance organization that contracts with the Department and is subject to this subtitle shall act in concert with the Department or with the written consent of the Department concerning all information that the Commissioner requires.

§19–724.

(a) Except as provided in subsection (b) of this section, a health maintenance organization may solicit members through advertising its services, charges, or nonprofessional aspects of its operation.

(b) A health maintenance organization may not use any advertising that makes any qualitative judgment about any person who provides services for a health maintenance organization.

§19–725.

(a) A health maintenance organization may not cancel the enrollment of a member or refuse to transfer a member from a group to an individual basis because of age, sex, sexual orientation, gender identity, religious beliefs, disability, race, or health status.

(b) A health maintenance organization may cancel a contract with a member who violates any published policy of the health maintenance organization that has been approved by the Commissioner and the Department under their joint internal procedures.

§19–726.

(a) (1) A health maintenance organization may not include in its name:

(i) The words "insurer", "casualty", "surety", or "health and accident"; or

(ii) Any other words generally regarded as descriptive of the insurance industry.

(2) This subsection does not apply to an insurer or health service corporation that is licensed and regulated under the laws of this State, except as to its health maintenance organization activities that are authorized and regulated under this subtitle.

(b) Except as authorized by the Commissioner under this subtitle, a person other than a health maintenance organization regulated under this subtitle may not designate its services, operations, or functions as a "health maintenance organization" or use any other title or designation if the arrangement of services, operations, or functions substantially fall under the definition of a health maintenance organization in § 19-701 of this subtitle.

§19–727.

(a) Except as provided in subsection (b) of this section, a health maintenance organization is not exempted from any State, county, or local taxes solely because of this subtitle.

(b) (1) A nonprofit health maintenance organization that is exempt from taxation under § 501(c)(3) of the Internal Revenue Code is not subject to the insurance premium tax under Title 6, Subtitle 1 of the Insurance Article.

(2) Premiums received by an insurer under policies that provide health maintenance organization benefits are not subject to the premium tax imposed under Title 6, Subtitle 1 of the Insurance Article to the extent:

(i) Of the amounts actually paid by the insurer to a nonprofit health maintenance organization that operates only as a health maintenance organization; or

(ii) The premiums have been paid by that nonprofit health maintenance organization.

§19–728.

(a) The Commissioner is responsible for:

(1) Determining whether each health maintenance organization is or will be able to provide a fiscally sound operation and adequate provision against risk of insolvency and may adopt reasonable rules and regulations designed to achieve this goal; and

(2) Actuarial and financial evaluations and determinations of each health maintenance organization.

(b) (1) If the Commissioner determines that a health maintenance organization is not operating in a fiscally sound manner, the Commissioner shall notify the Department of the determination.

(2) After notifying the Department in accordance with the provisions of paragraph (1) of this subsection, the Commissioner shall monitor the health maintenance organization on a continuous basis until the Commissioner determines that the health maintenance organization is operating in a fiscally sound manner.

§19–729.

(a) A health maintenance organization may not:

(1) Violate any provision of this subtitle or any rule or regulation adopted under it;

(2) Fail to fulfill its obligations to provide the health care services specified in its contracts with subscribers;

(3) Make any false statement with respect to any report or statement required by this subtitle or by the Commissioner under this subtitle;

(4) Advertise, merchandise, or attempt to merchandise its services in a way that misrepresents its services or capacity for service;

(5) Engage in a deceptive, misleading, unfair, or unauthorized practice as to advertising or merchandising;

(6) Prevent or attempt to prevent the Commissioner or the Department from performing any duty imposed by this subtitle;

(7) Fraudulently obtain or fraudulently attempt to obtain any benefit under this subtitle;

(8) Fail to fulfill the basic requirements to operate as a health maintenance organization as provided in § 19–710 of this subtitle;

(9) Violate any applicable provision of Title 15, Subtitle 12 of the Insurance Article;

(10) Fail to provide services to a member in a timely manner as provided in § 19–705.1(b)(1) of this subtitle;

(11) Fail to comply with the provisions of Title 15, Subtitle 10A, 10B, 10C, or 10D or § 2–112.2 of the Insurance Article;

(12) Violate any provision of § 19–712.5 of this subtitle; or

(13) Violate any provision of Title 33 of the Insurance Article.

(b) If any health maintenance organization violates this section, the Commissioner may pursue any one or more of the courses of action described in § 19-730 of this subtitle.

§19–730.

(a) If any person violates any provision of § 19-729 of this subtitle, the Commissioner may:

(1) Issue an administrative order that requires the health maintenance organization to:

(i) Cease inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(ii) Fulfill its contractual obligations;

(iii) Provide a service that has been denied improperly;

(iv) Take appropriate steps to restore its ability to provide a service that is provided under a contract;

(v) Cease the enrollment of any additional enrollees except newborn children or other newly acquired dependents of existing enrollees; or

(vi) Cease any advertising or solicitation;

(2) In addition to suspending or revoking a certificate of authority:

(i) Impose a penalty of not less than $100, but not more than $125,000 for each violation; and

(ii) Order the health maintenance organization to pay restitution to any person who has suffered financial injury because of the violation;

(3) Suspend, revoke, or refuse to renew the certificate of authority to do business as a health maintenance organization;

(4) Suspend, revoke, or refuse to renew the certificate of a medical director of a health maintenance organization; or

(5) Apply to any court for legal or equitable relief considered appropriate by the Commissioner or the Department, in accordance with the joint internal procedures.

(b) If the Commissioner issues an order or imposes any penalty under this section, the Commissioner immediately shall provide written notice of the order or penalty to the Secretary.

§19–731.

(a) If a person violates any provision of §§ 19-705 and 19-705.1 of this subtitle, the Secretary may:

(1) Issue an administrative order that requires the health maintenance organization to:

(i) Cease inappropriate conduct or practices by it or any of the personnel employed by or associated with it and comply with the standards established by the Department; or

(ii) Provide any service required by §§ 19-705 and 19-705.1 of this subtitle that has been denied improperly;

(2) Impose a penalty of not less than $100 and not more than $125,000 for each violation; or

(3) Apply to any court for legal or equitable relief considered appropriate by the Secretary.

(b) If the Secretary issues an order or imposes any penalty under this section, the Secretary immediately shall provide written notice of the order or penalty to the Commissioner.

§19–732.

(a) Except as otherwise provided in Title 15, Subtitle 10A of the Insurance Article, a party aggrieved by a final action of the Commissioner under this subtitle has the right to a hearing and the right to appeal from the action of the Commissioner under §§ 2–210 through 2–215 of the Insurance Article.

(b) A party aggrieved by an order of the Secretary under this subtitle may petition for judicial review as provided by the Administrative Procedure Act.

§19–734.

This subtitle may be cited as the "Maryland Health Maintenance Organization Act".

§19–735.

(a) Any foreign health maintenance organization with a certificate of authority to operate a health maintenance organization in this State may become a domestic health maintenance organization of this State by complying with all of the requirements of the law relating to the formation and organization of a domestic health maintenance organization and by designating its principal place of business at a place in this State. On becoming a domestic health maintenance organization, the health maintenance organization shall be entitled to certificates and licenses to transact business in this State issued to domestic health maintenance organizations, and shall be given recognition in all respects as a health maintenance organization formed under the laws of this State as of the date of authorization as a health maintenance organization in its original domiciliary state, district, territory, commonwealth, or possession of the United States of America, and shall be subject to the authority and jurisdiction of this State.

(b) (1) The certificate of authority, insurance producers' appointments, rates, and other forms which the Commissioner allows which are in existence at the time any foreign health maintenance organization with a certificate of authority to operate a health maintenance organization in this State transfers its corporate domicile to this State or to any other state by merger, consolidation, or any other lawful method shall continue in full force and effect on transfer if the health maintenance organization at all times retains a certificate of authority in this State.

(2) All outstanding subscriber contracts of a transferring health maintenance organization shall remain in full force and effect and need not be endorsed as to the new name of the health maintenance organization or its new domiciliary and location unless so ordered by the Commissioner.

(3) A transferring health maintenance organization may file new contract forms with the Commissioner on or before the effective date of the transfer, or may use any existing contract form previously filed with the Commissioner with appropriate endorsements if allowed by and under such conditions as approved by the Commissioner.

(4) A foreign health maintenance organization transferring its domicile to another state shall notify the Commissioner of the details of the proposed transfer, and shall file promptly any resulting amendments to corporate documents and other items on file with the Commissioner.

§19–7A–01.

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

(b) "Commissioner" means the Maryland Insurance Commissioner.

(c) "Health care services" means a health or medical care procedure or service rendered by a health care provider that:

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

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

(d) "License" includes a certificate of authority, as defined in § 1-101 of the Insurance Article.

(e) "Provider" means any person, including a physician or hospital, that is licensed or otherwise authorized in this State to provide health care services.

(f) "Provider-sponsored organization" means an entity that:

(1) Is a legal aggregation of providers operating collectively for the purpose of providing health care services to Medicare beneficiaries under the federal Medicare+Choice Program;

(2) Acts through a licensed entity, such as a partnership, corporation, limited liability company, limited liability partnership, or sole proprietorship, that has authority over the entity's activities and responsibility for satisfying the requirements of § 19-7A-02 of this subtitle; and

(3) Provides a substantial proportion of the health care services required to be provided under the federal Medicare+Choice Program directly through providers or affiliated groups of providers.

§19–7A–02.

(a) A license issued to a provider-sponsored organization under this subtitle authorizes the licensee to provide health care services only to Medicare beneficiaries under the federal Medicare+Choice Program.

(b) Nothing in this subtitle may be construed to limit a provider-sponsored organization from participating in the Medicaid program as a managed care organization.

§19–7A–03.

(a) (1) Before an entity may operate as a provider-sponsored organization under the federal Medicare+Choice Program, the entity must obtain a license from the Commissioner.

(2) The Commissioner shall issue a license under paragraph (1) of this subsection to any entity to operate as a provider-sponsored organization that meets the requirements of subsection (b) of this section.

(b) To operate as a provider-sponsored organization under the federal Medicare+Choice Program in this State, an entity shall:

(1) Meet the definition of a provider-sponsored organization under § 19-7A-01 of this subtitle; and

(2) Meet the requirements applicable to a health maintenance organization under Subtitle 7 of this title to the extent those requirements are not preempted by federal law.

§19–7A–04.

(a) The Commissioner shall adopt regulations to implement the provisions of this subtitle.

(b) Except as provided in subsection (c) of this section, regulations relating to the solvency of a provider-sponsored organization adopted under subsection (a) of this section shall impose solvency requirements the same as required under federal law.

(c) Upon the expiration, repeal, or termination of solvency requirements under federal law for provider-sponsored organizations, the requirements of § 19-710(d) of this title shall apply.

§19–801.

In this subtitle, "problem gambler" means an individual:

(1) Who is preoccupied chronically and progressively with gambling and the urge to gamble; and

(2) Whose gambling behavior compromises, disrupts, or damages the individual's personal, family, or vocational pursuits.

§19–802.

The General Assembly finds that:

(1) Problem gambling is a serious social problem;

(2) There is evidence that the availability of gambling increases the risk of becoming a problem gambler; and

(3) This State, with its extensive legalized gambling, has an obligation to provide a program of treatment for problem gamblers.

§19–803.

The Secretary shall establish a network of clinically appropriate services to problem gamblers throughout the State.

§19–804.

(a) (1) The Secretary shall make grants from or agreements for the use of State funds, including the funds provided under § 9–1A–33 of the State Government Article, and federal funds to help public agencies or nonprofit organizations operate the network of clinically appropriate services for problem gamblers who reside in the State to provide the following:

(i) Inpatient and residential services;

(ii) Outpatient services;

(iii) Intensive outpatient services;

(iv) Continuing care services;

(v) Educational services;

(vi) Services for victims of domestic violence; and

(vii) Other preventive or rehabilitative services or treatment.

(2) Research and training that are designed to improve or extend these services are proper items of expense.

(b) The Secretary shall conduct a prevalence study and replication prevalence studies to measure the rate of problem and pathological gambling in the State.

(c) (1) Subject to paragraph (2) of this subsection, the Secretary shall contract with an independent researcher to conduct the prevalence studies.

(2) The Secretary shall utilize the most current psychiatric or diagnostic criteria for problem and pathological gambling as the basis for the prevalence studies.

(d) The initial prevalence study shall be completed on or before July 1, 2009.

(e) Replication prevalence studies shall be conducted no less than every 5 years with measures taken to permit comparisons between the initial prevalence study and subsequent replication prevalence studies.

(f) Services under this subtitle shall be provided by public agencies or, under contract, by nonprofit organizations.

§19–901.

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

(b) "General hospice care program" means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement:

(1) To individuals who have no reasonable prospect of cure as estimated by a physician; and

(2) To the families of those individuals.

(c) "General license" means a license issued by the Secretary to operate a general hospice care program.

(d) "Home–based hospice care program" means a program that directly or through a contractual arrangement provides a hospice care program in the residence of the patient.

(e) "Hospice facility" means a facility that:

(1) Provides a hospice care program;

(2) Is separate from any other facility; and

(3) Admits at least 2 individuals who:

(i) Are unrelated; and

(ii) Have no reasonable prospect of a cure.

(f) "Limited hospice care program" means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive nonskilled services through a home–based hospice care program during illness and bereavement:

(1) To individuals who have no reasonable prospect of cure as estimated by a physician; and

(2) To the families of those individuals.

(g) "Limited license" means a license issued by the Secretary to operate a limited hospice care program.

§19–902.

The purposes of this subtitle are:

(1) To simplify and clarify the laws that govern the use of a hospice care program by individuals who want a supportive environment;

(2) To encourage the establishment of hospice care programs; and

(3) To ensure the quality of these hospice care programs.

§19–903.

(a) (1) The Secretary shall adopt regulations to carry out the provisions of this subtitle.

(2) The regulations for general hospice care programs shall set standards for general hospice care programs that are comparable to the standards established by the National Hospice Organization.

(3) The Secretary, by regulation, after consultation with interested groups, including The Hospice Network of Maryland, Inc., shall establish standards for the operation of a hospice care program.

(b) (1) The regulations shall set qualifications for medical directors of hospices. A medical director of a hospice care program need not be an employee or a contractee of a hospice care program.

(2) The regulations for a hospice facility shall require:

(i) The medical director to be a physician licensed to practice medicine in this State;

(ii) The dietary, nursing, pastoral care, pharmaceutical, and social worker services to be adequate; and

(iii) A physician other than an attending physician to be on call and available at all times.

(3) The regulations for a home-based hospice care program shall require:

(i) The medical director to be a physician licensed to practice medicine in this State;

(ii) The provision of bereavement services;

(iii) The provision of services to meet the spiritual or social needs of dying individuals and their families;

(iv) The provision of palliative and supportive medical, nursing, and other health services:

1. Directly or by contract for a general licensee; or

2. By referral only for a limited licensee;

(v) Submission of an annual report which includes service utilization statistics in the format prescribed;

(vi) Written transfer agreements to provide acute inpatient care as needed; and

(vii) Minimum standards concerning the training and role of volunteers in a hospice care program.

§19–904.

(a) A building that contains a hospice facility shall:

(1) Be constructed soundly; and

(2) Meet the standards for construction and safety that the county or municipality imposes on a single-family residence.

(b) A building that contains a hospice facility may not be required to comply with health and safety standards for an institution.

§19–905.

(a) A person shall be licensed by the Secretary before a person may operate a hospice care program.

(b) A home health agency, hospital, related institution, or other licensed facility that operates a hospice care program that is distinct from the other services that the home health agency or facility offers shall be licensed by the Secretary as a hospice care program before the home health agency or facility may operate that hospice care program.

§19–906.

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

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

(1) At least 18 years old; and

(2) Of reputable and responsible character.

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

(2) The Secretary, in consultation with the Maryland Health Care Commission, shall specify those jurisdictions in which a general hospice is authorized to provide home-based hospice services.

(3) A general hospice may not be licensed to provide home-based hospice services in a jurisdiction unless the general hospice or an entity acquired by the general hospice provided home-based hospice services to a patient in the jurisdiction during the 12-month period ending December 31, 2001.

(4) Notwithstanding paragraph (3) of this subsection:

(i) A general hospice may provide home-based hospice services to a specific patient outside of the jurisdictions in which the hospice is licensed if the Maryland Health Care Commission approves the service provision; and

(ii) A general hospice that is a hospital-based hospice or that had an affiliation agreement before April 5, 2003 with a health care facility or health care system may serve patients immediately upon discharge from the hospital, health care facility, or health care system, regardless of the jurisdiction in which the patient resides.

(5) Upon the notification by the Maryland Health Care Commission of the issuance of a certificate of need to a general hospice, the Secretary shall append to the general hospice license any additional jurisdictions in which the general hospice may provide home-based hospice services.

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

§19–907.

(a) An applicant for a license shall submit an application to the Secretary.

(b) The application:

(1) Shall be on the form that the Secretary requires;

(2) Shall be signed and verified by the individual; and

(3) Shall include:

(i) The name of the applicant;

(ii) A statement that the applicant meets the requirements of this subtitle;

(iii) The location of the proposed hospice;

(iv) The name of the individual who is to be the medical director of the hospice care program; and

(v) Any other information that the Secretary requires.

§19–908.

The Secretary shall issue a license to any applicant if the applicant and the hospice care program and its medical director meet the requirements of this subtitle.

§19–909.

(a) While it is effective, a general license authorizes the general licensee to operate a general hospice care program.

(b) (1) While it is effective, a limited license authorizes the limited licensee to operate a limited hospice care program.

(2) A limited licensee may not provide any medical, nursing, or other health services directly or through a contractual arrangement.

§19–911.

(a) The Secretary shall deny a license to any applicant or revoke a license if the applicant or licensee has been convicted of a felony that relates to Medicaid or to a nursing home.

(b) The Secretary may deny a license to an applicant or revoke a license if the applicant or licensee does not meet the requirements of this subtitle or any rule or regulation that the Secretary adopts under this subtitle.

(c) (1) In addition to the provisions of subsections (a) and (b) of this section, the Secretary may, for a violation of any provision of this subtitle or any regulation adopted under this subtitle, impose an administrative penalty of up to:

(i) $500 for a first violation; and

(ii) $1,000 for a subsequent, repeated violation.

(2) The Secretary shall adopt regulations to provide standards for the imposition of an administrative penalty under paragraph (1) of this subsection.

§19–912.

A person may not operate a hospice care program unless licensed by the Secretary.

§19–913.

A hospice facility may not admit an individual unless a physician estimates that the individual has no reasonable prospect of cure.

§19–914.

(a) (1) This section applies to a general hospice care program only when providing hospice services in an in–home setting.

(2) This section does not apply to a general hospice care program when providing hospice services in a nursing home, assisted living facility, or a general hospice care program facility.

(b) A general hospice care program shall establish a written policy that outlines the procedures for the collection and disposal of a patient's unused prescription medication, including a procedure that requires a general hospice care employee, at the time that a patient is enrolled in the general hospice care program, to:

(1) Discuss with the patient and the patient's family member or personal representative the requirements under subsection (c) of this section; and

(2) Provide a written copy of the unused prescription medication collection and disposal policy to the patient and the patient's family member or personal representative.

(c) (1) In accordance with a general hospice care program's policy and subject to paragraphs (2) and (3) of this subsection, a general hospice care program employee shall, as soon as practicable, collect and dispose of a patient's unused prescription medication on:

(i) The death of the patient; or

(ii) The termination of a prescription medication by the patient's prescriber.

(2) Before a general hospice care program employee collects or disposes of a patient's unused prescription medication under paragraph (1) of this subsection, the employee shall provide to the patient or the patient's family member or personal representative a written request for authorization to collect and dispose of the patient's unused prescription medication in accordance with the patient's care plan.

(3) A general hospice care program employee may not collect or dispose of a patient's unused prescription medication unless the patient or the patient's family member or representative provides written authorization to the general hospice care program.

(4) If a patient or the patient's family member or personal representative refuses to authorize the collection or disposal of the patient's unused prescription medication, the general hospice care program employee shall urge that the patient or the patient's family member or personal representative dispose of any unused prescription medication in a safe and legal manner in accordance with federal Environmental Protection Agency and federal Drug Enforcement Administration guidelines for the safe disposal of prescription drugs.

(d) If authorized, a general hospice care program employee shall, as soon as practicable, dispose of a patient's unused prescription medication at the site where hospice care was provided:

(1) In accordance with federal Environmental Protection Agency and federal Drug Enforcement Administration guidelines for the safe disposal of prescription drugs; and

(2) Under the witness of:

(i) The patient or the patient's family member or personal representative;

(ii) Another general hospice care program employee; or

(iii) If none of the individuals under items (i) or (ii) of this item are available, a local law enforcement officer.

(e) (1) The collection and disposal of a patient's unused prescription medication by the general hospice care program shall be documented in the patient's medical record by the general hospice care program employee who conducted the collection and disposal.

(2) The medical record shall include the following information:

(i) The name and quantity of each unused prescription medication;

(ii) The name of the individual who authorized the collection and disposal of the unused prescription medication and the individual's relationship to the patient;

(iii) The date of disposal for each unused prescription medication;

(iv) The name of the individual who conducted the collection and disposal; and

(v) The name of the individual who witnessed the disposal of unused prescription medication by the employee as required under subsection (d)(2) of this section.

(3) If a patient or the patient's family member or personal representative refuses to authorize the collection and disposal of the patient's unused prescription medication by the general hospice care program, the general hospice care program employee shall document in the patient's medical record:

(i) The refusal to authorize the collection and disposal of the patient's unused prescription medication; and

(ii) The name and quantity of each unused prescription medication not surrendered.

(f) A general hospice care program may not be held liable in a civil or criminal action for any good faith act or omission taken in accordance with the requirements of this section.

§19–1001.

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

(b) "Health care facility" means:

(1) A hospital, as defined in § 19–301 of this title;

(2) A limited service hospital, as defined in § 19–301 of this title;

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

(4) An ambulatory surgical facility; or

(5) A freestanding medical facility, as defined in § 19–3A–01 of this title.

(c) "Smoke evacuation system" means equipment that effectively captures and filters surgical smoke at the site of origin before the surgical smoke makes contact with the eyes or respiratory tract of occupants in the room.

(d) "Surgical smoke" means the gaseous by–product produced by energy–generating devices, including surgical plume, smoke plume, bio–aerosols, laser–generated airborne contaminants, or lung–damaging dust.

§19–1002.

By January 1, 2028, each health care facility that performs surgical procedures shall adopt and implement policies that require the use of a smoke evacuation system during a surgical procedure that may generate surgical smoke.

§19–1201.

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

(b) "Comprehensive physical rehabilitation services" means:

(1) A program of coordinated, integrated, interdisciplinary, physician-directed services provided by or under the supervision of physicians qualified or experienced in rehabilitation that:

(i) Includes evaluation and treatment of individuals with physical disabilities;

(ii) Emphasizes education and training of individuals with disabilities; and

(iii) Incorporates:

1. At least 4 of the following core disciplines:

A. Physical therapy;

B. Occupational therapy;

C. Speech and language therapy;

D. Psychotherapy;

E. Rehabilitation nursing; and

F. Social work; and

2. At least 2 of the following disciplines:

A. Psychology;

B. Audiology;

C. Respiratory therapy;

D. Therapeutic recreation;

E. Orthotics;

F. Prosthetics;

G. Special education or instruction; and

H. Vocational rehabilitation; and

(2) Any other service that the Secretary may designate by regulation.

(c) "Comprehensive rehabilitation facility" means:

(1) Any person that provides or holds himself out as providing comprehensive physical rehabilitation services on an out-patient basis; or

(2) A hospital that is licensed as a special rehabilitation hospital under Subtitle 3 of this title.

(d) (1) "Health care facility" includes any facility defined in § 19-114(d) of this title.

(2) "Health care facility" does not include a home health agency that is licensed under Subtitle 4 of this title.

(e) "Specialized rehabilitation program" means any of the specialty programs that the Commission on Accreditation of Rehabilitation Facilities accredits, including:

(1) Spinal cord injury programs;

(2) Head injury programs; and

(3) Infant and early childhood developmental programs.

§19–1202.

A comprehensive rehabilitation facility shall meet the requirements of this subtitle before the facility may provide:

(1) Comprehensive physical rehabilitation services; or

(2) Any specialized rehabilitation program.

§19–1203.

(a) This section does not apply to a special rehabilitation hospital that is licensed under Subtitle 3 of this title.

(b) Any person that provides or holds himself out as providing comprehensive physical rehabilitation services on an out–patient basis shall obtain a comprehensive rehabilitation license before the person may provide comprehensive physical rehabilitation services in the State.

(c) The Department shall issue a comprehensive rehabilitation license to any person for whom a comprehensive rehabilitation license is required if the person submits an application on the form established and provided for the Secretary.

(d) While it is effective, a comprehensive rehabilitation license authorizes the licensed person to provide comprehensive physical rehabilitation services.

(e) A person may not provide or hold himself out as providing comprehensive physical rehabilitation services on an out–patient basis unless the person has been issued a comprehensive rehabilitation license under this section.

§19–1204.

A comprehensive rehabilitation facility shall meet any standard that the Secretary adopts by regulation.

§19–1205.

The Secretary may inspect a comprehensive rehabilitation facility to assure that the facility meets the requirements of this subtitle.

§19–1206.

The Secretary may revoke a license issued under this subtitle or may revoke the authority to provide comprehensive physical rehabilitation services for any health care facility or person that does not meet each requirement of this subtitle or any regulation adopted by the Secretary under this subtitle.

§19–1207.

(a) A person may not hold himself out as providing a complete array of rehabilitation services unless the person provides comprehensive physical rehabilitation services.

(b) A health care facility may not provide or hold itself out as providing any specialized rehabilitation program unless the facility is licensed by the Department.

(c) A person may not provide comprehensive physical rehabilitation services unless the person meets the requirements of this subtitle.

§19–1208.

A person who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, or imprisonment not exceeding 1 year, or both.

§19–1401.

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

(b) "Actual harm deficiency" means a condition existing in a nursing home or an action or inaction by the nursing home staff that has caused physical or emotional injury or impairment to a resident.

(c) "Concurrent review" means daily rounds by a licensed nurse which include:

(1) Appraisal and observation of each resident by the licensed nurse to determine any change in the resident's physical or mental status; and

(2) If there is a change in the resident's physical or mental status, an evaluation by the licensed nurse of:

(i) The resident's medications;

(ii) Laboratory values relating to the resident;

(iii) Clinical data relating to the resident, including the resident's:

1. Hydration and nutritional need;

2. Skin integrity;

3. Noted weight changes; and

4. Appetite;

(iv) Injuries sustained by the resident that result from accident or incidents involving the resident; and

(v) Any other relevant parameters affecting or reflecting the resident's physical and mental status.

(d) "Deficiency" means a condition existing in a nursing home or an action or inaction by the nursing home staff that results in potential for more than minimal harm, actual harm, or serious and immediate threat to one or more residents.

(e) (1) "Nursing home" means a facility that offers nonacute inpatient care to patients suffering from a disease, chronic illness, condition, disability of advanced age, or terminal disease requiring maximal nursing care without continuous hospital services and who require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent, restorative, or rehabilitative services.

(2) "Nursing home" does not mean a facility offering domiciliary care or personal care as those terms are defined in § 19–301 of this title.

(f) "Ongoing pattern" means the occurrence of any potential for more than minimal harm or greater deficiency on two consecutive on-site visits as a result of annual surveys, follow-up visits, any unscheduled visits, or complaint investigations.

(g) "Potential for more than minimal harm deficiency" means a condition existing in a nursing home or an action or inaction by the nursing home staff that has the potential to cause actual harm to a resident.

(h) "Serious and immediate threat" means a situation in which immediate corrective action is necessary because a nursing home's noncompliance with one or more State regulations has caused or is likely to cause serious injury, harm, impairment to, or death of a resident receiving care in the nursing home.

(i) "Sustained compliance" means a period of 30 days following the date of notice of corrective action with no deficiencies.

§19–1401.1.

(a) (1) In addition to the requirements for licensure of a related institution as provided in this title, an applicant for licensure of a nursing home shall include in the application the identity of:

(i) Any person with an ownership interest in the nursing home; and

(ii) Any management company, landlord, or other business entity that will operate or contract with the applicant to manage the nursing home.

(2) (i) The person acquiring a nursing home shall provide the Department with written notice of the acquisition or change in operator at the same time as the notice required under § 19–120.2 of this title is filed with the Maryland Health Care Commission.

(ii) For other changes to the information required under paragraph (1) of this subsection, the nursing home shall notify the Department within 30 days after the effective date of the change.

(b) An applicant for licensure shall submit to the Secretary or the Secretary's designee evidence:

(1) That affirmatively demonstrates the ability of the applicant to comply with minimum standards of:

(i) Medical care;

(ii) Nursing care;

(iii) Financial condition; and

(iv) Other applicable State or federal laws and regulations;

(2) Regarding the regulatory compliance history and financial condition of any health care facility owned or operated by the applicant in other jurisdictions; and

(3) That a request for acquisition for the nursing home was approved in accordance with § 19–120.2 of this title.

§19–1401.2.

(a) On review of the information required under § 19–1401.1 of this subtitle and any other information that is relevant to the ability of the applicant to operate a nursing home, the Secretary may:

(1) Approve an application for a license;

(2) Deny an application for a license;

(3) Approve an application for a license subject to conditions; or

(4) Revoke a license.

(b) Before taking action on a license under subsection (a) of this section, the Secretary shall consider any findings and decisions of the Maryland Health Care Commission provided to the Office of Health Care Quality under § 19–120.2 of this title.

§19–1401.3.

(a) A licensee shall report to the Secretary or the Secretary's designee any significant change in the financial condition of the nursing home, including cash flow or any other circumstances that could adversely affect the nursing home's delivery of essential services to patients, including nursing services, dietary services, and utilities.

(b) Except as provided by subsection (c) of this section, any information obtained by the Secretary under this section is confidential and may not be disclosed without the consent of the licensee.

(c) The provisions of subsection (b) of this section do not apply to:

(1) The holder of a license that has been suspended or revoked; or

(2) The use of information in:

(i) An administrative proceeding initiated by the Department; or

(ii) A judicial proceeding.

§19–1402.

(a) If a deficiency exists, the Secretary may impose sanctions that include:

(1) A directed plan of correction with corrective measures necessary to protect residents;

(2) Imposing adequate staffing levels in a nursing home;

(3) Appointing a State monitor subject to § 19-1405 of this subtitle; and

(4) Imposing a civil money penalty.

(b) A civil money penalty may be imposed when a deficiency exists or an ongoing pattern of deficiencies exists in a nursing home.

(c) In determining whether a civil money penalty is to be imposed, the Secretary shall consider, pursuant to guidelines set forth in regulations promulgated by the Secretary, the following factors:

(1) The number, nature, and seriousness of the deficiencies;

(2) The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;

(3) The degree of risk to the health, life, or safety of the residents of the nursing home caused by the deficiency or deficiencies;

(4) The efforts made by, and the ability of, the nursing home to correct the deficiency or deficiencies; and

(5) A nursing home's prior history of compliance.

(d) Upon determination by the Department that a deficiency or deficiencies exist, the Department shall notify the nursing home that:

(1) Unless corrective action taken pursuant to this section is substantially completed, a civil money penalty will be imposed; or

(2) An order imposing a civil money penalty will be issued, pursuant to § 19-1403 of this subtitle which shall include a list of all deficiencies and notice that a civil money penalty may be imposed until the time that the cited deficiencies have been rectified.

§19–1403.

(a) If a civil money penalty is proposed, the Secretary shall issue an order which shall state the basis on which the order is made, the deficiency or deficiencies on which the order is based, the amount of civil money penalties to be imposed, and the manner in which the amount of civil money penalties imposed was calculated.

(b) An order issued pursuant to subsection (a) of this section shall be void unless issued within 60 days of the inspection or reinspection at which the deficiency is identified.

§19–1404.

(a) A civil money penalty imposed under this section for potential for more than minimal harm deficiencies:

(1) May not exceed $10,000 per instance; or

(2) May not exceed $1,000 per day for an ongoing pattern of deficiencies until the nursing home is in compliance.

(b) A civil money penalty imposed under this subtitle for actual harm deficiencies:

(1) May not exceed $10,000 per instance; or

(2) May not exceed $5,000 per day for an ongoing pattern of deficiencies until the nursing home is in compliance.

(c) A civil money penalty imposed under this section for a serious and immediate threat:

(1) May not exceed $10,000 per instance; or

(2) May not exceed $10,000 per day for an ongoing pattern of deficiencies until the nursing home is in compliance.

(d) In setting the amount of a civil money penalty under this section, the Secretary shall consider, pursuant to guidelines set forth in regulations promulgated by the Secretary, the following factors:

(1) The number, nature, and seriousness of the deficiencies;

(2) The degree of risk to the health, life, or safety of the residents of the nursing home caused by the deficiency or deficiencies;

(3) The efforts made by the nursing home to correct the deficiency or deficiencies;

(4) Current federal guidelines for money penalties;

(5) Whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing home to continue operating as a nursing home; and

(6) Such other factors as justice may require.

§19–1405.

(a) When the Department determines that there is a deficiency in a nursing home, the Department may appoint an independent monitor to oversee efforts made by the nursing home to achieve compliance with State and federal regulations governing nursing homes that participate in the Medicare and Medicaid programs.

(b) The appointment of a State monitor is an intermediate sanction that may be in addition to or in lieu of other sanctions.

(c) The State monitor's duties may include:

(1) Periodic inspections of a nursing home for the purpose of assessing the nursing home's compliance with State and federal regulations; and

(2) Reporting to the Department and the nursing home its findings.

(d) The State monitor may not be an employee of the Department.

(e) A nursing home shall be responsible for the costs associated with the appointment of a State monitor to the nursing home.

§19–1406.

(a) Within 15 days of the request for an appeal by a nursing home, the nursing home shall deposit the amount of the civil money penalty in an interest bearing escrow account, the nursing home shall bear any cost associated with establishing the escrow account, and the account shall be titled in the name of the nursing home and the Maryland Department of Health as joint owners.

(b) When the Secretary issues the final decision of the Department:

(1) If the decision upholds the imposition of the full civil money penalty, the escrow funds will be released to the Department within 15 days from the date of the decision;

(2) If the decision upholds the imposition of a civil penalty, but reduces the amount of the civil penalty, the amount due the Department will be released to the Department with accrued interest within 15 days of the date of the decision and the balance will be released to the nursing home within 15 days of the date of the decision; or

(3) If the decision reverses the imposition of the civil penalty, the escrow funds will be released to the nursing home within 15 days of the decision.

(c) (1) A hearing on the appeal shall be held in accordance with the Administrative Procedure Act, under Title 10, Subtitle 2 of the State Government Article.

(2) The Secretary shall have the burden of proof with respect to the imposition of civil money penalties under § 19–1404 or § 19–1413.1 of this subtitle.

(3) A decision shall be rendered by the Office of Administrative Hearings within 10 working days of the hearing.

(d) A nursing home is entitled to a 40% reduction in the amount of the civil money penalty if it waives its right to a hearing within 30 days of the Department's order.

§19–1407.

(a) (1) There is a Health Care Quality Account established in the Department.

(2) The Health Care Quality Account shall be funded by civil money penalties paid by nursing homes and other penalties that the Office of Health Care Quality may assess.

(3) The Department shall pay all penalties collected under this title to the Comptroller of the State.

(4) The Comptroller shall distribute the funds collected under this title to the Health Care Quality Account.

(5) The Health Care Quality Account is a continuing, nonlapsing fund, not subject to § 7–302 of the State Finance and Procurement Article.

(6) Any unspent portions of the Health Care Quality Account may not be transferred or reverted to the General Fund of the State, but shall remain in the Health Care Quality Account to be used for the purposes specified in this section.

(b) The Health Care Quality Account shall be used for training, grant awards, demonstration projects, or other purposes designed to improve the quality of care.

(c) The Department shall adopt regulations for the distribution of funds from the Health Care Quality Account.

§19–1408. IN EFFECT

(a) (1) Subject to subsection (c) of this section, the Department shall make a site visit and conduct a full survey of each licensed nursing home at least once per calendar year.

(2) Unless otherwise required by federal law, all surveys shall be unannounced.

(b) (1) Subject to paragraphs (2) and (3) of this subsection, the Department shall initiate an investigation of a nursing home complaint alleging actual harm within 10 business days after receiving the complaint.

(2) If the Department receives a complaint against a nursing home alleging immediate jeopardy to a resident, the Department:

(i) Shall make every effort to investigate the complaint within 24 hours after receiving the complaint; and

(ii) Shall investigate the complaint not later than 48 hours after receiving the complaint.

(3) (i) If the Department initiates an investigation of a nursing home complaint under this subsection, the Department shall:

1. Notify the local health department for the county in which the nursing home is located within 24 hours after initiating the investigation; and

2. To the extent practicable and as permitted by federal law, consult and coordinate with the local health department on the complaint investigation and response.

(ii) This paragraph may not be construed to require a local health department to assist with or otherwise assume the nursing home oversight responsibilities of the Department as required by federal or State law.

(c) If ownership of a licensed nursing home is transferred to a person that does not own or operate another nursing home in the State at the time of the transfer, the Department shall conduct:

(1) The first full survey of the licensed nursing home as required under subsection (a) of this section within 3 months after the date of transfer; and

(2) An unannounced, on–site follow–up survey of the licensed nursing home that covers any deficiencies noted in the full survey within 120 days after the full survey was completed.

(d) (1) Beginning July 1, 2025, and every 3 months thereafter, the Department shall report to the Senate Finance Committee and the House Health Committee, in accordance with § 2–1257 of the State Government Article, the number of surveys conducted in each county, disaggregated by the following types of surveys:

(i) Standard survey;

(ii) Complain survey;

(iii) Follow–up survey;

(iv) Revisit survey;

(v) Special focus facility survey;

(vi) Abbreviated survey; and

(vii) Life safety code survey.

(2) Beginning July 1, 2025, and every 6 months thereafter, the Office of Health Care Quality shall report to the local area agency on aging for each county the name of each nursing home in the county that was surveyed in the immediately preceding 6 months and the date each survey was conducted.

§19–1408. // EFFECTIVE MAY 31, 2029 PER CHAPTER 680 OF 2025 //

(a) (1) Subject to subsection (c) of this section, the Department shall make a site visit and conduct a full survey of each licensed nursing home at least once per calendar year.

(2) Unless otherwise required by federal law, all surveys shall be unannounced.

(b) (1) Subject to paragraphs (2) and (3) of this subsection, the Department shall initiate an investigation of a nursing home complaint alleging actual harm within 10 business days after receiving the complaint.

(2) If the Department receives a complaint against a nursing home alleging immediate jeopardy to a resident, the Department:

(i) Shall make every effort to investigate the complaint within 24 hours after receiving the complaint; and

(ii) Shall investigate the complaint not later than 48 hours after receiving the complaint.

(3) (i) If the Department initiates an investigation of a nursing home complaint under this subsection, the Department shall:

1. Notify the local health department for the county in which the nursing home is located within 24 hours after initiating the investigation; and

2. To the extent practicable, and as permitted by federal law, consult and coordinate with the local health department on the complaint investigation and response.

(ii) This paragraph may not be construed to require a local health department to assist with or otherwise assume the nursing home oversight responsibilities of the Department as required by federal or State law.

(c) If ownership of a licensed nursing home is transferred to a person that does not own or operate another nursing home in the State at the time of the transfer, the Department shall conduct:

(1) The first full survey of the licensed nursing home as required under subsection (a) of this section within 3 months after the date of transfer; and

(2) An unannounced, on–site follow–up survey of the licensed nursing home that covers any deficiencies noted in the full survey within 120 days after the full survey was completed.

§19–1408.1.

(a) The Department shall develop a clear and easy–to–understand graphic data dashboard that includes:

(1) The number of staff hired by the agency in each unit in the fiscal year to date;

(2) The number of surveyors employed by the agency in each unit in the fiscal year to date; and

(3) The number of vacancies within the agency in each unit in the fiscal year to date.

(b) The Department shall:

(1) Update the data dashboard developed under subsection (a) of this section at least every 2 weeks; and

(2) Post the most recent updated data dashboard prominently on its website.

§19–1409.

(a) There is an Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities.

(b) The Oversight Committee shall consist of the following members:

(1) One member of the Senate Finance Committee, appointed by the President of the Senate;

(2) One member of the House Health Committee, appointed by the Speaker of the House;

(3) The Secretary of Aging, or the Secretary's designee;

(4) The Director of the Office of Health Care Quality, or the Director's designee;

(5) The Deputy Secretary for Behavioral Health, or the Deputy Secretary's designee;

(6) The Secretary of Human Services, or the Secretary's designee;

(7) The Secretary of Disabilities, or the Secretary's designee;

(8) The State Long–Term Care Ombudsman;

(9) Two representatives of area agencies on aging, one of which shall be a member of a local long–term care ombudsman program established under Title 10, Subtitle 9 of the Human Services Article, selected by the President of the Maryland Association of Area Agencies on Aging;

(10) One representative of a local long–term care ombudsman entity, selected by the State Long–Term Care Ombudsman;

(11) Three consumer members, selected by the State Long–Term Care Ombudsman, all of whom shall be consumers living in an assisted living facility or a nursing home or have a family member living in an assisted living facility or a nursing home;

(12) The following representatives, selected by the organizations the individual represents:

(i) One representative from the Mid–Atlantic LifeSpan;

(ii) One representative of the Hospice Network of Maryland;

(iii) One representative of the Maryland Hospital Association;

(iv) One representative of 1199SEIU United Health Workers East;

(v) One representative of the Maryland Chapter of AARP;

(vi) One representative of United Seniors of Maryland;

(vii) One representative of the Mental Health Association of Maryland knowledgeable in issues of aging;

(viii) One representative of the Greater Maryland Chapter of the Alzheimer's Association;

(ix) One representative of the Maryland Association for Medical Adult Day Services; and

(x) One representative of LeadingAge Maryland; and

(13) Three representatives from the assisted living industry, of which, to the extent practicable, one shall represent a program that cares for one to four residents, one shall represent a program that cares for five to nine residents, and one shall represent a program that cares for more than 10 residents.

(c) The Secretary of Aging, or the Secretary's designee, shall chair the Oversight Committee.

(d) The Oversight Committee shall evaluate the progress in improving nursing home care quality and assisted living facility quality statewide, which may include consideration of:

(1) Quality of care standards for nursing homes and assisted living facilities;

(2) Standards for the identification of the onset of dementia and Alzheimer's disease;

(3) Standards for the identification of conditions appropriate for hospice services;

(4) Staffing patterns and staffing standards;

(5) Policies and procedures for inspecting nursing homes and assisted living facilities, and responding to quality of care complaints;

(6) A comparison of Maryland standards, policies, and procedures to those in other states;

(7) The labor pool available to fill nursing and nursing aide jobs;

(8) State funding mechanisms for nursing homes and assisted living facilities, including the Medicaid Nursing Home Reimbursement System, potential barriers to eligibility in the Maryland Medical Assistance Program, potential barriers to the timely payment of claims submitted to the Maryland Medical Assistance Program, and regulation of nursing homes;

(9) The provision and quality of dementia care and behavioral health supports and services to meet the needs of nursing home and assisted living facility residents;

(10) Staff training and development;

(11) The rights of residents;

(12) Data on resident satisfaction;

(13) Resident assessments;

(14) Resident care planning;

(15) The monitoring of residents; and

(16) The change of resident status.

(e) The Office of Health Care Quality in the Maryland Department of Health shall submit a report to the Oversight Committee annually on the status of quality of care in nursing homes and assisted living facilities.

(f) The Deputy Secretary of Health Care Financing, or the Deputy Secretary's designee, shall report annually to the Oversight Committee on the status of the Medicaid Nursing Home Reimbursement System, which shall include but not be limited to:

(1) Elements of the existing methodology that are no longer relevant;

(2) Elements of the existing methodology that can be revised;

(3) The appropriateness of redesigning the system given changing demographics of the target population; and

(4) General Fund and federal fund savings from a system redesign that may be redirected to nursing home staff development in the nursing cost center.

(g) The Oversight Committee shall review the reports of the Office of Health Care Quality and the Deputy Secretary of Health Care Financing and develop recommendations to continue improvement in nursing home and assisted living facility care.

(h) The Oversight Committee may:

(1) Review legislation introduced in the General Assembly that may affect nursing home and assisted living facility care; and

(2) Make recommendations about the legislation to the General Assembly.

(i) The Oversight Committee may:

(1) Review proposed regulations that may affect nursing home and assisted living facility care; and

(2) Make recommendations about the regulations to the departments proposing the regulations and to the Joint Committee on Administrative, Executive, and Legislative Review.

(j) The Oversight Committee shall report its findings and recommendations to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly on or before December 1 of each year.

(k) The Department of Aging, with assistance from the Maryland Department of Health, the Department of Human Services, and the Department of Legislative Services, shall provide staff support for the Oversight Committee.

§19–1410. IN EFFECT

(a) Each nursing home shall develop and implement a quality assurance program.

(b) (1) Each nursing home shall designate a qualified individual to coordinate and manage the nursing home's quality assurance program.

(2) Each nursing home shall establish a quality assurance committee and shall include at least the following members:

(i) The nursing home administrator;

(ii) The director of nursing;

(iii) The medical director;

(iv) A social worker;

(v) A licensed dietitian; and

(vi) A geriatric nursing assistant.

(3) The quality assurance committee shall:

(i) Meet at least monthly;

(ii) Maintain records of all quality assurance activities;

(iii) Keep records of committee meetings that shall be available to the Department during any on–site visit; and

(iv) Prepare monthly reports that shall be presented to the ombudsman, the resident's council, and the family council.

(4) The quality assurance committee for a nursing home shall review and approve annually the quality assurance plan for the nursing home.

(5) Each nursing home shall establish a written quality assurance plan that:

(i) Includes procedures for concurrent review for all residents;

(ii) Provides criteria that routinely monitors nursing care including medication administration, prevention of decubitus ulcers, dehydration and malnutrition, nutritional status and weight loss or gain, accidents and injuries, unexpected deaths, changes in mental or psychological status, and any other data necessary to monitor quality of care;

(iii) Includes methods to identify and correct problems; and

(iv) Is readily available to nursing home residents and their families, guardians, or surrogate decision makers.

(6) The quality assurance plan shall be submitted to the Department every 2 years.

(7) The nursing home administrator shall take appropriate remedial actions based on the recommendations of the nursing home's quality assurance committee.

(8) The Secretary may not require the quality assurance committee to disclose the records and the reports prepared by the committee except as necessary to assure compliance with the requirements of this section.

(9) If the Department determines that a nursing home is not implementing its quality assurance program effectively and that quality assurance activities are inadequate, the Department may impose appropriate sanctions on the nursing home to improve quality assurance including mandated employment of specified quality assurance personnel.

(c) (1) Each nursing home shall display on each floor of the nursing home a notice that explains the current ratio of licensed personnel to residents and unlicensed personnel to residents.

(2) The notice shall be:

(i) Posted in a location that is visible and accessible to residents and their family or guardians and any potential consumers; and

(ii) On a form provided by the Department.

§19–1410. ** TAKES EFFECT APRIL 1, 2026 PER CHAPTER 416 OF 2025 **

(a) Each nursing home shall develop and implement a quality assurance program.

(b) (1) Each nursing home shall designate a qualified individual to coordinate and manage the nursing home's quality assurance program.

(2) Each nursing home shall establish a quality assurance committee and shall include at least the following members:

(i) The nursing home administrator;

(ii) The director of nursing;

(iii) The medical director;

(iv) A social worker;

(v) A licensed dietitian; and

(vi) A certified nursing assistant–I.

(3) The quality assurance committee shall:

(i) Meet at least monthly;

(ii) Maintain records of all quality assurance activities;

(iii) Keep records of committee meetings that shall be available to the Department during any on–site visit; and

(iv) Prepare monthly reports that shall be presented to the ombudsman, the resident's council, and the family council.

(4) The quality assurance committee for a nursing home shall review and approve annually the quality assurance plan for the nursing home.

(5) Each nursing home shall establish a written quality assurance plan that:

(i) Includes procedures for concurrent review for all residents;

(ii) Provides criteria that routinely monitors nursing care including medication administration, prevention of decubitus ulcers, dehydration and malnutrition, nutritional status and weight loss or gain, accidents and injuries, unexpected deaths, changes in mental or psychological status, and any other data necessary to monitor quality of care;

(iii) Includes methods to identify and correct problems; and

(iv) Is readily available to nursing home residents and their families, guardians, or surrogate decision makers.

(6) The quality assurance plan shall be submitted to the Department every 2 years.

(7) The nursing home administrator shall take appropriate remedial actions based on the recommendations of the nursing home's quality assurance committee.

(8) The Secretary may not require the quality assurance committee to disclose the records and the reports prepared by the committee except as necessary to assure compliance with the requirements of this section.

(9) If the Department determines that a nursing home is not implementing its quality assurance program effectively and that quality assurance activities are inadequate, the Department may impose appropriate sanctions on the nursing home to improve quality assurance including mandated employment of specified quality assurance personnel.

(c) (1) Each nursing home shall display on each floor of the nursing home a notice that explains the current ratio of licensed personnel to residents and unlicensed personnel to residents.

(2) The notice shall be:

(i) Posted in a location that is visible and accessible to residents and their family or guardians and any potential consumers; and

(ii) On a form provided by the Department.

§19–1410.1.

(a) On or before December 1, 2008, each nursing home shall establish a safe patient lifting workgroup with equal membership from management and employees.

(b) (1) On or before July 1, 2009, the safe patient lifting workgroup shall develop a safe patient lifting policy for the nursing home.

(2) The goal of the policy shall be to reduce employee injuries associated with patient lifting.

(c) While developing a safe patient lifting policy, the workgroup shall consider, based on the patient population of that nursing home, the appropriateness and effectiveness of:

(1) Developing or enhancing patient handling hazard assessment processes;

(2) Enhanced use of mechanical lifting devices;

(3) Developing specialized lift teams;

(4) Training programs for safe patient lifting required for all patient care personnel at the nursing home;

(5) Incorporating physical space and construction design for mechanical lifting devices in any architectural plans for nursing home construction and renovation; and

(6) Developing an evaluation process to determine the effectiveness of the policy.

§19–1410.2. IN EFFECT

(a) In this section, "workplace safety" means the prevention of any physical assault or threatening behavior against an employee in a nursing home.

(b) This section applies to nursing homes that are licensed for 45 beds or more.

(c) Each nursing home shall assign to an appropriate committee the task of:

(1) Conducting an annual assessment of workplace safety issues; and

(2) Making recommendations to the nursing home for reducing workplace injuries.

(d) In conducting an annual assessment of workplace safety issues, the committee assigned to conduct the assessment under subsection (c)(1) of this section shall consult with geriatric nursing assistants and other employees of the nursing home who are involved in assisting residents with activities of daily living.

§19–1410.2. ** TAKES EFFECT APRIL 1, 2026 PER CHAPTER 416 OF 2025 **

(a) In this section, "workplace safety" means the prevention of any physical assault or threatening behavior against an employee in a nursing home.

(b) This section applies to nursing homes that are licensed for 45 beds or more.

(c) Each nursing home shall assign to an appropriate committee the task of:

(1) Conducting an annual assessment of workplace safety issues; and

(2) Making recommendations to the nursing home for reducing workplace injuries.

(d) In conducting an annual assessment of workplace safety issues, the committee assigned to conduct the assessment under subsection (c)(1) of this section shall consult with certified nursing assistants and other employees of the nursing home who are involved in assisting residents with activities of daily living.

§19–1410.3.

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

(2) "Catastrophic health emergency" means a health emergency with regard to which the Governor issues a proclamation under § 14–3A–02 of the Public Safety Article.

(3) "Compassionate care visitor" means a family member or legal guardian of a resident or any individual who is important to the mental, physical, or social well–being of the resident during critical situations including the end of the resident's life, the significant mental or physical decline of the resident, or when exigent circumstances exist regarding the resident.

(4) "COVID–19" means, interchangeably and collectively, the coronavirus known as COVID–19 or 2019–nCoV and the SARS–CoV–2 virus.

(5) "Personal care visitor" means a family member or legal guardian of a resident who is important to the mental, physical, or social well–being of the resident.

(b) (1) Consistent with federal requirements, the Department shall develop guidelines relating to the restrictions on visitation that a nursing home may impose to reduce the spread of COVID–19 or another disease that constitutes a catastrophic health emergency.

(2) The guidelines shall:

(i) Describe the circumstances under which visitation may be restricted to only compassionate care visitors and personal care visitors;

(ii) Limit the movement of visitors within the nursing home, which may include restricting visitors to the resident's room or another designated room;

(iii) Require each visitor to follow safety protocols to limit the spread of COVID–19 or another disease that constitutes a catastrophic health emergency, which may include:

1. Testing for COVID–19 or another disease that constitutes a catastrophic health emergency;

2. Checking body temperature;

3. Health screenings;

4. The use of personal protective equipment;

5. Social distancing; and

6. Any other safety protocol that the Department considers appropriate to limit the spread of COVID–19 or another disease that constitutes a catastrophic health emergency in a nursing home;

(iv) Require, as practicable and when available, alternative means of communication with visitors if a nursing home determines that an in–person visit would endanger the health and safety of a patient, resident, or member of the staff; and

(v) Provide additional guidance necessary to promote access to residents by compassionate care visitors.

(3) In addition to the requirements in paragraph (2) of this subsection, the guidelines regarding personal care visitation shall:

(i) Establish procedures for the designation of a personal care visitor by a resident or a legal representative of the resident that:

1. May include requiring a health care professional to determine whether a personal care visitor is necessary for the mental, physical, or social well–being of the resident; and

2. If a determination is required, authorize the determination to be made by a health care professional who is not affiliated with the nursing home;

(ii) Provide that a resident may designate not more than one personal care visitor;

(iii) Establish procedures for changing the designation of a resident's personal care visitor;

(iv) Require a personal care visitor to waive a nursing home from liability for exposure to COVID–19 or another disease that constitutes a catastrophic health emergency;

(v) Establish the circumstances under which visitation by a personal care visitor may be limited, suspended, or terminated, including increased local infection rates and health care capacity;

(vi) Establish standards for the frequency and duration of personal care visits; and

(vii) Establish the total number of personal care visitors authorized to visit a nursing home facility at any one time.

§19–1411.

(a) (1) Each nursing home shall designate a physician to serve as medical director.

(2) The medical director is responsible for monitoring physician services at the nursing home.

(3) The medical director shall report monthly to the quality assurance committee on the quality of medical care at the nursing home.

(b) The Secretary, in consultation with the Medical and Chirurgical Faculty of Maryland, and representatives of the nursing home industry, shall:

(1) Establish qualifications for the medical director of a nursing home or anyone acting for the medical director in his or her absence;

(2) Define the duties of the medical director; and

(3) Adopt regulations for the attending physicians who treat residents of nursing homes that will provide for physician accountability.

§19–1412.

(a) The Secretary shall:

(1) Establish a technical assistance unit within the Department to support compliance efforts and best practices; and

(2) Establish a list of approved medical automated systems.

(b) The Secretary may:

(1) Partially reimburse a nursing home for installation of automated systems that have been approved by the Department;

(2) Develop guidelines for reimbursement; and

(3) Adopt regulations for the implementation of this subtitle.

§19–1413.

Each nursing home shall:

(1) Establish a procedure to provide for the smooth and orderly transfer of residents in the event of closure;

(2) Provide a 30-day notice to residents and their families or guardians prior to closure of the nursing home unless the Department waives the notice requirement;

(3) Provide a 15-day notice to residents and their families or guardians prior to termination of public funding unless the Department waives the notice requirement; and

(4) Immediately notify, if known, a resident's family or guardian of:

(i) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(ii) A significant change in the resident's physical, mental, or psychosocial status; or

(iii) A need to alter the resident's treatment significantly.

§19–1413.1.

(a) A nursing home that violates § 19-1413(2) of this subtitle is subject to a civil money penalty not exceeding expenses incurred by the Office of Health Care Quality in ensuring a smooth and orderly transition of residents, including payroll expenses.

(b) If a civil money penalty is imposed on a nursing home under subsection (a) of this section, the nursing home is subject to § 19-1406 of this subtitle.

§19–1414.

The Department may review financial and performance records of an applicant for a license or management firm under contract with an applicant for a license to determine ability of the applicant or management firm to comply with appropriate laws and regulations.

§19–1415.

(a) In this section, "change in condition" means a significant change in the resident's physical, mental, or psychological status including:

(1) Life-threatening conditions such as heart attack or stroke;

(2) Clinical complications such as:

(i) Development of a pressure sore;

(ii) Onset of recurrent periods of delirium;

(iii) Onset of recurrent urinary tract infection;

(iv) Onset of depression; or

(v) Onset of aggressive or inappropriate behavior;

(3) The need to discontinue a medication or treatment because of:

(i) Adverse consequences; or

(ii) The need to begin a new form of treatment;

(4) Evaluation at or admission to a hospital; and

(5) Accidents that result in injury having the potential for requiring a physician's intervention.

(b) Consistent with State and federal confidentiality laws and in a timely manner, a nursing home shall notify a resident and, if applicable, the resident's representative or interested family member of any:

(1) Change in condition;

(2) Adverse event that may result in a change in condition;

(3) Outcome or care that results in an unanticipated consequence; or

(4) Corrective action, if appropriate.

(c) If the Department determines that a nursing home failed to notify a resident, resident's representative, or interested family member under subsection (b) of this section, the Department shall require as part of a plan of correction that the nursing home notify the resident, the resident's representative, or interested family member as soon as possible.

§19–1416.

(a) In this section, "family council" means a group of individuals who work together to protect the rights of and improve the quality of life of residents of a nursing home.

(b) (1) A family council for a nursing home may consist of the following members:

(i) Members of a resident's family; or

(ii) An individual appointed by the resident, or if the resident is incapable of appointing an individual, an individual appointed by the resident's family.

(2) (i) Subject to subparagraph (ii) of this paragraph, a family council may be created by the owner, operator, or staff of a nursing home.

(ii) Except as provided in paragraph (3) of this subsection, in order to facilitate the development of a family council, the owner, operator, or staff of

a nursing home may lead the family council for no longer than 6 months at which time the family council shall be led by a member of the family council.

(3) On the written request of a family council, the nursing home may assist the family council in the administrative functions of operating the family council in a mutually agreed upon manner.

(c) A nursing home shall give each new or prospective resident the following written information about the family council:

(1) The name, address, and phone number of a current member of the family council;

(2) A brief description of the purpose and function of the family council;

(3) Instructions on how the resident or prospective resident may review the public files described in subsection (e) of this section; and

(4) The name, address, and phone number of the State or local ombudsman.

(d) A nursing home shall respond in writing to any written grievance or other written communication from the family council within 14 calendar days after receiving a communication.

(e) (1) A nursing home shall create and maintain a public correspondence file and a regulatory correspondence file for communications with a family council.

(2) The correspondence files shall include a copy of each written communication and response described in subsection (d) of this section.

(3) (i) The records in the regulatory file shall be unedited.

(ii) The records in the public file shall delete any information that identifies an individual resident.

(4) The public file may be reviewed by a resident, prospective resident, or the representative of either a resident or prospective resident during normal business hours and at any other time the nursing home agrees to make the public file available.

(5) The nursing home shall promptly comply with a request by a licensing authority to review the records in either the public or regulatory files.

§19–1417.

(a) Each nursing home in the State shall notify each resident and prospective resident in writing or by written electronic communication if:

(1) The nursing home does not maintain professional liability insurance coverage; or

(2) The nursing home's professional liability insurance coverage has lapsed for any period of time and has not been renewed.

(b) The notification under subsection (a) of this section shall be:

(1) (i) Provided to a prospective resident:

1. At the first visit by the prospective resident during any period during which the nursing home does not maintain professional liability coverage; and

2. If the nursing home does not maintain professional liability insurance at the time the prospective resident applies for admission, at the time of application; and

(ii) If the professional liability insurance lapses, provided to each resident within 30 days after the date the coverage lapsed;

(2) Signed by:

(i) The prospective resident at the time of application for admission; or

(ii) The resident at the time the notification of the lapse in coverage is provided under item (1)(ii) of this subsection; and

(3) Retained by the nursing home as part of the nursing home's records.

(c) Each nursing home operating in the State that does not maintain professional liability insurance coverage shall post in a conspicuous place visible to residents and guests that the nursing home does not maintain professional liability coverage.

§19–1418.

This subtitle may be cited as the "Maryland Nursing Home Quality Assurance Act".

§19–14A–01.

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

(b) "Final report" means the third party liability audit report issued to a nursing home stating the total amount due to the Department as a result of the completed audit.

(c) "Nursing home" has the meaning stated in § 19-1401(e) of this title.

(d) (1) "Third party" means any individual, entity, or program that is or may be liable to pay all or part of the medical cost of any medical assistance furnished to a recipient under the Medical Assistance Program.

(2) "Third party" includes private health insurance, employment-related health insurance, medical support from absent parents, automobile insurance, court judgments or settlements from a liability insurer, State workers' compensation, first party probate-estate recoveries, or any federal programs.

(e) "Third party liability audit" means a financial review of Medical Assistance payments to a provider to ascertain the legal liability of third parties to pay for care and services available under the Medical Assistance Program.

(f) "Third party liability review" means a financial review of the credit balances of a nursing home to ascertain the legal liability of third parties to pay for care and services available under the Medical Assistance Program.

§19–14A–02.

(a) A nursing home that receives payment from the Medical Assistance Program shall provide a report of the credit balances of the nursing home to the Department on a quarterly basis.

(b) The Department shall conduct a third party liability review of the report of the credit balances provided under subsection (a) of this section.

(c) The Department may conduct a third party liability audit of a random sample of the reports of credit balances reviewed under subsection (b) of this section.

(d) (1) Subject to paragraph (2) of this subsection, the Department may conduct a third party liability audit of a nursing home that is found to be noncompliant as a result of the audit conducted under subsection (c) of this section.

(2) In conducting the third party liability audit authorized under paragraph (1) of this subsection, the Department may only review the financial information of the nursing home for the 2-year period immediately prior to the date of the audit period in which the nursing home was found to be noncompliant.

§19–14A–03.

(a) A nursing home may appeal the results of a final report of a third party liability audit by filing written notice with the Department within 30 days after the nursing home receives the final report from the Department.

(b) An individual at the Department who did not participate in the final report shall:

(1) Review the appeal authorized under subsection (a) of this section; and

(2) Issue a report that either revises or concurs with the final report of the third party liability audit.

(c) A nursing home may appeal the results of the report issued by the Department under subsection (b) of this section by filing written notice with the Nursing Home Appeal Board within 30 days of receipt of the report.

§19–14A–04.

The Department may adopt rules and regulations to carry out the provisions of this subtitle.

§19–14B–01.

(a) (1) As provided in subsection (e) of this section, a portion of the revenues from the quality assessment that is assessed under § 19–310.1 of this title shall be distributed to nursing facilities subject to § 19–310.1 of this title based on accountability measures that indicate quality of care or a commitment to quality of care.

(2) In consultation with representatives of the nursing facilities and other stakeholders, the Maryland Department of Health shall develop accountability

measures to use in a pay–for–performance program that take into account both performance and improvement.

(3) The accountability measures shall be objective, measurable, and when considered in combination with each other, deemed to have a correlation to residents' quality of life and care.

(b) (1) On or before December 1, 2009, and each year thereafter, the Department shall, in consultation with representatives of nursing facilities and other interested stakeholders, make necessary changes to the pay–for–performance program to determine the effect on providers and to determine if the measures satisfy the requirements of being objective, measurable, and, when considered in combination with each other, have a correlation to residents' quality of life and care.

(2) In performing the review required under paragraph (1) of this subsection, on or before December 1, 2009, and on or before December 1, 2010, the Department shall examine and modify the pay–for–performance program to include improvement measures in the scoring criteria.

(c) (1) A portion of the revenues generated by the quality assessment under § 19–310.1 of this title shall be in an incentive program to be distributed as provided in this section, to the extent federal law allows.

(2) The distribution of revenues as provided in this section shall be used as an incentive for nursing facilities to provide quality care and may not be used to directly or indirectly hold harmless any nursing facility.

(d) On or before December 1, 2008, the plan required under this section shall be submitted by the Department, in accordance with § 2–1257 of the State Government Article, to the General Assembly.

(e) (1) On or before July 1, 2009, the Department shall:

(i) Score nursing facilities based on scoring criteria developed and reported to the General Assembly in the December 1, 2008 report as required by Chapter 200 of the Acts of the General Assembly of 2008; and

(ii) Send each nursing facility a transmittal with the scoring criteria, the performance of the nursing facility relative to the scoring, and the money that would have been received by the nursing facility using the scoring criteria.

(2) Beginning July 1, 2010, the Department shall distribute 50% of the revenues generated by the quality assessment that is assessed under § 19–310.1

of this title and required for use in a pay–for–performance program to nursing facilities as provided in this section.

(3) Beginning July 1, 2011, the Department shall fully implement the pay–for–performance program as provided in this section.

§19–14C–01.

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

(b) "Deficiency" has the meaning stated in § 19–1401 of this title.

(c) "Monitoring agency" means:

(1) The Centers for Medicare and Medicaid Services;

(2) The Office of Health Care Quality within the Department;

(3) The Maryland Department of Labor;

(4) A local health department;

(5) The U.S. Department of Veterans Affairs; or

(6) The federal Occupational Safety and Health Administration.

(d) "Nursing home" has the meaning stated in § 19–1401 of this title.

§19–14C–02.

(a) (1) If a State–owned nursing home that is operated by a contractor receives a deficiency from or is subject to an enforcement action by a monitoring agency, within 15 days after the final survey finding, the department charged with oversight of the nursing home shall provide notice of the deficiency or enforcement action to:

(i) The Governor;

(ii) In accordance with § 2–1257 of the State Government Article, the Senate Finance Committee, the House Health Committee, and the members of the General Assembly who represent the district in which the nursing home is located; and

(iii) The local governing body of the county in which the nursing home is located.

(2) Within 30 days after the contractor's final acceptance of a plan of correction or completion of an informal dispute resolution, the department charged with oversight of the nursing home shall provide to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee, the House Health Committee, and the members of the General Assembly who represent the district in which the nursing home is located:

(i) A statement of the deficiencies found by the monitoring agency;

(ii) The plan of correction or results of the informal dispute resolution; and

(iii) All communications from the monitoring agency regarding survey activities conducted at the nursing home.

(b) On or before January 1 each year, beginning in 2024, the Department shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on all federal and State:

(1) Survey activities conducted during the immediately preceding 12–month period at each State–owned nursing home that is operated by a contractor; and

(2) Enforcement actions imposed during the immediately preceding 12–month period on each State–owned nursing home that is operated by a contractor.

§19–1801.

In this subtitle:

(1) "Assisted living program" means a residential or facility–based program that provides housing and supportive services, supervision, personalized assistance, health–related services, or a combination thereof that meets the needs of individuals who are unable to perform or who need assistance in performing the activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for the individuals.

(2) "Assisted living program" does not include:

(i) A nursing home, as defined under § 19–1401 of this title;

(ii) A State facility, as defined under § 10–101 of this article;

(iii) A program licensed by the Department under Title 7 or Title 10 of this article;

(iv) A hospice care program regulated by the Department under Subtitle 9 of this title;

(v) Services provided by family members;

(vi) Services provided in an individual's own home; or

(vii) A program certified by the Department of Human Services under Title 6, Subtitle 5, Part II of the Human Services Article as a certified Adult Residential Environment Program.

§19–1802.

The Department shall be the lead agency for supervising and monitoring a statewide interagency system for regulating the establishment and operation of assisted living programs.

§19–1803.

(a) The Department shall encourage, but may not require, providers of assisted living program services to offer a continuum of care.

(b) Providers of assisted living program services may provide services at a variety of levels and in a variety of settings.

§19–1804.

The Department shall:

(1) Serve as the point of entry for persons desiring information on assisted living programs;

(2) Provide the Department of Aging and other State agencies that routinely receive inquiries from the public about assisted living with information that will enable the agencies to respond to the inquiries accurately and effectively; and

(3) Delegate various aspects of its responsibilities under this subtitle to monitor and inspect assisted living programs and facilities to the Department of

Aging and the Department of Human Services, in accordance with an interagency agreement, for the purpose of ensuring compliance with the regulations adopted by the Department under this subtitle.

§19–1804.1.

(a) A person shall be licensed by the Department to conduct, operate, or maintain an assisted living program in the State.

(b) (1) A person shall submit an application for licensure to conduct, operate, or maintain an assisted living program to the Secretary on a form developed by the Secretary.

(2) (i) The Secretary shall develop the application for licensure required under paragraph (1) of this subsection.

(ii) The application shall include the name and address of each officer, manager, alternate manager, and delegating nurse or case manager of the assisted living program.

(3) In addition to the application, an applicant for initial licensure shall submit to the Secretary:

(i) Information concerning any license or certification held by the applicant under the Health Occupations Article or under this article, including the prior or current operation by the applicant of a health care facility, residential facility, or similar health care program;

(ii) Information demonstrating the financial and administrative ability of the applicant to operate an assisted living program in compliance with this subtitle;

(iii) The policies and procedures to be implemented by the assisted living program;

(iv) Identification of the personnel and relief personnel to be employed by the assisted living program; and

(v) Any other information that is relevant to the ability of the applicant to care for the residents of the assisted living program.

(c) (1) The Secretary shall:

(i) Review the application and information received under subsection (b) of this section; and

(ii) Conduct an independent investigation of the assisted living program applying for initial licensure.

(2) Based on the review and investigation conducted under paragraph (1) of this subsection, the Secretary shall:

(i) Authorize the unconditional approval of the application;

(ii) Authorize the conditional approval of the application; or

(iii) Deny the application.

(d) The Secretary may issue a probationary license that is valid for a period of time determined by the Secretary in accordance with regulations adopted by the Secretary.

§19–1805.

(a) The Department shall:

(1) Define different levels of assisted living according to the level of care provided;

(2) Require all assisted living programs to be licensed to operate according to the level of the program;

(3) Develop a waiver process for authorizing an assisted living program to continue to care for an individual whose medical or functional condition has changed since admission to the program to an extent that the level of care required by the individual exceeds the level of care for which the program is licensed;

(4) Promote affordable and accessible assisted living programs throughout the State;

(5) Establish and enforce quality standards for assisted living programs;

(6) Require periodic inspections of assisted living program facilities, including at least an annual unannounced on–site inspection;

(7) Establish requirements for the qualifications or training or both of assisted living program employees;

(8) Establish a "resident bill of rights" for residents of assisted living program facilities that includes, at a minimum:

(i) The right to be treated with consideration, respect, and full recognition of human dignity and individuality;

(ii) The right to receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant federal and State laws, rules, and regulations;

(iii) The right to be free from mental and physical abuse;

(iv) The right to be free from mental, verbal, sexual, and physical abuse, neglect, or involuntary seclusion or exploitation;

(v) The right to notice, procedural fairness, and humane treatment when being transferred or discharged from a facility;

(vi) The right to participate in decision making regarding transitions in care, including a transfer or discharge from a facility;

(vii) The right to be free from physical and chemical restraints, except for restraints that a physician authorizes for a clearly indicated medical need; and

(viii) The right to manage personal financial affairs;

(9) Define which, if any, assisted living programs may be exempt from the requirements of § 19–311 of this title; and

(10) For Alzheimer's special care units:

(i) Establish the number of dementia–specific training hours to be completed for those staff working in Alzheimer's special care units;

(ii) Determine the topic content for dementia–specific training required for those staff working in Alzheimer's special care units; and

(iii) Require staff sufficient to meet the needs of residents in Alzheimer's special care units.

(b) (1) The Department, in consultation with representatives of the affected industry and advocates for residents of the facilities and with the approval of the Department of Aging and the Department of Human Services, shall adopt regulations to implement this subtitle.

(2) The regulations adopted under paragraph (1) of this subsection shall:

(i) Provide for the licensing of assisted living programs;

(ii) Require the Department, during a survey or other inspection of an assisted living program, to review the number of waivers granted to the program under subsection (a)(3) of this section and determine whether a change in the program's licensure status is warranted; and

(iii) Require an assisted living program facility to post in a conspicuous place visible to actual and potential residents of the facility and other interested parties:

1. A. Its statement of deficiencies for the most recent survey;

B. Any subsequent complaint investigations conducted by federal, State, or local surveyors; and

C. Any plans of correction in effect with respect to the survey or complaint investigation; or

2. A notice of the location, within the facility, of the items listed in item 1 of this item.

§19–1805.1.

(a) To prevent irreparable harm to residents in a program, the Attorney General may seek injunctive relief on behalf of the State on the basis of an imminent or ongoing violation of a basic right of assisted living program residents provided under § 19–1805(a)(8)(i) through (viii) of this subtitle.

(b) In exercising the authority granted under this section, the Attorney General may not duplicate the corrective action imposed by the Department for the same violation.

§19–1806.

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

(2) "Continuing care" has the meaning stated in § 10–401 of the Human Services Article.

(3) "Continuing care agreement" has the meaning stated in § 10–401 of the Human Services Article.

(b) This section applies to assisted living programs that offer assisted living program services as part of a continuum of care in accordance with a continuing care agreement that does not require a subscriber to execute a separate assisted living agreement to receive those services.

(c) (1) An assisted living program subject to this section that meets the requirements of Title 10, Subtitle 4 of the Human Services Article with regard to assisted living is not required to execute a separate assisted living resident agreement that is in addition to the continuing care agreement.

(2) For purposes of paragraph (1) of this subsection, if a separate assisted living resident agreement is not utilized, references to a resident agreement in any regulations adopted under this subtitle shall mean the continuing care agreement.

(d) A continuing care agreement that contains a provision to provide assisted living program services and does not require a subscriber to execute a separate assisted living agreement to receive those services is not required to contain general or specific contract provisions, except as required under Title 10, Subtitle 4 of the Human Services Article, that apply to assisted living programs that are not subject to this section.

(e) (1) In addition to subsection (c) of this section, an assisted living program subject to this section is not required to provide a disclosure statement relating to its assisted living program separate from any disclosure statement required by Title 10, Subtitle 4 of the Human Services Article for continuing care.

(2) Any disclosure statement required to be provided to a resident under Title 10, Subtitle 4 of the Human Services Article shall include information that is required to be disclosed by an assisted living program in accordance with this subtitle.

(f) A transfer of a resident from an assisted living program subject to this section to another assisted living or continuing care arrangement governed by the same continuing care agreement may not be considered a relocation or discharge from the assisted living program for purposes of triggering any regulatory requirements

adopted under this subtitle for matters relating to notice, financial accounting, or refunds.

§19–1807.

(a) (1) Except as provided in subsection (d) of this section, an assisted living manager who is employed by an assisted living program shall have completed a manager training course that is approved by the Department and includes an examination.

(2) The manager training course shall:

(i) Consist of at least 80 hours; and

(ii) Provide the training through in–person courses, virtual training methods, or a combination of both.

(b) An assisted living manager employed by a program shall be required to complete 20 hours of Department–approved continuing education every 2 years.

(c) In addition to the sanctions specified in COMAR 10.07.14.48, an assisted living program that fails to employ an assisted living manager who meets the requirements of this section may be subject to a civil money penalty not to exceed $10,000.

(d) (1) The requirements of subsection (a) of this section do not apply to an individual who:

(i) Is employed by an assisted living program and has enrolled in a Department–approved manager training course that the individual expects to complete within 6 months;

(ii) Is temporarily serving as an assisted living manager under § 9–3A–01 of the Health Occupations Article due to an assisted living manager leaving employment and prior to the hiring of a permanent assisted living manager; or

(iii) Subject to paragraph (2) of this subsection:

1. Has been employed as an assisted living manager in the State for 1 year prior to January 1, 2006; or

2. Is licensed as a nursing home administrator in the State.

(2) The Department may require an individual who is exempt under paragraph (1)(iii) of this subsection to complete a manager training course and examination if the Department finds that the assisted living manager repeatedly has violated State law or regulations on assisted living and that those violations have caused actual physical or emotional harm to a resident.

(e) The Department shall ensure that manager training courses approved by the Department are affordable and accessible to assisted living programs and to individuals seeking to enroll in the courses.

§19–1808.

(a) The Department, in consultation with the Maryland Health Care Commission and stakeholders, including advocates, consumers, and providers of assisted living services, shall develop a standard assisted living program services disclosure statement.

(b) The purpose of the assisted living program services disclosure statement is to inform potential consumers about the services provided by an assisted living program in order to assist a consumer in choosing the most appropriate assisted living program.

(c) (1) An assisted living program, as part of the application for licensure, shall file with the Office of Health Care Quality the assisted living program services disclosure statement developed by the Department.

(2) If an assisted living program changes the services reported on the assisted living program services disclosure statement, the assisted living program shall file with the Office of Health Care Quality an amended assisted living program services disclosure statement within 30 days of the change in services.

(d) (1) If an individual requests a copy of an assisted living program's services disclosure statement, the assisted living program shall provide a copy of the services disclosure statement to the individual making the request.

(2) An assisted living program shall provide a copy of the services disclosure statement to individuals as part of the program's marketing materials.

§19–1808.1.

(a) Each assisted living program in the State shall notify a resident or prospective resident in writing or by written electronic communication if:

(1) The assisted living program does not maintain professional liability insurance coverage; or

(2) The assisted living program's professional liability insurance coverage has lapsed for any period of time and has not been renewed.

(b) The notification under subsection (a) of this section shall be:

(1) (i) Provided to a prospective resident:

1. At the first visit by the prospective resident during any period in which an assisted living program does not maintain professional liability insurance; and

2. If the assisted living program does not maintain professional liability insurance at the time the prospective resident applies for admission, at the time of application; and

(ii) If the professional liability coverage lapses, provided to each resident within 30 days after the date the coverage lapsed;

(2) Signed by:

(i) The prospective resident at the time of application for admission; or

(ii) The resident at the time the notification of the lapse in coverage is provided under item (1)(ii) of this subsection; and

(3) Retained by the assisted living program as part of the assisted living program's records.

(c) Each facility–based assisted living program in the State that does not maintain professional liability insurance coverage shall post a notification in a conspicuous place visible to residents and guests that the assisted living program does not maintain professional liability insurance.

§19–1809.

(a) (1) A person may not knowingly and willfully operate, maintain, or own an assisted living program without a license.

(2) A person who violates paragraph (1) of this subsection is guilty of a felony and on conviction is subject to:

(i) For a first offense, a fine not exceeding $10,000 or imprisonment not exceeding 5 years or both; or

(ii) For a subsequent offense, a fine not exceeding $20,000 or imprisonment not exceeding 5 years or both.

(3) If the Department finds a credible allegation that an assisted living program is operating without a license, the Department, or the Office of Health Care Quality, shall investigate whether residents in the assisted living program have been subjected to neglect, exploitation, or abuse.

(4) (i) On receipt of a credible allegation, or after an investigation that results in a finding that residents in an unlicensed assisted living program have been subjected to neglect, exploitation, or abuse, the person operating the unlicensed program shall be subject to immediate prosecution under paragraph (2) of this subsection.

(ii) If the person operating an unlicensed assisted living program fails or refuses to cooperate fully in an investigation by the Department, or the Office of Health Care Quality, conducted under paragraph (3) of this subsection, the person operating the unlicensed assisted living program shall be subject to immediate prosecution under paragraph (2) of this subsection.

(5) If the Department finds, after an investigation conducted under paragraph (3) of this subsection, that there is no reason to believe that residents in the assisted living program operating without a license have been subject to exploitation, neglect, or abuse:

(i) The Department shall provide written notice to the unlicensed assisted living program that the program shall come into compliance with licensure requirements within 30 days after receipt of the written notification; and

(ii) The person operating the program may not be subject to prosecution under paragraph (2) of this subsection if the person has:

1. Promptly and in good faith submitted a complete application to the Department for an assisted living program license;

2. Is awaiting a decision from the Department regarding the application; and

3. Has not been denied an assisted living program license on a prior occasion.

(6) In recommending the amount of the criminal penalty under paragraph (2) of this subsection, the State shall consider factors including the nature, number, and seriousness of the violations.

(7) The Department, the Attorney General, a State's Attorney, or a local health officer may petition a circuit court for injunctive relief against the operation of an assisted living program operating without a license.

(8) A violation of paragraph (1) of this subsection shall be a violation of the Consumer Protection Act.

(b) (1) (i) A person may not advertise, represent, or imply to the public that an assisted living program is authorized to provide a service that the program is not licensed, certified, or otherwise authorized by the Department to provide when the license, certificate, or authorization is required under this subtitle.

(ii) A person may not advertise an assisted living program in a misleading or fraudulent manner.

(2) (i) A person who violates paragraph (1) of this subsection is subject to a civil money penalty imposed by the Secretary not exceeding $10,000 for each offense.

(ii) In setting the amount of a civil money penalty on the program under subparagraph (i) of this paragraph, the Secretary shall consider factors including the nature, number, and seriousness of the violations and the ability of the assisted living program to pay the penalty.

(c) (1) A person may not willfully and knowingly refer another person to an assisted living program that is operating without a license.

(2) A person who violates paragraph (1) of this subsection is subject to the following civil penalties:

(i) For a first offense, a civil penalty not exceeding $1,000;

(ii) For a second offense, a civil penalty not exceeding $2,000; or

(iii) For a third or subsequent offense, a civil penalty not exceeding $3,000.

(3) The Secretary shall remit all civil penalties collected under this subsection to the Office of Health Care Quality for the purposes of carrying out the provisions of § 19–1813 of this subsection.

(d) The Department may adopt regulations to carry out this section.

§19–1810.

(a) An assisted living program may request an appeal of a civil money penalty imposed under this subtitle.

(b) A hearing on the appeal shall be held in accordance with:

(1) The Administrative Procedure Act under Title 10, Subtitle 2 of the State Government Article; and

(2) Regulations adopted by the Secretary.

§19–1811.

(a) (1) There is a Health Care Quality Account for Assisted Living Programs established in the Department.

(2) The Account shall be funded by civil money penalties paid by assisted living programs and other penalties that the Office of Health Care Quality may assess.

(3) The Department shall pay all penalties collected under this title to the Comptroller.

(4) The Comptroller shall distribute funds collected under this title to the Health Care Quality Account for Assisted Living Programs.

(5) The Account is a continuing, nonlapsing fund, not subject to § 7–302 of the State Finance and Procurement Article.

(6) Any unspent portions of the Account may not be transferred or reverted to the General Fund of the State, but shall remain in the Account to be used for the purposes specified in this section.

(b) The Health Care Quality Account for Assisted Living Programs shall be used for training, grant awards, demonstration projects, or other purposes designed to improve the quality of care.

(c) The Department shall adopt regulations for the distribution of funds from the Health Care Quality Account for Assisted Living Programs.

§19–1812.

(a) Except as provided in subsections (g) and (h) of this section, the Department shall require that each assisted living program facility that provides services to 50 or more individuals have an emergency electrical power generator on the premises.

(b) The Department shall require that each facility provide emergency electrical power as provided in this section.

(c) (1) The emergency power source shall be a generating set and prime mover located on the facility premises with automatic transfer.

(2) An emergency power system shall meet the following requirements:

(i) In the event of failure of the normal electric service, the emergency electrical power shall be activated immediately;

(ii) The emergency generator set shall come to full speed and load acceptance within 10 seconds; and

(iii) The emergency generator shall have the capability of 48 hours of operation from fuel stored on–site.

(3) (i) The emergency power system shall be tested one time each month.

(ii) The emergency power system test shall require that the generator be exercised for a minimum of 30 minutes under normal emergency facility connected load.

(iii) The test shall be recorded in a permanent log book maintained for that purpose.

(d) The emergency power system shall provide lighting in the following areas of the facility:

(1) Areas of egress and protection as required by the State Fire Prevention Code and Life Safety Code 101 adopted by the State Fire Prevention Commission;

(2) Nurses' station;

(3) Drug distribution station or unit dose station;

(4) An area for emergency telephone use;

(5) Boiler or mechanical room;

(6) Kitchen;

(7) Emergency generator location and switch gear location;

(8) Elevator, if operable on emergency power;

(9) Areas where life support equipment is used;

(10) If applicable, common areas or areas of refuge; and

(11) If applicable, toilet rooms of common areas or areas of refuge.

(e) Emergency electrical power shall be provided for the following:

(1) Nurses' call system;

(2) At least one telephone in order to make and receive calls;

(3) Fire pump;

(4) Sewerage pump and sump pump;

(5) If required for evacuation purposes, an elevator;

(6) If necessary, heating equipment needed to maintain a minimum temperature of 70 degrees Fahrenheit (24 degrees Celsius) in all common areas or areas of refuge;

(7) Life support equipment; and

(8) Nonflammable medical gas systems.

(f) (1) If the emergency power system does not provide heat to all patient rooms or toilet rooms in the event of a loss of electricity from the main source of power, the facility shall provide common areas or areas of refuge for all patients.

(2) The Department shall adopt regulations regarding the requirements for designating parts of the facility as common areas or areas of refuge.

(g) An assisted living program facility shall be exempt from the requirements of this section if the facility can safely transfer residents through an enclosed corridor to a building that is equipped with an electrical power generator that satisfies the requirements of this section.

(h) (1) The Department may grant a facility a waiver from the requirements of this section if the facility:

(i) Provides evidence to the Department that the requirements of this section will create an undue financial burden on the facility and will require the facility to cease operation; and

(ii) Discloses to the residents of the facility that the facility does not have an emergency electrical power generator that meets the requirements of this section.

(2) Subject to paragraph (3) of this subsection, a waiver granted under paragraph (1) of this subsection may not exceed a period of 3 years.

(3) The Department may extend a waiver granted under paragraph (1) of this subsection for an additional period of 2 years beyond the period specified in paragraph (2) of this subsection.

§19–1813.

(a) In this section, "assisted living referrer" means an individual or agency that:

(1) Makes referrals to assisted living programs without cost to the person receiving the referral; and

(2) Is compensated by an assisted living program or other third party for referring individuals to a licensed assisted living program.

(b) Each assisted living referrer:

(1) Shall register with the Office of Health Care Quality;

(2) Shall disclose to a client or potential client of the assisted living referrer all financial relationships the assisted living referrer has with assisted living programs;

(3) If referring a client or potential client to an assisted living program, shall affirm that the assisted living program is licensed;

(4) If referring a client or potential client to an assisted living program, may refer the client or potential client only to a licensed assisted living program;

(5) Shall maintain general liability insurance;

(6) Shall require employees to obtain a criminal history records check;

(7) Shall provide to the client or the client's representative a description of the services that will be provided by the referrer;

(8) If the referrer has a financial agreement with the client or the client's representative, shall provide the agreement to the client or the client's representative in writing or by electronic means; and

(9) Shall notify the Office of Health Care Quality immediately on learning that the assisted living program is operating without a license.

(c) An assisted living referrer may not:

(1) Receive funding from the Department if the assisted living referrer is in violation of this subtitle;

(2) Make referrals only to licensed assisted living programs from which the assisted living referrer receives compensation as described in subsection (a)(2) of this section; or

(3) Request payment of a referral fee from an assisted living program more than 2 years after the assisted living referrer provided the referral.

(d) If requested by any person or on its own initiative, the Office of the Attorney General may investigate whether an assisted living referrer violated this subtitle and may seek appropriate relief.

(e) The Office of Health Care Quality shall maintain a user–friendly database of licensed assisted living programs.

(f) (1) On or before September 30, 2025, an assisted living referrer:

(i) Shall keep a client or potential client's medical record, as defined in § 4–301 of this article, confidential and may disclose the medical record only for the purpose of making a referral if the client or potential client gives informed written, electronic, or audio recorded consent; and

(ii) May not sell the personal data of a client, potential client, or client's representative to another person unless the client or the client's representative gives informed written, electronic, or audio recorded consent.

(2) On or after October 1, 2025, an assisted living referrer shall comply with all applicable data privacy laws.

§19–1814.

The Office of Health Care Quality within the Department shall refer an allegation of an unfair, abusive, or deceptive trade practice by an assisted living program to the Division of Consumer Protection of the Office of the Attorney General and to the Office of the Inspector General within the Department.

§19–1815. IN EFFECT

// EFFECTIVE UNTIL DECEMBER 31, 2022 PER CHAPTERS 29 AND 31 OF 2021 SPECIAL SESSION //

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

(2) "COVID–19" means, interchangeably and collectively, the coronavirus known as COVID–19 or 2019–nCoV and the SARS–CoV–2 virus.

(3) "COVID–19 test" means an in vitro diagnostic test for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, as described in § 3201 of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.

(b) For calendar years 2021 and 2022, an assisted living program shall adopt and implement a COVID–19 testing plan for residents of the assisted living program and staff who provide services to residents of the assisted living program.

(c) The COVID–19 testing plan shall ensure that residents and staff are tested for COVID–19 on a regular basis and at a frequency that is sufficient to prevent the spread of COVID–19 among residents and staff of the assisted living program.

(d) (1) The Department shall adopt regulations that set standards for a COVID–19 testing plan required under this section.

(2) The standards set by the Department under this subsection shall:

(i) Be guided by applicable federal orders and policies; and

(ii) Include requirements for testing frequency that are reasonably related to the COVID–19 testing positivity rate in the local jurisdiction in which an assisted living program is located.

§19–1901.

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

(b) "Adult dependent care program" means:

(1) An adult day care facility regulated under Title 14, Subtitle 2 of this article;

(2) An assisted living program facility regulated under Subtitle 18 of this title;

(3) A group home regulated under Title 10, Subtitle 5 or Title 7, Subtitle 6 of this article;

(4) A home health agency regulated under Subtitle 4 of this title;

(5) A congregate housing services program regulated under Title 10, Subtitle 2 of the Human Services Article;

(6) A residential service agency as defined under § 19–4A–01 of this title;

(7) An alternative living unit as defined under § 7–101 of this article;

(8) A hospice facility regulated under Subtitle 9 of this title; or

(9) A related institution regulated under Subtitle 3 of this title.

(c) "Background check" means a check of court and other records by a private agency.

(d) "Conviction" means a:

(1) Plea or verdict of guilty;

(2) Plea of nolo contendere;

(3) Disposition of probation before judgment; or

(4) Disposition of not criminally responsible.

(e) "Criminal history records check" means a check of criminal history record information, as defined in § 10-201 of the Criminal Procedure Article, by the Department of Public Safety and Correctional Services.

(f) "Department" means the Department of Public Safety and Correctional Services.

(g) "Disclosure statement" means a sworn statement or affirmation of the existence of a criminal conviction or pending criminal charges without a final disposition.

(h) (1) "Eligible employee" means an individual:

(i) Who, for compensation, works for an adult dependent care program;

(ii) Who has routine, direct access to dependent adults in the program; and

(iii) Who is not licensed or certified under the Health Occupations Article.

(2) "Eligible employee" does not include an individual delivering or retrieving medical equipment.

(i) "Printed statement" means a document issued by the Criminal Justice Information System Central Repository in the Department of Public Safety and Correctional Services in response to an application for a criminal history records check.

(j) "Private agency" means a person that:

(1) Is licensed as a private detective agency under Title 13, Subtitle 3 of the Business Occupations and Professions Article;

(2) Maintains an errors and omissions insurance policy in an amount not less than $1,000,000;

(3) Offers customer assistance in the use of background checks for employment purposes; and

(4) Is capable of conducting a background check within the State within 2 working days of a request and outside the State within 5 working days of a request.

(k) "Secretary" means the Secretary of Public Safety and Correctional Services.

§19–1902.

(a) Before an eligible employee may begin work for an adult dependent care program, each adult dependent care program shall, for each eligible employee:

(1) (i) Apply for a State criminal history records check; or

(ii) Request a private agency to conduct a background check; and

(2) Request a reference from the potential employee's most recent employer.

(b) The reference request required under subsection (a)(2) of this section shall, at a minimum, seek information about any history of physical abuse on the part of the potential employee.

(c) An adult dependent care program shall pay for each eligible employee:

(1) A State criminal history records check; or

(2) A private agency background check.

(d) If an adult dependent care program requests a private agency to conduct a background check, the private agency shall conduct a background check in each state in which the adult dependent care program knows or has reason to know the eligible employee worked or resided during the past 7 years.

§19–1903.

(a) In addition to the checks required under this subtitle, an adult dependent care program may require an alcohol or controlled dangerous substance test of the potential employee.

(b) An alcohol or controlled dangerous substance test conducted under this section shall comply with the provisions of § 17-214 of this article.

§19–1904.

(a) As part of the application for a State criminal history records check to be conducted by the Department, an eligible employee shall submit to the adult dependent care program:

(1) Except as provided in subsection (c) of this section, a complete set of legible fingerprints taken on forms specified by the Director of the Criminal Justice Information System Central Repository; and

(2) The disclosure statement required under § 19-1905 of this subtitle.

(b) The adult dependent care program shall submit the fingerprints, disclosure statement, and payment for the costs of the criminal history records check.

(c) The requirement that a complete set of legible fingerprints taken on forms specified by the Director of the Criminal Justice Information System Central Repository be submitted as part of the application for a criminal history records check may be waived by the Department if:

(1) The eligible employee has attempted to have a complete set of fingerprints taken on at least two occasions;

(2) The taking of a complete set of legible fingerprints is not possible because of a physical or medical condition of the eligible employee's fingers or hands;

(3) The eligible employee submits documentation satisfactory to the Department of the requirements of this subsection; and

(4) The eligible employee submits the other information required for a criminal history records check to be conducted by the Department as part of the application process.

§19–1905.

(a) As part of the application process for a criminal history records check, an eligible employee shall complete and sign a disclosure statement.

(b) The Department or its designee shall mail an acknowledged receipt of the application with a disclosure statement from an eligible employee within 3 days after receipt of the application to:

(1) The adult dependent care program seeking to hire the eligible employee; and

(2) The eligible employee.

§19–1906.

(a) If the adult dependent care program requests a private agency background check:

(1) The private agency shall issue a statement of its findings to:

(i) On request, the eligible employee; and

(ii) The adult dependent care program; and

(2) The eligible employee shall have an opportunity to contest the findings.

(b) The adult dependent care program shall comply with the federal Fair Credit Reporting Act that includes the issuance of a statement by the program of its findings to an eligible employee when adverse information is obtained that precludes the hiring of that employee.

§19–1907.

(a) (1) The Department shall conduct the criminal history records check and issue the printed statement provided for under this subtitle.

(2) The Department shall update an initial criminal history records check and issue a revised printed statement, listing any of the convictions or pending charges occurring in the State after the date of the initial criminal history records check.

(3) The Department shall provide an initial and a revised statement of an eligible employee's State criminal record to the recipients of the acknowledgments specified in § 19-1905(b) of this subtitle.

(4) The Department shall adopt regulations requiring employers to verify periodically the continuing employment of an employee.

(b) The Department shall provide a printed statement of the eligible employee's State criminal record to the recipients of the acknowledgments specified in § 19-1905(b) of this subtitle.

(c) Information obtained from the Department or a private agency under this subtitle shall be confidential and may be disseminated only to the eligible employee who is the subject of the criminal history records check or private agency background check and to an adult dependent care program seeking to hire the eligible employee.

(d) Information obtained from the Department or a private agency under this subtitle may not:

(1) Be used for any purpose other than that for which it was disseminated; or

(2) Be redisseminated.

(e) Information obtained from the Department or a private agency under this subtitle shall be maintained in a manner to insure the security of the information.

§19–1908.

(a) An eligible employee may contest the finding of a criminal conviction or pending charge reported in a printed statement issued by the Department as provided in this section.

(b) (1) In contesting the finding of a conviction or a pending charge, the eligible employee shall contact the office of the Secretary, or a designee of the Secretary, and a hearing shall be convened within 20 workdays, unless subsequently waived by the eligible employee.

(2) The Secretary, or a designee of the Secretary, shall render a decision regarding the appeal within 5 workdays after the hearing.

(c) (1) For the purposes of this subtitle, the record of a conviction for a crime or a copy of the record certified by the clerk of the court or by a judge of the court in which the conviction occurred, shall be conclusive evidence of the conviction.

(2) In a case where a pending charge is recorded, documentation provided by a court to the Secretary, or a designee of the Secretary, that a pending charge for a crime which has not been finally adjudicated shall be conclusive evidence of the pending charge.

(d) Failure of the eligible employee to appear at the scheduled hearing shall be considered grounds for dismissal of the appeal.

§19–1909.

(a) An eligible employee who fails to disclose a conviction or the existence of pending charges for a criminal offense or attempted criminal offense as required under § 19-1905 of this subtitle shall be guilty of perjury and on conviction is subject to the penalty provided by law.

(b) Unless otherwise provided, an eligible employee who violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

§19–1910.

The following persons or agencies shall have the immunity from civil or criminal liability described under § 5-619 of the Courts and Judicial Proceedings Article in connection with a criminal history records check under this subtitle:

(1) An adult dependent care program; and

(2) A State agency.

§19–1911.

(a) An employer providing a reference for employment under this subtitle and acting in good faith may not be held liable for disclosing any information about the job performance or the reason for termination of employment of an employee or former employee of the employer.

(b) An employer providing a reference under this subtitle shall be presumed to be acting in good faith unless it is shown by clear and convincing evidence that the employer:

(1) Acted with actual malice toward the employee or former employee; or

(2) Intentionally or recklessly disclosed false information about the employee or former employee.

§19–1912.

Nothing in this subtitle may be construed to prevent an adult dependent care program from obtaining a criminal history records check or background check on any other individual applying for a job or volunteering services in the program.

§19–2001.

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

(2) "Client facility" means a health care facility that contracts with a health care staff agency for the referral of health care practitioners.

(3) "Health care facility" means a hospital or related institution as defined in § 19–301 of this title.

(4) (i) Except as provided in subparagraph (ii) of this paragraph, "health care practitioner" means any individual licensed or certified under the Health Occupations Article who:

1. Is a licensed practical nurse, registered nurse, or certified nursing assistant; or

2. Practices in an allied health care field, as defined by the Office in regulation.

(ii) "Health care practitioner" does not include:

1. An acupuncturist;

2. A dentist;

3. A nurse anesthetist;

4. A nurse midwife;

5. A nurse practitioner;

6. A pharmacist;

7. A physician;

8. A physician assistant; or

9. A podiatrist.

(5) (i) "Health care staff agency" means any person, firm, corporation, partnership, or other business entity engaged in the business of referring health care practitioners as employees or independent contractors to render temporary health care services at a health care facility in the State.

(ii) "Health care staff agency" does not include:

1. A health care staff agency operated by a health care facility or its affiliates solely for the purpose of procuring, furnishing, or referring temporary or permanent health care personnel for employment at that health care facility or its affiliates;

2. A home health agency regulated under Subtitle 4 of this title; or

3. Any health care practitioners procuring, furnishing, or referring their own services to a health care facility without the direct or indirect assistance of a health care staff agency.

(6) "Initially providing or referring" means the first time a health care staff agency provides or refers a particular health care practitioner to a health care facility.

(7) "Office" means the Office of Health Care Quality in the Department.

(8) "Responsible party" means the individual at a health care staff agency who controls the day to day operation of the health care staff agency.

(b) (1) A health care staff agency shall be licensed by the Office before referring health care practitioners to a health care facility to render temporary health care services at a health care facility in this State.

(2) All health care staff agencies shall submit to the Office:

(i) The health care staff agency's:

1. Business name;

2. Business address;

3. Business telephone number; and

4. Responsible party; and

(ii) Any other information the Office requires by regulation to ensure compliance with the provisions of this subtitle.

(c) (1) A health care staff agency shall notify the Office of any change in ownership, agency name, or address within 30 days of the change.

(2) Notwithstanding the provisions of subsection (g)(1) of this section, if a health care staff agency fails to notify the Office within the time required under this subsection, the Office may impose a fine of $100.

(d) (1) Before initially providing or referring a health care practitioner to health care facilities to render temporary health care services, the health care staff agency shall verify the licensure or certification status of the health care practitioner.

(2) At the time a health care practitioner who is being referred to health care facilities by a health care staff agency must renew the health care practitioner's license or certificate, the health care staff agency shall:

(i) Submit the name and license or certificate number of the health care practitioner to the Office; and

(ii) Verify the licensure or certification status of the health care practitioner.

(e) A health care staff agency may not knowingly provide or refer an individual who is not licensed or certified under the Health Occupations Article to a health care facility to render health care services.

(f) (1) Except as provided in paragraph (2) of this subsection:

(i) If a health care staff agency knows of an action or condition performed by a health care practitioner provided or referred by that health care staff agency that might be grounds for action relating to a license or certificate issued under the Health Occupations Article, the health care staff agency shall report the action or condition to the appropriate health occupation board; and

(ii) An individual shall have immunity from liability described under § 5–709 of the Courts and Judicial Proceedings Article for making a report as required under this paragraph.

(2) A health care staff agency is not required under this subsection to make any report that would be in violation of any federal or State law, rule, or regulation concerning the confidentiality of alcohol and drug abuse patient records.

(g) (1) Subject to the provisions of Title 10, Subtitle 2 of the State Government Article, the Office may impose a penalty for a violation of any provision of this section:

(i) For a first offense, up to $2,500 per violation or up to $2,500 per day until the health care staff agency complies with the requirements of this subtitle;

(ii) For a second offense, up to $5,000 per violation or up to $5,000 per day until the health care staff agency complies with the requirements of this subtitle; and

(iii) For a third or subsequent offense, up to $10,000 per violation or up to $10,000 per day until the health care staff agency complies with the requirements of this subtitle.

(2) Each day a violation continues is a separate violation.

(h) A health care staff agency is not a health care provider.

§19–2002.

(a) In this section, "Office" means the Office of Health Care Quality in the Department.

(b) The Office may inspect a health care staff agency to verify compliance with this subtitle.

(c) When the Office conducts an inspection, the Office shall verify that the health care practitioners referred by the health care staff agency are licensed or certified by the appropriate health occupation board.

(d) When the Office conducts an inspection, the Office shall verify that the health care staff agency has developed, documented, and implemented procedures for:

(1) Selecting and verifying the credentials of health care practitioners referred by the health care staff agency;

(2) Validating experience of health care practitioners prior to referral by the health care staff agency;

(3) Tracking and acting on serious or life–threatening complaints received by a client facility or the client facility's agent;

(4) Reporting of an action or condition under § 19–2001(f) of this subtitle;

(5) Verifying that health care practitioners referred by the health care staff agency are of satisfactory health status and have received the necessary testing and immunization as required or requested by the client facility;

(6) Verifying I–9 status;

(7) Verifying, prior to initial referral of health care practitioners to a client facility by the health care staff agency, drug screening of health care practitioners referred by the health care staff agency if the client facility requires drug screening for facility employees;

(8) Verifying, when there is probable cause to perform a drug test or when a client facility requests a drug test, drug testing of health care practitioners referred by the health care staff agency;

(9) Verifying, prior to initial referral of health care practitioners to a client facility by the health care staff agency, criminal background checks of health care practitioners referred by the health care staff agency if the client facility requires criminal background checks for facility employees; and

(10) Verifying the references of health care practitioners referred by the health care staff agency.

(e) A health care staff agency shall attest that the health care staff agency is in compliance with the:

(1) Civil Rights Act of 1964;

(2) Rehabilitation Act of 1973;

(3) Americans with Disabilities Act of 1990; and

(4) Drug Free Workplace Act of 1988, if applicable.

(f) The Office may inspect a health care staff agency upon receiving a complaint, and may give notice of the inspection to the health care staff agency.

§19–2101. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

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

(b) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010, and any regulations adopted or guidance issued under the Acts.

(c) "Commission" means the Maryland Community Health Resources Commission.

(d) (1) "Community health resource" means a nonprofit or for profit health care center or program that offers the primary health care services required by the Commission under § 19–2109(a)(2) of this subtitle to an individual on a sliding scale fee schedule and without regard to an individual's ability to pay.

(2) "Community health resource" includes:

(i) A federally qualified health center;

(ii) A federally qualified health center "look–alike";

(iii) A community health center;

(iv) A migrant health center;

(v) A health care program for the homeless;

(vi) A primary care program for a public housing project;

(vii) A local nonprofit and community–owned health care program;

(viii) A school–based health center;

(ix) A teaching clinic;

(x) A wellmobile;

(xi) A health center controlled operating network;

(xii) A historic Maryland primary care provider;

(xiii) An outpatient behavioral health program; and

(xiv) Any other center or program identified by the Commission as a community health resource.

§19–2102. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) There is a Maryland Community Health Resources Commission.

(b) The Commission is an independent commission that operates within the Department.

(c) The purpose of the Commission is to increase access to health care through community health resources.

§19–2103. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) (1) The Commission consists of eleven members appointed by the Governor with the advice and consent of the Senate.

(2) Of the eleven members:

(i) One shall be a representative of a nonprofit health maintenance organization;

(ii) One shall be a representative of a nonprofit health service plan;

(iii) One shall be a representative of a Maryland hospital;

(iv) Four shall be individuals who:

1. Do not have any connection with the management or policy of a community health resource, nonprofit health service plan, or nonprofit health maintenance organization; and

2. Have a background or experience in health care;

(v) One shall be an individual who has a background or experience with an outpatient mental health clinic within the past 5 years; and

(vi) Three shall be individuals who have a background or experience with a community health resource within the past 5 years.

(3) At least two of the eleven members shall be health care professionals licensed in the State.

(b) To the extent practicable, when appointing members to the Commission, the Governor shall assure geographic balance and promote racial and gender diversity in the Commission's membership.

(c) (1) On or after July 1, 2009, the term of a member is 4 years.

(2) The terms of members are staggered as required by the terms provided for members of the Commission on July 1, 2009.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) A member may not serve more than two consecutive terms, except that a member appointed before July 1, 2009, may serve one additional 4–year term when the member's current term expires.

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

§19–2104. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

From among the members of the Commission:

(1) The Governor shall appoint a chair; and

(2) The chair shall appoint a vice chair.

§19–2105. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) With the approval of the Governor, the Commission shall appoint an Executive Director, who is the chief administrative officer of the Commission.

(b) The Executive Director serves at the pleasure of the Commission.

(c) Under the direction of the Commission, the Executive Director shall perform any duty or function that the Commission requires.

§19–2106. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) (1) A majority of the full authorized membership of the Commission is a quorum.

(2) The decision of the Commission shall be by a majority of the quorum present and voting.

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

(c) A member of the Commission is entitled to:

(1) Compensation in accordance with the State budget; and

(2) Reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) (1) The Commission may employ a staff in accordance with the State budget.

(2) The Commission, in consultation with the Secretary, shall determine the appropriate job classifications and grades for all staff.

(3) The Commission, in consultation with the Secretary, may set the compensation of a Commission employee in a position that:

(i) Is unique to the Commission;

(ii) Requires specific skills or experience to perform the duties of the position; and

(iii) Does not require the employee to perform functions that are comparable to functions performed in other units of the Executive Branch of State government.

(4) The Secretary of Budget and Management, in consultation with the Commission, shall determine the positions for which the Commission may set compensation under paragraph (3) of this subsection.

§19–2107. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) In addition to the powers set forth elsewhere in this subtitle, the Commission may:

(1) Adopt regulations to carry out the provisions of this subtitle;

(2) Create committees from among its members;

(3) Appoint advisory committees, which may include individuals and representatives of interested public or private organizations;

(4) Apply for and accept any funds, property, or services from any person or government agency;

(5) Make agreements with a grantor or payor of funds, property, or services, including an agreement to make any study, plan, demonstration, or project;

(6) Publish and give out any information that relates to expanding access to health care through community health resources that is considered desirable in the public interest;

(7) Subject to the limitations of this subtitle, exercise any other power that is reasonably necessary to carry out the purposes of this subtitle; and

(8) Assist community health resources in preparing to implement the Affordable Care Act.

(b) In addition to the duties set forth elsewhere in this subtitle, the Commission shall:

(1) Adopt rules and regulations that relate to its meetings, minutes, and transactions;

(2) Keep minutes of each meeting;

(3) Prepare annually a budget proposal that includes the estimated income of the Commission and proposed expenses for its administration and operation; and

(4) On or before October 1 of each year, submit to the Governor, to the Secretary, and, in accordance with § 2–1257 of the State Government Article, to the General Assembly an annual report on the operations and activities of the Commission during the preceding fiscal year.

(c) (1) The Commission may contract with a qualified, independent third party for any service that is necessary to carry out the powers and duties of the Commission.

(2) Unless permission is granted specifically by the Commission, a third party with whom the Commission contracts under paragraph (1) of this subsection may not release, publish, or use in a manner not authorized by the contract any information to which the third party has access under the contract.

§19–2108. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that the Commission makes under authority specifically delegated by law to the Commission.

(b) The power of the Secretary to transfer by rule, regulation, or written directive any staff, functions, or funds of units in the Department does not apply to any staff, functions, or funds of the Commission.

(c) (1) The power of the Secretary over the procurement procedure for units in the Department does not apply to the procurement procedure of the Commission.

(2) Notwithstanding paragraph (1) of this subsection, when procuring services or supplies, the Commission is subject to the provisions of the State Finance and Procurement Article.

§19–2109. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission shall, to the extent budgeted resources permit:

(1) Establish by regulation the criteria to qualify as a community health resource under this subtitle;

(2) Establish by regulation the services that a community health resource shall provide to qualify as a community health resource under this subtitle;

(3) Require community health resources to submit a plan to the Commission on how the community health resource will provide or arrange to provide mental health services;

(4) Identify and seek federal and State funding for the expansion of community health resources;

(5) Establish by regulation the criteria for community health resources to qualify for operating grants and procedures for applying for operating grants;

(6) Administer operating grant fund programs for qualifying community health resources;

(7) Taking into consideration regional disparities in income and the cost of medical services, establish guidelines for sliding scale fee payments at community health resources that are not federally qualified health centers, for individuals whose family income is between 100% and 200% of the federal poverty guidelines;

(8) Identify and implement programs and policies to encourage specialist providers to serve individuals referred from community health resources;

(9) Identify and implement programs and policies to encourage hospitals and community health resources to partner to increase access to health care services;

(10) Establish a reverse referral pilot program under which a hospital will identify and assist patients in accessing health care services through a community health resource;

(11) Work with community health resources, hospital systems, and others to develop a unified information and data management system for use by all community health resources that is integrated with the local hospital systems to track the treatment of individual patients and that provides real–time indicators of available resources;

(12) Work in cooperation with clinical education and training programs, area health education centers, and telemedicine centers to enhance access to quality primary and specialty health care for individuals in rural and underserved areas referred by community health resources;

(13) Evaluate the feasibility of developing a capital grant program for community health resources that are not federally qualified health centers;

(14) Develop an outreach program to educate and inform individuals of the availability of community health resources and assist individuals under 200% of the federal poverty level who do not have health insurance to access health care services through community health resources;

(15) Study school–based health center funding and access issues including:

(i) Reimbursement of school–based health centers by managed care organizations, insurers, nonprofit health service plans, and health maintenance organizations; and

(ii) Methods to expand school–based health centers to provide primary care services;

(16) Study access and reimbursement issues regarding the provision of dental services;

(17) Evaluate the feasibility of extending liability protection under the Maryland Tort Claims Act to health care practitioners who contract directly with a community health resource that is also a Maryland qualified health center or a school–based health center; and

(18) Establish criteria and mechanisms to pay for office–based specialty care visits, diagnostic testing, and laboratory tests for uninsured

individuals with family income that does not exceed 200% of the federal poverty guidelines who are referred through community health resources.

(b) The reverse referral pilot program established under subsection (a)(10) of this section shall include at least one hospital and one community health resource from a rural, urban, and suburban area of this State.

(c) The Commission, in developing and implementing the outreach program established under subsection (a)(14) of this section, shall consult and coordinate with the Motor Vehicle Administration, workforce development boards, local departments of social services, local health departments, Medbank Inc., the Comptroller, the Maryland Health Care Commission, hospitals, community health resources, and physicians to provide outreach and consumer information.

(d) The Commission, in conducting the school–based health center study required under subsection (a)(15) of this section, shall:

(1) Solicit input from and consult with local governments that operate school–based health centers, the State Department of Education, the Maryland Insurance Commissioner, representatives from school–based health centers, providers, and insurers; and

(2) Identify the following:

(i) A fee schedule for individuals accessing a school–based community health center;

(ii) Reimbursement rates to be paid by managed care organizations and insurers, nonprofit health services plans, and health maintenance organizations to the school–based community health center;

(iii) Insurance payments owed to school–based community health centers and how much of the payments should be collected to offset any State subsidy;

(iv) Barriers to the reimbursement of licensed health care providers who provide services at school–based health centers, including nurse practitioners and physician assistants;

(v) A system of registering individuals who receive health care services from a school–based community health center that requires an individual to pay premiums and sliding scale fees; and

(vi) Security measures to be used by school–based community health centers.

(e) The Commission, in conducting the dental services study required under subsection (a)(16) of this section, shall select input from and consult with community health resources that provide dental services, managed care organizations, the University of Maryland School of Dentistry, and dental service providers.

§19–2111. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2035 PER CHAPTER 386 OF 2024 //

(a) The Commission, in collaboration with community health resources and local health departments, shall develop a specialty care network for individuals:

(1) With family income that does not exceed 200% of the federal poverty level; and

(2) Who are referred through a community health resource.

(b) The specialty care network shall:

(1) Consist of health care practitioners who agree to provide care to individuals referred through a community health resource for a discounted fee established by the Commission; and

(2) Include health care practitioners who historically have served the uninsured.

(c) Individuals receiving health care through the specialty care network shall pay for specialty care according to a sliding fee scale developed by the Commission.

(d) In addition to patient fees, office–based specialty care visits, diagnostic testing, and laboratory tests shall be subsidized by funds provided from:

(1) General funds; and

(2) Money collected from a nonprofit health maintenance organization in accordance with § 6–121(b)(3) of the Insurance Article.

(e) Subject to available funding, the Commission shall provide subsidies to community health resources for office–based specialty care visits, diagnostic testing, and laboratory tests.

§19–2201. IN EFFECT

(a) In this section, "Fund" means the Community Health Resources Commission Fund.

(b) There is a Community Health Resources Commission Fund.

(c) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(d) The Fund consists of:

(1) Money collected from a nonprofit health service plan in accordance with § 14–106.1 of the Insurance Article;

(2) Money from the Cigarette Restitution Fund, appropriated in accordance with § 7–317 of the State Finance and Procurement Article;

(3) Interest earned on investments;

(4) Money donated to the Fund;

(5) Money awarded to the Fund through grants; and

(6) Any other money from any other source accepted for the benefit of the Fund.

(e) (1) Subject to paragraph (2) of this subsection, the Fund may be used only to:

(i) Cover the administrative costs of the Commission;

(ii) Cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle;

(iii) Provide operating grants to qualifying community health resources; and

(iv) Provide funding for the development, support, and monitoring of a unified data information system among primary and specialty care providers, hospitals, and other providers of services to community health resource members.

(2) (i) For fiscal years 2014, 2015, and 2016, the Fund may be used for any project or initiative authorized under Title 20, Subtitle 14 of this article and approved by the Commission if no less than $4,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in each fiscal year for the purposes under paragraph (1) of this subsection.

(ii) For fiscal year 2017, the Fund may be used for any project or initiative authorized under Title 20, Subtitle 14 of this article and approved by the Commission if no less than $8,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in each fiscal year for the purposes under paragraph (1) of this subsection.

(iii) For fiscal year 2018, the Fund may be used for any project or initiative authorized under Title 10, Subtitle 2 and Title 13, Subtitle 3 of this article and approved by the Commission if no less than $4,750,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in that fiscal year for the purposes under paragraph (1) of this subsection.

(iv) For fiscal years 2019 through 2021, the Fund may be used for any project or initiative authorized under Title 10, Subtitle 2 and Title 13, Subtitle 3 of this article and approved by the Commission if no less than $8,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in each fiscal year for the purposes under paragraph (1) of this subsection.

(v) For fiscal year 2022, the Fund may be used for any project or initiative authorized under Title 10, Subtitle 2 and Title 13, Subtitle 3 of this article and approved by the Commission if not more than $8,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in that fiscal year for the purposes under paragraph (1) of this subsection.

(3) The funding for a unified data information system under paragraph (1)(iv) of this subsection shall be limited to:

(i) $500,000 in fiscal year 2006; and

(ii) $1,700,000 in fiscal year 2007 and annually thereafter.

(f) The Commission shall adopt regulations that:

(1) Establish the criteria for a community health resource to qualify for a grant;

(2) Establish the procedures for disbursing grants to qualifying community health resources;

(3) Develop a formula for disbursing grants to qualifying community health resources;

(4) Establish criteria and mechanisms for funding a unified data information system; and

(5) In consultation with the Secretary, implement a program to provide subsidies to community health resources for office–based specialty care visits, diagnostic testing, and laboratory tests.

(g) In developing regulations under subsection (f)(1) of this section, the Commission shall:

(1) Consider geographic balance; and

(2) Give priority to community health resources that:

(i) In addition to normal business hours, have evening and weekend hours of operation;

(ii) Have partnered with a hospital to establish a reverse referral program at the hospital;

(iii) Reduce the use of the hospital emergency department for nonemergency services;

(iv) Assist patients in establishing a medical home with a community health resource;

(v) Coordinate and integrate the delivery of primary and specialty care services;

(vi) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;

(vii) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;

(viii) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and

(ix) Support the implementation of evidence–based clinical practices.

(h) Grants awarded to a community health resource under this section may be used:

(1) To provide operational assistance to a community health resource; and

(2) For any other purpose the Commission determines is appropriate to assist a community health resource.

(i) (1) The Treasurer shall invest the money in the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be retained to the credit of the Fund.

(j) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2–1220 of the State Government Article.

§19–2201. // EFFECTIVE JUNE 30, 2029 PER CHAPTER 644 OF 2023 //

(a) In this section, "Fund" means the Community Health Resources Commission Fund.

(b) There is a Community Health Resources Commission Fund.

(c) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(d) The Fund consists of:

(1) Money collected from a nonprofit health service plan in accordance with § 14–106.1 of the Insurance Article;

(2) Interest earned on investments;

(3) Money donated to the Fund;

(4) Money awarded to the Fund through grants; and

(5) Any other money from any other source accepted for the benefit of the Fund.

(e) (1) Subject to paragraph (2) of this subsection, the Fund may be used only to:

(i) Cover the administrative costs of the Commission;

(ii) Cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle;

(iii) Provide operating grants to qualifying community health resources; and

(iv) Provide funding for the development, support, and monitoring of a unified data information system among primary and specialty care providers, hospitals, and other providers of services to community health resource members.

(2) (i) For fiscal years 2014, 2015, and 2016, the Fund may be used for any project or initiative authorized under Title 20, Subtitle 14 of this article and approved by the Commission if no less than $4,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in each fiscal year for the purposes under paragraph (1) of this subsection.

(ii) For fiscal year 2017, the Fund may be used for any project or initiative authorized under Title 20, Subtitle 14 of this article and approved by the Commission if no less than $8,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in each fiscal year for the purposes under paragraph (1) of this subsection.

(iii) For fiscal year 2018, the Fund may be used for any project or initiative authorized under Title 10, Subtitle 2 and Title 13, Subtitle 3 of this article and approved by the Commission if no less than $4,750,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in that fiscal year for the purposes under paragraph (1) of this subsection.

(iv) For fiscal years 2019 through 2021, the Fund may be used for any project or initiative authorized under Title 10, Subtitle 2 and Title 13, Subtitle 3 of this article and approved by the Commission if no less than $8,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in each fiscal year for the purposes under paragraph (1) of this subsection.

(v) For fiscal year 2022, the Fund may be used for any project or initiative authorized under Title 10, Subtitle 2 and Title 13, Subtitle 3 of this article and approved by the Commission if not more than $8,000,000 of the subsidy required under § 14–106(d)(2)(ii)2 of the Insurance Article is used in that fiscal year for the purposes under paragraph (1) of this subsection.

(3) The funding for a unified data information system under paragraph (1)(iv) of this subsection shall be limited to:

(i) $500,000 in fiscal year 2006; and

(ii) $1,700,000 in fiscal year 2007 and annually thereafter.

(f) The Commission shall adopt regulations that:

(1) Establish the criteria for a community health resource to qualify for a grant;

(2) Establish the procedures for disbursing grants to qualifying community health resources;

(3) Develop a formula for disbursing grants to qualifying community health resources;

(4) Establish criteria and mechanisms for funding a unified data information system; and

(5) In consultation with the Secretary, implement a program to provide subsidies to community health resources for office–based specialty care visits, diagnostic testing, and laboratory tests.

(g) In developing regulations under subsection (f)(1) of this section, the Commission shall:

(1) Consider geographic balance; and

(2) Give priority to community health resources that:

(i) In addition to normal business hours, have evening and weekend hours of operation;

(ii) Have partnered with a hospital to establish a reverse referral program at the hospital;

(iii) Reduce the use of the hospital emergency department for nonemergency services;

(iv) Assist patients in establishing a medical home with a community health resource;

(v) Coordinate and integrate the delivery of primary and specialty care services;

(vi) Promote the integration of mental and somatic health with federally qualified health centers or other somatic care providers;

(vii) Fund medication management or therapy services for uninsured individuals up to 200% of the federal poverty level who meet medical necessity criteria but who are ineligible for the public mental health system;

(viii) Provide a clinical home for individuals who access hospital emergency departments for mental health services, substance abuse services, or both; and

(ix) Support the implementation of evidence–based clinical practices.

(h) Grants awarded to a community health resource under this section may be used:

(1) To provide operational assistance to a community health resource; and

(2) For any other purpose the Commission determines is appropriate to assist a community health resource.

(i) (1) The Treasurer shall invest the money in the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be retained to the credit of the Fund.

(j) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2–1220 of the State Government Article.

§19–22A–01.

The Secretary, in consultation with the State Department of Education and other stakeholders, shall develop guidelines to support the expansion of school–based health centers.

§19–22A–04.

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

(b) "Commission" means the Maryland Community Health Resources Commission.

(c) "Council" means the Maryland Council on Advancement of School–Based Health Centers.

§19–22A–05.

(a) There is a Maryland Council on Advancement of School–Based Health Centers in the Department.

(b) The purpose of the Council is to improve the health and educational outcomes of students who receive services from school–based health centers by advancing the integration of school–based health centers into:

(1) The health care system at the State and local levels; and

(2) The educational system at the State and local levels.

(c) (1) Staff support for the Council shall be provided by the Commission.

(2) The Commission may seek the assistance of organizations with expertise in school–based health care or other matters within the duties of the Council provided in § 19–22A–08 of this subtitle to provide additional staffing resources to the Commission and the Council.

§19–22A–06.

(a) The Council consists of the following 16 voting members and 6 ex officio members:

(1) One member of the Senate of Maryland, appointed by the President of the Senate, as an ex officio member;

(2) One member of the House of Delegates, appointed by the Speaker of the House, as an ex officio member;

(3) The Secretary of Health, or a designee of the Secretary, as an ex officio member;

(4) The State Superintendent of Schools as an ex officio member;

(5) The Executive Director of the Maryland Health Benefit Exchange as an ex officio member;

(6) The Chairman of the Commission, or a designee of the Chairman, as an ex officio member; and

(7) The following 16 members, appointed by the Governor:

(i) The President of the Maryland Assembly on School–Based Health Care, or a designee of the President;

(ii) Three representatives of school–based health centers, nominated by the Maryland Assembly on School–Based Health Care:

1. From a diverse array of sponsoring organizations; and

2. For at least one of the representatives, from a nursing background;

(iii) One representative of the Public Schools Superintendents Association of Maryland;

(iv) One representative of the Maryland Association of Boards of Education;

(v) One elementary school principal of a school that has a school–based health center;

(vi) One secondary school principal of a school that has a school–based health center;

(vii) One representative of the Maryland Hospital Association;

(viii) One representative of the Maryland Association of County Health Officers;

(ix) One representative of a federally qualified health center, nominated by the Mid–Atlantic Association of Community Health Centers;

(x) One representative of a managed care organization;

(xi) One representative of a commercial health insurance carrier;

(xii) One pediatrician, nominated by the Maryland Chapter of the American Academy of Pediatrics;

(xiii) One parent or guardian of a student who utilizes services at a school–based health center; and

(xiv) One school nurse, nominated by the Maryland Association of School Health Nurses.

(b) In making the appointments required under this section, the Governor shall ensure that the Council is representative of:

(1) The geographic regions of the State; and

(2) Minority populations of the State.

(c) (1) The term of a member appointed under subsection (a) of this section is 3 years.

(2) The terms of voting members are staggered as required by the terms provided for members of the Council on October 1, 2015.

(3) At the end of a term, a member shall continue to serve until a successor is appointed and qualifies.

(4) A member who is appointed after a term has begun shall serve for the rest of the term or until a successor is appointed and qualifies.

(d) The Governor shall appoint a successor in the event of a vacancy on the Council.

(e) From among the members of the Council, the voting members of the Council shall elect a chair for a 2–year term.

(f) A member of the Council may not receive compensation but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§19–22A–07.

(a) A majority of the members then serving on the Council is a quorum.

(b) The Council shall determine the times and places of its meetings and any other necessary operating procedures in accordance with the Open Meetings Act.

(c) (1) The Council may establish workgroups to advise the Council on specific issues, including behavioral health, oral health, and primary care.

(2) (i) The chair of the Council shall appoint the members of a workgroup established by the Council under paragraph (1) of this subsection.

(ii) The chair of the Council may appoint the following individuals to a workgroup:

1. Members of the Council with expertise in the issue to be studied; and

2. Members of the public, including consumers and stakeholder group representatives, with expertise in the area to be studied.

§19–22A–08.

(a) The Council shall develop policy recommendations to improve the health and educational outcomes of students who receive services from school–based health centers by:

(1) Supporting local community efforts to establish or expand school–based health center capacity in primary care, behavioral health, and oral health;

(2) Integrating school–based health centers into existing and emerging patient–centered models of care;

(3) Promoting the inclusion of school–based health centers in networks of managed care organizations and commercial health insurance carriers;

(4) Advancing the public health goals of State and local health officials;

(5) Promoting the inclusion of school–based health centers into networks of school health services and coordinated student service models for the range of services offered in school settings;

(6) Supporting State and local initiatives to promote student success;

(7) Reviewing and revising best practice guidelines; and

(8) Supporting the long–term sustainability of school–based health centers.

(b) The Council shall review the collection and analysis of school–based health center data collected by the State Department of Education to:

(1) Make recommendations on best practices for the collection and analysis of the data; and

(2) Provide guidance on the development of findings and recommendations based on the data.

(c) The Council shall conduct other activities the Council considers appropriate to meet the purpose of the Council.

(d) On or before December 31 of each year, the Council shall report the findings and recommendations of the Council to the Maryland Department of Health, the State Department of Education, the Commission, and, in accordance with § 2–1257 of the State Government Article, the General Assembly on improving the health and educational outcomes of students who receive services from school–based health centers.

§19–2301.

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

(b) "Accreditation organization" means a private entity that conducts inspections and surveys of health care facilities or health care staff agencies based on nationally recognized and developed standards.

(c) "Deemed status" means a status under which a health care facility or a health care staff agency may be exempt from routine surveys conducted by the Department.

(d) "Health care facility" means:

(1) A hospital as defined in § 19–301 of this title;

(2) A health maintenance organization as defined in § 19–701(g) of this title;

(3) A freestanding ambulatory care facility as defined in § 19–3B–01 of this title;

(4) An assisted living facility as defined in § 19–1801 of this title;

(5) A laboratory as defined in § 17–201 of this article;

(6) A home health agency as defined in § 19–401 of this title;

(7) A residential treatment center as defined in § 19–301 of this title;

(8) A comprehensive rehabilitation facility as defined in § 19–1201 of this title;

(9) A forensic laboratory as defined in § 17–2A–01 of this article;

(10) A substance–related disorder program as defined in § 7.5–101 of this article; and

(11) A mental health program as defined in § 7.5–101 of this article.

(e) "Health care staff agency" has the meaning stated in § 19–2001 of this title.

§19–2302.

(a) An accreditation organization shall apply to the Secretary for approval.

(b) Prior to approval of an accreditation organization, the Secretary shall:

(1) Determine that the standards of the accreditation organization are equal to or more stringent than existing State requirements;

(2) Evaluate the survey or inspection process of the accreditation organization to ensure the integrity of the survey or inspection process; and

(3) Enter into a formal written agreement with the accreditation organization that includes requirements for:

(i) Notice of all surveys and inspections;

(ii) Sharing of complaints and other relevant information;

(iii) Participation of the Department in accreditation organization activities; and

(iv) Any other provision necessary to ensure the integrity of the accreditation and licensure process.

(c) (1) When an approved accreditation organization has issued a final report finding a health care facility or a health care staff agency to be in substantial compliance with the accreditation organization's standards, the Department shall accept the report as evidence that the health care facility or health care staff agency has met State licensure requirements and shall grant the health care facility or health care staff agency deemed status.

(2) A health care facility or a health care staff agency that fails to achieve substantial compliance with the standards of an approved accreditation organization may be subject to the provisions of § 19–360 of this title.

(d) (1) An approved accreditation organization shall send the Department any preliminary and final report of each inspection and survey at the time it is sent to the health care facility or health care staff agency.

(2) A final report of an approved accreditation organization shall be made immediately available to the public on request.

(3) A preliminary or final report of an approved accreditation organization is not admissible in evidence in any civil action or proceeding.

(e) The Department may inspect an accredited health care facility or a health care staff agency to:

(1) Determine compliance with any quality requirement;

(2) Follow up on any serious problem identified by an approved accreditation organization;

(3) Investigate a complaint; or

(4) Validate the findings of an approved accreditation organization.

(f) The Department may participate in or observe a survey or inspection of a health care facility or a health care staff agency conducted by an approved accreditation organization.

(g) On a determination by the Secretary that an approved accreditation organization has failed to meet its obligations under this section, the Secretary may withdraw:

(1) The approval from the accreditation organization; and

(2) The deemed status given to a health care facility or a health care staff agency by the accreditation organization.

§19–2401.

(a) The General Assembly finds that:

(1) In 2011, the State, Prince George's County, and the University of Maryland Medical System came together in a historic public–private partnership to transition the last county–owned hospital system in the State to a private, nonprofit institution that is part of the State's largest academic medical system, with the goal of transforming health care delivery in the second most populous county in the State;

(2) The goals established under the partnership include:

(i) Growing access to high–quality clinical programs in Prince George's County;

(ii) Establishing a delivery system that enables residents to receive care within Prince George's County;

(iii) Addressing the disproportionate burden of chronic health conditions impacting residents of Prince George's County, including heart disease and cancer; and

(iv) Serving as an anchor institution and engine of economic development for Prince George's County and the southern Maryland region;

(3) Key to the transformation of care in Prince George's County are efforts to:

(i) Build high–quality specialty clinical programs, such as cancer, cardiac, and stroke care;

(ii) Expand primary care;

(iii) Attract and retain highly qualified clinicians; and

(iv) Preserve services that address community needs;

(4) Since the establishment of the University of Maryland Capital Region Health as part of the University of Maryland Medical System in 2017, the organization has succeeded in advancing the vision articulated by the historic partnership between the State, Prince George's County, and the University of Maryland Medical System to transform care delivery in Prince George's County and the southern Maryland region; and

(5) The University of Maryland Capital Region Health requires State support and investment to continue its mission to provide high–quality care and transform health care delivery in Prince George's County and the southern Maryland region.

(b) (1) Subject to subsection (c) of this section, for the purpose of providing an operating grant to ensure and assist in the transition of a new Prince George's County Regional Medical System to the University of Maryland Medical System Corporation:

(i) For fiscal year 2018, the Governor shall include in the budget bill an appropriation of $28,000,000;

(ii) For fiscal year 2019, the Governor shall include in the budget bill an appropriation of $27,000,000;

(iii) For fiscal years 2020 and 2021, the Governor shall include in the budget bill an appropriation of $15,000,000; and

(iv) For fiscal year 2022 and each fiscal year thereafter, the Governor shall include in the budget bill an appropriation of $10,000,000.

(2) Subject to subsection (c) of this section, Prince George's County shall provide a combination of matching funds and other financial assistance to the University of Maryland Medical System Corporation that constitutes total financial assistance as follows:

(i) $15,000,000 annually for fiscal year 2017 through fiscal year 2019; and

(ii) $5,000,000 annually for fiscal years 2020 and 2021.

(c) The State and county funds described in subsection (b) of this section:

(1) Shall be used to support the transition of the Prince George's County Regional Medical Center from operation under the Dimensions Health Care System to operation as a participating institution of the University of Maryland Medical System Corporation; and

(2) May be used only for:

(i) Providing increased access to critical health care services for the region served by the Prince George's County Regional Medical Center and improving the quality of the services provided; and

(ii) Facilitating cost containment measures to prevent additional operating losses for the Prince George's County Regional Medical Center and its affiliated institutions.

(d) (1) The Governor shall include in the capital or operating budget bill the following amounts that are equal to the capital funds committed by Prince George's County to be used for the construction of the Prince George's County Regional Medical Center:

(i) $11,300,000 for fiscal year 2018;

(ii) $48,000,000 for fiscal year 2019; and

(iii) $56,200,000 for fiscal year 2020.

(2) Prince George's County shall provide matching funds of $208,000,000 for the capital construction of the Prince George's County Regional Medical Center.

§19–2501.

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

(b) "Certificate of compliance" means a certificate that is issued to a recovery residence by a credentialing entity.

(c) "Certified recovery residence" means a recovery residence that holds a certificate of compliance.

(d) "Credentialing entity" means a nonprofit organization that develops and administers professional certification programs according to nationally recognized certification standards.

(e) "Recovery residence" has the meaning stated in § 7.5–101 of this article.

§19–2502.

(a) The Department shall approve a credentialing entity to develop and administer a certification process for recovery residences.

(b) The credentialing entity shall:

(1) Subject to subsection (c) of this section, establish recovery residence certification requirements;

(2) Establish processes to administer the application, certification, and recertification process;

(3) Establish processes to monitor and inspect a recovery residence;

(4) Conduct an on–site inspection of a recovery residence:

(i) Before issuing a certificate of compliance; and

(ii) At least once during each certification renewal period; and

(5) Issue a certificate of compliance on approval of the application process and the inspection of the recovery residence.

(c) The requirements established by a credentialing entity under subsection (b)(1) of this section shall prohibit a certified recovery residence from:

(1) Refusing services to an individual based on the individual receiving medication–assisted treatment for opioid use disorder; and

(2) Requiring an individual to cease receiving or modify how the individual receives medication–assisted treatment for opioid use disorder before the individual may receive services at the recovery residence.

(d) A certificate of compliance issued by the credentialing entity is valid for 1 year from the date of issuance.

(e) The credentialing entity may revoke the certificate of compliance of a certified recovery residence if the credentialing entity finds that the recovery residence is not in compliance with the requirements established by the credentialing entity.

§19–2503.

(a) On or before October 1, 2017, the credentialing entity shall submit a list to the Department of the recovery residences that have obtained a certificate of compliance.

(b) (1) On or before November 1, 2017, the Department shall publish on its website:

(i) A list of each credentialing entity and the contact information for the credentialing entity; and

(ii) A list of each recovery residence operating in each county in the State.

(2) The list published under paragraph (1)(ii) of this subsection shall indicate whether the owner of a recovery residence has received a valid certificate of compliance.

(c) (1) On or before November 1, 2017, a credentialing entity shall publish on its website a list of each recovery residence that holds a valid certificate of compliance.

(2) The list published under paragraph (1) of this subsection shall include only the owner of the recovery residence and the contact information of the owner.

§19–2504.

(a) A person may not advertise, represent, or imply to the public that a recovery residence is a certified recovery residence unless the recovery residence has obtained a certificate of compliance under this subtitle.

(b) (1) A person who violates subsection (a) of this section is subject to a civil penalty imposed by the Department not exceeding $1,000 for each offense.

(2) In setting the amount of a civil penalty under paragraph (1) of this subsection, the Department shall consider the nature, number, and seriousness of the violations, the ability of the certified recovery residence to pay the penalty, and any other factors the Department determines are relevant.

§19–2505.

(a) In this section, "Program" means the Recovery Residence Grant Program.

(b) (1) There is a Recovery Residence Grant Program in the Department.

(2) The purpose of the Program is to provide grants to recovery residences in the State in accordance with this section.

(c) The Department shall administer the Program.

(d) The Program shall award competitive grants to recovery residences to support operations, services, and programs.

(e) To qualify for a grant under the Program, a recovery residence must:

(1) Be a nonprofit organization in good standing with the Internal Revenue Service;

(2) Submit a current copy of the Form 990 that the organization files with the Internal Revenue Service;

(3) Be certified by the credentialing entity as a Level I, Level II, or Level III recovery residence in accordance with the National Alliance for Recovery Residences standards;

(4) Not accept or receive reimbursement from private insurance or the Maryland Medical Assistance Program; and

(5) Meet any other requirement established by the Department in regulation.

(f) (1) The Department shall establish:

(i) Application procedures;

(ii) Criteria for prioritizing applications under the Program;

(iii) Procedures for awarding grants under the Program; and

(iv) Any other procedures or criteria necessary to carry out this section.

(2) In establishing procedures and criteria under this subsection, the Department shall consult the credentialing entity.

(g) For each of fiscal years 2024 through 2030, the annual budget bill shall include an appropriation of $500,000 for the Program.

(h) On or before December 1 each year, beginning in 2024, the Department shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report that includes, for the most recent closed fiscal year:

(1) The number of grants distributed; and

(2) Information about grant recipients and programs and services provided.

§19–2601.

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

(b) "Doula" means a nonmedical professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the prenatal, labor, and postpartum periods.

(c) "Hospital" means a hospital, as defined in § 19–301 of this title, that provides obstetric care.

(d) "Significant medical intervention" means a cesarean section, induction of labor, augmentation of labor, operative vaginal delivery, or episiotomy.

§19–2602.

(a) A hospital shall adopt and provide evidence to the Department that the hospital has:

(1) A doula policy that allows every birthing parent to have at least one doula present during birth in addition to authorized guests;

(2) An informed consent policy for significant medical intervention for the birthing parent; and

(3) A transfer acceptance policy that includes the hospital's process for receiving:

(i) A patient from a health care practitioner regulated under Title 8 of the Health Occupations Article who had provided services to a birthing parent in a home birth setting;

(ii) A birthing parent's or newborn's medical information from the home birth provider; and

(iii) A transfer from a licensed direct–entry midwife that is consistent with the requirements of § 8–6C–08 of the Health Occupations Article.

(b) A hospital shall provide evidence to the Department that the hospital has adopted a policy under subsection (a) of this section:

(1) (i) On or before January 1, 2026; or

(ii) If the hospital is established after January 1, 2026, on the establishment of the hospital; and

(2) Whenever the policy is updated.

(c) The Department shall adopt regulations to carry out this section, including regulations that establish the form and manner in which a hospital may prove to the Department that the hospital has adopted a policy in compliance with this section.

(d) The Department shall make the policies provided by a hospital under this section available to the public on request and in a manner determined by the Department.

(e) This section does not prohibit a hospital from setting a policy that restricts the number of doulas or authorized guests.

§20–101.

(a) Notwithstanding any other provision of law, a minor who is at least 17 years old, without the consent of a parent or legal guardian, may give blood to a program that:

(1) Is voluntary;

(2) Does not pay money for the blood; and

(3) Is approved by:

(i) The American Association of Blood Banks; or

(ii) The American Red Cross.

(b) (1) Notwithstanding any other provision of law, a minor who is at least 16 years old, and has obtained the consent of a parent or legal guardian, may give blood to the programs listed in subsection (a) of this section.

(2) Consent may be obtained via telephone or electronic means.

§20–102.

(a) A minor has the same capacity as an adult to consent to medical or dental treatment if the minor:

(1) Is married;

(2) Is the parent of a child; or

(3) (i) Is living separate and apart from the minor's parent, parents, or guardian, whether with or without consent of the minor's parent, parents, or guardian; and

(ii) Is self–supporting, regardless of the source of the minor's income.

(b) A minor has the same capacity as an adult to consent to medical treatment if, in the judgment of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.

(c) A minor has the same capacity as an adult to consent to:

(1) Treatment for or advice about drug abuse;

(2) Treatment for or advice about alcoholism;

(3) Treatment for or advice about venereal disease;

(4) Treatment for or advice about pregnancy;

(5) Treatment for or advice about contraception other than sterilization;

(6) Physical examination and treatment of injuries from an alleged rape or sexual offense;

(7) Physical examination to obtain evidence of an alleged rape or sexual offense;

(8) Initial medical screening and physical examination on and after admission of the minor into a detention center; and

(9) Treatment for the prevention of human immunodeficiency virus (HIV).

(c–1) The capacity of a minor to consent to treatment for drug abuse or alcoholism under subsection (c)(1) or (2) of this section does not include the capacity to refuse treatment for drug abuse or alcoholism in an inpatient or intensive outpatient alcohol or drug abuse treatment program certified under Title 8 of this article for which a parent or guardian has given consent.

(d) A minor has the same capacity as an adult to consent to psychological treatment as specified under subsection (c)(1) and (2) of this section if, in the judgment of the attending physician or a psychologist, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual.

(e) A licensed health care practitioner who treats a minor is not liable for civil damages or subject to any criminal or disciplinary penalty solely because the minor did not have capacity to consent under this section.

(f) Without the consent of or over the express objection of a minor, a licensed health care practitioner may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section, except information about an abortion.

§20–103.

(a) In this section, "qualified provider" means a physician, nurse practitioner, nurse–midwife, licensed certified midwife, physician assistant, or any other individual:

(1) Who is licensed, certified, or otherwise authorized by law to practice in the State; and

(2) For whom the performance of an abortion is within the scope of the individual's license or certification.

(b) Except as provided in subsections (c) and (d) of this section, a qualified provider may not perform an abortion on an unmarried minor unless the qualified provider first gives notice to a parent or guardian of the minor.

(c) The qualified provider may perform the abortion without notice to a parent or guardian if:

(1) The minor does not live with a parent or guardian; and

(2) A reasonable effort to give notice to a parent or guardian is unsuccessful.

(d) (1) The qualified provider may perform the abortion, without notice to a parent or guardian of a minor if, in the professional judgment of the qualified provider:

(i) Notice to the parent or guardian may lead to physical or emotional abuse of the minor;

(ii) The minor is mature and capable of giving informed consent to an abortion; or

(iii) Notification would not be in the best interest of the minor.

(2) The qualified provider is not liable for civil damages or subject to a criminal penalty for a decision under this subsection not to give notice.

(e) The postal receipt that shows an article of mail was sent by certified mail, return receipt requested, bearing a postmark from the United States Postal Service, to the last known address of a parent or guardian and that is attached to a copy of the notice letter that was sent in that article of mail shall be conclusive evidence of notice or a reasonable effort to give notice, as the case may be.

(f) A qualified provider may not provide notice to a parent or guardian if the minor decides not to have the abortion.

§20–104.

(a) In this section, "health care provider" means an individual who is:

(1) Licensed under the Health Occupations Article; and

(2) Acting within the scope of the individual's license to diagnose and treat mental and emotional disorders.

(b) (1) Subject to paragraph (2) of this subsection, a minor who is 12 years old or older who is determined by a health care provider to be mature and capable of giving informed consent has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by the health care provider or a clinic.

(2) The capacity of a minor to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a health care provider or a clinic under paragraph (1) of this subsection does not include the capacity to:

(i) Refuse consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has given consent; or

(ii) Except as otherwise provided in this subtitle, if the minor is under the age of 16 years, consent to the use of prescription medications to treat a mental or emotional disorder.

(c) (1) Except as provided in paragraph (2) of this subsection and subject to paragraph (3) of this subsection, without the consent of or over the express objection of a minor, the health care provider or, on advice or direction of the health care provider, a member of the medical staff of a hospital or public clinic may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section.

(2) Subject to paragraph (3) of this subsection, if a health care provider is on a treatment team for a minor that is headed by a physician, the physician heading the treatment team shall decide whether a parent, guardian, or custodian of the minor or the spouse of the parent should receive information about treatment needed by the minor or provided to the minor under this section.

(3) A health care provider may decide to provide information to a parent, guardian, or custodian of a minor under paragraphs (1) and (2) of this subsection unless the health care provider believes that the disclosure will lead to harm to the minor or deter the minor from seeking care.

(d) Unless the parent, guardian, or custodian of a minor consents to consultation, diagnosis, or treatment of the minor, the parent, guardian, or custodian is not liable for any costs of the consultation, diagnosis, or treatment of the minor under this section.

§20–105.

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

(2) "Informal kinship care" means a living arrangement in which a relative of a child, who is not in the care, custody, or guardianship of the local department of social services, provides for the care and custody of the child due to a serious family hardship.

(3) "Relative" means an adult related to the child by blood or marriage within the fifth degree of consanguinity.

(4) "Serious family hardship" means:

(i) Death of a parent or legal guardian of the child;

(ii) Serious illness of a parent or legal guardian of the child;

(iii) Drug addiction of a parent or legal guardian of the child;

(iv) Incarceration of a parent or legal guardian of the child;

(v) Abandonment by a parent or legal guardian of the child; or

(vi) Assignment of a parent or legal guardian to active uniformed services duty.

(b) A relative providing informal kinship care for a child may consent to health care on behalf of the child if:

(1) A court has not appointed a guardian for the child or awarded custody of the child to an individual other than the relative providing informal kinship care; and

(2) The relative verifies the informal kinship care relationship through a sworn affidavit that:

(i) Meets the requirements of this section; and

(ii) Is filed with the Department of Human Services, Social Services Administration.

(c) The affidavit shall include:

(1) The name and date of birth of the child;

(2) The name and address of the child's parent or legal guardian;

(3) The name and address of the relative providing informal kinship care;

(4) The date the relative assumed informal kinship care;

(5) The nature of the serious family hardship and why it resulted in informal kinship care; and

(6) The kinship relation to the child of the relative providing informal kinship care.

(d) The affidavit shall be in the following form:

(1) I, the undersigned, am over eighteen (18) years of age and competent to testify to the facts and matters set forth herein.

(2) _____ (name of child), whose date of birth is _____, is living with me because of the following serious family hardship (check each that is applicable):

_____ Death of father/mother/legal guardian
_____ Serious illness of father/mother/legal guardian
_____ Drug addiction of father/mother/legal guardian
_____ Incarceration of father/mother/legal guardian
_____ Abandonment by father/mother/legal guardian
_____ Assignment of father/mother/legal guardian to active uniformed services duty

(3) The name and last known address of the child's parent(s) or legal guardian is:

_____

_____

_____

(4) My kinship relation to the child is _____

(5) My address is:

_____

Street Apt. No.

_____

City State Zip Code

(6) I assumed informal kinship care of this child for 24 hours a day and 7 days a week on _____ (day/month/year).

(7) The name and address of the school that the child attends is:

_____

_____

(8) I solemnly affirm under the penalties of perjury that the contents of the foregoing are true to the best of my knowledge, information, and belief.

_____

Signature of affiant

_____

(Day/month/year)

(e) Affidavit forms that comply with subsection (d) of this section shall be made available free of charge at the offices of each county board of education and each local health department.

(f) If a change occurs in the care or in the serious family hardship of the child, the relative providing informal kinship care shall notify the Department of Human Services, Social Services Administration in writing within 30 days after the change occurs.

(g) The relative providing informal kinship care shall file an affidavit annually with the Department of Human Services, Social Services Administration for each year the child continues to live with the relative because of a serious family hardship.

(h) A copy of the affidavit shall be given to the health care provider that treats the child.

(i) The relative providing informal kinship care may apply on behalf of the child for all medical and public assistance entitlements for which the child may be eligible.

(j) An affidavit under this section does not abrogate the right of the parent or guardian of a child to consent to health care on behalf of the child in a future health care decision.

§20–106.

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

(2) "Phototherapy device" means any equipment that emits ultraviolet radiation and is used in the diagnosis or treatment of disease or injury.

(3) "Tanning device" means any equipment that emits radiation used for tanning of the skin, including sunlamps, tanning booths, or tanning beds.

(4) "Tanning facility" means any place where a tanning device is used for a fee, membership dues, or other compensation.

(b) (1) This section does not apply to the use of any phototherapy device by a health care practitioner acting within the scope of the license of the health care practitioner or by order of a health care practitioner acting within the scope of the license of the health care practitioner.

(2) Paragraph (1) of this subsection may not be construed to authorize a prescription to be written for a minor for the use of a tanning device.

(c) An owner, employee, or operator of a tanning facility may not allow a minor under the age of 18 years to use a tanning device.

(d) The owner, employee, or operator of a tanning facility shall:

(1) Require appropriate documentation to verify the age of an individual before allowing the individual access to a tanning device; and

(2) Ensure that the notice developed under subsection (e) of this section is posted in a conspicuous place in the tanning facility.

(e) The Department shall develop and make available to each tanning facility a notice that includes the following information:

(1) That it is unlawful for a tanning facility owner, employee, or operator to allow a minor to use any tanning device;

(2) That a tanning facility owner, employee, or operator that violates one or more provisions of this section may be subject to a civil penalty;

(3) That an individual may report a violation of one or more provisions of this section to the local law enforcement agency; and

(4) The health risks associated with tanning, including skin cancer, premature skin aging, injuries including burns, and adverse reactions when combined with certain medications, foods, and cosmetics.

(f) (1) The Secretary may impose on a person who violates this section:

(i) For a first violation, a civil penalty not to exceed $250;

(ii) For a second violation, a civil penalty not to exceed $500; and

(iii) For each subsequent violation, a civil penalty not to exceed $1,000.

(2) The Secretary may adopt regulations to implement and carry out this section.

§20–108.

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

(2) "Disabled individual" means an individual with actual or potential limitations in self-care, mobility, hygiene, vocation, family role, or coping mechanisms.

(3) "Reportable condition" means a:

(i) Spinal cord injury;

(ii) Stroke;

(iii) Amputation; or

(iv) Head injury.

(b) (1) Each hospital shall report to the Department within 7 days of the occurrence of a reportable condition.

(2) (i) The report shall contain the individual's name, age, residence, the type of disability, and any additional information that the Department requires.

(ii) The information collected under this section is confidential and not open to inspection nor considered a public record. The information shall only be used statistically for the use of the Department in the performance of its duties, except that the identities of individuals reported may be disclosed for research purposes in accordance with the criteria set forth in § 4–501(e) of the General Provisions Article.

(c) The report form shall be developed by the Department with input from physicians, disabled individuals, and consumer advocates. The Department shall be responsible for distributing the form to physicians and institutions.

(d) The Department shall establish a central registry to compile information about disabled individuals with reportable conditions.

(e) (1) Within 15 days of receiving a report of an individual with a reportable condition, the Department shall notify the individual or the individual's parent or guardian of any assistance or services that may be available from the State and of the eligibility requirements for such assistance or services.

(2) Upon request, the Department shall refer the individual to appropriate divisions of the Department and other agencies, public or private, which provide rehabilitation services for persons with reportable conditions.

(3) The Department shall make each public and private health and social agency aware of the rehabilitation information provided by the Department and advise them how to contact the Department to obtain the information.

(4) All other agencies of the State shall cooperate with the Department to provide available, appropriate rehabilitation services to an individual with a reportable condition who meets the eligibility requirements for such services.

§20–109.

(a) In this section, "Alzheimer's special care unit or program" means a secured or segregated special unit or program specifically designed for individuals with a probable or confirmed diagnosis of Alzheimer's disease or a related disorder.

(b) An assisted living program that provides care for or offers to provide care for persons with Alzheimer's disease or a related disorder by means of an Alzheimer's special care unit or program, shall disclose how the form of care and treatment provided by the Alzheimer's special care unit or program is specifically designed for the specialized care of individuals diagnosed with Alzheimer's disease or a related disorder.

(c) At the time of licensure, an assisted living program with an Alzheimer's special care unit or program shall send to the Department a written description of the special care unit or program.

(d) An assisted living program with an Alzheimer's special care unit or program shall disclose the written description of the special care unit to:

(1) Any person on request; and

(2) The family or party responsible for any resident prior to admission of the resident to the Alzheimer's special care unit or program.

(e) The description of the Alzheimer's special care unit or program shall include:

(1) A statement of philosophy or mission;

(2) Staff training and staff job titles;

(3) Admission procedures including screening criteria;

(4) Assessment and care planning protocol;

(5) Staffing patterns;

(6) A description of the physical environment and any unique design features appropriate to support the functioning of cognitively impaired individuals;

(7) A description of activities including frequency and type;

(8) Charges to residents for services provided by the Alzheimer's special care unit or program;

(9) Discharge procedures;

(10) Any services, training, or other procedures that are over and above those that are provided in the existing assisted living program; and

(11) Any other information that the Department may require.

(f) The Department, in consultation with the Alzheimer's Association, the Health Facilities Association of Maryland, and Lifespan, may adopt regulations that govern the submission of disclosure materials to the Department and to consumers.

§20–110.

(a) Except as provided in subsection (b) of this section, the following are not civilly liable for taking a blood sample from an individual without consent of the individual or for testing the blood sample, if the blood is taken at the request of a police officer or a sheriff or officer in a sheriff's office for a criminal investigation:

(1) A licensed hospital.

(2) A physician.

(3) Any of the following who take the blood in the course of duties at a licensed hospital:

(i) A resident.

(ii) An intern.

(iii) A registered nurse.

(iv) A health career technician.

(b) A person who negligently takes blood samples in a manner otherwise than according to accepted medical practices or who negligently performs tests is subject to civil liability for injury resulting from the person's negligence.

§20–111.

(a) (1) This section applies to the use of sperm or eggs from a donor known to the individual who intends to become a parent through the use of the sperm or eggs.

(2) This section does not apply to the use of sperm or eggs donated to a tissue bank or fertility clinic by a donor who intended to remain anonymous either indefinitely or until a child that results from the use of the sperm or eggs becomes an adult.

(b) A person may not use sperm or eggs from a known donor after the donor's death for the purpose of assisted reproduction, if:

(1) The person knows that the known donor died and did not give consent for the posthumous use of the sperm or eggs; or

(2) The donor or the individual who intends to become a parent through the use of the sperm or eggs receives any remuneration for the donation or use of the sperm or eggs.

(c) A donor's consent to the posthumous use of the donor's sperm or eggs given on or after October 1, 2012 is not valid unless it is:

(1) In writing; and

(2) Signed by the donor or by some other person for the donor, in the presence of the donor, and at the express direction of the donor.

(d) A person who violates this section is guilty of a misdemeanor and on conviction is subject to:

(1) For a first offense, a fine not exceeding $1,000; and

(2) For a second or subsequent offense, a fine not exceeding $5,000.

§20–113.

(a) Before a physician treats any patient for any form of breast cancer, the physician shall educate the patient of alternative methods of treatment that may be medically practicable.

(b) The Maryland Department of Health shall:

(1) Provide a standardized written summary in layman's language that:

(i) Lists all effective methods of treatment for breast cancer that may be medically practicable including surgical, radiological, chemotherapeutic, and combinations of those treatments; and

(ii) Describes the advantages, disadvantages, risks, and procedures associated with each method of treatment listed;

(2) Update the standardized written summary annually; and

(3) Distribute the standardized written summary to each hospital, clinic, and physician's office and other facility that performs treatments of breast cancer.

(c) A physician satisfies the requirements of subsection (a) of this section if:

(1) The physician provides a breast cancer patient with the standardized written summary described in subsection (b) of this section in language that the patient understands;

(2) The patient receives the standardized written summary within 5 days of the start of the treatment for breast cancer; and

(3) The patient signs a statement provided by the Maryland Department of Health acknowledging the receipt of the standardized written summary.

(d) This section does not apply if the attending physician certifies that:

(1) Treatment for breast cancer occurred within 5 days of the physician informing the patient of the diagnosis; and

(2) Treatment within this period of time was necessary to save the life of the patient.

(e) A physician who violates any provision of subsection (a) of this section is subject to the provisions of § 14–404(a)(27) of the Health Occupations Article.

§20–114.

(a) Before a physician operates on a patient to insert a breast implant, the physician shall inform the patient of the advantages, disadvantages, and risks associated with a breast implantation.

(b) The Department shall:

(1) Provide a standardized written summary in layman's language that:

(i) Contains all the information on breast implantation generally contained in the information sheet for the breast implant; and

(ii) Discloses side effects, warnings, and cautions for a breast implantation operation;

(2) Update as necessary the standardized written summary; and

(3) Distribute the standardized written summary to each hospital, clinic, and physician's office and any other facility that performs breast implantations.

(c) A physician satisfies the requirements of subsection (a) of this section if:

(1) The physician provides the breast implantation patient with the standardized written summary described in subsection (b) of this section;

(2) The patient receives the standardized written summary 5 days before the breast implantation operation; and

(3) The patient signs a statement provided by the Department acknowledging the receipt of the standardized written summary.

§20–115.

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

(2) (i) "Center" means any facility that produces, develops, or interprets:

1. Screening mammograms; or

2. Diagnostic mammograms.

(ii) "Center" includes a hospital, outpatient department, medical laboratory, clinic, radiology practice, office of a health care provider, or other testing facility conducting mammography testing.

(iii) "Center" does not include a facility of the federal Department of Veterans Affairs.

(3) "Dense breast tissue" means heterogeneously dense or extremely dense tissue as defined in nationally recognized guidelines or systems for breast

imaging reporting of mammography screening, including the breast imaging reporting and data system of the American College of Radiology.

(4) "Mammogram" means a radiographic image produced through mammography.

(5) "Mammography testing" means the imaging of the breast with ionizing radiation.

(b) On or after July 1, 1992, a person may not perform mammography testing unless:

(1) The individual performing mammography testing is qualified under Title 14 of the Health Occupations Article; and

(2) The center where the mammography testing is performed:

(i) Is accredited or has applied for accreditation under the American College of Radiology Screening Mammography Accreditation Program; and

(ii) Has obtained a certificate of approval from the federal Food and Drug Administration as specified in the federal Mammography Quality Standards Act of 1992.

(c) (1) (i) This subsection does not apply if the federal Mammography Quality Standards Act of 1992, or regulations adopted under the Act, requires a notice regarding breast density to be included in the screening results letter that is sent to a patient.

(ii) This subsection may not be construed to:

1. Require a notice regarding breast density to be sent to a patient that is inconsistent with the provisions of the federal Mammography Quality Standards Act of 1992, or regulations adopted under the Act; or

2. Create a standard of care, obligation, or duty that provides a basis for a cause of action.

(2) Subject to paragraph (3) of this subsection, a center where mammography testing is performed shall include in a screening results letter that is sent to a patient, as required by federal law, the following notice: "This notice contains the results of your recent mammogram, including information about breast density.

If your mammogram shows that your breast tissue is dense, you should know that dense breast tissue is a common finding and is not abnormal, with about half of women having dense or highly dense breasts. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with an increased risk of cancer.

This information about the result of your mammogram is given to you to raise your awareness and to inform your conversations with your physician. Together, you can decide whether additional screening options are right for you based on your mammogram results, individual risk factors, or physical examination. A report of your results was sent to your physician.".

(3) If the Department finds significant differences between the content of the notice that is required to be provided under paragraph (2) of this subsection and current medical evidence on breast density, the Department may adopt regulations that change the content of the notice.

(d) (1) This subsection may not be construed to create a standard of care, obligation, or duty that provides a basis for a cause of action.

(2) Subject to paragraph (3) of this subsection, a center where mammography testing is performed shall include in a screening results letter that is sent to a patient, as required by federal law, the following notice:

"This notice contains the results of your recent mammogram, including information about breast arterial calcification.

If your mammogram shows breast arterial calcification, you should know that breast arterial calcification is a common finding. However, breast arterial calcification may be an indicator of an increased risk of cardiovascular disease. If you have breast arterial calcifications, please discuss this with your physician to assess your cardiovascular risks and determine if additional testing may be appropriate for you.

This information about the result of your mammogram is given to you to raise your awareness and to inform your conversations with your physician. Together you can decide whether additional screening options are right for you based on your mammogram results, individual risk factors, or physical examination. A report of your results was sent to your physician.".

(3) If the Department finds significant differences between the content of the notice that is required to be provided under paragraph (2) of this subsection and current medical evidence on breast arterial calcification, the Department may adopt regulations that change the content of the notice.

(e) Notwithstanding any other provision of this title, the penalty for a violation of subsection (b) of this section may not exceed $1,000.

§20–116.

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

(2) "Biennial" means once every other year.

(3) "Clinical breast examination" means a breast examination performed by a health care professional for the purpose of detecting breast cancer.

(4) "Eligible individual" means an individual who is eligible to receive benefits under the Program in accordance with subsection (e) of this section.

(5) "Mammogram" means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films, and cassettes, specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast.

(6) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

(7) "Program" means the Breast Cancer Program.

(b) (1) The Department shall establish a Breast Cancer Program.

(2) The purpose of the Program is to:

(i) Provide at least biennial screening mammograms and clinical breast examinations to low-income, underinsured and low-income, uninsured women aged 40 years to 49 years;

(ii) Provide annual screening mammograms and clinical breast examinations to low-income, underinsured and low-income, uninsured women aged 50 years and older; and

(iii) Provide diagnosis and treatment for individuals who are identified by this Program as being in need.

(c) Treatment provided to a Program participant who has undergone a mastectomy shall include:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) Prostheses; and

(4) Any physical complications related to the mastectomy.

(d) The Department shall administer the Program through the local health departments using a grant program under which a local health department makes arrangements with health care facilities to provide screening mammograms and clinical breast examinations to eligible individuals.

(e) An individual is eligible for the Program if the individual:

(1) Has a family income that does not exceed 250% of the federal poverty level; and

(2) Does not have access to health insurance coverage that covers screening mammograms and clinical breast examinations for women aged 40 years and older.

(f) For each fiscal year, the Governor shall include an appropriation of general funds to the Program in an amount not less than the amount appropriated for breast cancer screening, diagnosis, and treatment in the State budget for fiscal year 1999, subject to the availability of State funds.

(g) The Department shall:

(1) Adopt regulations necessary to implement the Program; and

(2) Work with all interested parties to assure that breast cancer screening services are available to women at least 40 years old.

§20–117.

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

(2) "Cancer research" includes research to develop and advance the understanding of cancer and the techniques and modalities effective in the prevention, cure, screening, and treatment of cancer.

(3) "Fund" means the Maryland Cancer Fund established under this section.

(4) "Income tax checkoff system" means the checkoff system established under § 2–112 of the Tax – General Article.

(b) (1) There is a Maryland Cancer Fund.

(2) The net proceeds from contributions under the income tax checkoff system and any other donations to the Fund shall be credited to the Fund.

(3) The Secretary shall administer the Fund.

(4) The Fund shall be used only for cancer research, prevention, and treatment as provided in subsection (c) of this section.

(5) The Fund shall be maintained for the purposes stated in this section and unspent portions of the Fund shall remain in the Fund and may not revert to the General Fund of the State.

(6) Money expended from the Fund for cancer research, prevention, and treatment is supplemental and is not intended to take the place of funding that would otherwise be appropriated to the Department for cancer research, prevention, and treatment.

(7) All expenditures from the Fund shall be made only in accordance with an appropriation approved by the General Assembly in the annual State budget or through an approved budget amendment under §§ 7–209 and 7–210 of the State Finance and Procurement Article.

(c) (1) The Secretary may distribute not more than 5% of the net proceeds of the Fund to a promotional account to be used to promote further donations to the Fund.

(2) After making the distribution allowed under paragraph (1) of this subsection, the Secretary shall use the remainder of the net proceeds of the Fund only to provide grants to eligible physicians, hospitals, laboratories, educational institutions, and other organizations and persons to conduct cancer research, prevention, and treatment.

(d) (1) On or before August 31 of each year, the Secretary shall submit a report to the General Assembly, pursuant to § 2–1257 of the State Government Article, on the administration of the Maryland Cancer Fund.

(2) The report required under this subsection shall include:

(i) The gross amount of donations to the Fund through the income tax checkoff system and otherwise;

(ii) The costs of administration by the Comptroller of the income tax checkoff system;

(iii) A description of promotional efforts undertaken with money from the Fund; and

(iv) A detailed accounting of the use of the Fund.

(e) The Secretary shall adopt regulations to implement a Maryland Cancer Grant Program under this section.

§20–120.

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

(2) "Fund" means the Maryland Pediatric Cancer Fund established under this section.

(3) "Pediatric cancer research" includes research to develop and advance the understanding of pediatric cancer and the techniques and modalities effective in the prevention, cure, screening, and treatment of pediatric cancer.

(b) (1) There is a Maryland Pediatric Cancer Fund.

(2) The Fund consists of:

(i) Money appropriated in the State budget to the Fund; and

(ii) Any donations or other money from any other source accepted for the benefit of the Fund.

(3) The Secretary shall administer the Fund.

(4) The Fund shall be used only for pediatric cancer research and administrative expenses as provided in subsection (c) of this section.

(5) The Fund shall be maintained for the purposes stated in this section and unspent portions of the Fund shall remain in the Fund and may not revert to the General Fund of the State.

(6) Money expended from the Fund for pediatric cancer research is supplemental and is not intended to take the place of funding that would otherwise be appropriated to the Department for pediatric cancer research.

(7) All expenditures from the Fund shall be made only in accordance with an appropriation approved by the General Assembly in the annual State budget or through an approved budget amendment under §§ 7–209 and 7–210 of the State Finance and Procurement Article.

(8) (i) For fiscal year 2023, the Governor shall include in the annual budget bill an appropriation of $5,000,000 to the Fund.

(ii) If $5,000,000 is not included in the annual budget bill for fiscal year 2023, then the Governor shall include in the annual budget bill for fiscal year 2024 an appropriation of $5,000,000 to the Fund.

(c) (1) (i) Each year, the Secretary may:

1. Distribute funds from the Fund to a promotional account to be allocated to a State–based childhood cancer organization to be used to promote further donations to the Fund and to educate the State scientific community about the opportunities for childhood cancer research through the Fund; and

2. Use funds from the Fund to administer the Fund, including for staff and administrative costs associated with the Commission established under § 20–121 of this title.

(ii) The amounts distributed and used under subparagraph (i) of this paragraph may not exceed a total of 5% of the Fund.

(2) (i) After making the distribution allowed under paragraph (1) of this subsection, the Secretary shall use the remainder of the Fund only to provide grants to nonprofit hospitals, educational institutions, and other nonprofit organizations to conduct pediatric cancer research.

(ii) Money received from the grant program under this section may not be used to pay for institutional overhead expenses, organizational expenses, or charges that are not directly related to pediatric cancer research or expenses arising from community–based support services.

(d) (1) On or before August 31 each year, the Secretary shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the administration of the Fund.

(2) The report required under this subsection shall include:

(i) A description of promotional efforts undertaken with money from the Fund; and

(ii) A detailed accounting of the use of the Fund.

(e) The Secretary shall adopt regulations to implement a pediatric cancer grant program under this section.

§20–121.

(a) In this section, "Commission" means the Pediatric Cancer Research Commission.

(b) There is a Pediatric Cancer Research Commission.

(c) The purpose of the Commission is to oversee the award of competitive grants from the Pediatric Cancer Fund, established under § 20–120 of this subtitle, to public and private entities in the State.

(d) The Commission consists of:

(1) The Secretary of Health, or the Secretary's designee; and

(2) The following members appointed by the Governor:

(i) Two individuals who are adult survivors of pediatric cancer or caregivers of pediatric cancer patients, who may be identified in consultation with the American Childhood Cancer Organization;

(ii) One representative of the American Childhood Cancer Organization;

(iii) Four scientists with expertise in pediatric cancer research;

(iv) Two advanced practice registered nurses who have experience in pediatric cancer care; and

(v) Three physicians with expertise in treating pediatric cancer patients.

(e) (1) The term of an appointed member is 3 years.

(2) The terms of the appointed members of the Commission are staggered as required by the terms provided for members of the Commission on October 1, 2024.

(3) If a vacancy occurs during the term of an appointed member, the Governor shall appoint a successor who shall serve until the term expires.

(4) At the end of a term, a member may continue to serve only until a successor is appointed and qualifies.

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

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

(f) Each member of the Commission shall disclose to the State Ethics Commission whether the member is employed by or has a financial interest in an entity that may apply to conduct State–funded pediatric cancer research.

(g) (1) The Governor may remove a member for neglect of duty, incompetence, misconduct, malfeasance, misfeasance, nonfeasance, or any other sufficient cause.

(2) The Governor may not remove a member for political party preference.

(h) (1) A majority of the full authorized membership of the Commission is a quorum.

(2) The decision of the Commission shall be by a majority of the quorum present and voting.

(i) The Commission shall meet at least twice a year, at the times and places that it determines.

(j) A member of the Commission:

(1) May not receive compensation as a member of the Commission; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(k) The Commission annually shall elect a chair and vice chair from among its members.

(l) The Commission shall:

(1) Develop criteria, standards, and requirements for the review of applications for pediatric cancer research grants from the Pediatric Cancer Fund;

(2) Establish procedures and guidelines to be used in the review, evaluation, ranking, and rating of the research grant proposals;

(3) Develop criteria and a process for reviewing grant applications to ensure that each application is complete and satisfies the criteria, standards, and requirements developed by the Commission under item (1) of this subsection;

(4) Develop disclosure and recusal guidelines to be followed by members of the Commission when considering grant applications;

(5) Establish standards for the oversight of awards; and

(6) Conduct progress reviews of grant recipients.

(m) The Commission may consult with experts in performing its duties.

§20–207.

In Part II of this subtitle, "qualified provider" means an individual:

(1) Who is licensed, certified, or otherwise authorized by law to practice in the State; and

(2) For whom the performance of an abortion is within the scope of the individual's license or certification.

§20–208.

An abortion must be performed by a qualified provider.

§20–209.

(a) In this section, "viable" means that stage when, in the best clinical judgment of the qualified provider based on the particular facts of the case before the qualified provider, there is a reasonable likelihood of the fetus's sustained survival outside the womb.

(b) Except as otherwise provided in this subtitle, the State may not interfere with the decision of a woman to terminate a pregnancy:

(1) Before the fetus is viable; or

(2) At any time during the woman's pregnancy, if:

(i) The termination procedure is necessary to protect the life or health of the woman; or

(ii) The fetus is affected by genetic defect or serious deformity or abnormality.

(c) The Department may adopt regulations that:

(1) Are both necessary and the least intrusive method to protect the life or health of the woman; and

(2) Are not inconsistent with established clinical practice.

(d) The qualified provider is not liable for civil damages or subject to a criminal penalty for a decision to perform an abortion under this section made in good faith and in the qualified provider's best clinical judgment in accordance with accepted standards of clinical practice.

§20–214.

(a) (1) A person may not be required to perform or participate in, or refer to any source for, any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy.

(2) The refusal of a person to perform or participate in, or refer to a source for, these medical procedures may not be a basis for:

(i) Civil liability to another person; or

(ii) Disciplinary or other recriminatory action against the person.

(b) (1) Except as provided in § 19–342.1 of this article, a licensed hospital, hospital director, or hospital governing board may not be required:

(i) To allow, within the hospital, the performance of any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy; or

(ii) To refer to any source for these medical procedures.

(2) The refusal to allow or to refer to a source for these procedures may not be grounds for:

(i) Civil liability to another person; or

(ii) Disciplinary or other recriminatory action against the person by this State or any person.

(c) (1) The refusal of an individual to submit to or give consent for an abortion or sterilization may not be grounds for loss of any privileges or immunities to which the individual otherwise would be entitled.

(2) Submitting to or granting consent for an abortion or sterilization may not be a condition precedent to the receipt of any public benefits.

(d) Notwithstanding any other provision of this section, a health care provider, a licensed hospital, a hospital director, or a hospital governing board is not immune from civil damages, if available at law, or from disciplinary or other recriminatory action, if the failure to refer a patient to a source for any medical procedure that results in sterilization or termination of pregnancy would reasonably be determined as:

(1) The cause of death or serious physical injury or serious long-lasting injury to the patient; and

(2) Otherwise contrary to the standards of medical care.

§20–301.

(a) In this subtitle, "nuisance" means a condition that is dangerous to health or safety including:

(1) An inadequately protected swimming pool;

(2) An unprotected open ditch;

(3) An unsanitary outhouse;

(4) A foul pigpen;

(5) An improperly functioning sewage system;

(6) An unkempt junkyard;

(7) An unkempt scrap metal processing facility;

(8) An excessive accumulation of trash or garbage;

(9) A dead animal;

(10) A contaminated water supply;

(11) An inadequately protected water supply;

(12) A rodent harborage;

(13) Poor housekeeping that could endanger the health of the owner, occupant, employee, or a neighbor; or

(14) Any condition that may endanger health that may be transmitted by means including:

(i) Running streams;

(ii) Surface drainage;

(iii) Air currents;

(iv) Birds;

(v) Domestic animals; or

(vi) Human beings.

(b) "Nuisance" does not include:

(1) Any condition resulting from a farm operation following generally accepted agricultural practices that are not creating a condition dangerous to health or safety; or

(2) Any condition resulting from a commercial fishing or seafood operation following generally accepted industry standards and processes that are not creating a condition dangerous to health or safety.

§20–301.1.

Notwithstanding the provisions of Title 10 of the Environment Article, the Secretary is responsible for the general care of the sanitary interests of the people of the State.

§20–302.

The Secretary or a local health officer may investigate a suspected nuisance and devise means for the control of the nuisance.

§20–303.

(a) The Secretary may adopt rules and regulations to govern the character and location of:

(1) Plumbing;

(2) Drainage;

(3) Water supply;

(4) Offensive trades; and

(5) Disposal of any waste material, including sewage or garbage.

(b) The Secretary may adopt rules and regulations to govern the sanitary condition of:

(1) Streets;

(2) Cesspools;

(3) Outhouses; and

(4) Any sanitary feature connected with any of these.

§20–304.

The Secretary may enter on and inspect any private property to determine whether a nuisance exists.

§20–305.

The Secretary or a local health officer may bring an action to enjoin any person from committing any nuisance subject to this subtitle.

§20–306.

(a) The health officer for each county:

(1) May investigate any suspected nuisance; and

(2) Shall investigate and report on the sanitary conditions of schools, places of business, and places of employment in the county.

(b) (1) If the health officer finds that a nuisance exists, the health officer shall serve a written notice to the person who is causing the nuisance, ordering the person to abate the nuisance within a time specified in the notice.

(2) The notice shall be served:

(i) On the person who is causing the nuisance; or

(ii) If the person who is causing the nuisance cannot be found, on the owner or occupant of the property where the nuisance exists.

(c) Failure to comply with the requirements of a notice served under this section is a violation of this subtitle.

(d) If a question arises between health officers as to the jurisdiction or duties of a health officer in the abatement of a nuisance, the question shall be referred to the Secretary for resolution.

(e) (1) A health officer may file a complaint in the circuit court for the county where the nuisance exists if:

(i) The person served with the notice under this section fails to comply with the requirements of the notice; or

(ii) Although the person served with a notice under this section complies with the requirements of the notice, the nuisance is likely to recur on the same property.

(2) A complaint filed under this subsection may seek a court order requiring the individual served with a notice under subsection (b) of this section to:

(i) Comply with the requirements of the health officer's abatement notice;

(ii) Abate the nuisance within a specified time;

(iii) Prevent the nuisance from recurring; or

(iv) Pay a fine of not more than $1,000.

§20–307.

(a) The Secretary may investigate any suspected nuisance.

(b) (1) If the Secretary finds that a nuisance exists, the Secretary shall serve a written notice to the person who is causing the nuisance, ordering the person to abate the nuisance within a time specified in the notice.

(2) The notice shall be served:

(i) On the person who is causing the nuisance; or

(ii) If the person who is causing the nuisance cannot be found, on the owner or occupant of the property where the nuisance exists.

(c) (1) The Secretary may file a complaint in the circuit court for the county where the nuisance exists if:

(i) The person served with the notice fails to comply with the requirements of the notice; or

(ii) Although the person served complies with the requirements of the notice, the nuisance is likely to recur on the same property.

(2) A complaint filed under this subsection may seek a court order requiring the person served with the notice to:

(i) Comply with the requirements of the Secretary's abatement notice;

(ii) Abate the nuisance within a time specified in the order;

(iii) Prevent the nuisance from recurring; or

(iv) Pay a fine of not more than $1,000.

§20–308.

(a) If, after investigation, the Secretary or a local health officer finds that a nuisance exists that presents an immediate hazard to public health, the Secretary or local health officer may summarily abate the nuisance.

(b) Before summarily abating a nuisance under this section, the Secretary or a local health officer shall:

(1) Serve an abatement order on the owner of the property where the nuisance exists or, if the owner cannot be found, on the occupant or tenant of the property; or

(2) If the property is unoccupied and the owner cannot be found, attach an abatement order to the property where the nuisance exists.

(c) (1) The abatement order shall require and state:

(i) A time period within which the owner, occupant, or tenant of the property where the nuisance exists shall abate the nuisance; and

(ii) The work and materials necessary to abate the nuisance.

(2) The time period within which to abate the nuisance may not be less than 24 hours nor more than 5 days from the date and hour that the order is served.

(d) (1) If the owner, occupant, or tenant served with an abatement order fails to abate or only partially abates the nuisance within the time specified in the order, the Secretary, local health officer, or the representative of the Secretary or local health officer shall:

(i) Enter on the property; and

(ii) At the expense of the owner, occupant, or tenant of the property, do any work and use any materials necessary to abate the nuisance.

(2) The Secretary or local health officer may not expend more than $5,000 to abate the nuisance.

(e) If, within 60 days after the Secretary or local health officer has completed an abatement under this section, the owner, occupant, or tenant does not pay to the Secretary or local health officer the cost of the abatement, the Secretary or local health officer shall file suit against the owner, occupant, or tenant in the District Court for the county where the nuisance was abated.

(f) A person may not:

(1) Interfere with the Secretary, local health officer, or the representative of the Secretary or local health officer summarily abating a nuisance under this section; or

(2) Refuse to allow the Secretary, local health officer, or the representative of the Secretary or local health officer to enter on any property for the purpose of summarily abating a nuisance under this section.

§20–309.

A person who fails to comply with the requirements of a notice served under § 20-306 or § 20-307 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

§20–310.

(a) A person who fails to exercise due diligence under a court order to abate a condition under § 20-306 or § 20-307 of this subtitle is guilty of a misdemeanor and on conviction is subject to:

(1) A fine not exceeding $1,000; and

(2) The cost of prosecution.

(b) A person who knowingly or willfully acts contrary to a court order to abate a condition under § 20-306 or § 20-307 of this subtitle is guilty of a misdemeanor and on conviction is subject to:

(1) A fine not exceeding $1,000; and

(2) The cost of prosecution.

§20–311.

In addition to any other penalty provided by law, a person is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 30 days or both, if the person:

(1) Interferes with the Secretary, local health officer, or the representative of the Secretary or local health officer summarily abating a nuisance under § 20-308 of this subtitle; or

(2) Refuses to allow the Secretary, local health officer, or the representative of the Secretary or local health officer to enter on any property for the purpose of summarily abating a nuisance under § 20-308 of this subtitle.

§20–312.

(a) The Secretary may adopt regulations to implement the provisions of this subtitle.

(b) A person who violates any rule or regulation that the Secretary adopts under this subtitle is guilty of a misdemeanor.

§20–313.

In Cecil County or Allegany County, in addition to any other penalty imposed by this subtitle, a person who refuses or neglects to comply with a notice or order to abate a nuisance by the Secretary, or by the health officer for the county where the nuisance exists, is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 a day for each day the violation continues.

§20–314.

Sections 20-310 through 20-313 of this subtitle may not be construed to abrogate any equitable or legal right or remedy otherwise available under the law to abate a nuisance.

§20–401.

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

(b) "Born" means the complete expulsion or extraction of a product of human conception from the mother, regardless of the period of gestation, if, after the expulsion or extraction, it breathes or shows any other evidence of life, such as heartbeat, pulsation of the umbilical cord, or definite movement of voluntary muscle, whether or not the umbilical cord is cut or the placenta is attached.

(c) "Cord blood sampling" means:

(1) Taking a sample of a newborn infant's blood from the infant's umbilical cord; or

(2) The act of producing such a sample.

(d) "Footprinting" means:

(1) An ink or other type of impression of the skin patterns located on the sole of a foot; or

(2) The act of producing such an impression.

(e) "Institution" means:

(1) A hospital or related institution as defined in § 19-301 of this article;

(2) A freestanding birthing center as defined in § 19-3B-01(f) of this article; or

(3) Any other facility that delivers an infant from its mother.

§20–402.

(a) Except as provided in subsection (b) of this section, after an infant is born in an institution and before the infant leaves the delivery room of the institution, the institution shall perform at least one of the following infant identification procedures on all newborn infants:

(1) Cord blood sampling;

(2) Footprinting; or

(3) Any other procedure the Secretary deems equivalent and appropriate.

(b) (1) An institution shall maintain the record of a newborn infant's identification for a period of time the Secretary establishes by regulation.

(2) In establishing the regulations required under paragraph (1) of this subsection, the Secretary shall:

(i) Consider the varying nature of infant identification procedures that may be used by an institution under this subtitle; and

(ii) Adopt appropriate time periods for each type of infant identification procedure.

(c) All personnel of an institution responsible for performing newborn infant identification procedures under this subtitle shall be adequately trained in all infant identification procedures used by the institution.

(d) An institution acting in good faith in accordance with the provisions of this subtitle may not be liable in any cause of action related to the failure to produce an identifiable newborn infant identification.

§20–601.

In this subtitle, "female genital mutilation" means a procedure performed for nonmedical reasons that involves partial or total removal of or other injury to the external female genitalia, including:

(1) A clitoridectomy or the partial or total removal of the clitoris, prepuce, or clitoral hood;

(2) Excision or the partial or total removal, with or without excision of the clitoris, of the labia minora, with or without removal of the labia majora;

(3) Infibulation or the narrowing of the vaginal opening, with or without excision of the clitoris; or

(4) Any other procedure that is harmful to the external female genitalia, including pricking, piercing, incising, scraping, or cauterizing the genital area.

§20–602.

(a) Except as provided in § 20–603 of this subtitle, a person may not:

(1) Knowingly perform, attempt to perform, or conspire to perform female genital mutilation on an individual who is under the age of 18 years; or

(2) Transport an individual who is under the age of 18 years out of the State for the purpose of performing or facilitating the performance of female genital mutilation on the individual.

(b) Except as provided in § 20–603 of this subtitle, a parent, guardian, or other individual is guilty of female genital mutilation if the individual:

(1) Is legally responsible and charged with the care or custody of a child under the age of 18 years; and

(2) Knowingly consents to the performance of female genital mutilation on the child.

§20–603.

(a) A surgical operation is not a violation of this subtitle if the operation is necessary to the health of the individual on whom it is performed and is performed by a person licensed in the State as a medical practitioner.

(b) In determining whether an operation is necessary to the health of the individual, no account may be taken of the belief on the part of any individual that the operation is required as a matter of custom or ritual.

§20–604.

(a) A person who violates the provisions of this subtitle is guilty of a felony and on conviction is subject to imprisonment not exceeding 10 years or a fine not exceeding $10,000 or both.

(b) If an individual who holds a license issued under the Health Occupations Article is convicted of, enters a plea of guilty or of nolo contendere for, or receives probation before judgment for a violation of this subtitle, the applicable health occupations board shall revoke the license of the individual.

§20–605.

(a) A victim of female genital mutilation performed in violation of this subtitle may file an action in the circuit court in the county in which the violation occurred or the victim resides.

(b) If the court finds that a person violated this subtitle, the court may award the plaintiff:

(1) Actual damages;

(2) Compensatory damages;

(3) Punitive damages;

(4) Reasonable attorney's fees, court costs, and litigation expenses, including expert witness fees and expenses; and

(5) Any other appropriate relief.

(c) An action brought under subsection (a) of this section shall be filed the later of:

(1) Not more than 10 years after the date on which the violation occurred; or

(2) The date on which the victim of the violation reaches 28 years of age.

§20–606.

(a) On or before December 1 each year, beginning in 2027, the Department, in consultation with the Social Services Administration, State and local law enforcement agencies, and other appropriate government agencies and public and private organizations, shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, containing de–identified and disaggregated data on the number of:

(1) Reports of female genital mutilation submitted in accordance with § 5–704 of the Family Law Article;

(2) Individuals prosecuted for a violation of this subtitle;

(3) Individuals convicted of a violation of this subtitle;

(4) Civil actions filed in accordance with this subtitle; and

(5) Civil actions under this subtitle in which a judgment was entered, whether by settlement or adjudication.

(b) The Department shall make the report required under subsection (a) of this section available to the public.

§20–607.

The Department, in collaboration with community–based organizations, shall:

(1) Develop and publish culturally and linguistically appropriate educational materials on female genital mutilation, including:

(i) The signs that an individual has been subjected to female genital mutilation;

(ii) The physical and mental health risks caused by female genital mutilation; and

(iii) The criminal penalties for a violation of this subtitle; and

(2) Distribute the educational materials described under item (1) of this section to:

(i) Health care providers;

(ii) Law enforcement agencies;

(iii) Schools;

(iv) The public; and

(v) Any other professional or community–based organizations that may work or interact with individuals who are at risk of female genital mutilation.

§20–701.

(a) This section applies only in:

(1) Allegany County;

(2) Anne Arundel County;

(3) Charles County;

(4) Harford County;

(5) Kent County;

(6) Montgomery County;

(7) Prince George's County;

(8) Somerset County;

(9) Talbot County; and

(10) Wicomico County.

(b) A physician, pharmacist, dentist, or nurse who treats an individual for an injury that was caused or shows evidence of having been caused by an automobile accident or a lethal weapon, or the individual in charge of a hospital that treats the injured individual, shall notify the county sheriff, the county police, or the Department of State Police of the injury as soon as practicable.

(c) A report of injury shall include:

(1) The injured individual's name and address, if known;

(2) A description of the injury; and

(3) Any other facts concerning the matter that might assist in detecting crime.

(d) An individual who fails to make a report required by this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $25.

§20–702.

(a) In this section, "moving vessel" means a vessel as defined in § 8-701 of the Natural Resources Article that:

(1) Is in the water; and

(2) Is not anchored or tied to a fixed object.

(b) (1) A physician, pharmacist, dentist, or nurse who treats an individual for an injury that was caused or shows evidence of having been caused by an accident involving a moving vessel, or the individual in charge of a hospital that treats the injured individual, shall notify the county sheriff, the county police, the Department of State Police, or the Natural Resources Police of the injury as soon as practicable.

(2) A police department notified of an accident involving a moving vessel promptly shall advise the Department of Natural Resources.

(c) A report of injury shall include:

(1) The injured individual's name and address, if known;

(2) A description of the injury; and

(3) Any other facts concerning the matter that might assist in detecting crime.

(d) An individual who fails to make a report under subsection (b)(1) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $25.

§20–703.

(a) A physician, pharmacist, dentist, or nurse who treats an individual for an injury that was caused or shows evidence of having been caused by a gunshot of any type, or the individual in charge of a hospital that treats the injured individual, shall notify the county sheriff, the county police, or the Department of State Police of the injury as soon as practicable.

(b) A report of injury shall include:

(1) The injured individual's name and address, if known;

(2) A description of the injury; and

(3) Any other facts concerning the matter that might assist in detecting crime.

(c) A person who fails to make a report required by this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $25.

§20–801.

(a) A mother may breast-feed her child in any public or private location in which the mother and child are authorized to be.

(b) A person may not restrict or limit the right of a mother to breast-feed her child.

§20–901.

In adopting this subtitle, the General Assembly intends to encourage courses or seminars that address the identification and elimination of health care services disparities of minority populations as part of:

(1) Curriculum courses or seminars offered or required by institutions of higher education;

(2) Continuing education requirements for health care providers; and

(3) Continuing education programs offered by hospitals for hospital staff and health care practitioners.

§20–902.

(a) An institution of higher education in the State that includes in the curriculum courses necessary for the licensing of health care professionals in the State may include in the curriculum courses or offer special seminars that address the identification and elimination of health care services disparities of minority populations as reported in the findings of:

(1) The Institute of Medicine's report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"; and

(2) The Surgeon General's "Healthy People 2020" report.

(b) The courses or special seminars described under subsection (a) of this section shall address, with cultural competence, sensitivity, and health literacy the issue of health care services disparities of minority populations identified by:

(1) Race;

(2) Ethnicity;

(3) Poverty; and

(4) Gender.

§20–903.

A hospital with a continuing education program may offer and require the hospital's medical staff and health care practitioners to take a continuing medical education or continuing education unit course that addresses health care services disparities of minority populations.

§20–1001.

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

(b) "Director" means the Director of the Office of Minority Health and Health Disparities.

(c) "Minority person" includes African Americans, Hispanics, Asian and Pacific Islanders, and American Indians statewide.

(d) "Office" means the Maryland Office of Minority Health and Health Disparities established under § 20-1002 of this subtitle.

§20–1002.

There is an Office of Minority Health and Health Disparities in the Department.

§20–1003.

The Director shall report to the Secretary.

§20–1004.

The Office shall:

(1) Be an advocate for the improvement of minority health care by working with the Department on its own, or in partnership with other public and private entities to establish appropriate forums, programs, or initiatives designed to educate the public regarding minority health and health disparities issues, with an emphasis on preventive health and healthy lifestyles;

(2) Assist the Secretary in identifying, coordinating, and establishing priorities for programs, services, and resources that the State should provide for minority health and health disparities issues;

(3) Collect, classify, and analyze relevant research information and data collected or compiled by:

(i) The Department;

(ii) The Department in collaboration with others; and

(iii) Other public and private entities;

(4) Research innovative methods and obtain resources to improve existing data systems to ensure that the health information that is collected includes specific race and ethnicity identifiers;

(5) Serve as a clearinghouse and resource library for information about minority health and health disparities data, strategies, services, and programs that address minority health and health disparities issues;

(6) Develop a strategic plan to improve public services and programs targeting minorities;

(7) Obtain funding and, contingent upon funding, provide grants to community–based organizations and historically black colleges and universities to conduct special research, demonstration, and evaluation projects for targeted at–risk racial and ethnic minority populations and to support ongoing community–based programs that are designed to reduce or eliminate racial and ethnic health disparities in the State;

(8) Develop criteria for the awarding of grants for programs that are designed to improve minority health care;

(9) Review existing laws and regulations to ensure that they facilitate the provision of adequate health care to the minorities of this State;

(10) Recommend to the Secretary any additions or changes to existing laws and regulations designed to facilitate the adequate provision of health care to minorities in this State;

(11) Identify and review health promotion and disease prevention strategies relating to the leading health causes of death and disability among minority populations;

(12) Develop and implement model public and private partnerships in racial and ethnic minority communities for health awareness campaigns and to improve the access, acceptability, and use of public health services;

(13) Develop recommendations for the most effective means of providing outreach to racial and ethnic minority communities throughout the State to ensure their maximum participation in publicly funded health benefits programs;

(14) Develop a statewide plan for increasing the number of racial and ethnic minority health care professionals which includes recommendations for the financing mechanisms and recruitment strategies necessary to carry out the plan;

(15) Work collaboratively with universities and colleges of medicine, nursing, pharmacy, dentistry, social work, public health, and allied health in this State and other health care professional training programs to develop courses with cultural competency, sensitivity, and health literacy, that are designed to address the problem of racial and ethnic disparities in health care access, utilization, treatment decisions, quality, and outcomes;

(16) Work collaboratively with the Maryland Health Care Disparities Initiative, the Morgan–Hopkins Center for Health Disparities Solutions, the University of Maryland Disparity Project, the Monumental City Medical Society, faculty and researchers at historically black colleges and universities, and other existing alliances or plans, to reduce or eliminate racial and ethnic disparities in the State;

(17) Seek to establish a statewide alliance with community–based agencies and organizations, historically black colleges and universities, health care facilities, health care provider organizations, managed care organizations, and pharmaceutical manufacturers to promote the objectives of the Office;

(18) Evaluate multicultural or racial and ethnic minority health programs in other states to assess their efficacy and potential for replication in this State and make recommendations regarding the adoption of such programs, as appropriate;

(19) Apply for and accept any grant of money from the federal government, private foundations, or other sources which may be available for programs related to minority health and health disparities;

(20) Serve as the designated State agency for receipt of federal funds specifically designated for minority health and health disparities programs;

(21) Work collaboratively with the Governor's Office of Small, Minority, and Women Business Affairs as the Office determines necessary;

(22) To the extent authorized under federal and State privacy laws, publish on its website health data that includes race and ethnicity information collected by the Office and update the data at least once every 6 months; and

(23) To the extent authorized under federal and State privacy laws, respond to requests for health data that includes race and ethnicity information within 30 days after receipt of the request.

§20–1005.

Subject to the limitations of any law that governs the activities of other units of the Executive Branch of State government, the Director shall:

(1) Promote health and the prevention of disease among members of minority groups;

(2) Distribute grants from available federal and special funds to community–based health groups to be used to promote health and the prevention of disease among members of minority groups;

(3) Fund projects which are innovative, culturally sensitive, and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations; and

(4) Meet with representatives from the Maryland Health Care Commission and the Department at least annually to:

(i) Examine the collection of health data that includes race and ethnicity information in the State; and

(ii) Identify any changes for improving the health data that includes race and ethnicity information that is accessible by the Office.

§20–1006.

(a) On or before the 15th day of each regular session of the General Assembly, the Department shall submit an annual report on the Office of Minority Health and Health Disparities to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly.

(b) The report shall include:

(1) The projects and services developed and funded by the Office and the health care problems that the grant funds are intended to ameliorate;

(2) A "Health Care Disparities Policy Report Card", developed in collaboration with the Maryland Health Care Commission, and the health occupations boards established under the Health Occupations Article, that includes:

(i) An analysis of racial and ethnic variations in insurance coverage for low–income, nonelderly individuals;

(ii) The racial and ethnic composition of the individuals who hold a license or certificate issued by a health occupations board established under the Health Occupations Article compared to the racial and ethnic composition of the State's population;

(iii) The racial and ethnic disparities in morbidity and mortality rates for cardiovascular disease, cancer, diabetes, HIV/AIDS, infant mortality, asthma, dementia, and other diseases identified by the Maryland Health Care Commission; and

(iv) A comparison of the information included under items (i) and (ii) of this item with previously published "Health Care Disparities Policy Report Cards" including the same information; and

(3) The following information from the immediately preceding fiscal year:

(i) The Office's efforts to obtain funding described under § 20–1007(b) of this subtitle; and

(ii) The amount of funding from federal and special funding sources the Office received.

(c) The report may include any recommendations for administrative or legislative action that it deems appropriate.

§20–1007.

(a) For fiscal year 2023 and each fiscal year thereafter, the Governor shall include in the annual budget bill an appropriation for the Office in an amount that is at least $1,788,314 or 0.012% of the total funds appropriated to the Department in that fiscal year, whichever is greater.

(b) It is the intent of the General Assembly that the Office supplement the funding for the Office provided under subsection (a) of this section with funding from federal and special funding sources.

§20–1301.

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

(b) "Cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including:

(1) Direct communication in the patient's primary language;

(2) Understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care; and

(3) Awareness of how the attitudes, values, and beliefs of health care providers and patients influence and impact professional and patient relations.

(c) "Health care professional" includes a physician, nurse, dentist, social worker, psychologist, pharmacist, health educator, or other allied health professional.

(d) "Implicit bias" means a bias in judgment that results from subtle cognitive processes, including the following prejudices and stereotypes that often operate at a level below conscious awareness and without intentional control:

(1) Prejudicial negative feelings or beliefs about a group that an individual holds without being aware of the feelings or beliefs; and

(2) Unconscious attributions of particular qualities to a member of a specific social group that are influenced by experience and based on learned associations between various qualities and social categories, including race and gender.

(e) "Program" means the Cultural and Linguistic Health Care Professional Competency Program.

(f) "Structural racism" means the totality of ways in which societies foster racial discrimination by mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice.

§20–1302.

(a) There is a Cultural and Linguistic Health Care Professional Competency Program.

(b) The purpose of the Program is to:

(1) Provide for a voluntary program in which educational classes are offered to health care professionals to teach health care professionals:

(i) Methods to improve the health care professionals' cultural and linguistic competency to communicate with non–English speaking patients and patients from other cultures who are English speaking;

(ii) Cultural beliefs and practices that may impact patient health care practices and allow health care professionals to incorporate the knowledge of the beliefs and practices in the diagnosis and treatment of patients; and

(iii) Methods to enable health care professionals to increase the health literacy of their patients to improve the patient's ability to obtain, process, and understand basic health information and services to make appropriate health care decisions;

(2) Establish and provide an evidence–based implicit bias training program for health care professionals involved in the perinatal care of patients under § 20–1305 of this subtitle; and

(3) Identify and approve implicit bias and structural racism training programs for health occupation licensure and certification under § 1–225 of the Health Occupations Article.

§20–1303.

The Medical and Chirurgical Faculty of Maryland, the State Medical Society, the Maryland Nurses Association, the Maryland State Dental Association, the National Association of Social Workers – Maryland Chapter, the Maryland Clinical Social Work Coalition, the Maryland Psychological Association, the Maryland Pharmacists Association, or any other health professional association or public health entity in the State is encouraged to identify training programs, or, if feasible, to develop or collaborate in the development of training programs, that:

(1) Address ethnic language or racial groups of interest to the health care professional members;

(2) Are based on the established knowledge of health care professionals serving target populations;

(3) Are developed in collaboration with the Office of Minority Health and Health Disparities; and

(4) Include standards that identify the degree of competency for participants to qualify for completion of a program.

§20–1304.

(a) The Maryland Department of Health shall develop a method through which the appropriate professional licensing board recognizes the training received

by health care professionals under this subtitle, either through continuing education credits or otherwise.

(b) The Program shall provide a certificate of training completion for any individual who completes the training established under § 20–1305 of this subtitle, and to a facility on request.

§20–1305.

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

(2) "Perinatal care" means the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods.

(3) "Perinatal care facility" includes:

(i) A hospital, as defined in § 19–301 of this article, that provides perinatal care; and

(ii) A freestanding birthing center, as defined in § 19–3B–01 of this article.

(b) (1) On or before January 1, 2021, the Program shall establish an evidence–based implicit bias training program for all health care professionals involved in the perinatal care of patients in a perinatal care facility.

(2) (i) The Program shall establish the implicit bias program required under paragraph (1) of this subsection using best practices in implicit bias training.

(ii) The implicit bias program required under paragraph (1) of this subsection may include best practices used in other states.

(c) On or before January 1, 2022, and once every 2 years thereafter or more frequently, as determined by the perinatal care facility, a health care professional who is an employee of, and involved in the perinatal care of patients at, a perinatal care facility shall complete the training established under subsection (b) of this section.

(d) The Program shall offer the training established under subsection (b) of this section to any health care professional involved in perinatal care of patients at a perinatal care facility who is not required to complete the training under subsection (c) of this section because the health care professional is not an employee of a perinatal care facility.

§20–1306.

(a) (1) The Program shall, in coordination with the Office of Minority Health and Health Disparities, identify and approve implicit bias and structural racism training programs that an individual may complete to satisfy the requirements of § 1–225 of the Health Occupations Article.

(2) The Program may approve only implicit bias and structural racism training programs under paragraph (1) of this subsection that are recognized by a health occupations board established under the Health Occupations Article or accredited by the Accreditation Council for Continuing Medical Education or the Accreditation Council for Pharmacy Education.

(b) The Program shall provide a list of training programs approved under subsection (a) of this section on request.

§20–1401.

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

(b) "Advisory Committee" means the Health Equity Resource Community Advisory Committee.

(c) "Commission" means the Community Health Resources Commission.

(d) "Community health worker" has the meaning stated in § 13–3701 of this article.

(e) "Federally qualified health center" has the meaning stated in § 24–1301 of this article.

(f) "Fund" means the Health Equity Resource Community Reserve Fund established under § 20–1407 of this subtitle.

(g) "Health care practitioner" means an individual or, collectively, a group of individuals working together within the same practice, each of whom is licensed, certified, or otherwise authorized by law to provide health care services under the Health Occupations Article.

(h) "Health disparity" means a particular type of health difference, such as a difference in rates of hypertension, heart disease, asthma, diabetes, substance abuse, mental health disorders, and maternal and infant mortality, that:

(1) Is closely linked with social, economic, or environmental disadvantage; and

(2) Adversely affects groups of individuals who have systematically experienced greater obstacles to health care based on their:

(i) Race or ethnicity;

(ii) Religion;

(iii) Socioeconomic status;

(iv) Gender, gender identity, or sexual orientation;

(v) Age;

(vi) Mental health status;

(vii) Cognitive, sensory, or physical disability;

(viii) Geographic location; or

(ix) Other characteristic historically linked to discrimination or exclusion.

(i) "Health Equity Resource Community" means a contiguous geographic area that:

(1) Demonstrates measurable and documented health disparities and poor health outcomes;

(2) Is small enough to allow for the incentives offered under this subtitle to have a significant impact on improving health outcomes and reducing health disparities, including racial, ethnic, geographic, and disability related health disparities;

(3) Is designated by the Commission in accordance with the provisions of this subtitle; and

(4) Has a minimum population of 5,000 residents.

(j) "Hospital" has the meaning stated in § 19–301 of this article.

(k) "Institution of higher education" has the meaning stated in § 10–101 of the Education Article.

§20–1402.

(a) The purpose of establishing Health Equity Resource Communities is to target State resources to specific areas of the State to:

(1) Reduce health disparities;

(2) Improve health outcomes;

(3) Improve access to primary care;

(4) Promote primary and secondary prevention services; and

(5) Reduce health care costs and hospital admissions and readmissions.

(b) (1) The Commission may adopt regulations to carry out the provisions of this subtitle and to specify eligibility criteria and application, approval, and monitoring processes for the resources allocated under this subtitle.

(2) (i) The Office of Minority Health and Health Disparities and the Chesapeake Regional Information System for our Patients (CRISP) shall provide technical assistance to the Commission in implementing the provisions of this subtitle.

(ii) At the request of the Commission, any other unit in the Department shall provide technical assistance to the Commission in implementing the provisions of this subtitle.

(c) Two additional staff shall be added to the Commission to carry out the provisions of this subtitle.

§20–1403.

(a) (1) On or before July 1, 2021, the Commission shall establish a Health Equity Resource Community Advisory Committee.

(2) The duties of the Advisory Committee include:

(i) Providing initial and ongoing assistance and guidance regarding program evaluation and data collection metrics for Health Equity Resource Communities and health equity research practitioners;

(ii) Assisting the Commission in preparing the required annual report described in § 20–1408(b) of this subtitle and § 19–2112 of this article;

(iii) Proposing strategies for tax incentives and loan repayments to assist Health Equity Resource Communities in achieving their mission; and

(iv) Providing guidance, as determined by the Commission, to the Commission as necessary to implement the provisions of this subtitle.

(b) The Advisory Committee consists of:

(1) The Chair of the Community Health Resources Commission or the Chair's designee;

(2) The Director of the Office of Minority Health and Health Disparities, or the Director's designee;

(3) Three members appointed by the Governor, including:

(i) One individual representing the Maryland Department of Health; and

(ii) One individual with expertise in health care financing;

(4) Three members appointed by the President of the Senate, including:

(i) One individual with expertise in the social determinants of health; and

(ii) One individual who is a member of the general public residing in an area that has been or may be designated a Health Equity Resource Community; and

(5) Three members appointed by the Speaker of the House, including:

(i) One individual with expertise in health equity; and

(ii) One individual who is a member of the general public residing in an area that has been or may be designated a Health Equity Resource Community.

(c) (1) Collectively, the members of the Advisory Committee shall have knowledge of the following:

(i) Existing or potential health disparities in the State;

(ii) Groups of residents negatively affected by health disparities;

(iii) Systems, policies, and methods likely to improve health outcomes and reduce health disparities;

(iv) Effective prevention services;

(v) Health care costs, trends, and drivers;

(vi) Clinical health services research;

(vii) Consumer or patient perspectives; and

(viii) Innovative ways to address social determinants of health through the use of community health workers.

(2) To the extent practicable and consistent with federal and State law, the membership of the Advisory Committee shall reflect the racial, ethnic, geographic, and gender diversity of the State.

(3) The Chair of the Maryland Community Health Resources Commission shall chair the Advisory Committee.

(d) (1) The term of a member of the Advisory Committee is 4 years.

(2) The Commission shall stagger the terms of the initial appointed members.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

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

(5) The Commission may remove an appointed member for incompetence, misconduct, or failure to perform the duties of the position.

(e) A member of the Advisory Committee:

(1) May not receive compensation as a member of the Advisory Committee; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Advisory Committee shall:

(1) On or before January 1, 2022, hold an initial meeting; and

(2) Meet at least once every 6 months thereafter.

(g) The Commission may convene working or advisory groups to facilitate the implementation of this subtitle that shall include individuals who reside in an area that has been or may be designated as a Health Equity Resource Community.

§20–1404.

(a) For an area to receive a designation as a Health Equity Resource Community, a nonprofit community–based organization, a nonprofit hospital, an institution of higher education, a federally qualified health center, or a local government agency shall:

(1) Apply to the Commission on behalf of the area to receive the designation; and

(2) Include federally qualified health centers or other community–based organizations to provide health or wraparound support services within the Health Equity Resource Community.

(b) Subject to subsections (c) and (e) of this section, the application shall be in the form and manner and contain the information that the Commission requires.

(c) (1) The application shall contain an effective and sustainable plan to reduce health disparities, reduce costs or produce savings to the health care system, and improve health outcomes.

(2) The application shall include:

(i) A description of how the plan will expand federally qualified health centers' or other community–based organizations' capacity to provide health care services or wraparound services to address social determinants of health; and

(ii) A description of how funding available under this subtitle will be used to address health disparities through evidence–based, cross–sector strategies that may include:

1. Building health care provider capacity;

2. Improving health services delivery;

3. Effectuating community improvements;

4. Conducting outreach and education efforts;

5. Implementing systemic strategies to improve coordination and communication across organizations that provide health care services;

6. Supporting community leadership development efforts;

7. Facilitating policy interventions to address upstream determinants of health; and

8. Implementing scalable approaches to meet the nonmedical social needs of populations identified in the most recent community health needs assessment, such as unstable housing, inadequate food, or job development.

(d) The application may include:

(1) A proposal to use funding available under this subtitle to provide for loan repayment incentives to induce health care practitioners to practice in the area;

(2) A proposal to use innovative public health strategies to reduce health disparities in the area that may be supported by grants awarded under this subtitle, such as the use of community health workers, community health centers, federally qualified health centers, institutions of higher education, and community–based disease management activities; and

(3) A proposal to use other incentives or mechanisms to address health disparities that focus on ways to expand access to care, expand access to nonmedical interventions that promote improved health outcomes, promote hiring, and reduce costs to the health care system.

(e) The application submitted in accordance with this section shall allocate sufficient funding to cover salary and benefit costs for the evaluator required under § 20–1406 of this subtitle.

§20–1405.

(a) (1) On or before October 1, 2023, the Commission shall issue a request for proposals to designate areas as Health Equity Resource Communities in accordance with this subtitle.

(2) The Commission:

(i) Shall consider geographic diversity, among other factors, when designating areas as Health Equity Resource Communities; and

(ii) May conduct outreach efforts to facilitate a geographically diverse pool of applicants, including efforts to facilitate submission of applications from rural areas.

(3) After receiving all applications submitted to the Commission, the Commission shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the names of applicants and geographic areas in which applicants are located.

(b) The Commission shall give priority to applications that demonstrate:

(1) Support from and participation of key stakeholders in the public and private sectors, including residents of the area and local government;

(2) A plan for long–term funding and self–sustainability;

(3) Inclusion of supporting funds from the private sector;

(4) Integration with the State Health Improvement Process and the goals set out in the strategic plan of the local health improvement coalition;

(5) A plan for evaluation of the impact of designation of the proposed area as a Health Equity Resource Community and strategies for quality improvement;

(6) Other factors that the Commission determines are appropriate to demonstrate a commitment to reduce health disparities and improve health outcomes; and

(7) A previous designation as a Health Enterprise Zone or inclusion of areas previously included in a Health Enterprise Zone.

(c) (1) An application for designation of an area as a Health Equity Resource Community submitted by a nonprofit community–based organization, a nonprofit hospital, an institution of higher education, a federally qualified health center, or a local government agency shall provide for the employment and supervision of employment of one full–time employee to serve as an evaluator of the operation, impact, and effectiveness of the Health Equity Resource Community designated under this subtitle.

(2) To be designated as an evaluator under this subsection, the employee must demonstrate experience in methods of qualitative and quantitative research methodology.

(3) An employee designated as an evaluator under this subsection shall coordinate with the Commission to:

(i) Monitor the operation, effectiveness, and impact of the Health Equity Resource Community; and

(ii) Provide data, statistics, and analysis to the Commission that shall address the reporting elements specified under § 20–1408(b) of this subtitle.

(d) Notwithstanding the requirement to hire a full–time employee to serve as an evaluator under subsection (c) of this section, a nonprofit community–based organization, a nonprofit hospital, an institution of higher education, a federally qualified health center, or a local government agency may contract with a historically black college or university in the State to provide evaluator services.

(e) The decision of the Commission to designate an area as a Health Equity Resource Community shall be a final decision.

(f) A designation by the Commission of an area as a Health Equity Resource Community shall have a term of 5 years and may be renewed in accordance with an application approved by the Commission.

§20–1406.

(a) Health care practitioners and community health workers that practice in a Health Equity Resource Community may receive loan repayment assistance, as provided for in the application for designation for the Health Equity Resource Community and approved by the Commission under this subtitle.

(b) (1) A health care practitioner or community health worker may apply to the Commission for a grant to defray the costs of capital or leasehold improvements to, or medical or dental equipment to be used in, a Health Equity Resource Community.

(2) To qualify for a grant under paragraph (1) of this subsection, a health care practitioner or a community health worker shall:

(i) Own or lease the health care facility; and

(ii) Provide health care from that facility.

(3) (i) A grant to defray the cost of medical or dental equipment may not exceed the lesser of $25,000 or 50% of the cost of the equipment.

(ii) Grants for capital or leasehold improvements shall be for the purposes of improving or expanding the delivery of health care in the Health Equity Resource Community.

(c) (1) A nonprofit community–based organization, a nonprofit hospital, an institution of higher education, a federally qualified health center, or a local government agency that receives approval of an application submitted under § 20–1403 of this subtitle may submit an application, on its own behalf, to receive grants for capital or leasehold improvements, as determined by the Commission, for the purposes described under subsection (b)(3)(ii) of this section.

(2) Subject to § 20–1408(a)(2) of this subtitle, the term of any grant awarded to a nonprofit community–based organization, a nonprofit hospital, an institution of higher education, a federally qualified health center, or a local government agency for capital or leasehold improvements shall have a term of 5 years, and may be renewed in accordance with an application approved by the Commission.

§20–1407.

(a) There is a Health Equity Resource Community Reserve Fund.

(b) The purpose of the Fund is to:

(1) Support areas designated by the Commission as Health Equity Resource Communities by providing grants to community–based organizations, nonprofit hospitals, institutions of higher education, federally qualified health centers, local government agencies, health care practitioners, and community health workers to facilitate reduction of health disparities, improve health outcomes, provide drug treatment and rehabilitation, and reduce health costs and hospital admissions and readmissions in specific areas of the State; and

(2) Provide funding to supplement and not supplant existing funding for behavioral health programs that provide prevention, recovery support, and harm reduction services for individuals with substance use and mental health disorders.

(c) The Commission shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) Any unspent portion of the Fund may not be transferred or revert to the General Fund but shall remain in the Fund to be used for the purposes specified in this subtitle.

(3) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund in accordance with § 31–107 of the Insurance Article;

(2) Interest earnings of the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(f) (1) Except as provided in paragraph (2) of this subsection, the Fund may be used only to provide funding to the Commission for the support of areas designated as Health Equity Resource Communities by providing grants to community–based organizations, nonprofit hospitals, institutions of higher

education, local government agencies, health care practitioners, federally qualified health centers, and community health workers to reduce health disparities, improve health outcomes, provide addiction and mental health services, and reduce health costs and hospital admissions and readmissions.

(2) (i) The Fund may be used for the purpose of funding one full–time staff position under § 19–2112(a)(4) of this article and two full–time staff positions under § 20–1402(c) of this subtitle on the Commission.

(ii) In fiscal year 2024 and each fiscal year thereafter, the Fund may be used to pay for the costs incurred by the Chesapeake Regional Information System for our Patients (CRISP) in providing technical assistance to the Commission.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) Money expended from the Fund to support areas designated by the Commission as Health Equity Resource Communities under this subtitle is supplemental to and not intended to supplant funding that otherwise would be appropriated for those purposes.

§20–1408.

(a) (1) Each nonprofit community–based organization, nonprofit hospital, institution of higher education, federally qualified health center, or local government agency that has submitted a successful application for designation of an area as a Health Equity Resource Community under § 20–1403 of this subtitle shall submit to the Commission a report that includes:

(i) A description of progress made toward the objectives set forth in the application;

(ii) A description of objectives to be met during the immediately following year; and

(iii) Any other information as requested by the Commission.

(2) The reporting required under paragraph (1) of this subsection shall be submitted periodically in accordance with a schedule determined by the Commission.

(3) The Commission may revoke a designation of an area as a Health Equity Resource Community if the nonprofit community–based organization, nonprofit hospital, institution of higher education, federally qualified health center, or local government agency that has submitted a successful application for designation of an area as a Health Equity Resource Community fails to meet the objectives provided to the Commission under subsection (a)(1) of this section for a given year.

(b) (1) On or before December 15 each year, the Commission shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report that includes:

(i) The number and types of incentives granted in each Health Equity Resource Community;

(ii) Evidence of the impact of the loan repayment incentives in attracting health care practitioners and community health workers to Health Equity Resource Communities;

(iii) Evidence of the impact of the incentives offered in Health Equity Resource Communities in reducing health disparities and improving health outcomes; and

(iv) Evidence of the progress in reducing health costs and hospital admissions and readmissions in Health Equity Resource Communities.

(2) The report described in paragraph (1) of this subsection shall include data disaggregated by the following:

(i) Race;

(ii) Ethnicity;

(iii) Primary language;

(iv) Gender;

(v) Socioeconomic status; and

(vi) Zip code.

§20–1501.

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

(b) "Down syndrome" means a chromosomal condition caused by an error in cell division that results in the presence of an extra whole or partial copy of chromosome 21.

(c) (1) "Health care facility" means a facility or an office where health or medical care is provided to patients by a health care provider.

(2) "Health care facility" includes a hospital and a limited service hospital.

(d) (1) "Health care provider" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health or medical care in the ordinary course of business or practice of a profession.

(2) "Health care provider" includes a genetic counselor.

(e) "Hospital" has the meaning stated in § 19–301 of this article.

(f) "Limited service hospital" has the meaning stated in § 19–301 of this article.

§20–1502.

(a) The Department shall identify up–to–date, evidence–based, written information about Down syndrome that:

(1) Has been reviewed by medical experts and national and local Down syndrome organizations;

(2) Is designed for use by an expectant parent who receives a prenatal test result for Down syndrome or a parent of a child who receives a diagnosis of Down syndrome;

(3) Is culturally and linguistically appropriate for potential recipients of the information; and

(4) Includes:

(i) Information addressing physical, developmental, educational, and psychosocial outcomes, life expectancy, clinical course, and intellectual and functional development and treatment options for individuals with Down syndrome; and

(ii) Contact information for national and local Down syndrome education and support programs and services, including information hotlines, resource centers, and clearinghouses.

(b) The Department shall:

(1) Provide the information identified by the Department under subsection (a) of this section to health care facilities and health care providers that provide prenatal care, postnatal care, or genetic counseling to expectant parents who receive a prenatal test result for Down syndrome and parents of a child diagnosed with Down syndrome; and

(2) Make available the information identified by the Department under subsection (a) of this section on the Department's website.

(c) (1) On receipt of a positive test result from a test for Down syndrome, a health care facility or health care provider may provide to the expectant parent who receives a prenatal test result for Down syndrome or the parent of the child diagnosed with Down syndrome the written information provided or made available by the Department under subsection (b) of this section.

(2) The information provided under this subsection shall be culturally and linguistically appropriate for the recipient of the information.

§20–1601.

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

(b) "Anatomical gift" means the donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation or transfusion.

(c) "Auxiliary aids and services" includes:

(1) Qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments;

(2) Qualified readers, taped texts, texts in accessible electronic format, or other effective methods of making visually delivered materials available to individuals with visual impairments;

(3) Supported decision–making services, including:

(i) The use of a support individual to assist in making medical decisions, communicating information to the individual, or ascertaining an individual's wishes;

(ii) The provision of information to a person designated by the individual consistent with the federal Health Insurance Portability and Accountability Act and other applicable laws and regulations governing the disclosure of health information; and

(iii) If an individual has a court–appointed guardian or other individual responsible for making medical decisions on behalf of the individual, any measures used to ensure that the individual is included in decisions involving the individual's health care and that medical decisions are in accordance with the individual's own expressed interests; and

(4) Any other aid or service that is used to provide information in a format that is easily understandable and accessible to individuals with cognitive, neurological, developmental, or intellectual disabilities.

(d) "Covered entity" means:

(1) A licensed health care provider;

(2) A health care facility as defined in § 19–114 of this article;

(3) A laboratory;

(4) A State psychiatric hospital;

(5) A State residential center as defined in § 7–101 of this article;

(6) An alternative living unit as defined in § 7–101 of this article;

(7) A group home as defined in § 7–101 of this article;

(8) An institutional medical unit in a correctional facility; or

(9) Any entity responsible for potential recipients of the anatomical gift.

(e) "Disability" has the meaning stated in the federal Americans with Disabilities Act.

(f) "Organ transplant" means the transplantation or transfusion of a part of a human body into the body of another individual for the purpose of treating or curing a medical condition.

(g) "Qualified individual" means an individual who:

(1) Has a disability; and

(2) Meets the essential eligibility requirements for the receipt of an anatomical gift, with or without:

(i) The support networks available to the individual;

(ii) The provision of auxiliary aids and services; or

(iii) Reasonable modifications to the policies or practices of a covered entity, including modifications to allow:

1. Communication with individuals responsible for supporting the individual with postsurgical and posttransplantation care, including medication; and

2. The consideration of support networks available to the individual, including family, friends, and home– and community–based services funded through the Maryland Medical Assistance Program, Medicare, or another health plan in which the individual is enrolled, or any program or source of funding available to the individual, in determining whether the individual is able to comply with posttransplantation medical requirements.

§20–1602.

This subtitle may not be construed to require a covered entity to make a referral or recommendation for or perform a medically inappropriate organ transplant.

§20–1603.

The General Assembly finds that:

(1) A mental or physical disability does not diminish an individual's right to health care;

(2) The federal Americans with Disabilities Act prohibits discrimination against individuals with disabilities, yet many individuals with disabilities still experience discrimination in accessing critical health care services;

(3) In other states nationwide, individuals with mental and physical disabilities have historically been denied life–saving organ transplants based on assumptions that their lives are less worthy, that they are incapable of complying with posttransplantation medical requirements, or that they lack adequate support systems to ensure compliance with posttransplantation medical requirements;

(4) Although organ transplant centers must consider medical and psychosocial criteria when determining if a patient is suitable to receive an organ transplant, transplant centers that participate in Medicare, the Maryland Medical Assistance Program, and other federally funded programs are required to use patient selection criteria that result in a fair and nondiscriminatory distribution of organs; and

(5) State residents in need of organ transplants are entitled to assurances that they will not encounter discrimination on the basis of a disability.

§20–1604.

This subtitle applies to each part of the organ transplant process.

§20–1605.

(a) A covered entity may not solely on the basis of an individual's disability:

(1) Consider a qualified individual ineligible to receive an anatomical gift or organ transplant;

(2) Deny medical and other services related to organ transplantation, including evaluation, surgery, counseling, and posttransplantation treatment and services;

(3) Refuse to refer the individual to a transplant center or a related specialist for the purpose of evaluation or receipt of an organ transplant;

(4) Refuse to place a qualified individual on an organ transplant waiting list; or

(5) Place a qualified individual at a lower–priority position on an organ transplant waiting list than the position at which the qualified individual would have been placed if not for the disability.

(b) (1) Subject to paragraph (2) of this subsection, a covered entity may take an individual's disability into account when making treatment or coverage recommendations or decisions, solely to the extent that the disability has been found by a physician, following an individualized evaluation of the individual, to be medically significant to the provision of the anatomical gift.

(2) If an individual has the necessary support system to assist the individual in complying with posttransplantation medical requirements, a covered entity may not consider the individual's inability to independently comply with the posttransplantation medical requirements to be medically significant for the purposes of paragraph (1) of this subsection.

(c) A covered entity shall make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to allow an individual with a disability access to services, including transplantation–related counseling, information, coverage, or treatment, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the services.

(d) A covered entity shall take such steps as may be necessary to ensure that an individual with a disability is not denied services, including transplantation–related counseling, information, coverage, or treatment, due to the absence of auxiliary aids and services, unless the covered entity can demonstrate that taking the steps would fundamentally alter the nature of the services being offered or would result in an undue burden.

§20–1606.

(a) If a covered entity violates this subtitle, the affected individual may bring an action in the appropriate circuit court for injunctive or other equitable relief.

(b) In an action brought under subsection (a) of this section, the circuit court shall:

(1) Schedule a hearing as soon as possible; and

(2) Apply the same standards in rendering a judgment in the action as would be applied in an action brought in federal court under the federal Americans with Disabilities Act.

§20–1701.

(a) A health care provider licensed in the State who draws the blood of a patient to perform a laboratory test for Lyme disease or a medical laboratory, as defined in § 17–201 of this article, that performs a laboratory test for the presence of Lyme disease shall provide the following written notice to the patient at the time the patient's blood is drawn:

"Your health care provider has ordered a laboratory test for the presence of Lyme disease for you. Current laboratory testing for Lyme disease can be problematic and standard laboratory tests often result in false negative and false positive results and, if done too early, you may not have produced enough antibodies to be considered positive because your immune response requires time to develop antibodies. If you are tested for Lyme disease and the results are negative, this does not necessarily mean you do not have Lyme disease. If you continue to experience unexplained symptoms, you should contact your health care provider and inquire about the appropriateness of retesting or initial or additional treatment.".

(b) If the Department finds significant differences between the content of the notice required by subsection (a) of this section and current medical evidence on Lyme disease testing, the Department may adopt regulations that change the content of the notice.

(c) The Department shall provide written notice to the Senate Finance Committee and the House Health Committee before submitting any proposed regulation under subsection (b) of this section to the Maryland Register for publication.

(d) The provision by a health care provider or medical laboratory of the notice required by subsection (a) of this section may not be the sole basis for a cause of action.

§20–1801. IN EFFECT

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

(2) (i) "Health care facility" means a facility or an office where health or medical care is provided to patients by a health care provider.

(ii) "Health care facility" includes a hospital and a limited service hospital.

(3) "Health care provider" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health or medical care in the ordinary course of business or practice of a profession.

(4) "Hospital" has the meaning stated in § 19–301 of this article.

(5) "Limited service hospital" has the meaning stated in § 19–301 of this article.

(b) The Department, in consultation with stakeholders, shall identify up–to–date, evidence–based, written information about perinatal mood and anxiety disorders that:

(1) Has been reviewed by medical experts and national and local organizations specializing in maternal mental health;

(2) Is designed for use by health care providers and pregnant and postpartum women and their families;

(3) Is culturally and linguistically appropriate for potential recipients of the information; and

(4) Includes:

(i) Information addressing:

1. The signs and symptoms of perinatal mood and anxiety disorders;

2. Perinatal medication usage;

3. Risk factors of perinatal mood and anxiety disorders, including perinatal loss and high–risk pregnancy;

4. How and when to screen for symptoms of perinatal mood and anxiety disorders;

5. Brief intervention strategies; and

6. Evidence–based psychosocial treatments; and

(ii) Contact information for national and local maternal mental health programs and services.

(c) The Department shall:

(1) Provide the information identified by the Department under subsection (b) of this section to health care facilities and health care providers that provide prenatal care, labor and delivery services, and postnatal care to expectant parents; and

(2) Make the information identified by the Department under subsection (b) of this section available on the Department's website.

§20–1801. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 636 AND 637 OF 2026 **

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

(b) "Health care provider" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health or medical care in the ordinary course of business or practice of a profession.

(c) (1) "Perinatal behavioral health condition" means a behavioral health condition occurring during pregnancy or within 1 year after the conclusion of a pregnancy, including a pregnancy that does not result in a live birth.

(2) "Perinatal behavioral health condition" includes postpartum depression.

§20–1802. IN EFFECT

(a) The Department, in collaboration with MedChi, The Maryland State Medical Society, the Maryland Nurses Association, the Maryland Affiliate of the American College of Nurse Midwives, the Maryland Psychological Association, and any other health professional association or public health entity in the State identified by the Department, shall identify and develop training programs that improve early identification of postpartum depression and perinatal mood and anxiety disorders.

(b) The programs developed under subsection (a) of this section shall include continuing medical education programs developed by organizations that are accredited by the Accreditation Council for Continuing Medical Education.

§20–1802. ** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 636 AND 637 OF 2026 **

(a) The Department, in consultation with stakeholders, shall identify up–to–date, evidence–based, written information about perinatal behavioral health conditions that:

(1) Has been reviewed by medical experts and national and local organizations specializing in maternal mental health;

(2) Is designed for use by health care providers and pregnant and postpartum women and their families;

(3) Is culturally and linguistically appropriate for potential recipients of the information; and

(4) Includes:

(i) Information addressing:

1. The signs and symptoms of perinatal mood and anxiety disorders;

2. Perinatal medication usage;

3. Risk factors of perinatal behavioral health conditions, including perinatal loss and high–risk pregnancy;

4. How and when to screen for symptoms of perinatal behavioral health conditions;

5. Brief intervention strategies; and

6. Evidence–based psychosocial treatments; and

(ii) Contact information for national and local maternal mental health programs and services.

(b) The Department shall:

(1) Provide the information identified by the Department under subsection (a) of this section to:

(i) Health care facilities and health care providers that provide prenatal care, labor and delivery services, and postnatal care to expectant parents; and

(ii) Each local Special Supplemental Nutrition Program for Women, Infants, and Children agency in the State; and

(2) Make the information identified by the Department under subsection (a) of this section available on the Department's website.

(c) At least once during each trimester, a health care provider who evaluates and manages perinatal care while acting within the scope of the health care provider's license or certificate shall provide to a patient:

(1) The information identified by the Department under subsection (a) of this section; or

(2) Other appropriate information on perinatal behavioral health conditions.

(d) A hospital shall provide the information identified by the Department under subsection (a) of this section to a birthing parent on discharge from the birthing hospital.

§20–1803. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 636 AND 637 OF 2026 **

(a) The Department, in consultation with the State Board of Physicians, the State Board of Nursing, and Postpartum Support International, shall identify and develop training programs that improve early identification of perinatal behavioral health conditions that an individual may use to satisfy the requirements of § 1–232 of the Health Occupations Article.

(b) The programs identified or developed under subsection (a) of this section shall include continuing medical education programs developed by organizations that are accredited by the Accreditation Council for Continuing Medical Education.

(c) The Department shall provide a list of training programs identified or developed under subsection (a) of this section on request.

§20–1804. NOT IN EFFECT

** TAKES EFFECT JANUARY 1, 2027 PER CHAPTERS 636 AND 637 OF 2026**

(a) A health care provider who evaluates and manages pregnancy or postpartum care while acting within the scope of the health care provider's license or certificate shall conduct a screening for perinatal behavioral health conditions at well

child visits within the first year of the child's life, as determined appropriate by the treating health care provider.

(b) (1) The Department shall identify acceptable screening tools for conducting the screenings required under subsection (a) of this section.

(2) The screening tools identified under paragraph (1) of this subsection shall be validated, routinely used, free, easy to administer and score, and available in multiple languages.

(c) The Department shall assist health care providers with accessing resources and referral services through Maryland Behavioral Health Integration in Pediatric Primary Care, Maternal Health Innovation Program, and Postpartum Support International to assist providers in finding timely and effective care for individuals identified as at risk for a perinatal behavioral health condition.

§20–1901.

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

(b) (1) "Identification device" means an item, an application, or a product that is passively or actively capable of transmitting personal information, including devices using radio frequency technology.

(2) "Identification device" does not include an item, an application, or a product that is used in the diagnosis, monitoring, treatment, or prevention of a health condition.

(c) "Personal information" includes the following data elements to the extent that the data elements are used alone or in conjunction with other information used to identify an individual:

(1) First or last name;

(2) Address;

(3) Telephone number;

(4) E–mail, Internet Protocol, or website address;

(5) Date of birth;

(6) Driver's license number or identification card number;

(7) Bank, credit card, or other financial account number;

(8) Any unique personal identifier contained or encoded on a health insurance, health benefit, or benefit card or record issued in conjunction with a government–supported aid program;

(9) Religion;

(10) Ethnicity or nationality;

(11) Photograph;

(12) Fingerprint or other biometric identifier;

(13) Social Security number; and

(14) Any other unique personal identifier.

(d) "Require, coerce, or compel" includes the use of physical violence, threat, intimidation, retaliation, the conditioning of any private or public benefit, including employment, promotion, or other employment benefit, and any other means to cause a reasonable individual of ordinary susceptibilities to acquiesce when the individual otherwise would not.

(e) "Subcutaneous" means existing, performed, or introduced under or on the skin.

§20–1902.

(a) A person or an agent, a representative, or a designee of the State or a local government may not require, coerce, or compel an individual to undergo the subcutaneous implanting of an identification device.

(b) (1) An individual who is implanted with a subcutaneous identification device in violation of subsection (a) of this section may file a civil action in the circuit court in the county where the violation occurred.

(2) If the court finds that the person or agent, representative, or designee of the State or a local government violated subsection (a) of this section, the court may:

(i) Assess against the defendant:

1. A civil penalty not exceeding $10,000; and

2. An additional civil penalty not exceeding $1,000 for each day after the day of implantation that the violation continues until corrected; and

(ii) Award the plaintiff:

1. Compensatory damages;

2. Injunctive relief;

3. Reasonable attorney's fees and litigation expenses, including expert witness fees and expenses; or

4. Any other appropriate relief.

(3) In addition to the damages or relief awarded under paragraph (2) of this subsection, the court may award the plaintiff punitive damages on a finding of proof of the defendant's malice, oppression, fraud, or duress inflicted in requiring, coercing, or compelling the plaintiff to undergo the subcutaneous implanting of an identification device.

(c) (1) Except as provided in paragraph (2) of this subsection, an action brought under subsection (b) of this section shall be filed within 3 years after the date on which the identification device was implanted.

(2) If a defendant induces the plaintiff to delay the filing of the action or the plaintiff delays the filing due to threats made by the defendant that caused the plaintiff duress, the defendant may not assert the limitation specified under paragraph (1) of this subsection.

(d) The remedies provided by this section are in addition to any other statutory, legal, or equitable remedies that may be available and are not intended to be prerequisite to or exclusive of any other remedies.

(e) The provisions of this section shall be liberally construed in the protection of privacy and bodily integrity.

§20–2001.

In this subtitle, "health care facility" means a facility or an office where health or medical care is provided to patients by a health care provider, including:

(1) A health care facility as defined in § 19–114(d)(1) of this article;

(2) A kidney dialysis center;

(3) A facility operated by the Department or a health officer; and

(4) The office of a health care provider.

§20–2002.

(a) A health care facility may not provide peritoneal dialysis or hemodialysis treatment services unless the individual performing the dialysis procedure has received training in the peritoneal dialysis or hemodialysis technique being performed.

(b) A person who violates subsection (a) of this section is subject to a civil penalty imposed by the Department not exceeding $5,000 for each violation.

(c) The Department shall adopt regulations to carry out this section.

§20–2101.

(a) On or before April 1, 2022, the Department shall develop and publish materials to assist Maryland residents with long–term care family planning.

(b) The materials developed under subsection (a) of this section, consistent with recommendation number 4 in the Report of the Maryland Governor's Task Force on Long–Term Care Planning published in 2018 as required by Chapters 212 and 213 of the Acts of the General Assembly of 2017, shall:

(1) Meet the requirements for the PLAN NOW Starter Kit described in recommendation number 4;

(2) Be consistent with the mock–up PLAN NOW Starter Kit materials detailed in recommendation number 4; and

(3) Include contact information, including websites and phone numbers, for organizations that a State resident may contact for assistance with long–term care family planning.

(c) The Department shall:

(1) Make the materials published under this section available in English, Spanish, and any other language, as the Department determines is necessary; and

(2) Ensure that the materials published under this section are understandable to individuals with limited literacy skills.

§20–2201.

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

(b) "Hub" means the Consumer Health Information Hub.

(c) "Plain language" means language that is clear, concise, well–organized, and complies with other best practices appropriate to the subject or field and intended audience.

(d) (1) "Public communication" means a document that:

(i) Is necessary for obtaining a government benefit or service;

(ii) Provides information about a government benefit or service; or

(iii) Explains to the public how to comply with a requirement that the government administers or enforces.

(2) "Public communication" includes a letter, a publication, a form, a notice, or an instruction.

(3) "Public communication" does not include a regulation.

§20–2202.

The General Assembly finds that health literacy is:

(1) Part of the State's critical public health and health systems infrastructure; and

(2) An essential contributor to health equity.

§20–2203.

State and local agencies shall use plain language in public communications about health, health insurance, safety, and social services benefits.

§20–2204.

(a) The University of Maryland Herschel S. Horowitz Center for Health Literacy is designated as the State's Consumer Health Information Hub.

(b) The purpose of the Hub is to promote and ensure public access to accurate, consistent, evidence–based, plain–language information in preferred languages to inform decisions about health, safety, and social services benefits.

(c) To the extent funding is available, the Hub shall:

(1) Protect and promote public health by engaging with State and local government agencies, health systems, nonprofit and community–based organizations, and other entities to carry out the Hub's purpose and duties under this subtitle;

(2) Establish and promote health literacy criteria, certifications, and best practices that advance the effectiveness of the State's health care system;

(3) Identify health literacy challenges and provide recommendations to agencies and organizations on how to address the challenges, including by improving programs and materials to provide the public with access to plain–language health, safety, and social services benefits information;

(4) Monitor and report on the use of health literacy and plain–language initiatives and support public reporting of vital public health information, including health care quality reports from the Maryland Health Care Commission; and

(5) Support the identification and ongoing training of health literacy officers in State and local agencies.

(d) On or before July 1 each year, beginning in 2024, the Hub shall submit a report to the Senate Finance Committee and the House Health Committee, in accordance with § 2–1257 of the State Government Article, on the implementation of this subtitle, including the status of statewide health literacy efforts and materials provided.

§20–2205.

(a) The Hub shall facilitate consistent State and local government use of health literacy and plain–language criteria, which may include by:

(1) Identifying vendors of health information products that adopt the Hub's health literacy criteria;

(2) Offering a health literacy review of sources of public information or public media regarding health, safety, and social services benefits information;

(3) Publishing templates that aid the development of plain–language health information materials; and

(4) Publishing templates and model language for use by State agencies and local government agencies for awarding grants and contracts to ensure that recipients:

(i) Address health literacy issues in their proposals and workplans; and

(ii) Refrain from creating additional health literacy barriers.

(b) The Hub shall support workforce development, which may include by:

(1) Offering or recommending educational sessions on health literacy for health professionals and individuals who develop health, safety, and social services benefits information for the public; and

(2) Providing educational and age–appropriate resources that teach students health literacy and health literacy skills for primary and secondary schools and institutions of higher education.

(c) The Hub shall assist programs and organizations to promote community health literacy, which may include by:

(1) Offering Hub assessments of programs and organizations to identify barriers to public access of health, safety, and social services benefits information and services; and

(2) Assisting entities with providing consumers with plain–language health information and referral and support services in a consumer's preferred language.

(d) In carrying out this section, the Hub may collaborate with entities that directly educate the public, including education institutions, libraries, and consumer referral services.

§20–2206.

(a) The Hub shall develop and publish criteria for evaluating whether media or a media campaign follows best practices for the promotion of health literacy.

(b) (1) If a person submits its media or media campaign to the Hub for review, the Hub shall use the criteria developed under subsection (a) of this section to evaluate whether the media or media campaign follows best practices for the promotion of health literacy.

(2) The Department and the Hub shall encourage persons that promote public health, health education, or health awareness to submit media for evaluation by the Hub under this section.

(c) When awarding grants, the Department and local health departments shall give special consideration, in a manner determined to be appropriate by the department awarding the grant, to entities that are designated by the Hub to meet health literacy criteria under subsection (b) of this section.

§20–2207.

(a) Alleged compliance or noncompliance with a provision of this subtitle is not subject to judicial review.

(b) This subtitle does not create or authorize a right enforceable by administrative or judicial action.

§20–2208.

The Department shall adopt regulations to carry out this subtitle.

§20–2301.

(a) In this section, "plain language" means language that is clear, concise, and well–organized and complies with other best practices, including generally accepted guidelines regarding compliance with the federal Plain Writing Act of 2010, appropriate to the subject or field and intended audience.

(b) The Department shall:

(1) Create and distribute to dental practices plain language materials regarding:

(i) The importance of regular dental appointments for an individual's overall health; and

(ii) Various dental procedures, as determined by the Department; and

(2) Encourage dentists and dental hygienists to distribute the plain language materials created in accordance with item (1) of this subsection to their patients.

§20–2401. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTER 844 OF 2024 //

In this subtitle, "Commission" means the Maryland Emergency Department Wait Time Reduction Commission.

§20–2402. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTER 844 OF 2024 //

(a) (1) There is a Maryland Emergency Department Wait Time Reduction Commission.

(2) The purpose of the Commission is to address factors throughout the health care system that contribute to increased emergency department wait times.

(b) The Commission consists of the following members:

(1) The Secretary, or the Secretary's designee;

(2) The Executive Director of the Maryland Institute for Emergency Medical Services Systems, or the Executive Director's designee;

(3) The Executive Director of the Health Services Cost Review Commission, or the Executive Director's designee;

(4) The Executive Director of the Maryland Health Care Commission, or the Executive Director's designee; and

(5) The following members, appointed by the Secretary:

(i) Two individuals who have operations leadership responsibilities over a hospital emergency department in the State, including one emergency department physician;

(ii) One individual with professional experience in an emergency department who is not a physician or an advanced practice provider, such as a nurse or care manager;

(iii) One representative of a local emergency medical service;

(iv) One representative of a managed care plan with experience in care management or care coordination;

(v) One representative of an advanced primary care practice;

(vi) One representative of the Maryland Hospital Association;

(vii) One representative of a patient advocacy organization; and

(viii) One representative of a behavioral health provider.

(c) The Secretary of Health and the Executive Director of the Health Services Cost Review Commission shall cochair the Commission.

(d) The Health Services Cost Review Commission shall provide staff for the Commission.

(e) A member of the Commission:

(1) May not receive compensation as a member of the Commission; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§20–2403. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTER 844 OF 2024 //

The Commission shall develop strategies and initiatives to recommend to State and local agencies, hospitals, and health care providers to reduce emergency department wait times, including:

(1) Initiatives that:

(i) Ensure that patients are seen in the most appropriate setting to reduce unnecessary use of emergency departments;

(ii) Improve hospital efficiency, including by increasing emergency department and inpatient throughput; and

(iii) Improve postdischarge resources to facilitate timely emergency department and inpatient discharges;

(2) By identifying and recommending improvements for the collection and submission of data that is necessary to monitor and reduce emergency department wait times;

(3) By making recommendations to State and local agencies, hospitals, and health care providers; and

(4) By facilitating the sharing of best practices for reducing emergency department wait times.

§20–2404. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTER 844 OF 2024 //

In carrying out its duties, the Commission may:

(1) Recommend that State and local agencies, hospitals, and health care providers implement the strategies and initiatives developed under § 20–2403 of this subtitle;

(2) Request interviews with State and local officials;

(3) Request data from:

(i) The Department;

(ii) The Maryland Institute for Emergency Medical Services Systems;

(iii) The Health Services Cost Review Commission;

(iv) The Maryland Health Care Commission;

(v) The State–designated health information exchange;

(vi) Hospitals in the State;

(vii) Other providers of health care services; and

(viii) Payors for health care services; and

(4) Create advisory workgroups that do not include members of the Commission.

§20–2405. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTER 844 OF 2024 //

(a) Except as provided in subsection (b) of this section, an entity that receives a request for data under § 20–2404 of this subtitle shall:

(1) For data that does not contain personally identifiable information, promptly transmit the data to the staff of the Commission provided by the Health Services Cost Review Commission; and

(2) For data that contains personally identifiable information:

(i) Promptly enter into an appropriate data sharing and use agreement with the Health Services Cost Review Commission; and

(ii) On the approval of an appropriate agreement by the parties, promptly transmit the data, through a secure and encrypted manner, to the staff of the Commission provided by the Health Services Cost Review Commission.

(b) If an entity that receives a data request under § 20–2404 of this subtitle is prohibited from sharing the data under federal law, the Commission may not require the submission of the data.

(c) The Commission may use personally identifiable information requested under § 20–2404 of this subtitle only for the purpose of meeting the requirements of § 20–2403 of this subtitle and completing the reports required under § 20–2406 of this subtitle.

(d) Personally identifiable information submitted under subsection (a)(2) of this section may not be shared with:

(1) A member of the Commission who is not an employee of the Health Services Cost Review Commission; or

(2) Any other person that is not a party to the data sharing and use agreement for the information.

(e) Commission staff shall:

(1) Analyze personally identifiable information shared with the Commission staff; and

(2) Share the findings of the analysis with the members of the Commission in a manner that does not reveal personally identifiable information.

§20–2406. IN EFFECT

// EFFECTIVE UNTIL JUNE 30, 2027 PER CHAPTER 844 OF 2024 //

On or before November 1 each year, beginning in 2025, the Commission shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report on its activities and its findings and recommendations, including an update on the development, implementation, and impact of the recommended policies and programs developed to improve emergency department wait times.

§20–2501.

In this subtitle:

(1) "Caregiver" means an individual who provides care, supervision, or assistance to another individual due to the individual's age, disability, chronic illness, cognitive impairment, or other functional limitation;

(2) "Caregiver" includes:

(i) A parent or guardian of a child with a disability, chronic illness, cognitive impairment, or other functional limitation;

(ii) An individual caring for an adult family member or loved one with a disability, chronic illness, cognitive impairment, or other functional limitation; and

(iii) A minor or dependent providing care to a parent, grandparent, or other adult due to the age, disability, chronic illness, cognitive impairment, or other functional limitation of the parent, grandparent, or other adult; and

(3) "Caregiver" does not include a parent or guardian providing care, supervision, or assistance to a child that does not have a disability, chronic illness, cognitive impairment, or other functional limitation.

§20–2502.

(a) The Department shall develop and maintain a centralized caregiver resource webpage for caregivers in the State.

(b) The caregiver resource webpage shall:

(1) Be posted in a conspicuous location on the Department's website; and

(2) Provide plain–language, easily accessible information to support all types of caregivers at different stages of caregiving.

(c) The caregiver resource webpage shall include information and links to resources related to:

(1) Caregiving for:

(i) Children with disabilities and special health care needs, including educational and school–based supports;

(ii) Adults with disabilities, chronic illness, or behavioral health needs; and

(iii) Older adults, including individuals with dementia or cognitive impairment;

(2) Caregiver health, wellness, and respite resources;

(3) State and local programs that may provide financial assistance, training, or support to caregivers;

(4) Safety planning, including wandering and elopement risks; and

(5) Privacy, data minimization, and data security considerations when technology is used to support caregiving or safety.

(d) In developing the webpage under subsection (a) of this section, the Department shall coordinate with:

(1) The State Department of Education;

(2) The Department of Aging;

(3) The Developmental Disabilities Administration; and

(4) Any other relevant State or local agencies.

(e) The Department shall review and update the webpage as necessary, but not less than annually.

§20–2503.

This subtitle may not be construed to require the Department, any State or local agency, or any other person described, listed, or linked to on the caregivers resource webpage to provide or fund a specific service, device, resource, or program described, listed, or linked to on the caregivers resource webpage.

§21–101.

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

(b) "Advertisement" means any representation that:

(1) Is intended or is likely to induce, directly or indirectly, any person to purchase any food, drug, device, or cosmetic; and

(2) Is published by any means other than labeling.

(c) (1) "Color additive" means any material that:

(i) Is a dye, pigment, or other substance made by a process of synthesis or similar artifice, or extracted, isolated, or otherwise derived, with or without intermediate or final change of identity, from a vegetable, animal, mineral, or other source; or

(ii) When added or applied to a food, drug, or cosmetic, or to any part of the human body, is capable, alone or through reaction with any other substance, of imparting color, including black, white, or intermediate grays, to the food, drug, cosmetic, or body.

(2) "Color additive" does not include any material that is not a color additive under the federal act.

(d) "Consumer commodity" means any food, drug, device, or cosmetic that is not:

(1) Tobacco or a tobacco product;

(2) A commodity that is subject to packaging or labeling requirements imposed under the Federal Insecticide, Fungicide, and Rodenticide Act or the federal Animal Virus, Serum, Toxin, Antitoxin Act;

(3) A drug that is subject to the provisions of § 353(b)(1) of the federal act;

(4) A beverage that is subject to or complies with packaging or labeling requirements imposed by the federal Bureau of Alcohol, Tobacco, Firearms and Explosives; or

(5) A seed or other commodity that is subject to the provisions of §§ 9–206 through 9–213 of the Agriculture Article.

(e) (1) "Cosmetic" means any substance, or any component of a substance, that is intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body for cleansing, beautifying, promoting attractiveness, or altering appearance.

(2) "Cosmetic" does not include soap.

(f) "Device" means any instrument, apparatus, or contrivance, or any part or accessory of an instrument, apparatus, or contrivance, that is intended:

(1) For use in the diagnosis, cure, mitigation, treatment, or prevention of human disease; or

(2) To affect the structure or any function of the human body for medical, surgical, or therapeutic purposes.

(g) (1) "Drug" means any substance or component of a substance:

(i) That is recognized in an official compendium;

(ii) That is intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings; or

(iii) Except for food, that is intended to affect the structure or any function of the human body.

(2) "Drug" does not include a device.

(h) "Federal act" means the Federal Food, Drug, and Cosmetic Act as that act appears at 21 U.S.C. § 301 et seq.

(i) "Food" means:

(1) Any substance that is used as food or drink for human beings or as a component of food or drink for human beings; or

(2) Chewing gum or any substance that is used as a component of chewing gum.

(j) (1) "Food additive" means any substance:

(i) The intended use of which results or reasonably may be expected to result, directly or indirectly, in the substance becoming a component of food or otherwise affecting the characteristics of food, including any substance used to produce, manufacture, pack, process, prepare, treat, package, transport, or hold food, or any source of radiation that is intended for any of these uses; and

(ii) That is not recognized generally by qualified scientific experts as having been shown to be safe under the conditions of its intended use:

1. Through scientific procedures; or

2. Through either scientific procedures or experience based on common use, if the substance was used in a food before January 1, 1958.

(2) "Food additive" does not include a color additive.

(k) "Label" means a display of written, printed, or graphic matter on the container, other than the package liner, of a substance.

(l) "Labeling" means any label or other written or graphic material that:

(1) Is on a substance or its container or its wrapping; or

(2) Accompanies a substance.

(m) "Official compendium" means the most recent revision of the United States Pharmacopoeia and National Formulary, the official Homeopathic Pharmacopoeia of the United States, or any of their current supplements.

(n) (1) "Package" means any container or wrapping of a consumer commodity that is used for delivery or display to retail consumers.

(2) "Package" does not include any container or wrapping that is used only for:

(i) Transportation of a consumer commodity in bulk or quantity to a manufacturer, packer, processor, or wholesale or retail distributor; or

(ii) Shipment or delivery of a consumer commodity to a retail customer, if the container or wrapping bears no printed material that relates to a particular consumer commodity.

(o) "Person" includes:

(1) An operator of a facility that is owned by a State or local unit of government; or

(2) A State or local unit of government if the State or local unit of government is the operator of the facility.

(p) "Secretary" means for the purposes of this subtitle and Subtitles 2, 3, 4, 8, and 11 of this title, the Secretary of Health or the Secretary's designee.

§21–102.

(a) The provisions of this title that relate to the sale of a consumer commodity also apply to:

(1) Manufacturing, producing, processing, packing, exposing, offering, possessing, or holding the consumer commodity for sale;

(2) Dispensing or giving the consumer commodity; and

(3) Supplying or applying the consumer commodity in the operation of any food, drug, or cosmetic establishment.

(b) If a substance is alleged to be misbranded because the labeling is misleading or if an advertisement is alleged to be false because it is misleading, there shall be taken into account:

(1) The representations made or suggested by statement, word, design, symbol, or sound, alone or in combination; and

(2) The extent to which the labeling or advertisement fails to reveal consequences that may result from use of the substance.

§21–201.

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

(b) "Counterfeit drug" means a drug that:

(1) Bears, or the container or labeling of which bears, without authorization, the trademark, trade name, imprint, symbol, or any other identifying mark, or any likeness of any of these markings, of a manufacturer, processor, packer, or distributor other than the one who, in fact, manufactured, processed, packed, or distributed the drug; and

(2) By use of these markings falsely purports or is represented to be the product of, or to have been packed or distributed by, the other drug manufacturer, processor, packer, or distributor.

(c) (1) "Established name" means, in regard to a drug or an ingredient of a drug:

(i) The name designated under the federal act;

(ii) If a name has not been designated under the federal act, but the drug or ingredient has been recognized in an official compendium, then the title used in the compendium; or

(iii) If a name cannot be determined under item (i) or (ii) of this paragraph, the common or usual name of the drug or ingredient.

(2) In applying the provisions of paragraph (1)(ii) of this subsection, if a drug or an ingredient of a drug is recognized in both the United States Pharmacopoeia and National Formulary and in the Homeopathic Pharmacopoeia of the United States under different official titles, the title used in the United States Pharmacopoeia and National Formulary is the established name, unless the drug is labeled and offered for sale as a homeopathic drug, in which event the official title used in the Homeopathic Pharmacopoeia of the United States is the established name.

(d) "New drug" means any drug that:

(1) Among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, is not recognized generally as safe and effective for use under the conditions specified, recommended, or suggested in the labeling of the drug; or

(2) As a result of investigations to determine its safety and effectiveness for use, has become recognized by these experts as safe and effective under the conditions, but that, other than in the investigations, has not been used to a material extent or for a material time under the conditions.

(e) "Prescription drug" means a drug that, under § 21-220 of this subtitle, may be dispensed only on the prescription of a health practitioner who is authorized by law to prescribe the drug.

(f) "State adopted federal rule or regulation" means any rule or regulation that is adopted by the federal government under the federal act and that becomes a rule or regulation by automatic adoption under the provisions of this subtitle.

§21–202.

(a) Any drug that is designated as a "controlled dangerous substance" under Title 5 of the Criminal Law Article is governed by that title as well as by this subtitle.

(b) If, as to any drug that is a "controlled dangerous substance", there is any conflict between the provisions of this subtitle and those of Title 5 of the Criminal Law Article, the provisions of the Criminal Law Article apply.

§21–203.

If there is an outside container or wrapper for a food, drug, device, or cosmetic, then, to comply with any requirement that is imposed under this subtitle that a word, statement, or any other information appear on the label or the article, the word, statement, or other information also shall:

(1) Be placed on the outside container or wrapper; or

(2) Be legible through the outside container or wrapper.

§21–204.

Unless the drug is purported to be an antiseptic for inhibitory use as a wet dressing, ointment, or dusting powder, or as some other substance that involves prolonged contact with the body, the representation of any drug, in its labeling or in an advertisement, as an antiseptic shall be considered to be a representation that the drug is a germicide.

§21–205.

For purposes of the construction and enforcement of this subtitle, an act or omission of any officer, agent, employee, or any other person acting for or employed by any corporation, company, society, or association, shall be considered to be the act or omission of the corporation, company, society, or association, as well as of the person.

§21–207.

(a) In addition to any other ground that may be applicable under this title, a food is considered to be adulterated for purposes of this subtitle if the standards in this section or in § 21-208 or § 21-209 of this subtitle apply.

(b) A food is adulterated if:

(1) It contains any poisonous or otherwise deleterious substance that, in the quantity present, reasonably would be expected to make it injurious to health;

(2) It contains any added poisonous or added deleterious substance:

(i) That is not a food or color additive; and

(ii) The particular use of which has not been found safe as provided under § 21-239 of this subtitle;

(3) It is or contains any food additive or color additive the particular use of which has not been found safe as provided under § 21-239 of this subtitle;

(4) Any part of it is a diseased, contaminated, filthy, putrid, or decomposed substance;

(5) It was produced, prepared, packed, or held under unsanitary conditions that reasonably would be expected to have:

(i) Contaminated it with filth; or

(ii) Caused it to be diseased, unwholesome, or injurious to health;

(6) Any part of its container is composed of any poisonous or otherwise deleterious substance that reasonably would be expected to have caused the food to be injurious to health;

(7) It has been subjected intentionally to radiation, unless the use of the radiation conforms to that allowed by a rule or regulation under the federal act or under § 21-239 of this subtitle;

(8) At any time after its manufacturing, processing, or packaging, it was refrozen after having been permitted to thaw from a prior freezing; or

(9) It otherwise is unfit as food for human beings.

§21–208.

In addition to any other ground that may be applicable under § 21-207 or § 21-209 of this subtitle, a food is adulterated if:

(1) Any part of an important component that normally would be present in the food has been omitted or withdrawn from it;

(2) Any substance has been substituted for any part of an important component that normally would be present in the food;

(3) Any damage to or inferiority of the food has been concealed in any way; or

(4) It has had any substance added, mixed, or packed with it solely for any of the following purposes:

(i) To increase its bulk or weight;

(ii) To reduce its quality or strength below that which normally would be expected of the food; or

(iii) To mislead the consumer by making the food appear to be better or more valuable than it is.

§21–209.

(a) In addition to any other ground that may be applicable under § 21–207 or § 21–208 of this subtitle, a confectionary food product is adulterated if:

(1) It contains any nonnutritive object, except as permitted by the rules and regulations adopted under subsection (b)(1) of this section; or

(2) It contains any nonnutritive substance other than a safe substance:

(i) That is in or on the confectionery because of some practical functional purpose in the manufacture, packaging, or storing of the confectionery; and

(ii) The use of which does not promote deception of the consumer or otherwise result in any adulteration or misbranding in violation of this subtitle.

(b) (1) If, in the judgment of the Secretary, a nonnutritive object is of practical, functional value to a confectionary food product and its use is not injurious or hazardous to health, the Secretary may adopt a rule or regulation that permits an exception to subsection (a)(1) of this section, regarding nonnutritive objects.

(2) To avoid or resolve uncertainty, the Secretary may by rule or regulation:

(i) Interpret subsection (a)(2) of this section as that subsection applies to use of a particular nonnutritive substance; and

(ii) Allow or prohibit the use of the particular nonnutritive substance.

§21–210.

(a) For purposes of this subtitle, a food is considered to be misbranded under any condition specified in this section.

(b) A food is misbranded if:

(1) Its labeling or packaging is false or misleading in any way;

(2) It is an imitation of another food, and it does not have a label that bears, in type of uniform size and prominence, the word "imitation" followed immediately by the name of the food imitated;

(3) It is in package form and it does not bear a label that contains the name and place of business of the manufacturer, packer, or distributor;

(4) Any word, statement, or other information required under this subtitle to appear on its labeling is not placed prominently on the labeling in a manner that is:

(i) Conspicuous, as compared with other words, statements, designs, or devices on the labeling; and

(ii) In terms likely to be read and understood by the ordinary individual under customary conditions of purchase and use;

(5) It purports to be or is represented as a food for which a definition and standard of identity has been set by a rule or regulation as provided under § 21-237 of this subtitle and:

(i) The food does not conform to the definition or standard; or

(ii) Its label either does not bear the name of the food specified in the definition and standard or, contrary to the rule or regulation, it does not bear the common name of an optional ingredient, other than spices, flavoring, and coloring, that is in the food;

(6) It purports to be or is represented as a food for which a standard of quality has been set by a rule or regulation under § 21-237 of this subtitle and its quality falls below that standard, unless its label bears, in the manner and form that the rule or regulation specifies, a statement that the food falls below the standard;

(7) It is not subject to item (5) of this subsection and does not bear labeling that clearly gives:

(i) The common or usual name of the food, if there is such a name; and

(ii) Except as provided under subsections (d) and (e) of this section, if the food is made from 2 or more ingredients, the common or usual name of each ingredient;

(8) It purports to be or is represented for special dietary uses, unless its label bears the information about its vitamin, mineral, and other dietary properties that the Secretary determines by a rule or regulation adopted under § 21-213 of this subtitle to be necessary to inform purchasers fully of its value for those uses;

(9) Except as provided under subsections (c) and (e) of this section, it contains any artificial flavoring, artificial coloring, or chemical preservative, unless it bears labeling that states that fact;

(10) It is a color additive and its packaging and labeling do not conform to the applicable requirements of the federal act;

(11) After it was manufactured, processed, or packaged, the food was in a frozen state and it then is offered for sale in an unfrozen state, unless its labeling clearly and conspicuously states that the food was previously frozen and should not be refrozen;

(12) It is a product that:

(i) Is intended to be used as an ingredient of another food; and

(ii) If used according to the directions of the supplier, would result in the final food product being adulterated or misbranded; or

(13) It is offered for sale under the name of another food.

(c) As they relate to the use of artificial coloring, the provisions of subsection (b)(7), (9), and (10) of this section do not apply to butter, cheese, or ice cream.

(d) Notwithstanding the provisions of subsection (b)(7)(ii) of this section, regarding the labeling requirements for a food that is made from 2 or more ingredients, spices, flavorings, and coloring ingredients may be designated as "spices", "flavorings", and "colorings", without naming each specific item. However, this exception does not apply if the food product itself is sold as a spice, flavoring, or food coloring.

(e) (1) If, as applied to a particular food, compliance with the requirement that each of the 2 or more ingredients in the food be set forth in its labeling is impractical or results in deception or unfair competition, the Secretary shall adopt a rule or regulation that exempts that food product from the provisions of subsection (b)(7)(ii) of this section.

(2) If, as applied to a particular food product, it is impractical to comply with the requirement that the labeling disclose the presence of an artificial flavoring, an artificial coloring, or a chemical preservative, the Secretary shall adopt a rule or regulation that, to the extent appropriate, exempts that food product from any appropriate provision of subsection (b)(9) of this section.

§21–211.

(a) By the issuance, denial, or suspension of permits as provided in this section, the Secretary may regulate the distribution in this State of any class of food that may be contaminated with microorganisms.

(b) (1) The Secretary shall adopt rules and regulations that provide for the issuance of permits to food manufacturers, processors, or packers in any locality if, on investigation, the Secretary finds:

(i) That the distribution in this State of any class of food manufactured, processed, or packed in that locality may be injurious to health because of possible contamination with microorganisms; and

(ii) That the danger imposed by the food normally would not be determinable after the food has entered commerce.

(2) For whatever temporary period of time that may be necessary, the rules and regulations shall specify the conditions necessary to govern the manufacturing, processing, and packing of the class of food in question in order to protect the public from the dangers imposed by that food. These conditions shall be attached to and be considered part of any permit that is issued under this section.

(c) A person may not introduce or deliver for introduction into commerce in this State any food that was manufactured, processed, or packed by an establishment that was required by rule or regulation adopted under this section to hold a permit, unless each manufacturer, processor, and packer of the food held the required permit.

(d) (1) At any reasonable time, a representative of the Secretary may enter any establishment that holds a permit issued under this section and inspect the establishment to determine if it is in compliance with the permit conditions.

(2) If access for inspection is denied to a representative of the Department who is acting under this subsection, the Secretary may suspend the permit of the establishment involved until access is allowed.

(e) (1) If the Secretary finds that an establishment has violated any condition of a permit issued under this section, the Secretary may suspend the permit immediately after giving notice to the permit holder.

(2) The holder of a suspended permit may apply to the Secretary at any time for reinstatement of the permit.

(3) On receipt of an application for reinstatement, the Secretary shall hold a hearing and have the establishment inspected.

(4) If the Secretary finds that adequate measures have been taken to assure compliance with the permit, the Secretary immediately shall reinstate the permit:

(i) As originally issued; or

(ii) With any amendment that, under the provisions of this section, the Secretary considers proper.

§21–212.

(a) A food is not subject to the labeling requirements of this subtitle if a rule or regulation is adopted as provided under this section to exempt it.

(b) Subject to the provisions of § 21-241 of this subtitle, any rule or regulation adopted under the federal act to exempt a food from labeling requirements is effective automatically in this State.

(c) In addition to the State adopted federal rules and regulations, the Secretary shall adopt rules and regulations to exempt from the labeling requirements of this subtitle any food that is to be transported in substantial quantities from one establishment to another, if:

(1) In accordance with the practice of the trade, the food is to be processed, labeled, or repacked at the second establishment; and

(2) The Secretary has a reasonable basis to believe that the food will not be misbranded or adulterated when it is removed from the second establishment.

§21–213.

(a) Subject to the provisions of § 21-241 of this subtitle, any special dietary use rule or regulation that is adopted by the federal government under the federal act automatically is adopted as a rule or regulation of this State.

(b) Whether or not in accordance with any rule or regulation adopted under the federal act, the Secretary may adopt special dietary use rules or regulations if the Secretary finds that it is necessary to inform purchasers of the value of a food for special dietary use.

§21–214.

(a) This subtitle may not be construed to prohibit the addition of alcohol to a food product, including a confectionery and a frozen dessert.

(b) A food product that is manufactured or sold that contains more than one–half of one percent of alcohol per volume:

(1) May not be sold to individuals under 21 years of age; and

(2) Shall state on the label of the food product:

(i) That the sale of the product to individuals under 21 years of age is prohibited;

(ii) That the product contains alcohol; and

(iii) The product's alcohol percent per volume.

(c) Subsection (b) of this section may not be construed to limit the application of relevant provisions of the Alcoholic Beverages and Cannabis Article, and regulations adopted under that article, to a manufacturer or seller of a food product regulated under subsection (b) of this section.

§21–216.

(a) For purposes of this subtitle, a drug or device is adulterated if the standards in this section apply.

(b) A drug or device is adulterated if:

(1) Any part of it is a filthy, putrid, or decomposed substance; or

(2) It was produced, prepared, packed, or held under unsanitary conditions that reasonably would be expected to have:

(i) Contaminated it with filth; or

(ii) Caused it to be injurious to health.

(c) In addition to the grounds specified in subsection (b) of this section, a drug is adulterated if:

(1) Any part of its container is composed of any poisonous or otherwise deleterious substance that reasonably would be expected to have caused the drug to be injurious to health;

(2) For purposes of coloring only, it is or it contains a color additive, the particular use of which has not been found safe as provided under § 21–239 of this subtitle;

(3) The mixing or packing of any substance with the drug has reduced the quality or strength of the drug;

(4) Any substance has been substituted for any part of the drug;

(5) The methods, facilities, or controls used in the manufacture, processing, packing, or holding of the drug do not conform to, or are not administered in conformity to, good practice to assure that the drug:

(i) Meets the requirements of this subtitle as to safety; and

(ii) Has the identity, strength, quality, and purity that it purports to have;

(6) It is purported to be a drug the name of which is recognized in an official compendium and:

(i) The strength of the drug differs from, or the quality or purity of the drug falls below, the standard set in the official compendium; and

(ii) The difference in strength, quality, or purity is not stated plainly on its label; or

(7) Although not purported to be a drug recognized in an official compendium, the strength of the drug differs from, or the quality or purity of the drug falls below that which the drug purports to possess.

(d) (1) For purposes of administering subsection (c)(6) of this section, any determination as to whether the strength of a drug differs from or as to whether its quality or purity falls below the standard set in an official compendium shall be made in accordance with the tests or methods of assay set forth in the official compendium, or, in the absence of or inadequacy of those tests or methods of assay, those provided under the federal act.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, if a drug is recognized in both the United States Pharmacopoeia and National Formulary and in the Homeopathic Pharmacopoeia of the United States, it is subject to the requirements of the United States Pharmacopoeia and National Formulary.

(ii) If the drug is labeled and offered for sale as a homeopathic drug, it is subject to the provisions of the Homeopathic Pharmacopoeia of the United States and not to those of the United States Pharmacopoeia and National Formulary.

§21–217.

(a) For purposes of this subtitle, a drug or device is misbranded if the standards in this section or in § 21-218 or § 21-220(d) or (e) of this subtitle apply.

(b) A drug or device is misbranded if:

(1) Its labeling is false or misleading in any way;

(2) Its labeling or packaging does not conform with any provision of § 21-248 of this subtitle;

(3) It is in package form and it does not bear a label that contains the name and place of business of the manufacturer, packer, or distributor;

(4) Any word, statement, or other information required under this subtitle to appear on its labeling is not placed prominently on the labeling in a manner that is:

(i) Conspicuous as compared with other words, statements, designs, or symbols on the labeling; and

(ii) In terms likely to be read and understood by the ordinary individual under customary conditions of purchase and use;

(5) Its labeling does not include, in whatever manner and form that may be necessary to protect the user of the drug or device:

(i) Adequate directions for the use of the drug or device; and

(ii) Adequate warnings against:

1. The use of the drug or device by anyone suffering from a pathological condition that may cause its use to be dangerous to health;

2. The use of the drug or device by a child if its use by a child may be dangerous; and

3. Unsafe dosages, methods of administration, or duration of administration of the drug or device;

(6) It is dangerous to health when used in the dosage, with the frequency, or for the duration specified, recommended, or suggested in the labeling of the drug or device; or

(7) The trademark, trade name, imprint, symbol, or other identifying mark of another drug or any likeness of any of these markings of another drug or device is placed on the drug or device or its container with the intent to defraud.

(c) (1) Subsection (b)(5)(i) of this section, which concerns the provision of directions for the use of a drug or device, does not apply to a drug or device that is exempted by:

(i) A rule or regulation adopted under the federal act; or

(ii) A rule or regulation adopted by the Secretary under this subsection.

(2) If the Secretary finds that, as applied to a particular drug or device, any requirement of subsection (b)(5)(i) of this section is not necessary for the protection of the public health, the Secretary shall adopt a rule or regulation to exempt the drug or device from that requirement.

§21–218.

(a) In this section, "antibiotic drug" means any drug that:

(1) Is intended for use by a human being;

(2) Contains any quantity of a chemical substance or the chemically synthesized equivalent of a chemical substance that is produced by microorganisms; and

(3) Can inhibit or destroy microorganisms in dilute solution.

(b) In addition to any other ground that may apply under § 21–217 or § 21–220 of this subtitle, a drug is misbranded if:

(1) It is for use by a human being and contains any quantity of the narcotic or hypnotic substance alpha–eucaine, barbituric acid, beta–eucaine, bromal, cannabis, carbromal, chloral, coca leaves, cocaine, codeine, heroin, morphine, opium, paraldehyde, peyote, sulphonmethane, or any chemical derivative of any of these substances, which derivative, after investigation, has been designated as habit forming under a rule or regulation adopted under the federal act or by the Secretary under this subtitle, unless its label states the name and quantity or proportion of the substance or derivative and, immediately beside that information, a warning that states: "Warning — May be habit forming.";

(2) It has an established name and, to the exclusion of any other nonproprietary name except the applicable systematic chemical name or the chemical formula of the drug, its label does not bear the established name of the drug;

(3) Except as otherwise permitted by a rule or regulation adopted under the federal act or by the Secretary under subsection (d)(2) of this section, it is made from 2 or more ingredients and its label does not bear the established name, if any, of and the quantity of each active ingredient, including the kind and quantity or proportion of any alcohol and, whether active or not, the established name and quantity or proportion of any bromides, ether, chloroform, acetanilid, acetophenetidin, amidopyrine, antipyrine, atropine, hyoscine, hyoscyamine, arsenic, digitalis, digitalis glucosides, mercury, ouabain, strophanthin, strychnine, thyroid, or any derivative or preparation of any of these substances, but a nonprescription drug is not misbranded under this item on the ground that its label does not show the quantity or proportion of an active ingredient unless the ingredient is specifically named in this item;

(4) Except as otherwise permitted by a rule or regulation adopted under the federal act or by the Secretary under subsection (d)(2) of this section, it is a prescription drug, and the established name of the drug and any of its ingredients are not:

(i) Printed prominently on the label of the drug in type at least half as large as that used to print any proprietary name or other designation of the drug or of its ingredients; and

(ii) Printed in this same manner on any labeling of the drug on which any name for the drug or for an ingredient is used;

(5) It purports to be a drug whose name is recognized in an official compendium and it is not:

(i) Labeled as required by the applicable official compendium; or

(ii) Packaged as required by:

1. The applicable official compendium; or

2. A consent order granted under the federal act or by the Secretary to modify the packaging requirements of the official compendium;

(6) It has been found under the federal act or by the Secretary to be a drug liable to deterioration, and:

(i) It is not packaged in the form and manner required by the rules and regulations adopted under the federal act or by the Secretary; or

(ii) Its label does not bear a statement of precautions as required by those rules and regulations;

(7) It is a prescription drug that was manufactured after July 1, 1976, and its label does not bear the name of the actual manufacturer of the drug;

(8) Its container is made, formed, or filled in a manner that is misleading;

(9) It is an imitation of another drug;

(10) It is offered for sale under the name of another drug;

(11) It is or it is purported to be a drug that is composed in whole or in part of insulin and it is not from a batch for which a currently unexpired certificate or release has been issued under the federal act;

(12) It is or it is purported to be a drug composed in whole or in part of any kind of penicillin, streptomycin, chlortetracycline, chloramphenicol, bacitracin, or any other antibiotic drug, or of any derivative of these drugs and, unless the drug has been exempted by rules and regulations adopted under the federal act, it is not from a batch for which a currently unexpired certificate or release has been issued under the federal act;

(13) It is a color additive that is intended to be used in or on a drug for the purpose of coloring only and its packaging or labeling does not conform to any requirement adopted under § 21–239 of this subtitle; or

(14) It is a prescription drug that is distributed or offered for sale in this State, and the manufacturer, packer, or distributor of the drug does not include in any advertisement, or in any other descriptive printed matter that it issues or causes to be issued regarding the drug, a true statement of:

(i) The established name of the drug, which name is printed prominently and in type at least half as large as that used for any printed trade or brand name of the drug;

(ii) The formula of the drug showing quantitatively each ingredient of the drug to the extent required for labels under the federal act; and

(iii) A brief summary of any other information that relates to the side effects, contraindications, or effectiveness of the drug, as is required by the rules and regulations adopted under the federal act.

(c) (1) For purposes of subsection (b)(5) of this section, which imposes packaging and labeling requirements on any drug that is purported to be recognized in an official compendium, the provisions of this subsection shall apply.

(2) (i) Except as otherwise provided in this subsection, if the drug is recognized in both the United States Pharmacopoeia and National Formulary and in the Homeopathic Pharmacopoeia of the United States, it is subject to the packaging and labeling requirements of the United States Pharmacopoeia and National Formulary.

(ii) If the drug is labeled and offered for sale as a homeopathic drug, it is subject to the packaging and labeling requirements of the Homeopathic Pharmacopoeia of the United States and not to the requirements of the United States Pharmacopoeia and National Formulary.

(3) If there is an inconsistency between the provisions of paragraph (2) of this subsection and the requirements of subsection (b)(2), (3), or (4) of this section as to the name by which a drug or its ingredients shall be designated, the requirements of subsection (b)(2), (3), or (4) of this section control.

(d) (1) For purposes of subsection (b)(1) of this section, after investigation, the Secretary may adopt a rule or regulation that designates any chemical derivative of any substance named in that subsection as habit forming.

(2) If, as to a particular drug, compliance with any requirement of subsection (b)(3) or (4) of this section is impractical, the Secretary shall adopt a rule or regulation that, to the extent appropriate, exempts the drug from the provisions of those subsections.

(3) (i) If the Secretary finds that a drug is liable to deterioration, the Secretary may adopt a rule or regulation that specifies how the drug is to be packaged and requires that its label bear a statement of precautions.

(ii) The Secretary may not adopt a rule or regulation under subparagraph (i) of this paragraph before the Secretary has informed the appropriate body that is charged with the revision of the official compendium of the need for the packaging or labeling requirements and that body has failed to adopt the requirements within a reasonable time.

§21–219.

(a) A drug or device is not subject to the labeling or packaging requirements of this subtitle if a rule or regulation is adopted under the federal act or as provided under this section to exempt it.

(b) The Secretary shall adopt rules and regulations to exempt from the labeling requirements of this subtitle any drug or device that is to be transported in substantial quantities from one establishment to another, if in accordance with the practice of the trade, the drug or device is to be processed, labeled, or repacked at the second establishment.

§21–220.

(a) A drug that is intended for use by human beings and is in any of the following classifications may be dispensed by a pharmacist only on a written prescription, an electronic prescription, as defined in § 5–101 of the Criminal Law Article, or an oral prescription from a health practitioner authorized by law to prescribe the drug:

(1) A habit–forming drug to which § 21–218(b)(1) of this subtitle applies.

(2) A drug that because of its toxicity or other potentiality for harmful effect, the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a health practitioner who is authorized by law to administer such a drug.

(3) A drug that is limited by an approved application under § 355 of the federal act or § 21–223 of this subtitle to use under the professional supervision of a health practitioner authorized by law to administer such a drug.

(b) (1) Subject to paragraph (2) of this subsection and subsection (c) of this section, a prescription may be written or oral or made through an electronic prescription.

(2) A pharmacist may not dispense a drug on an oral prescription unless the pharmacist promptly writes out and files the prescription.

(c) (1) Except as provided in paragraph (2) of this subsection, a health practitioner authorized by law to prescribe a controlled dangerous substance within the meaning of Title 5 of the Criminal Law Article shall issue a prescription for a controlled dangerous substance using an electronic prescription, as defined in § 5–101 of the Criminal Law Article.

(2) A health practitioner may issue a written or, if authorized by State and federal law, oral prescription for a controlled dangerous substance only if:

(i) Electronic prescribing is not available due to temporary technological or electrical failure;

(ii) The prescription is to be dispensed by a pharmacy located outside the State;

(iii) The prescription is issued by a health practitioner outside the State;

(iv) The health practitioner is prescribing and dispensing the controlled dangerous substance directly to the patient;

(v) The prescription is being dispensed directly to the patient in accordance with § 12–102(c)(2)(iv) of the Health Occupations Article;

(vi) The prescription is for an individual who:

1. Resides in a nursing or assisted living facility;

2. Is receiving care through a hospice or palliative care program and the prescription is related to the care provided;

3. Is receiving care at an outpatient renal dialysis facility and the prescription is related to the care provided; or

4. Is detained or confined in a correctional facility, as defined in § 1–101 of the Correctional Services Article;

(vii) The prescription is issued by a licensed veterinarian;

(viii) The prescription includes elements that are not supported by the most recent version of the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard;

(ix) The prescription is issued for a drug for which the federal Food and Drug Administration requires the prescription to contain certain elements that cannot be transmitted electronically;

(x) The prescription prescribes a drug under a research protocol;

(xi) The prescription is issued by a health practitioner who has received a waiver under subsection (d)(1) of this section;

(xii) The prescription is issued by a health practitioner who requested a waiver under subsection (d)(1) of this section and the Department has not issued a waiver to the practitioner or has not rejected the practitioner's request for a waiver;

(xiii) The health practitioner issuing the prescription or the drug for which the prescription is issued falls under a waiver issued by the Secretary under subsection (d)(2) of this section;

(xiv) The prescription is issued by a health practitioner who writes a low volume of prescriptions for controlled dangerous substances, as determined by the Maryland Health Care Commission; or

(xv) The prescription is issued by a health practitioner under circumstances in which, although the practitioner has the ability to issue an electronic prescription as required by paragraph (1) of this subsection, the health practitioner reasonably determines that:

1. It would be impracticable for the practitioner to prescribe the drug or device by electronic prescription in a timely manner; and

2. The delay would adversely impact the patient's medical condition.

(3) This subsection may not be construed to limit the right of a patient to designate a specific pharmacy to dispense a prescribed drug or device to the individual.

(d) (1) The Secretary shall adopt regulations, in collaboration with the Maryland Health Care Commission, to establish a process for the Department to issue a waiver from the electronic prescription requirements in subsection (c)(1) of this section.

(2) (i) The Secretary may issue a waiver that applies generally to a group of health practitioners or drugs that meet conditions specified by the Secretary.

(ii) Any waiver issued under subparagraph (i) of this paragraph for a group of health practitioners shall apply to a health practitioner in that group without requiring the health practitioner to go through the process established in regulations under paragraph (1) of this subsection.

(3) Except for a waiver issued under paragraph (2) of this subsection, the regulations adopted under paragraph (1) of this subsection shall specify that a waiver:

(i) May not exceed 1 year; and

(ii) May be granted for the following reasons:

1. Economic hardship;

2. Technological limitations that are not reasonably within the control of the health practitioner; or

3. Any other exceptional circumstances as demonstrated by the health practitioner.

(4) The Secretary may adopt regulations on:

(i) Which temporary technological or electrical failures constitute an exception to the requirement to issue an electronic prescription under subsection (c)(1) of this section; and

(ii) The circumstances under which a health practitioner is exempt from the requirement to issue an electronic prescription under subsection (c)(1) of this section because the prescription will be dispensed by a pharmacy located outside the State.

(e) The appropriate health occupations board established under the Health Occupations Article may take disciplinary action against a health practitioner who violates subsection (c) of this section.

(f) (1) A pharmacist may dispense a drug on a written or oral prescription for a controlled dangerous substance that meets the requirements of this section.

(2) A pharmacist who receives a written or oral prescription is not required to verify that the prescription is an authorized exception to the electronic prescription requirement under subsection (c)(2) of this section.

(g) (1) If a prescription for a controlled dangerous substance within the meaning of Title 5 of the Criminal Law Article is written, it may not be written on a preprinted prescription form that states the name, quantity, or strength of the controlled dangerous substance.

(2) When a prescription is written, a separate prescription form is required for each controlled dangerous substance. If a pharmacist is otherwise satisfied that a prescription is valid the pharmacist may fill the prescription if the pharmacist promptly writes out and files a prescription for each substance and also files the original prescription.

(3) A written prescription shall be legible.

(h) A pharmacist may not refill and dispense a prescription unless the refilling is authorized by:

(1) The health practitioner's specification in the original prescription as to how many times it may be refilled; or

(2) An oral order of the health practitioner that promptly is written out and filed by the pharmacist.

(i) The dispensing of a drug without complying with the requirements of this section is the dispensing of a misbranded drug.

(j) (1) A drug that is subject to the prescription requirements of this section is misbranded if, at any time before it is dispensed, its label does not bear the statement "Caution: Federal Law Prohibits Dispensing Without Prescription", or "Caution: State Law Prohibits Dispensing Without Prescription".

(2) A drug to which the prescription requirements of this section do not apply is misbranded if, at any time before it is dispensed, its label bears the caution statement quoted in paragraph (1) of this subsection.

(k) (1) The prescription requirements of this section do not apply to any drug that is exempted under a rule or regulation adopted by the Secretary.

(2) The Secretary, by rule or regulation, may exempt any drug from the requirements of this section if the Secretary finds that, as to the drug, the requirements of this section are not necessary for the protection of the public health.

(3) The Secretary, by rule and regulation, may exempt from the requirements of this section any drug that is removed from the prescription requirements of the federal act by a rule or regulation adopted under that act.

§21–221.

(a) A drug that is dispensed under a prescription shall bear a label that states:

(1) The name and address of the dispenser;

(2) The serial number of the prescription;

(3) The date of the prescription or the date that the prescription was filled;

(4) The name of the prescriber; and

(5) If stated in the prescription:

(i) The name of the patient;

(ii) Any directions for use; and

(iii) Any cautionary statements.

(b) If a drug dispensed under a prescription meets the label requirements of this section, it is exempt from the provisions of:

(1) Section 21-217(b)(3) through (7) of this subtitle; and

(2) Section 21-218(b)(1) through (4), (7), (8), (13), and (14) of this subtitle.

(c) The exemptions under this section do not apply to any drug that is dispensed in the course of the conduct of a business of dispensing drugs on the basis of diagnosis made through the mail.

§21–222.

Nothing in § 21-220 or § 21-221 of this subtitle relieves any person from any requirement imposed by law with respect to any drug that is classified as a controlled dangerous substance within the meaning of Title 5 of the Criminal Law Article or the applicable federal law.

§21–223.

(a) This section does not apply to any drug that:

(1) Was sold in this State or introduced into interstate commerce at any time before the enactment of the federal act, if its labeling contained the same representations concerning the conditions of its use; or

(2) Is licensed under the Public Health Service Act of July 1, 1944, or under the Animal Virus, Serum, Toxin, Antitoxin Act of March 4, 1913.

(b) A person may not sell, give away, or deliver any new drug:

(1) Unless an approved application for the drug is in effect under § 355 of the federal act; or

(2) Unless an application has been approved by the Secretary and is in effect under this section, if the drug is not subject to the federal act.

(c) To have an application approved by the Secretary, an applicant shall file with the Secretary an application that sets forth:

(1) Full reports of the investigations that have been made to show whether the drug is safe for use and whether the drug is effective in use;

(2) A full statement of the composition of the drug;

(3) A full description of the methods used in, and the facilities and controls used for, the manufacture, processing, and packing of the drug;

(4) Any sample of the drug and of any article used as a component of the drug that the Secretary requires; and

(5) A specimen of the labeling that is proposed to be used for the drug.

(d) The Secretary may not approve an application filed under this section unless the drug has been tested and, under the conditions specified, recommended, or suggested in the proposed labeling of the drug, has been found to be safe for and effective in use.

(e) An application filed with the Secretary under this section shall be considered approved on the 180th day after it is filed, unless before that day and after giving the applicant notice and an opportunity for a hearing, the Secretary issues an order of disapproval under subsection (f) of this section on a finding that:

(1) The drug has not been tested properly, as required by subsection (d) of this section;

(2) Under the conditions specified, recommended, or suggested in the proposed labeling of the drug, it is not safe for or effective in use;

(3) The methods used in, and the facilities and controls used for, the manufacture, processing, and packing of the drug are inadequate to preserve its identity, strength, quality, and purity; or

(4) Based on a fair evaluation of all material facts, the proposed labeling is false or misleading in any way.

(f) If, before the date that the application otherwise would be considered approved the Secretary makes any of the findings that are enumerated in subsection (e) of this section concerning the drug, the Secretary shall issue an order that disapproves the application.

(g) (1) The Secretary may revoke an order that disapproved an application and the application then shall be considered approved.

(2) After providing an opportunity for a public hearing and judicial appeal, the Secretary may revoke an application that was approved under this section if, based on evidence that is acquired after approval, the Secretary finds that:

(i) The drug may not be safe for or effective in its intended use; or

(ii) The facilities or controls used in the manufacture, processing, or labeling of the drug may present a hazard to the public health.

(h) In accordance with any rule or regulation that is adopted or any order that is issued by the Secretary under this section, the person who holds an application for a drug that is approved under this section shall:

(1) Keep records; and

(2) Submit reports to the Secretary.

(i) (1) The Secretary may adopt rules and regulations that apply generally to persons whose applications for drugs have been approved or, as to a particular person whose application has been approved, issue an order that requires an applicant:

(i) To keep records of information that relates to clinical experience with the drug and any other information that the applicant obtains about the drug; and

(ii) To submit reports to the Secretary concerning that information.

(2) When adopting a rule or regulation or issuing an order that requires the submission of information under this subsection, the Secretary shall consider the professional ethics of the medical profession and the interests of patients.

(3) Any rule, regulation, or order under this section shall provide that if any person to whom the rule, regulation, or order applies requests it, and if the Secretary considers it to be appropriate, the person may examine similar information that is obtained by the Secretary concerning the drug.

§21–224.

(a) (1) A new drug is not subject to the requirements of § 21-223 of this subtitle if it is exempted by a rule or regulation adopted under this section.

(2) This section does not require any clinical investigator to submit directly to the Secretary any report on the investigational use of a drug.

(b) The Secretary shall adopt rules and regulations to exempt from the requirements of § 21-223 of this subtitle any drug that is intended only for investigational use by experts who are qualified by scientific training and experience to investigate the safety and effectiveness of the drug. In addition to any other conditions that may be imposed for the protection of the public health, the rules and regulations may require as a condition for the exemption of a drug that:

(1) Before any clinical testing of a new drug is undertaken, the manufacturer of the drug or the sponsor of the investigation of the drug submit to the Secretary reports of preclinical tests of the drug, including tests on animals, that are adequate to justify the proposed clinical testing;

(2) The manufacturer of a new drug that is proposed to be distributed to investigators for clinical testing or the sponsor of the investigation obtain a signed agreement from each investigator who is involved that:

(i) The patients to whom the drug is administered will be under that investigator's personal supervision or under the supervision of an investigator who is responsible to that investigator; and

(ii) The investigator will not supply the drug to any other investigator, or to any clinic, for administration to a human being; and

(3) The manufacturer of a new drug or the sponsor of the investigation of the drug keep records of, and make reports to the Secretary of, the information obtained from the investigational use of the drug, including analytical reports by investigators, as the Secretary finds will assist in the evaluation of the safety and effectiveness of the drug if an application for the drug is filed under § 21-223 of this subtitle.

(c) (1) When adopting a rule or regulation that requires the submission of information under this subsection, the Secretary shall consider the professional ethics of the medical profession and the interests of patients.

(2) Any rule, regulation, or order under this section shall provide that if any person to whom the rule, regulation, or order applies requests it, and if the Secretary considers it to be appropriate, the person may examine any similar information that is obtained by the Secretary concerning the drug.

(d) (1) Any rule or regulation adopted under § 355(i) of the federal act automatically shall be a rule or regulation of this State, as provided in § 21-241 of this subtitle.

(2) However, the Secretary may adopt a rule or regulation under this section even if it is not in accord with the rules and regulations adopted under the federal act.

§21–225.

Any person who is required under § 21-223 or § 21-224 of this subtitle to keep records and any person who is in charge or custody of any of these records, on the request of the Secretary, shall permit the Secretary to have access to, copy, and verify the records at any reasonable time.

§21–226.

(a) The manufacturer, packer, or distributor of any prescription drug that is sold or distributed in this State shall:

(1) Keep correct copies of any printed matter that is:

(i) Required to be included in any package in which the drug is sold or distributed; or

(ii) Approved under the federal act; and

(2) Send copies of the printed matter to any health practitioner who is authorized to administer the drug and who makes a written request for information about the drug.

(b) This section does not exempt any person from any labeling requirement imposed under any other provision of this subtitle.

§21–227.

On a specific written request by the Secretary, the manufacturer, packer, or distributor of any prescription drug that is sold or distributed in this State shall give the Secretary:

(1) Any information that the manufacturer, packer, or distributor has about the biological availability and clinical performance of the drug; and

(2) Any comparative information that the manufacturer, packer, or distributor has about any drug, of the same established name, that is manufactured, packed, or distributed by another person.

§21–228.

A person may not sell or offer for sale a natural membrane condom by means of a vending machine or other automatic device.

§21–230.

(a) In Part IV of this subtitle, "hair dye" does not mean eyelash dye or eyebrow dye.

(b) For purposes of this subtitle, a cosmetic is considered adulterated if:

(1) Except as provided for coal tar hair dye in subsection (c) of this section, it contains any poisonous or otherwise deleterious substance that, in the quantity present, reasonably would be expected to make it injurious to a user under the conditions of use:

(i) That are instructed, recommended, or suggested in the labeling or advertisement of the cosmetic; or

(ii) That are customary or usual for the cosmetic;

(2) It contains a filthy, putrid, or decomposed substance;

(3) It was produced, prepared, packed, or held under unsanitary conditions that reasonably would be expected to have:

(i) Contaminated it with filth; or

(ii) Caused it to be injurious to health;

(4) Any part of its container is composed of any poisonous or otherwise deleterious substance that reasonably would be expected to have caused the cosmetic to be injurious to health; or

(5) It is not a hair dye and it is or it contains a color additive the particular use of which has not been found safe as provided under § 21-239 of this subtitle.

(c) A coal tar hair dye is not considered adulterated under subsection (b)(1) of this section if it:

(1) Has on its label a conspicuously displayed warning that states: "Caution -- This product contains ingredients which may cause skin irritation on certain individuals and a preliminary test according to accompanying directions should first be made. This product must not be used for dyeing the eyelashes or eyebrows; to do so may cause blindness."; and

(2) Has on its labeling adequate directions for the preliminary testing that is referenced on the label.

§21–231.

(a) For purposes of this subtitle, a cosmetic is considered misbranded if:

(1) Its labeling or packaging is false or misleading in any way;

(2) It is in package form and it does not bear a label that contains the name and place of business of the manufacturer, packer, or distributor;

(3) Any word, statement, or other information required under this subtitle to appear on its labeling is not:

(i) Placed prominently on the labeling so that it is conspicuous, as compared with other words, statements, designs, or symbols, on the labeling; and

(ii) Expressed in terms likely to be read and understood by the ordinary individual under customary conditions of purchase and use; or

(4) Except as provided in subsection (b)(1) of this section for color additives to be used in hair dyes, it is a color additive and its packaging and labeling do not meet the applicable requirements of the federal act.

(b) (1) A package of color additive is not misbranded under subsection (a)(4) of this section if it is marketed and intended for use only in or on a hair dye.

(2) A cosmetic that, in accordance with the practice of the trade, is to be processed, labeled, or repacked in substantial quantities at an establishment other than the establishment in which it originally is processed or packed, is exempt from the affirmative labeling requirements of this section while the cosmetic is in transit from the one establishment to the other, if the transit is made for completion only.

§21–234.

(a) The Secretary may adopt rules and regulations to carry out the provisions of this subtitle.

(b) Except for a State adopted federal rule or regulation, the Secretary may not adopt any rule or regulation under this subtitle unless the requirements of this subtitle and the Administrative Procedure Act are met.

§21–235.

(a) So far as practicable, the Secretary may conform any rule or regulation adopted under this subtitle to the rules and regulations adopted under the federal act.

(b) The Secretary may adopt for purposes of this subtitle any rule or regulation adopted by the United States Department of Agriculture.

§21–236.

The Secretary shall give notice of and hold any hearing authorized or required by this subtitle in accordance with the Administrative Procedure Act.

§21–237.

(a) (1) Except as provided for meat and poultry products under paragraph (3) of this subsection and for frozen desserts under Subtitle 8 of this title, the definitions and standards of identity and quality adopted by rule or regulation

under the federal act for foods are the definitions and standards of identity and quality for foods in this State.

(2) By rule or regulation, the Secretary may adopt a definition or standard of identity or quality for any food if:

(i) A definition or standard has not been adopted for the food under the federal act; and

(ii) The Secretary finds that the definition or standard will promote honesty and fair dealing in the interest of consumers.

(3) Any definition or standard of identity or quality for a meat or poultry product that is adopted under a rule or regulation of the State Department of Agriculture is the definition or standard of identity or quality for that product in this State.

(b) (1) For purposes of this subtitle, the standards for the quality, purity, and strength of any drug are the standards set by an official compendium.

(2) If a drug is not standardized by an official compendium, then subject to § 21-241 of this subtitle, the standards of quality, purity, and strength adopted by rule or regulation under the federal act are the standards of quality, purity, and strength for the drug in this State.

§21–238.

(a) If a temporary permit is issued under the federal act to authorize an interstate shipment that varies from the definitions and standards of identity set under the federal act, the permit is effective in this State under the conditions provided in the permit.

(b) For experimental or other purposes, the Secretary may issue a permit that authorizes variations from the definitions and standards of identity and quality that are set under this subtitle if:

(1) The Secretary finds that issuance of the permit is in the public interest; and

(2) The permit is issued on terms and with safeguards that adequately protect the interests of consumers and potential consumers.

§21–239.

(a) (1) For purposes of §§ 21-207(b)(3), 21-216(b)(2), and 21-230(b)(5) of this subtitle, regarding food, drugs, and cosmetics respectively, the use of any added poisonous or otherwise deleterious substance, any food additive, or any color additive is considered unsafe unless the use of the substance or additive for the particular purpose is authorized by and the quantity of the substance that may be used for that purpose is limited by:

(i) A State adopted federal rule or regulation, as provided under subsection (b) of this section; or

(ii) A rule or regulation adopted by the Secretary under subsection (c) of this section.

(2) If a food, drug, or cosmetic contains any added poisonous or otherwise deleterious substance, any food additive, or any color additive in a quantity that is allowed by a rule or regulation as provided by paragraph (1) of this subsection, the food, drug, or cosmetic may not be considered adulterated because it contains that substance or additive.

(b) Subject to the provisions of § 21-241 of this subtitle, any rule or regulation that regulates the use of a food additive or a color additive and that is adopted by the federal government under the federal act automatically is adopted as a rule or regulation of this State.

(c) Whether or not in accordance with any rule or regulation that sets tolerances under the federal act and if public health or other considerations in this State make it necessary, the Secretary may adopt a rule or regulation that:

(1) As to any added poisonous or otherwise deleterious substance, any food additive, or any color additive:

(i) Prohibits its use; or

(ii) Sets tolerances for its use; or

(2) As to any food additive or any color additive:

(i) Sets conditions under which it may be used safely; or

(ii) Provides exemptions for its use for investigational or experimental purposes.

(d) (1) The rule or regulation may be adopted by the Secretary either on the Secretary's own initiative or on the petition of any interested party.

(2) Before the Secretary may adopt the rule or regulation on the basis of a petition, the petitioner shall establish by information that is submitted to the Secretary that the rule or regulation is needed and that the effect of the rule or regulation will not harm the public health.

(3) If the information submitted by the petitioner is not sufficient to allow the Secretary to determine whether, under the standards set forth in subsection (e) of this section, the rule or regulation should be adopted, the Secretary may require that additional information be submitted. Failure by the petitioner to comply with the Secretary's request is a sufficient ground to deny the petition.

(e) The Secretary, in determining whether to adopt a rule or regulation under this section, shall consider:

(1) The name of and all pertinent information that concerns the substance or additive, including, if available:

(i) Its chemical identity and composition;

(ii) The conditions of its proposed use, including directions, recommendations, and suggestions;

(iii) Samples of the proposed labeling for the substance or additive; and

(iv) All relevant information bearing on the physical or other technical effect of the substance or additive and the quantity of the substance or additive that is required to produce the effect;

(2) The probable composition of any substance that may be formed in or on a food, drug, or cosmetic as a result of the use of the substance or additive;

(3) The probable amount of the substance or additive that would be consumed in the average human diet, taking into account any chemically or pharmacologically related substance in the diet;

(4) Safety factors that, in the opinion of experts qualified by scientific training and experience to evaluate the safety of the substance or additive for its proposed use, are generally recognized as appropriate for the use of animal experimentation information;

(5) The availability of a practicable method of analysis for determining the identity and quantity of:

(i) The substance or the additive in or on an article;

(ii) Any other substance that is formed in or on the article because of the use of the added substance or color additive; and

(iii) The pure substance or additive and any intermediate or impurity of the substance or additive;

(6) Any fact that supports a contention that the proposed use of the substance or additive would serve a useful purpose; and

(7) Any other factor that is relevant to the issues of whether there is a need for the use of the substance or additive or whether the use would harm the public health.

§21–240.

(a) Unless a written protest is filed with the Secretary, a rule or regulation proposed by the Secretary under this subtitle takes effect on the date the Secretary designates but not earlier than 90 days after publication.

(b) Any person who may be affected adversely by a rule or regulation that is proposed by the Secretary under this subtitle may:

(1) File a protest within 30 days after publication of the proposed rule or regulation; and

(2) Request a hearing.

§21–241.

(a) Unless a written protest is filed with the Secretary, a State adopted federal rule or regulation takes effect in this State on the date that it becomes effective as a federal rule or regulation.

(b) Any person who may be affected adversely by a State adopted federal rule or regulation may:

(1) File a protest against the federal rule or regulation not more than 30 days after its effective date; and

(2) Request a hearing.

(c) A protest under this section stays the effect of the State adopted federal rule or regulation as a rule or regulation of this State.

§21–242.

If a written protest against a rule or regulation is filed in accordance with § 21-240 or § 21-241 of this subtitle, the Secretary shall hold a public hearing:

(1) To receive evidence on the issues raised by the protest; and

(2) To hear any interested person.

§21–243.

(a) (1) As soon as practicable after a hearing on a protest to a rule or regulation under § 21-242 of this subtitle, the Secretary shall:

(i) Act on the protest by issuing an order; and

(ii) Send a copy of the order to each protester by certified mail, return receipt requested, bearing a postmark from the United States Postal Service.

(2) Each order issued under this section shall be based on substantial evidence in the record of the hearing.

(b) An order issued by the Secretary under this section may:

(1) Reinstate, rescind, or modify a State adopted federal rule or regulation as a rule or regulation of this State; or

(2) As to any other rule or regulation proposed under this subtitle:

(i) Withdraw the proposal;

(ii) Modify the proposal and set an effective date for the modified proposal that is at least 60 days after publication of the order; or

(iii) Set a new effective date for the original proposal that is at least 60 days after publication of the order.

§21–244.

(a) The Secretary shall provide a copy of this subtitle and Subtitle 1 of this title:

(1) To the extent possible, to any person who in this State manufactures, packs, stores, or sells, at wholesale or retail, any food, drug, device, or cosmetic; and

(2) To any person who requests it.

(b) The Secretary may:

(1) Publish summaries of judgments, decrees, or court orders issued under this subtitle;

(2) Otherwise collect, report, or illustrate the results of any investigation conducted under this subtitle; and

(3) Disseminate any information regarding any food, drug, device, or cosmetic if the Secretary considers the information necessary for the public health or for the protection of consumers against fraud.

§21–247.

For purposes of this subtitle, an advertisement for a food, drug, device, or cosmetic is considered to be false if it is false or misleading in any way.

§21–248.

(a) In addition to any finding that may be made under § 21-247 of this subtitle and except as otherwise provided in this section, an advertisement is considered to be false if it represents that a drug or device has any effect regarding albuminuria, appendicitis, arteriosclerosis, blood poison, bone disease, Bright's disease, cancer, carbuncles, cholecystitis, diabetes, diphtheria, dropsy, erysipelas, gallstones, any heart or vascular disease, high blood pressure, mastoiditis, measles, meningitis, mumps, nephritis, otitis media, paralysis, pneumonia, poliomyelitis (infantile paralysis), any prostate gland disorder, pyelitis, scarlet fever, sexual impotence, sinus infection, smallpox, tuberculosis, tumors, typhoid, uremia, or any venereal disease.

(b) If an advertisement for a drug or device is not otherwise considered to be false under § 21-247 of this subtitle, it is not false under this section if:

(1) It is disseminated only to members of the medical, dental, or veterinary professions;

(2) It appears only in the scientific periodicals of these professions; or

(3) It is disseminated only for the purpose of public health education by a person who does not have a direct or indirect commercial interest in the sale of the drug or device.

(c) (1) An advertisement for a drug or device is not false under this section if a rule or regulation is adopted that authorizes the advertisement, as provided in this subsection.

(2) (i) If the Secretary finds that an advance in medical science has made any type of self-medication safe for the treatment of any disease or disorder named in subsection (a) of this section, the Secretary shall adopt a rule or regulation that authorizes the advertisement of any drug or device that has a curative or therapeutic effect for the disease or disorder.

(ii) A rule or regulation that authorizes an advertisement is subject to any condition or restriction that the Secretary considers necessary to protect the public health.

(d) This section does not indicate that self-medication for any disease or disorder other than the diseases and disorders named in subsection (a) of this section is safe or effective.

(e) Any representation made in the labeling of a drug or device that would be a false advertisement under this section if it appeared elsewhere, is a misbranding of the drug or device under § 21-217 of this subtitle.

§21–249.

(a) (1) For the purpose of enforcing this subtitle and after presentation of appropriate credentials to the owner, operator, or agent in charge, the Secretary or a representative of the Secretary may enter and inspect at any reasonable time:

(i) Any factory, warehouse, or other establishment in which any food, drug, device, or cosmetic is manufactured, processed, packed, or held for a commercial purpose; and

(ii) Any vehicle used to transport or hold any food, drug, device, or cosmetic for a commercial purpose.

(2) An inspection carried out under this section may include an inspection of the establishment or vehicle itself and of any pertinent equipment, labeling, and finished and unfinished products.

(3) An inspection carried out under this section shall be completed with reasonable promptness.

(b) (1) As to any factory, warehouse, consulting laboratory, or other establishment in which any prescription drug is manufactured, processed, packed, or held, an extended inspection under this section shall include everything in the establishment that may have a bearing on whether the establishment has violated a provision of this subtitle regarding prescription drugs, including the records, processes, controls, and facilities.

(2) The authority under this subsection to conduct extended inspections of the records of an establishment that relate to prescription drugs does not include the authority to inspect records of the establishment that relate to:

(i) Financial information;

(ii) Sale information, other than shipment information;

(iii) Pricing information;

(iv) Personnel information, other than information as to the qualifications of technical and professional personnel who perform functions subject to this subtitle; or

(v) Research information, other than information that:

1. Relates to a new drug or an antibiotic drug and is subject to requirements for reporting and inspection that are imposed by rules and regulations adopted under § 355(i) or (k) or § 357(d) or (g) of the federal act; or

2. Relates to any other drug and would be subject to reporting or inspection under rules and regulations adopted under § 355(k) of the federal act.

(3) Authority to conduct extended inspections under this subsection does not apply to:

(i) Any pharmacy that complies with the laws of this State that regulate practicing pharmacy or medicine and that does not, through a subsidiary or otherwise, manufacture, prepare, propagate, compound, or process any

drug for sale, other than in the regular course of its business of dispensing or selling drugs at retail;

(ii) Any health practitioner who is authorized by law to prescribe or administer drugs and who manufactures, prepares, propagates, compounds, or processes a drug solely for use in the course of the practitioner's professional practice;

(iii) Any person who manufactures, prepares, propagates, compounds, or processes any drug for use only in research, teaching, or chemical analysis, and not for sale; or

(iv) Any other class of person that the Secretary by rule or regulation exempts from the application of this subsection after a finding that, for that class of person, an inspection in accordance with this subsection is not necessary for the protection of the public health.

(c) (1) During any inspection under this section, the Secretary may obtain a sample of any item that is subject to the inspection.

(2) When obtaining a sample from an establishment under this subsection, the Secretary shall give the owner, operator, or agent in charge a receipt that describes the sample obtained.

(d) On completing an inspection under this section and before leaving the establishment, the Secretary or representative of the Secretary shall:

(1) Make a written report that sets forth any condition or practice that was observed during the inspection and that indicates that any food, drug, device, or cosmetic in the establishment:

(i) Contains any filthy, putrid, or decomposed substance; or

(ii) Has been prepared, packed, or held under unsanitary conditions by which it:

1. May have become contaminated with filth; or

2. Otherwise may have been rendered injurious to health; and

(2) Give the owner, operator, or agent in charge of the establishment a copy of the report.

§21–250.

(a) For the purpose of enforcing this subtitle and after presentation of appropriate credentials to any person who is in charge of or has custody of the records, the Secretary or a representative of the Secretary may have access to and may copy any record of a carrier in commerce if the record concerns the movement or holding, for commercial purposes, of any food, drug, device, or cosmetic, including information that shows the quantity, shipper, and consignee of the article.

(b) Any evidence that is obtained under this section may not be used in any criminal prosecution of the person from whom it is obtained.

(c) A carrier in commerce is not subject to any other provision of this subtitle other than this section simply because the carrier receives, carries, holds, or delivers any food, drug, device, or cosmetic in the usual course of its business as a carrier.

§21–251.

(a) If, while conducting an inspection under § 21-249 of this subtitle or while performing any other function under this subtitle, the Secretary obtains a sample of a food or drug, the Secretary may have an analysis or other examination made in a laboratory of the Department to determine:

(1) As to a food sample, whether the food:

(i) Is misbranded;

(ii) Contains any filthy, putrid, or decomposed substance; or

(iii) Is otherwise adulterated or unfit for food; or

(2) As to a drug sample, whether the drug:

(i) Is adulterated; or

(ii) Is misbranded.

(b) The results of an analysis or other examination conducted under this section shall be set forth in a written report and a copy of the report shall be given promptly to the owner, operator, or agent in charge of the establishment from which the sample was obtained.

§21–252.

In addition to and not instead of any other remedy authorized under this subtitle, the Secretary may bring an action to temporarily or permanently enjoin any violation of §§ 21-256 through 21-259 of this subtitle.

§21–253.

(a) Under this section, there is a ground for action against a food, drug, device, or cosmetic if it is:

(1) Adulterated;

(2) So misbranded that it is dangerous or fraudulent;

(3) A food that violates any requirement imposed under § 21-211 of this subtitle; or

(4) A drug that violates the provisions on new drugs under § 21-223 of this subtitle.

(b) If the Secretary finds or has probable cause to believe that there is ground for action against a food, drug, device, or cosmetic, the Secretary shall attach to the article a tag or other appropriate marking that gives notice that the article is, or is suspected of being, adulterated, misbranded, or in violation of § 21-211 or § 21-223 of this subtitle and that the article has been detained. The tag or other marking also shall warn all persons not to remove or dispose of the article, by sale or otherwise, until permission for removal or disposal is given by the Secretary, an authorized agent of the Secretary, or a court.

(c) If, after an article has been marked as provided in subsection (b) of this section, the Secretary finds that there is not a ground for action against the article, the Secretary shall remove the marking and release the article.

(d) (1) The Secretary may proceed further against any article as to which there is a ground for action by filing a petition for an order with the circuit court for the county in which the article is located. The petition may request any relief permitted by this subsection.

(2) If the court finds that there is a valid ground for action against the article, the court may proceed by issuing an order:

(i) Of forfeiture for destruction; or

(ii) To have the article delivered to its claimant and have the violation corrected by proper labeling or processing.

(3) If the court issues an order of forfeiture for destruction, the article shall be destroyed under the supervision of the Secretary and the owner shall pay all court, storage, and destruction costs, and any other cost that is incurred through the enforcement of this subtitle against the article.

(4) If the court issues an order to have the article delivered to its claimant for correction of the violation, the order shall require that the claimant:

(i) Correct the violation under the supervision of a representative of the Secretary;

(ii) Pay all court and storage costs, the expense of supervision by the representative of the Secretary, and any other cost that is incurred through the enforcement of this subtitle against the article; and

(iii) Post a bond that is conditioned on the obligation that the article be labeled or processed properly and that the expense of supervision by the representative of the Secretary be paid.

(5) A bond that is posted under this subsection shall be discharged on a representation to the court by the Secretary that there no longer is a ground for action against the article and that the expense of supervision has been paid.

§21–254.

(a) (1) For purposes of this section, an "immediate threat" exists if any meat, seafood, poultry, vegetable, fruit, or any other perishable substance that is intended for consumption as food:

(i) Contains any filthy, decomposed, or putrid substance;

(ii) Is poisonous or otherwise would be injurious to health if consumed; or

(iii) Is otherwise unsafe.

(2) If a food poses an immediate threat, it shall be considered a public nuisance.

(b) If the Secretary finds that a food poses an immediate threat, the Secretary immediately shall destroy the food or otherwise make the food unusable for consumption by human beings.

(c) The owner of a substance that is destroyed or otherwise made unusable under this section may bring a suit for damages against the Secretary.

(d) The Secretary shall have the immunity from liability described under § 5–633 of the Courts Article.

§21–255.

(a) Except as otherwise provided in this section, the Secretary shall report to the State's Attorney any alleged criminal violation of this subtitle.

(b) Before the Secretary reports any alleged violation of this subtitle to a State's Attorney for the institution of a criminal proceeding, the Secretary shall give the alleged violator notice and an opportunity to present that person's views to the Secretary either orally or in writing. The views of the alleged violator may be presented by counsel.

(c) If the Secretary believes that there has been a violation of this subtitle, but that the violation was minor and the public interest would be served adequately in the circumstances by a written notice or warning, the Secretary may issue a written notice or warning instead of reporting the violation to the State's Attorney.

§21–256.

A person may not:

(1) Manufacture or sell any food, drug, device, or cosmetic that is adulterated or misbranded;

(2) Adulterate or misbrand any food, drug, device, or cosmetic;

(3) Make a food, drug, device, or cosmetic become adulterated by altering, mutilating, destroying, obliterating, or removing any part of its labeling while the food, drug, device, or cosmetic is held for sale;

(4) Receive in commerce any adulterated or misbranded food, drug, device, or cosmetic;

(5) Deliver or offer for delivery any adulterated or misbranded food, drug, device, or cosmetic, whether or not for pay;

(6) Disseminate any false advertisement;

(7) Sell any food in violation of any requirement imposed under § 21-211 of this subtitle;

(8) Fail to comply with § 21-249 or § 21-250 of this subtitle by refusing to permit:

(i) An entry or inspection;

(ii) The taking of a sample; or

(iii) Access to or copying of any record;

(9) Remove or dispose of any article that is detained or restricted under § 21-253 of this subtitle; or

(10) Forge, counterfeit, simulate, falsely represent, or, without proper authority, use any mark, stamp, tag, label, or other identifying symbol that is authorized or required by any rule or regulation that is adopted under the provisions of the federal act or of this subtitle.

§21–257.

(a) Except to the extent that the person is engaged in the packing or labeling of the commodity or specifies, by any means, the manner in which the commodity is packed or labeled, this section does not apply to any person who is engaged in business as a wholesale or retail distributor of a consumer commodity.

(b) A person may not distribute a consumer commodity in commerce if:

(1) The commodity is contained in a package that does not conform to a requirement that is imposed under this subtitle; or

(2) A label that does not conform to a requirement imposed under this subtitle is attached to the commodity.

§21–258.

(a) In this section, "counterfeit marking tool" means any punch, die, plate, stone, or other thing that is designed to print, imprint, or otherwise reproduce the trademark, trade name, imprint, symbol, or any other identifying mark of a drug, or

a likeness of any of these markings, on a drug or on the container of a drug, other than the drug or container to which the marking belongs.

(b) A person may not:

(1) Sell any new drug in violation of § 21-223 of this subtitle;

(2) On the labeling of any drug or in any advertisement relating to the drug, use any representation or suggestion that an application as to the drug is effective under § 21-223 of this subtitle, or that the drug complies with that section;

(3) Fail to maintain and to provide to a health practitioner on request printed matter that relates to prescription drugs, as required under § 21-226 of this subtitle;

(4) Place or cause to be placed on any drug or device or on its container, with intent to defraud, the trade name, imprint, or other identifying mark of any other drug or any likeness of any of these markings;

(5) With knowledge that the trade name, imprint, or other identifying mark of another drug, or any likeness of any of these markings has been placed on a drug or device or its container in violation of item (4) of this subsection:

(i) Sell, dispense, or dispose of the drug or device or its container;

(ii) Cause the drug or device or its container to be sold, dispensed, or disposed of; or

(iii) Conceal or keep possession, control, or custody of the drug or device or its container with intent to sell, dispense, or dispose of it;

(6) Make, sell, or dispose of any counterfeit marking tool;

(7) Cause any counterfeit marking tool to be made, sold, or disposed of;

(8) Keep possession, control, or custody of any counterfeit marking tool;

(9) Conceal any counterfeit marking tool;

(10) Cause a drug to be a counterfeit drug;

(11) Sell or dispense a counterfeit drug or hold a counterfeit drug for sale or dispensing;

(12) Except as permitted under § 12-504 of the Health Occupations Article, dispense or cause to be dispensed, without the permission of the prescriber, a different drug or brand of drug instead of the drug or brand of drug prescribed;

(13) Prescribe any drug on a written prescription form without clearly identifying the name of the prescriber;

(14) Dispense any drug based on a prescription form that lacks the prescriber's name and signature which:

(i) May not be made by use of a rubber stamp; but

(ii) Except as otherwise required by State law for a controlled dangerous substance, is not required for oral prescription orders; or

(15) Fail to provide to the Secretary on request information about prescription drugs, as required under § 21-227 of this subtitle.

§21–259.

A person may not:

(1) Make a written report that falsely certifies the results of any inspection, examination, or test that is made to determine if there is a violation of any provision of this part;

(2) Use to that person's own personal advantage any information that is acquired under authority of this subtitle and concerns any method or process that is entitled to protection as a trade secret; or

(3) Other than to the Secretary, to the Secretary's authorized representative, or to a court in a judicial proceeding under this subtitle, reveal any information that:

(i) Is acquired under authority of this subtitle; and

(ii) Concerns any method or process that is entitled to protection as a trade secret.

§21–259.1.

(a) A person may not open a sealed, closed, or fastened food container in a food store or supermarket if opening the package or container will leave the item in an unsalable condition, unless the person:

(1) Intends to purchase the item; or

(2) Has received from the proprietor authority to open the item.

(b) A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $25.

(c) The penalty provisions of Subtitle 12 of this title do not apply to this section.

§21–259.2.

(a) In this section:

(1) "Ingredient" means any single chemical entity or mixture used as a component in the manufacture of a cosmetic product; and

(2) "Ingredient" does not include an incidental ingredient, as described in 21 C.F.R. § 701.3(l).

(b) Except as provided in subsection (c) of this section, a person may not knowingly manufacture, sell, deliver, hold, or offer for sale in the State a cosmetic product that contains any of the following intentionally added ingredients:

(1) Dibutyl phthalate (CAS no. 84–74–2);

(2) Diethylhexyl phthalate (CAS no. 117–81–7);

(3) Formaldehyde (CAS no. 50–00–0);

(4) Paraformaldehyde (CAS no. 30525–89–4);

(5) Methylene glycol (CAS no. 463–57–0);

(6) Quaternium–15 (CAS no. 51229–78–8);

(7) Mercury (CAS no. 7439–97–6);

(8) Isobutylparaben (CAS no. 4247–02–3);

(9) Isopropylparaben (CAS no. 4191–73–5);

(10) m–Phenylenediamine and its salts (CAS no. 108–45–2);

(11) o–Phenylenediamine and its salts (CAS no. 95–54–5);

(12) Lead (CAS no. 7439–92–1); or

(13) The following per– and polyfluoroalkyl substances (PFAS) and their salts:

(i) Perfluorooctane sulfonate (PFOS) or heptadecafluorooctane–1–sulfonic acid (CAS no. 1763–23–1);

(ii) Potassium perfluorooctanesulfonate or potassium heptadecafluorooctane–1–sulfonate (CAS no. 2795–39–3);

(iii) Diethanolamine perfluorooctane sulfonate (CAS no. 70225–14–8);

(iv) Ammonium perfluorooctane sulfonate or ammonium heptadecafluorooctanesulfonate (CAS no. 29081–56–9);

(v) Lithium perfluorooctane sulfonate or lithium heptadecafluorooctanesulfonate (CAS no. 29457–72–5);

(vi) Perfluorooctanoic acid (PFOA) (CAS no. 335–67–1);

(vii) Ammonium pentadecafluorooctanoate (CAS no. 3825–26–1);

(viii) Nonadecafluorodecanoic acid (CAS no. 335–76–2);

(ix) Ammonium nonadecafluorodecanoate (CAS no. 3108–42–7);

(x) Sodium nonadecafluorodecanoate (CAS no. 3830–45–3);

(xi) Perfluorononanoic acid (PFNA) (CAS no. 375–95–1);

(xii) Sodium heptadecafluorononanoate (CAS no. 21049–39–8); or

(xiii) Ammonium perfluorononanoate (CAS no. 4149–60–4).

(c) A person is not in violation of this section if the person manufactures, sells, delivers, holds, or offers for sale in the State a cosmetic product that:

(1) Was manufactured through a process intended to comply with this section; and

(2) Contains a technically unavoidable trace quantity of an ingredient listed in subsection (b) of this section due to:

(i) An impurity of a natural or synthetic ingredient;

(ii) The manufacturing process;

(iii) Storage; or

(iv) Packaging.

(d) (1) In addition to any other penalties under this title, a person who violates this section is liable for civil damages resulting from actual harm sustained by the individual resulting from the violation.

(2) An action under this section must be brought within 3 years after the date on which the plaintiff discovered or reasonably should have discovered that the exposure to an ingredient in violation of this section was the proximate cause of the injury sustained by the plaintiff.

(3) In any action brought to enforce this section, a court may award to a prevailing plaintiff:

(i) Treble damages;

(ii) If the violation was willful, punitive damages; and

(iii) Reasonable attorney's fees.

(e) (1) The Department may investigate any complaint alleging that a person has violated this section.

(2) On receipt of a complaint, a representative of the Department, at a reasonable time, may enter and inspect the premises of the person located in the State to determine compliance with this section.

(3) The person may not:

(i) Refuse to grant access to a representative who requests to enter and inspect the premises of the person under paragraph (2) of this subsection; or

(ii) Interfere with an inspection under paragraph (2) of this subsection.

(4) An investigation of a premises of a person conducted under this subsection may include sampling of a cosmetic product to determine if the cosmetic product contains a technically unavoidable trace quantity of an ingredient listed in subsection (b) of this section.

§21–259.3.

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

(2) "Animal testing" means the internal or external application or exposure of a cosmetic or any component of a cosmetic to the skin, eye, or any other body part of a live nonhuman vertebrate.

(3) "Ingredient" has the meaning stated in 21 C.F.R. § 700.3(e).

(4) "Manufacturer" means any person whose name appears on the label of a cosmetic in accordance with the requirements of 21 C.F.R. § 701.12.

(b) (1) Except as provided in subsection (c) of this section, a person may not conduct or contract for animal testing in the development of a cosmetic.

(2) Except as provided in subsection (c) of this section, beginning July 1, 2022, a manufacturer may not sell or offer for sale in the State a cosmetic if the manufacturer knows or reasonably should have known that the final product or any individual component of the final product was developed or manufactured using animal testing that was conducted or contracted by or for the manufacturer or any entity that supplies, directly or through a third party, any ingredient used by a manufacturer in the formulation of a cosmetic on or after January 1, 2022.

(c) The provisions of subsection (b) of this section do not apply to animal testing that is:

(1) Conducted or contracted to comply with a requirement of a federal or state regulatory agency if:

(i) The cosmetic or ingredient in the cosmetic that is tested is in wide use and cannot be replaced by another ingredient that is capable of performing a similar function in the product;

(ii) A specific human health problem relating to the cosmetic or an ingredient in the cosmetic is substantiated and the need to conduct animal testing is justified and supported by a detailed protocol for research that is proposed as the basis for the evaluation of the cosmetic or ingredient in the cosmetic; and

(iii) Animal testing is the only method of testing that is accepted for the relevant purpose by the federal or state regulatory agency;

(2) Conducted or contracted to comply with the requirement of a regulatory agency of a foreign jurisdiction if:

(i) No evidence derived from the testing was relied on to substantiate the safety of a cosmetic sold by the manufacturer within the State; and

(ii) The testing was not conducted in the State;

(3) Performed on a cosmetic or an ingredient in a cosmetic subject to the requirements of Subchapter V of the Federal Food, Drug, and Cosmetic Act;

(4) Conducted or contracted to comply with a requirement of a federal, state, or foreign regulatory agency for purposes unrelated to cosmetics testing if:

(i) No evidence derived from the testing was relied on to substantiate the safety of a cosmetic sold by the manufacturer within the State; or

(ii) 1. Documentary evidence demonstrates that the intent of the test that was performed was unrelated to cosmetics testing; and

2. The ingredient that was the subject of the testing has been used for purposes unrelated to cosmetics for at least 12 months; or

(5) Performed on:

(i) A cosmetic that, in its final form, was tested on animals before January 1, 2022, whether or not the cosmetic is manufactured on or after January 1, 2022; or

(ii) A cosmetic ingredient that was sold in the State and tested on animals before January 1, 2022, whether or not the ingredient is manufactured on

or after January 1, 2022, if any animal testing of the cosmetic ingredient after January 1, 2022, is conducted or relied on in accordance with this section.

(d) This section may not be construed to prevent a cosmetics manufacturer from reviewing, assessing, or retaining data resulting from animal testing.

(e) A political subdivision of the State may not adopt or enforce a provision of a local law relating to animal testing on cosmetics or animal testing on ingredients used in cosmetics.

(f) (1) A person who violates this section is subject to a civil penalty:

(i) Not exceeding $5,000 for the first offense; and

(ii) Not exceeding $1,000 for each subsequent offense.

(2) Each violation of this section with respect to a separate animal and each day on which a violation occurs is a separate violation under this section.

(3) If a person who is alleged to have violated this section claims the prohibition in subsection (b) of this section does not apply because the testing falls under subsection (c)(1)(ii) of this section, the person shall provide clear, documented evidence of the date on which the data were generated.

(g) (1) A local law enforcement agency may enforce the provisions of this section.

(2) (i) The State's Attorney for each county may seek appropriate relief for violations of this section.

(ii) A State's Attorney, in determining whether a violation of this section occurred, may review any testing data on which a manufacturer has relied in determining the safety of a cosmetic or an ingredient in a cosmetic sold in the State.

(iii) Any testing data reviewed under subparagraph (ii) of this paragraph is entitled to protection as a trade secret.

§21–260.

(a) Except as to an alleged violation that is enumerated under subsection (b)(2) of this section, a person may not be convicted of any violation of this part, if, with respect to the alleged violation, the person establishes by a preponderance of

evidence that the person did not commit the alleged violation purposely, knowingly, recklessly, or negligently.

(b) (1) A person may not be convicted of any violation of the provisions of this subtitle that are enumerated under paragraph (2) of this subsection, if, with respect to the alleged violation, the person establishes by a preponderance of the evidence that:

(i) For the purpose of disclosing the possible existence of the violation, the person:

1. Made an inspection, examination, or test; or

2. Received a written report that certified the results of an inspection, examination, or test that was made;

(ii) The inspection, examination, or test and the instruments, personnel, and methods used in connection with it reasonably would be expected to disclose the existence of the violation;

(iii) The inspection, examination, test, or the written report provided no basis for a belief that the alleged violation existed; and

(iv) The person did not commit the alleged violation purposely, knowingly, recklessly, or negligently.

(2) The provisions of paragraph (1) of this subsection apply to any violation of any of the following provisions of this subtitle:

(i) § 21-256(1) of this subtitle, concerning the manufacture or sale of an adulterated or misbranded article;

(ii) § 21-256(2) of this subtitle, concerning the adulteration or misbranding of any article;

(iii) § 21-256(4) of this subtitle, concerning the receipt in commerce of any adulterated or misbranded article;

(iv) § 21-256(5) of this subtitle, concerning the delivery of any adulterated or misbranded article;

(v) § 21-258(b)(13) of this subtitle, concerning the failure to identify on a prescription form the name of the prescriber of a drug;

(vi) § 21-258(b)(14) of this subtitle, concerning the dispensing of a drug on a written prescription that lacks the name of the prescriber; and

(vii) § 21-258(b)(15) of this subtitle, concerning the provision to the Secretary of information about prescription drugs.

(c) For purposes of this section, an inspection, examination, or test by representative samples of a lot, delivery, or other mercantile quantity is considered to be a method that reasonably would be expected to disclose the existence of a violation with respect to all of the articles included in the lot, delivery, or other mercantile quantity.

(d) Unless the person also is the manufacturer, packer, distributor, or seller of the article, a publisher, radio or television broadcast license holder, or other agency or medium for the dissemination of an advertisement is not liable under this subtitle for the dissemination by that person of a false advertisement concerning a food, drug, device, or cosmetic.

§21–261.

(a) If the Department believes that a person is violating any provision of this subtitle or any regulation adopted under this subtitle, the Department may have the person served with a written order that directs the person served to abate the violation within a time specified in the order.

(b) Except as otherwise provided in the Administrative Procedure Act, the Department shall give any person served with an order under this section an opportunity for a hearing before the Department.

(c) After a hearing under this section, the Department may affirm, modify, or withdraw the order.

§21–263.

This subtitle may be cited as the "Maryland Food, Drug, and Cosmetic Act".

§21–2A–01.

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

(b) "Board" means the Advisory Board on Prescription Drug Monitoring.

(c) (1) "Dispense" has the meaning stated in § 12–101 of the Health Occupations Article.

(2) "Dispense" does not include:

(i) Directly administering a monitored prescription drug to a patient; or

(ii) Giving out prescription drug samples.

(d) (1) "Dispenser" means a person authorized by law to dispense a monitored prescription drug to a patient or the patient's agent in the State.

(2) "Dispenser" includes a nonresident pharmacy.

(3) "Dispenser" does not include:

(i) A licensed hospital pharmacy that only dispenses a monitored prescription drug for direct administration to an inpatient of the hospital;

(ii) An opioid treatment services program;

(iii) A veterinarian licensed under Title 2, Subtitle 3 of the Agriculture Article when prescribing controlled substances for animals in the usual course of providing professional services;

(iv) A pharmacy issued a waiver permit under COMAR 10.34.17.03 that provides pharmaceutical specialty services exclusively to persons living in assisted living facilities, comprehensive care facilities, and developmental disabilities facilities; and

(v) A pharmacy that:

1. Dispenses medications to an inpatient hospice; and

2. Has been granted a waiver under § 21–2A–03(f) of this subtitle.

(e) "Licensing entity" means an entity authorized under the Health Occupations Article to license, regulate, or discipline a prescriber or dispenser.

(f) (1) "Monitored prescription drug" means a prescription drug that contains a Schedule II, Schedule III, Schedule IV, or Schedule V controlled dangerous substance designated under Title 5, Subtitle 4 of the Criminal Law Article.

(2) "Monitored prescription drug" does not include naloxone medication.

(g) "Naloxone medication" means an opioid antagonist approved by the federal Food and Drug Administration for the reversal of an opioid overdose.

(h) "Naloxone medication data" means the information submitted to the Program for naloxone medication.

(i) "Office" means the Office of Controlled Substances Administration in the Department.

(j) "Opioid treatment services program" means a program that:

(1) Is certified in accordance with § 8–401 of this article or licensed by the State under § 7.5–401 of this article;

(2) Is authorized to treat patients with opioid dependence with a medication approved by the federal Food and Drug Administration for opioid dependence;

(3) Complies with:

(i) The Code of Federal Regulations 42, Part 8;

(ii) COMAR 10.47.02.11; and

(iii) Requirements for the secure storage and accounting of opioid medication imposed by the federal Drug Enforcement Administration and the Office; and

(4) Has been granted a certification for operation by the Department, the federal Substance Abuse and Mental Health Services Administration, and the federal Center for Substance Abuse Treatment.

(k) "Pharmacist" means an individual who is licensed under Title 12 of the Health Occupations Article, or by another state, to dispense a monitored prescription drug.

(l) "Pharmacist delegate" means an individual who is:

(1) Authorized by a registered pharmacist to request or access prescription monitoring data; and

(2) Employed by or under contract with the same professional practice as the registered pharmacist.

(m) "Prescriber" means a licensed health care professional authorized by law to prescribe a monitored prescription drug.

(n) "Prescriber delegate" means an individual who is:

(1) Authorized by a registered prescriber to request or access prescription monitoring data; and

(2) Employed by or under contract with the same professional practice as the prescriber.

(o) "Prescription drug" has the meaning stated in § 21–201 of this title.

(p) "Prescription monitoring data" means the information submitted to the Program for a monitored prescription drug.

(q) "Program" means the Prescription Drug Monitoring Program established under this subtitle.

(r) "Registered" means registered with the Program to request or access prescription monitoring data for clinical use.

(s) "Terminal illness" means a medical condition that, within reasonable medical judgment, involves a prognosis for a patient that likely will result in the patient's death within 6 months.

§21–2A–02.

(a) There is a Prescription Drug Monitoring Program in the Department.

(b) The mission of the Program is to:

(1) Assist prescribers, pharmacists, and public health professionals in:

(i) The identification and prevention of prescription drug abuse; and

(ii) The identification and investigation of unlawful prescription drug diversion; and

(2) Promote a balanced use of prescription monitoring data to assist appropriate law enforcement activities while preserving the professional practice of health care providers and the access of patients to optimal pharmaceutical care.

(c) To carry out its mission, the Program shall monitor the prescribing and dispensing of all Schedule II, Schedule III, Schedule IV, and Schedule V controlled dangerous substances and the dispensing of naloxone medication by all prescribers and dispensers in the State.

§21–2A–03.

(a) The Department shall implement the Program, subject to the availability of funds.

(b) The Secretary may:

(1) Assign responsibility for the operation of the Program to any unit in the Department;

(2) Contract with any qualified person for the efficient and economical operation of the Program; and

(3) Identify and publish a list of monitored prescription drugs that have a low potential for abuse by individuals.

(c) Except as provided in subsection (d) of this section, each dispenser shall submit prescription monitoring data and naloxone medication data to the Program by electronic means, in accordance with regulations adopted by the Secretary.

(d) The Secretary, for good cause shown, may authorize a dispenser to submit prescription monitoring data or naloxone medication data by an alternative form of submission.

(e) The Secretary, in consultation with the Maryland Health Care Commission and the Board, shall:

(1) Determine the appropriate technology to support the operation of the Program; and

(2) Educate dispensers, prescribers, pharmacists, prescriber delegates, pharmacist delegates, and consumers about the purpose and operation of the Program.

(f) (1) The Secretary shall grant a waiver to a pharmacy that dispenses medications to an inpatient hospice from reporting to the Program prescription monitoring data for hospice inpatients if:

(i) The pharmacy demonstrates how it will distinguish hospice inpatients from other consumers receiving medications from the pharmacy; and

(ii) The pharmacy agrees that it will be subject to onsite, unannounced inspections by the Department to verify its reporting of the prescription data of consumers who are not hospice inpatients.

(2) A waiver granted under this subsection may remain in effect for up to 2 years.

(3) The Secretary may establish an application process for a pharmacy to apply for a waiver under this subsection.

§21–2A–04.

(a) The Secretary, in consultation with the Board, shall adopt regulations to carry out this subtitle.

(b) The regulations adopted by the Secretary shall:

(1) Specify the prescription monitoring data and naloxone medication data required to be submitted under § 21–2A–03 of this subtitle;

(2) Specify the electronic or other means by which information is to be submitted:

(i) Without unduly increasing the workload and expense on dispensers; and

(ii) In a manner as compatible as possible with existing data submission practices of dispensers;

(3) Specify that the information be submitted by dispensers once every 24 hours;

(4) Specify that the Program:

(i) Shall provide the information technology software to dispensers necessary to upload prescription drug monitoring data and naloxone medication data to the Program; and

(ii) May not impose any fees or other assessments on prescribers or dispensers to support the operation of the Program;

(5) Identify the mechanism by which:

(i) Prescription monitoring data are disclosed to a person, in accordance with § 21–2A–06 of this subtitle; and

(ii) Naloxone medication data are disclosed to a person, in accordance with § 21–2A–06.1 of this subtitle;

(6) Identify the circumstances under which a person may disclose prescription monitoring data or naloxone medication data received under the Program;

(7) Specify the process for the Program's review of prescription monitoring data and naloxone medication data and reporting of:

(i) Possible misuse or abuse of a monitored prescription drug under § 21–2A–06(c) of this subtitle; or

(ii) A possible violation of law or possible breach of professional standards under § 21–2A–06(d) of this subtitle;

(8) Establish requirements for Program retention of prescription monitoring data and naloxone medication data; and

(9) Require that:

(i) Confidential or privileged patient information be kept confidential; and

(ii) Records or information protected by a privilege between a health care provider and a patient, or otherwise required by law to be held confidential, be filed in a manner that, except as otherwise provided in §§ 21–2A–06 and 21–2A–06.1 of this subtitle, does not disclose the identity of the person protected.

§21–2A–04.1.

(a) A prescriber shall be registered with the Program before obtaining a new or renewal registration with the Department under § 5–304(a) of the Criminal Law Article or by July 1, 2017, whichever is sooner.

(b) A pharmacist shall be registered with the Program by July 1, 2017.

(c) Before registering with the Program, a prescriber and a pharmacist shall complete a course of instruction and training developed by the Department, including the effective use of the Program.

§21–2A–04.2.

(a) (1) Beginning July 1, 2018, a prescriber:

(i) Shall request at least the prior 4 months of prescription monitoring data for a patient before initiating a course of treatment for the patient that includes prescribing or dispensing an opioid or a benzodiazepine;

(ii) Shall, if a patient's course of treatment continues to include prescribing or dispensing an opioid or a benzodiazepine for more than 90 days after the initial request for prescription monitoring data, request prescription monitoring data for the patient at least every 90 days until the course of treatment has ended; and

(iii) Shall assess prescription monitoring data requested from the Program before deciding whether to prescribe or dispense or continue prescribing or dispensing an opioid or a benzodiazepine.

(2) If a prescriber decides to prescribe or continue to prescribe an opioid or a benzodiazepine after requesting prescription monitoring data from the Program and assessing the prescription monitoring data, the prescriber shall document in the patient's medical record that the prescription monitoring data was requested and assessed.

(b) A prescriber is not required to request prescription monitoring data from the Program if the opioid or benzodiazepine is prescribed or dispensed to an individual:

(1) In an amount indicated for a period not to exceed 3 days;

(2) For the treatment of cancer or cancer–related pain;

(3) Who is:

(i) A patient receiving treatment in an inpatient unit of a hospital;

(ii) 1. A patient in a general hospice care program as defined in § 19–901 of this article; or

2. Any other patient diagnosed with a terminal illness;

(iii) A patient who resides in:

1. An assisted living facility;

2. A long–term care facility;

3. A comprehensive care facility; or

4. A developmental disabilities facility; or

(4) To treat or prevent acute pain for a period of not more than 14 days following:

(i) A surgical procedure;

(ii) A fracture;

(iii) Significant trauma; or

(iv) Childbirth.

(c) A prescriber may not be required to comply with the provisions of this section when:

(1) Prescribing or dispensing an opioid or a benzodiazepine drug that has been listed by the Secretary under § 21–2A–03(b)(3) of this subtitle as having a low potential for abuse;

(2) Accessing prescription monitoring data would result in a delay in the treatment of a patient that would negatively impact the medical condition of the patient;

(3) Electronic access to prescription monitoring data is not operational as determined by the Department; or

(4) Prescription monitoring data cannot be accessed by the prescriber due to a temporary technological or electrical failure.

(d) If a prescriber does not access prescription monitoring data for any of the reasons provided under subsection (c)(2), (3), or (4) of this section:

(1) The prescriber shall use reasonable medical judgment in determining whether to prescribe or dispense an opioid or a benzodiazepine; and

(2) The prescriber shall enter an appropriate record in the patient's medical chart, including the reason why prescription monitoring data was not accessed.

(e) If a pharmacist or pharmacist delegate has a reasonable belief that a patient may be seeking a monitored prescription drug for any purpose other than the treatment of an existing medical condition:

(1) Before dispensing a monitored prescription drug to the patient, the pharmacist or pharmacist delegate shall request prescription monitoring data to determine if the patient has received other prescriptions that indicate misuse, abuse, or diversion of a monitored prescription drug; and

(2) The pharmacist shall have the responsibility described in 21 C.F.R. § 1306.04.

(f) The Secretary may adopt regulations to provide additional clinical, technical, or administrative exemptions based on new standards of practice.

§21–2A–04.3.

A prescriber or pharmacist may authorize a prescriber delegate or pharmacist delegate to request prescription monitoring data on behalf of the prescriber or pharmacist if:

(1) The prescriber or pharmacist takes reasonable steps to ensure that the prescriber delegate or pharmacist delegate is competent in the use of the Program;

(2) The prescriber or pharmacist remains responsible for:

(i) Ensuring that access to the Program by the prescriber delegate or pharmacist delegate is limited to purposes authorized by law;

(ii) Protecting the confidentiality of the prescription monitoring data; and

(iii) Any breach of confidentiality by the prescriber delegate or pharmacist delegate; and

(3) The decision whether to prescribe or dispense a monitored prescription drug for a patient:

(i) Remains with the prescriber or pharmacist; and

(ii) Is reasonably informed by the prescription monitoring data obtained from the Program.

§21–2A–05.

(a) There is an Advisory Board on Prescription Drug Monitoring in the Department.

(b) The Board shall consist of the following members:

(1) The Secretary, or the Secretary's designee;

(2) The President of the State Board of Pharmacy, or the President's designee;

(3) The Chair of the State Board of Physicians, or the Chair's designee;

(4) The President of the State Board of Nursing, or the President's designee;

(5) The President of the State Board of Dental Examiners, or the President's designee;

(6) The President of the State Board of Podiatric Medical Examiners, or the President's designee;

(7) The Chairman of the Maryland Health Care Commission, or the Chairman's designee;

(8) Four physicians and one nurse practitioner with expertise in clinical treatment using controlled dangerous substances, including pain

management, substance abuse, and behavioral disorders, appointed by the Secretary after consultation with:

(i) For the physician appointments, MedChi, The Maryland State Medical Society, the Maryland Physical Medicine and Rehabilitation Society, the Maryland Society of Anesthesiologists, the Maryland–D.C. Society of Clinical Oncology, the Hospice and Palliative Care Network of Maryland, and the Maryland Chapter of the American Academy of Pediatrics; and

(ii) For the nurse practitioner appointment, the Maryland Nurses Association;

(9) One pediatrician, appointed by the Secretary after consultation with the Maryland Chapter of the American Academy of Pediatrics;

(10) Three pharmacists who represent the perspective of independent and chain pharmacies, appointed by the Secretary after consultation with the Maryland Pharmacists Association, the Maryland Association of Chain Drug Stores, and any other appropriate organization;

(11) A local law enforcement official, appointed by the Secretary after consultation with the Maryland Chiefs of Police Association and the Maryland Sheriff's Association;

(12) The Secretary of State Police, or the Secretary's designee;

(13) The President of the Maryland Association of County Health Officers, or the President's designee;

(14) An academic or research professional; and

(15) Two Maryland residents who represent the perspective of patients, appointed by the Secretary.

(c) The Secretary shall designate the chair of the Board.

(d) (1) The term of a member appointed by the Secretary is 3 years.

(2) The terms of members appointed by the Secretary are staggered as required by the terms provided for members of the Board on October 1, 2011.

(3) If a vacancy occurs during the term of an appointed member, the Secretary shall appoint a successor who shall serve until the term expires.

(e) A member of the Board:

(1) May not receive compensation as a member of the Board; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Board shall:

(1) Meet not fewer than three times annually;

(2) Make recommendations to the Secretary relating to the design and implementation of the Program, including recommendations relating to:

(i) Regulations;

(ii) Legislation; and

(iii) Sources of funding, including grant funds under the Harold Rogers Prescription Drug Monitoring Program and other sources of federal, private, or State funds;

(3) Provide annually to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report that includes:

(i) The number of prescribers and prescriber delegates registered with and using the Program;

(ii) The number of pharmacists and pharmacist delegates registered with and using the Program;

(iii) The number of disclosures made to federal law enforcement agencies or State or local law enforcement agencies;

(iv) An analysis of the impact of the Program on patient access to pharmaceutical care and on curbing prescription drug diversion in the State;

(v) 1. The number of providers, by provider type, who received outreach and education from the Program; and

2. The number of cases for which the providers received outreach and education from the Program;

(vi) 1. The number of cases that were identified for technical advisory committee review before referral to the Office; and

2. The number of providers, by provider type, involved in the cases;

(vii) 1. The number of cases that were referred to the Office for further evaluation and the outcomes of the Office evaluations; and

2. The number of providers, by provider type, involved in the cases; and

(viii) Any recommendations related to modification or continuation of the Program; and

(4) Provide ongoing advice and consultation on the implementation and operation of the Program, including recommendations relating to:

(i) Changes in the Program to reflect advances in technology and best practices in the field of electronic health records and electronic prescription monitoring;

(ii) Changes to statutory requirements; and

(iii) The design and implementation of an ongoing evaluation component of the Program.

(g) The Secretary and the Board shall consult with stakeholders and professionals knowledgeable about prescription drug monitoring programs as appropriate to obtain input and guidance about implementation of the Program.

§21–2A–06.

(a) Prescription monitoring data:

(1) Are confidential and privileged, and not subject to discovery, subpoena, or other means of legal compulsion in civil litigation;

(2) Are not public records; and

(3) Except as provided in subsections (b), (c), (d), and (f) of this section or as otherwise provided by law, may not be disclosed to any person.

(b) The Program shall disclose prescription monitoring data, in accordance with regulations adopted by the Secretary, to:

(1) A prescriber, or a licensed health care practitioner authorized by the prescriber, in connection with the medical care of a patient;

(2) A dispenser, or a licensed health care practitioner authorized by the dispenser, in connection with the dispensing of a monitored prescription drug;

(3) A federal law enforcement agency or a State or local law enforcement agency, on issuance of a subpoena, for the purpose of furthering an existing bona fide individual investigation;

(4) A licensing entity, on issuance of an administrative subpoena, for the purposes of furthering an existing bona fide individual investigation;

(5) A rehabilitation program under a health occupations board, on issuance of an administrative subpoena;

(6) A patient with respect to prescription monitoring data about the patient;

(7) The Office of the Attorney General, on issuance of a subpoena for the purpose of furthering a bona fide existing investigation;

(8) Subject to subsection (i) of this section, authorized users of another state's prescription drug monitoring program or any other authorized local, state, territorial, or federal agency in connection with the provision of medical care;

(9) The following units of the Department, on approval of the Secretary, for the purpose of furthering an existing bona fide individual investigation:

(i) The Maryland Medical Assistance Program;

(ii) The Office of the Inspector General;

(iii) The Office of Health Care Quality; and

(iv) The Office;

(10) The technical advisory committee established under § 21–2A–07 of this subtitle for the purposes set forth in subsections (c), (d), and (e) of this section;

(11) The medical director of a health care facility, as defined in § 19–114 of this article, or the medical director's designee, for the purpose of providing health care practitioners employed or contractually employed at the health care facility access to the prescription monitoring data in connection with the provision of medical care or the dispensing of a monitored prescription drug to a patient of the health care facility;

(12) The Office of the Chief Medical Examiner in accordance with § 5–309 of this article; or

(13) The following entities, on approval of the Secretary and for the purpose of furthering an existing bona fide individual case review:

(i) The State Child Fatality Review Team or a local child fatality review team established under Title 5, Subtitle 7 of this article, on request from the chair of the State or local team;

(ii) A local drug overdose fatality review team established under § 5–902 of this article, on request from the chair of the local team;

(iii) The Maternal Mortality Review Program established under § 13–1203 of this article, on request from the Program; and

(iv) A medical review committee described in § 1–401(b)(3) of the Health Occupations Article, on request from the committee.

(c) (1) In accordance with regulations adopted by the Secretary:

(i) The Program shall review prescription monitoring data for indications of possible misuse or abuse of a monitored prescription drug; and

(ii) If the Program's review of prescription monitoring data indicates possible misuse or abuse of a monitored prescription drug, the Program shall:

1. Report the possible misuse or abuse to the prescriber or dispenser of the monitored prescription drug; and

2. Provide education to the prescriber or dispenser.

(2) Before the Program reports the possible misuse or abuse of a monitored prescription drug to a prescriber or dispenser under this subsection, the Program may obtain from the technical advisory committee:

(i) Clinical guidance regarding indications of possible misuse or abuse; and

(ii) Interpretation of the prescription monitoring data that indicates possible misuse or abuse.

(d) (1) In accordance with regulations adopted by the Secretary and subject to paragraph (3) of this subsection, the Program shall review prescription monitoring data for indications of a possible violation of law or a possible breach of professional standards by a prescriber or a dispenser.

(2) If the Program's review indicates a possible violation of law or a possible breach of professional standards by a prescriber or a dispenser, the Program:

(i) 1. Shall notify the prescriber or dispenser of the possible violation of law or possible breach of professional standards; and

2. Shall provide education to the prescriber or dispenser; and

(ii) Subject to paragraph (4) of this subsection, may provide prescription monitoring data to the Office for further investigation.

(3) (i) Before the Program provides notification of a possible violation of law or a possible breach of professional standards to a prescriber or a dispenser, the Program shall obtain from the technical advisory committee:

1. Clinical guidance regarding methods used to identify a possible violation of law or a possible breach of professional standards; and

2. Interpretation of the prescription monitoring data advising whether the method identifies a possible violation of law or a possible breach of professional standards.

(ii) In determining whether its review indicates a possible violation of law or a possible breach of professional standards by a prescriber or dispenser, the Program shall take into account to the extent practicable the particular specialty, circumstances, patient type, and location of the prescriber or dispenser.

(4) (i) If methods developed under paragraph (3)(i) of this subsection indicate a possible violation of law or a possible breach of professional standards and the Program determines that outreach and education to the prescriber or dispenser is inadequate to address the possible breach or violation, the Program may refer the possible violation of law or a possible breach of professional standards

along with prescription monitoring data to the Office for further investigation, provided that the Program:

1. Provides notice and an opportunity to the technical advisory committee to make recommendations within 10 business days regarding interpretation of the data;

2. Provides the recommendations of the technical advisory committee, if any, to the Office; and

3. Notifies the prescriber or the dispenser that the prescription monitoring data will be provided to the Office for further investigation.

(ii) On receipt of prescription monitoring data and relevant records under paragraph (2) of this subsection, the Office shall:

1. Review the prescription monitoring data and records, along with any additional information the Office may obtain as part of its investigation; and

2. If it determines that there has been a violation of law or a breach of professional standards, take any action authorized by law regarding the violation or breach, including providing the prescription monitoring data and records to the appropriate licensing entity for possible disciplinary action.

(e) (1) Before the Program discloses information under subsection (b)(3), (5), (6), (8), or (9) of this section, the Program may request that the technical advisory committee:

(i) Review the requests for information;

(ii) Provide clinical guidance and interpretation of the information requested to the Secretary to assist in the Secretary's decision on how to respond to a judicial subpoena, administrative subpoena, or other request; and

(iii) Provide clinical guidance and interpretation of the information requested to the authorized recipient of the information.

(2) The Program, in consultation with the Board, shall consider policies and procedures for determining the circumstances in which the review of requests for information and the provision of clinical guidance and interpretation of information by the technical advisory committee under paragraph (1) of this subsection is feasible and desirable.

(f) Except as provided by regulations adopted by the Secretary, a person who receives prescription monitoring data from the Program may not disclose the data.

(g) (1) In addition to the disclosures required under subsection (b) of this section, the Program may disclose prescription monitoring data for research, analysis, public reporting, and education:

(i) After redaction of all information that could identify a patient, prescriber, dispenser, or any other individual; and

(ii) In accordance with regulations adopted by the Secretary.

(2) The Secretary may require submission of an abstract explaining the scope and purpose of the research, analysis, public reporting, or education before disclosing prescription monitoring data under this subsection.

(h) The Office of the Attorney General may seek appropriate injunctive or other relief to maintain the confidentiality of prescription monitoring data as required under this section.

(i) The Program may provide prescription monitoring data to another state's prescription drug monitoring program only if the other state's prescription drug monitoring program agrees to use the prescription monitoring data in a manner consistent with the provisions of this subtitle.

(j) The Program may:

(1) Request and receive prescription monitoring data from another state's prescription drug monitoring program and use the prescription monitoring data in a manner consistent with the provisions of this subtitle; and

(2) Develop the capability to transmit prescription monitoring data to and receive prescription monitoring data from other prescription drug monitoring programs employing the standards of interoperability.

(k) The Program may enter into written agreements with other states' prescription drug monitoring programs for the purpose of establishing the terms and conditions for sharing prescription monitoring data under this section.

(l) Prescription monitoring data may not be used as the basis for imposing clinical practice standards.

§21–2A–06.1.

(a) Naloxone medication data:

(1) Are confidential and privileged, and not subject to discovery, subpoena, or other means of legal compulsion in civil litigation;

(2) Are not public records; and

(3) Except as provided in subsection (b) of this section or as otherwise by law, may not be disclosed to any person.

(b) (1) The Program shall disclose naloxone medication data, in accordance with regulations adopted by the Secretary, for public health surveillance, research, analysis, public reporting, and education after redaction of all information that could identify a patient, prescriber, dispenser, or any other individual.

(2) The Secretary may require submission of an abstract explaining the scope and purpose of the research, analysis, public reporting, or education before disclosing naloxone medication data under paragraph (1) of this subsection.

§21–2A–07.

(a) There is a technical advisory committee to the Program.

(b) The purpose of the technical advisory committee is to:

(1) Review requests for information from the Program under § 21–2A–06(b)(3), (4), (5), (8), or (9) of this subtitle; and

(2) Provide clinical guidance and interpretation to the Program regarding indications of possible misuse or abuse of a monitored prescription drug or a possible violation of law or a possible breach of professional standards by a prescriber or a dispenser under § 21–2A–06(c) and (d) of this subtitle.

(c) The technical advisory committee consists of members appointed by the Secretary, including:

(1) A board certified anesthesiologist licensed and practicing in the State, nominated by the Maryland Society of Anesthesiologists;

(2) A certified addiction medicine specialist licensed and practicing in the State, nominated by the Maryland Society for Addiction Medicine;

(3) A pharmacist licensed and practicing in the State;

(4) A medical professional, licensed and practicing in the State, who is treating cancer patients;

(5) A board certified physician specializing in the treatment of patients with pain, licensed and practicing in the State, nominated by the Maryland Society of Physical Medicine and Rehabilitation;

(6) Two medical professionals, licensed and practicing in the State with expertise or experience in providing care for patients with substance–related or mental health disorders;

(7) A dentist licensed and practicing in the State; and

(8) A medical professional licensed and practicing in the State in the field of internal medicine or family practice.

§21–2A–08.

(a) With respect to the administration and operation of the Program, the Department and its agents and employees are not subject to liability arising from:

(1) The inaccuracy of any information submitted to the Program in accordance with this subtitle; or

(2) The unauthorized use or disclosure of prescription monitoring data or naloxone medication data by a person to whom the Program was authorized to provide prescription monitoring data or naloxone medication data under this subtitle.

(b) Except as provided in § 21–2A–09(b)(3) of this subtitle, a prescriber, prescriber delegate, pharmacist, or pharmacist delegate, acting in good faith, is not subject to liability or disciplinary action arising solely from:

(1) Requesting or receiving, or failing to request or receive, prescription monitoring data from the Program; or

(2) Acting, or failing to act, on the basis of prescription monitoring data provided by the Program.

§21–2A–09.

(a) A dispenser who knowingly fails to submit prescription monitoring data or naloxone medication data to the Program as required under this subtitle shall be

subject to a civil penalty not exceeding $500 for each failure to submit required information.

(b) (1) A person who knowingly discloses, uses, obtains, or attempts to obtain by fraud or deceit, prescription monitoring data or naloxone medication data in violation of this subtitle shall be guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $10,000 or both.

(2) In addition to the penalties under paragraph (1) of this subsection, a prescriber, prescriber delegate, pharmacist, or pharmacist delegate who knowingly discloses or uses prescription monitoring data or naloxone medication data in violation of this subtitle shall be subject to disciplinary action by the appropriate licensing entity.

(3) A prescriber or pharmacist who violates § 21–2A–04.1 or § 21–2A–04.2 of this subtitle shall be subject to disciplinary action by the appropriate licensing entity.

(4) The release of prescription monitoring data by a prescriber, prescriber delegate, pharmacist, or pharmacist delegate to a licensed health care professional solely for treatment purposes in a manner otherwise consistent with State and federal law is not a violation of this subtitle.

§21–2B–01.

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

(b) "Carrier" has the meaning stated in § 15–10A–01(c) of the Insurance Article.

(c) "Eligible facility" means an institution operating under a federalwide assurance for the protection of human subjects in accordance with 42 U.S.C. § 289(a) and 28 C.F.R. Part 46.

(d) "Eligible patient" means an individual who:

(1) Has a life–threatening or severely debilitating illness, attested to by the individual's treating physician;

(2) Has considered all other treatment options currently approved by the United States Food and Drug Administration;

(3) Has received a recommendation from the individual's physician for an individualized investigational treatment based on analysis of the individual's

genomic sequence, human chromosomes, deoxyribonucleic acid, ribonucleic acid, genes, gene products, including enzymes and other types of proteins, or metabolites;

(4) (i) Has given informed consent for the use of the individualized investigational treatment; or

(ii) If the individual is a minor or lacks the mental capacity to provide informed consent, has a parent or legal guardian who has given informed consent on the individual's behalf for the use of the individualized investigational treatment; and

(5) Has documentation from the individual's physician that the individual meets the requirements of items (1) through (4) of this subsection.

(e) "Health occupations board" means a board established under the Health Occupations Article that issues licenses to practice a health occupation in the State.

(f) (1) "Individualized investigational treatment" means a drug, biological product, or device that is unique to and produced exclusively for use by an individual based on the genetic profile of the individual.

(2) "Individualized investigational treatment" includes individualized gene therapy, antisense oligonucleotides, and individualized neoantigen vaccines.

(g) "Informed consent" means a written document prepared using the informed consent form developed by the Office of the Attorney General in accordance with § 21–2B–02(b)(1) of this subtitle that:

(1) Is signed by the patient or a parent or legal guardian of the patient;

(2) Is attested to by the patient's treating physician and a witness; and

(3) At a minimum:

(i) Explains the currently approved products and treatments for the life–threatening or severely debilitating illness from which the patient suffers, including alternative procedures or courses of treatment, if known to the treating physician, that might be advantageous to the patient;

(ii) Attests to the fact that the patient concurs with the patient's treating physician in believing that all currently approved and conventionally recognized treatments are unlikely to prolong the patient's life;

(iii) Identifies clearly the specific proposed individualized investigational treatment that the patient is seeking to use;

(iv) Informs the provider and eligible patient of any known, anticipated, or reasonably foreseeable side effects, risks, or reported patient discomfort that is likely related to the treatment;

(v) Describes the best and worst potential outcomes of using the individualized investigational treatment with a realistic description of the most likely outcome, including the possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by the proposed treatment, based on the treating physician's knowledge of the proposed treatment in conjunction with an awareness of the patient's condition;

(vi) Makes clear that the patient's carrier and health care provider are not obligated to pay for any care or treatments that are necessary as a result of the use of the individualized investigational treatment except as required by federal or State law or contract;

(vii) Makes clear that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the individualized investigational treatment and that hospice care may be reinstated if this treatment ends and the patient meets hospice eligibility requirements;

(viii) States that the patient understands that the patient may be liable for all expenses relating to the use of the individualized investigational treatment and that this liability extends to the patient's estate, but not the heirs or legatees of the patient; and

(ix) Includes a statement describing the extent to which confidentiality of records that identify the patient will be maintained.

(h) "Life–threatening" has the meaning stated in 21 C.F.R. § 312.81.

(i) "Severely debilitating" has the meaning stated in 21 C.F.R. § 312.81.

§21–2B–02.

(a) A manufacturer of an individualized investigational treatment operating within an eligible facility and in compliance with all laws applicable to an eligible facility may:

(1) Provide the manufacturer's individualized investigational treatment to an eligible patient without compensation; or

(2) Require an eligible patient to pay the costs of or associated with the manufacture of the individualized investigational treatment provided to the eligible patient.

(b) (1) The Office of the Attorney General shall develop an informed consent form that:

(i) Complies with the requirements of § 21–2B–01(g)(3) of this subtitle;

(ii) Includes instructions for the physician or patient on how to complete the form; and

(iii) Provides spaces for a physician to include the information relating to a particular patient and the physician's recommendation for the patient.

(2) This subsection may not be construed to prohibit a treating physician or a manufacturer of an individualized investigational treatment from including additional information or advisements with the informed consent form developed under paragraph (1) of this subsection.

§21–2B–03.

(a) A health occupations board may not revoke, fail to renew, suspend, or take any action against a health care provider's license based solely on the health care provider's recommendation to an eligible patient regarding access to or treatment with an individualized investigational treatment.

(b) The Department may not take action against a health care provider's Medicare certification based solely on the health care provider's recommendation that an eligible patient have access to an individualized investigational treatment or the health care provider's treatment of an eligible patient with an individualized investigational treatment.

§21–2B–04.

(a) An official, employee, or agent of the State may not block or attempt to block an eligible patient's access to an individualized investigational treatment.

(b) This section does not prohibit a licensed health care provider from providing counsel, advice, or a recommendation that is consistent with medical standards of care.

§21–2B–05.

This subtitle does not create a private cause of action against a manufacturer of an individualized investigational treatment or against another person involved in the care of an eligible patient using the individualized investigational treatment for any harm to the eligible patient resulting from the individualized investigational treatment if the manufacturer or other person is complying in good faith with this subtitle and has exercised reasonable care.

§21–2B–06.

(a) This subtitle does not affect the coverage requirements under Title 15, Subtitle 8 of the Insurance Article.

(b) A carrier, third–party administrator, or government agency may provide coverage for the cost of an individualized investigational treatment or the cost of services related to the use of an individualized investigational treatment under this subtitle.

(c) This subtitle does not require:

(1) A government agency to pay costs associated with the use, care, or treatment of an individual with an individualized investigational treatment; or

(2) A hospital or another health care facility to provide new or additional services unless approved by the hospital or health care facility.

§21–2C–01.

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

(b) "Biologic" means a drug that is produced or distributed in accordance with a biologics license application approved under 42 C.F.R. § 447.502.

(c) "Biosimilar" means a drug that is produced or distributed in accordance with a biologics license application approved under 42 U.S.C. § 262(k)(3).

(d) "Board" means the Prescription Drug Affordability Board.

(e) (1) "Brand name drug" means a drug that is produced or distributed in accordance with an original new drug application approved under 21 U.S.C. § 355(c).

(2) "Brand name drug" does not include an authorized generic as defined by 42 C.F.R. § 447.502.

(f) "Current shortage" means a drug:

(1) Listed as current on the federal Food and Drug Administration's Drug Shortage Database; or

(2) Otherwise determined by the Board to be in short supply in the State.

(g) "Generic drug" means:

(1) A retail drug that is marketed or distributed in accordance with an abbreviated new drug application, approved under 21 U.S.C. § 355(j);

(2) An authorized generic as defined by 42 C.F.R. § 447.502; or

(3) A drug that entered the market before 1962 that was not originally marketed under a new drug application.

(h) "Manufacturer" means an entity that:

(1) (i) Engages in the manufacture of a prescription drug product; or

(ii) Enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name; and

(2) Sets or changes the wholesale acquisition cost of the prescription drug product it manufactures or markets.

(i) "Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar.

(j) "Stakeholder Council" means the Prescription Drug Affordability Stakeholder Council.

§21–2C–02.

(a) (1) There is a Prescription Drug Affordability Board.

(2) (i) The Board is a body politic and corporate and is an instrumentality of the State.

(ii) The Board is an independent unit of State government.

(iii) The exercise by the Board of its authority under this subtitle is an essential governmental function.

(b) The purpose of the Board is to protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system from the high costs of prescription drug products.

§21–2C–03.

(a) (1) The Board consists of the following members, who must have expertise in health care economics or clinical medicine:

(i) One member appointed by the Governor;

(ii) One member appointed by the President of the Senate;

(iii) One member appointed by the Speaker of the House of Delegates;

(iv) One member appointed by the Attorney General; and

(v) One member appointed jointly by the President of the Senate and the Speaker of the House of Delegates, who shall serve as chair of the Board.

(2) The Board shall have the following alternate members, who must have expertise in health care economics or clinical medicine and who shall be designated by the Board chair to participate in deliberations of the Board when a member is recused:

(i) One alternate member appointed by the Governor;

(ii) One alternate member appointed by the President of the Senate; and

(iii) One alternate member appointed by the Speaker of the House of Delegates.

(3) At least one member of the Board shall have expertise in:

(i) The 340B Program under the federal Public Health Service Act;

(ii) The State's all–payer model contract;

(iii) How the program and contract interact; and

(iv) How decisions made by the Board will affect the model and contract.

(4) A member or an alternate member may not be an employee of, a board member of, or a consultant to a manufacturer, pharmacy benefits manager, health insurance carrier, health maintenance organization, managed care organization, or wholesale distributor or related trade association.

(5) Any conflict of interest, including whether the individual has an association, including a financial or personal association, that has the potential to bias or has the appearance of biasing an individual's decision in matters related to the Board or the conduct of the Board's activities, shall be considered and disclosed when appointing members and alternate members to the Board.

(6) To the extent practicable and consistent with federal and State law, the membership of the Board shall reflect the racial, ethnic, and gender diversity of the State.

(b) (1) The term of a member or an alternate member is 5 years.

(2) The terms of the members and alternate members are staggered as required by the terms provided for members on October 1, 2019.

(c) (1) The chair shall hire an executive director and staff for the Board.

(2) The chair shall develop a 5–year budget and staffing plan and submit it to the Board for approval.

(3) Staff of the Board shall receive a salary as provided in the budget of the Board.

(d) A member of the Board:

(1) May receive compensation as a member of the Board in accordance with the State budget; and

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(e) (1) (i) Subject to subparagraphs (ii) and (iv) of this paragraph, the Board shall meet in open session at least four times a year.

(ii) At the chair's discretion, the chair may cancel or postpone a meeting.

(iii) The following actions by the Board shall be made in open session:

1. The study required under § 21–2C–07 of this subtitle;

2. Deliberations on whether to subject a prescription drug product to a cost review under § 21–2C–08(d) of this subtitle;

3. Any vote on whether to impose an upper payment limit on purchases and payor reimbursements of prescription drug products in the State; and

4. Any decision by the Board.

(iv) Notwithstanding the Open Meetings Act, the Board may meet in closed session to discuss trade secrets or confidential and proprietary data and information.

(2) The Board shall provide public notice of each Board meeting at least 2 weeks in advance of the meeting.

(3) (i) Materials for each Board meeting shall be made available to the public at least 1 week in advance of the meeting.

(ii) Materials containing trade secrets or confidential and proprietary data or information that is not otherwise available to the public may not be made available to the public.

(4) The Board shall provide an opportunity for public comment at each open meeting of the Board.

(5) The Board shall provide the public with the opportunity to provide written comments on pending decisions of the Board.

(6) The Board may allow expert testimony at Board meetings, including when the Board meets in closed session.

(7) To the extent practicable, the Board shall access pricing information for prescription drug products by:

(i) Entering into a memorandum of understanding with another state to which manufacturers already report pricing information; and

(ii) Accessing other available pricing information.

(8) A majority of the members of the Board constitutes a quorum.

(9) (i) Members of the Board shall recuse themselves from decisions related to a prescription drug product if the member, or an immediate family member of the member, has received or could receive any of the following:

1. A direct financial benefit of any amount deriving from the result or finding of a study or determination by or for the Board; or

2. A financial benefit from any person that owns, manufactures, or provides prescription drug products, services, or items to be studied by the Board that in the aggregate exceeds $5,000 per year.

(ii) For the purposes of subparagraph (i) of this paragraph, a financial benefit includes honoraria, fees, stock, the value of the member's or immediate family member's stock holdings, and any direct financial benefit deriving from the finding of a review conducted under this subtitle.

(f) In addition to the powers set forth elsewhere in this subtitle, the Board may:

(1) Adopt regulations to carry out the provisions of this subtitle; and

(2) Enter into a contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Board.

(g) Unless permission is granted by the Board, a third party hired by the Board in accordance with subsection (f)(2) of this section may not release, publish, or otherwise use any information to which the third party has access under its contract.

(h) (1) Except as provided in paragraph (2) of this subsection, any procurement for services to be performed or for supplies to be delivered to the Board is not subject to Division II of the State Finance and Procurement Article.

(2) The Board is subject to the following provisions of the State Finance and Procurement Article:

(i) Title 3.5, Subtitle 3 (Information Processing), to the extent that the Secretary of Information Technology determines that an information technology project of the Board is a major information technology development project;

(ii) Title 12, Subtitle 4 (Policies and Procedures for Exempt Units); and

(iii) Title 14, Subtitle 3 (Minority Business Participation).

(i) (1) The Attorney General is the legal adviser to the Board.

(2) The Attorney General shall designate an assistant attorney general as counsel to the Board.

(3) As needed, the Attorney General may assign additional assistant attorneys general to the Board to give effective legal advice and counsel.

(4) The counsel to the Board may not have a duty other than to:

(i) Give the legal aid, advice, and counsel required by the Board;

(ii) Supervise the other assistant attorneys general assigned to the Board, if any; and

(iii) Perform for the Board the duties that the Attorney General assigns.

(5) The counsel shall perform these duties subject to the control and supervision of the Attorney General.

(6) After the Attorney General designates the counsel to the Board, the Attorney General may not reassign the counsel without consulting the Board.

§21–2C–04.

(a) There is a Prescription Drug Affordability Stakeholder Council.

(b) The purpose of the Stakeholder Council is to provide stakeholder input to assist the Board in making decisions as required under this subtitle.

(c) (1) The Stakeholder Council consists of members appointed in accordance with this subsection.

(2) The Speaker of the House of Delegates shall appoint:

(i) One representative of generic drug corporations;

(ii) One representative of nonprofit insurance carriers;

(iii) One representative of a statewide health care advocacy coalition;

(iv) One representative of a statewide advocacy organization for seniors;

(v) One representative of a statewide organization for diverse communities;

(vi) One representative of a labor union;

(vii) One representative of the rare disease community;

(viii) One health services researcher specializing in prescription drugs; and

(ix) One public member at the discretion of the Speaker of the House of Delegates.

(3) The President of the Senate shall appoint:

(i) One representative of brand name drug corporations;

(ii) One representative of physicians;

(iii) One representative of nurses;

(iv) One representative of hospitals;

(v) One representative of dentists;

(vi) One representative of oncologists;

(vii) One representative of managed care organizations;

(viii) One representative of the Department of Budget and Management;

(ix) One clinical researcher; and

(x) One public member at the discretion of the President of the Senate.

(4) The Governor shall appoint:

(i) One representative of brand name drug corporations;

(ii) One representative of generic drug corporations;

(iii) One representative of biotechnology companies;

(iv) One representative of for–profit health insurance carriers;

(v) One representative of employers;

(vi) One representative of pharmacy benefits managers;

(vii) One representative of pharmacists;

(viii) One pharmacologist;

(ix) One representative of a patient advocacy organization; and

(x) One public member at the discretion of the Governor.

(5) Collectively, the members of the Stakeholder Council shall have knowledge of the following:

(i) The pharmaceutical business model;

(ii) Supply chain business models;

(iii) The practice of medicine or clinical training;

(iv) Consumer or patient perspectives;

(v) Health care costs trends and drivers;

(vi) Clinical and health services research; or

(vii) The State's health care marketplace.

(6) To the extent practicable and consistent with federal and State law, the membership of the Stakeholder Council shall reflect the racial, ethnic, and gender diversity of the State.

(7) From among the membership of the Stakeholder Council, the Board chair shall appoint two members to be cochairs of the Stakeholder Council.

(d) (1) The term of a member is 3 years.

(2) The initial members of the Stakeholder Council shall serve staggered terms as required by the terms provided for members on October 1, 2019.

(e) A member of the Stakeholder Council:

(1) May not receive compensation as a member of the Stakeholder Council; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

§21–2C–05.

(a) (1) A conflict of interest shall be disclosed:

(i) By the Board when hiring Board staff;

(ii) By the appointing authority when appointing members and alternate members to the Board and members to the Stakeholder Council; and

(iii) By the Board, when a member of the Board is recused in any final decision resulting from a review of a prescription drug product.

(2) A conflict of interest shall be disclosed:

(i) In advance of the first open meeting after the conflict is identified; or

(ii) Within 5 days after the conflict is identified.

(b) (1) A conflict of interest disclosed under subsection (a) of this section shall be posted on the website of the Board unless the chair of the Board recuses the member from any final decision resulting from a review of a prescription drug product.

(2) A posting under paragraph (1) of this subsection shall include the type, nature, and magnitude of the interests of the member involved.

§21–2C–06.

Members and alternate members of the Board, Board staff, and third–party contractors may not accept any gift or donation of services or property that indicates a potential conflict of interest or has the appearance of biasing the work of the Board.

§21–2C–07.

On or before December 31, 2021, the Board, in consultation with the Stakeholder Council, shall:

(1) Study:

(i) The entire pharmaceutical distribution and payment system in the State; and

(ii) Policy options being used in other states and countries to lower the list price of pharmaceuticals, including:

1. Setting upper payment limits;

2. Using a reverse auction marketplace; and

3. Implementing a bulk purchasing process; and

(2) Report its findings and recommendations, including findings for each option studied under item (1)(ii) of this section and any legislation required to implement the recommendations, to the Senate Finance Committee and the House

Health and Government Operations Committee in accordance with § 2–1257 of the State Government Article.

§21–2C–08.

(a) On or before December 31, 2021, the Board shall:

(1) Collect and review publicly available information regarding prescription drug product manufacturers, health insurance carriers, health maintenance organizations, managed care organizations, wholesale distributors, and pharmacy benefits managers; and

(2) (i) Identify states that require reporting on the cost of prescription drug products; and

(ii) Initiate a process of entering into memoranda of understanding with the states identified under item (i) of this item to aid in the collection of transparency data for prescription drug products.

(b) Based on the information collected under subsection (a)(1) of this section and obtained through memoranda of understanding under subsection (a)(2) of this section, the Board, in consultation with the Stakeholder Council, shall adopt regulations to:

(1) Establish methods for collecting additional data necessary to carry out its duties under this subtitle; and

(2) Identify circumstances under which the cost of a prescription drug product may create or has created affordability challenges for the State health care system and patients.

(c) The Board shall use the information collected under subsection (a)(1) of this section and obtained through memoranda of understanding under subsection (a)(2) of this section to identify prescription drug products that are:

(1) Brand name drugs or biologics that, as adjusted annually for inflation in accordance with the Consumer Price Index, have:

(i) A launch wholesale acquisition cost of $30,000 or more per year or course of treatment; or

(ii) A wholesale acquisition cost increase of $3,000 or more in any 12–month period, or course of treatment if less than 12 months;

(2) Biosimilar drugs that have a launch wholesale acquisition cost that is not at least 15% lower than the referenced brand biologic at the time the biosimilars are launched;

(3) Generic drugs that, as adjusted annually for inflation in accordance with the Consumer Price Index, have a wholesale acquisition cost:

(i) Of $100 or more for:

1. A 30–day supply lasting a patient for a period of 30 consecutive days based on the recommended dosage approved for labeling by the United States Food and Drug Administration;

2. A supply lasting a patient for fewer than 30 days based on the recommended dosage approved for labeling by the United States Food and Drug Administration; or

3. One unit of the drug if the labeling approved by the United States Food and Drug Administration does not recommend a finite dosage; and

(ii) That increased by 200% or more during the immediately preceding 12–month period, as determined by the difference between the resulting wholesale acquisition cost and the average of the wholesale acquisition cost reported over the immediately preceding 12 months; and

(4) Other prescription drug products that may create affordability challenges for the State health care system and patients, in consultation with the Stakeholder Council.

§21–2C–09.

(a) (1) After identifying prescription drug products as required by § 21–2C–08 of this subtitle, the Board shall determine whether to conduct a cost review as described in subsection (b) of this section for each identified prescription drug product by:

(i) Seeking Stakeholder Council input about the prescription drug product; and

(ii) Considering the average cost share of the prescription drug product.

(2) (i) To the extent there is no publicly available information to conduct a cost review as described in subsection (b) of this section, the Board shall request the information from:

1. The manufacturer of the prescription drug product; and

2. As appropriate, a wholesale distributor, pharmacy benefits manager, health insurance carrier, health maintenance organization, or managed care organization with relevant information on setting the cost of the prescription drug product in the State.

(ii) The information to conduct a cost review may include any document and research related to the manufacturer's selection of the introductory price or price increase of the prescription drug product, including life cycle management, net average price in the State, market competition and context, projected revenue, and the estimated value or cost–effectiveness of the prescription drug product.

(iii) Failure of a manufacturer, wholesale distributor, pharmacy benefits manager, health insurance carrier, health maintenance organization, or managed care organization to provide the Board with the information requested under this paragraph does not affect the authority of the Board to conduct a review as described in subsection (b) of this section.

(b) (1) If the Board conducts a review of the cost of a prescription drug product, the review shall determine whether use of the prescription drug product that is fully consistent with the labeling approved by the United States Food and Drug Administration or standard medical practice has led or will lead to affordability challenges for the State health care system or high out–of–pocket costs for patients.

(2) To the extent practicable, in determining whether a prescription drug product identified under § 21–2C–08 of this subtitle has led or will lead to an affordability challenge, the Board shall consider the following factors:

(i) The wholesale acquisition cost and any other relevant prescription drug cost index for the prescription drug product sold in the State;

(ii) The average monetary price concession, discount, or rebate the manufacturer provides to health plans in the State or is expected to provide to health plans in the State as reported by manufacturers and health plans, expressed as a percent of the wholesale acquisition cost for the prescription drug product under review;

(iii) The total amount of the price concession, discount, or rebate the manufacturer provides to each pharmacy benefits manager operating in the State for the prescription drug product under review, as reported by manufacturers and pharmacy benefits managers, expressed as a percent of the wholesale acquisition costs;

(iv) The price at which therapeutic alternatives have been sold in the State;

(v) The average monetary concession, discount, or rebate the manufacturer provides or is expected to provide to health plan payors and pharmacy benefits managers in the State for therapeutic alternatives;

(vi) The costs to health plans based on patient access consistent with United States Food and Drug Administration labeled indications;

(vii) The impact on patient access resulting from the cost of the prescription drug product relative to insurance benefit design;

(viii) The current or expected dollar value of drug–specific patient access programs that are supported by the manufacturer;

(ix) The relative financial impacts to health, medical, or social services costs as can be quantified and compared to baseline effects of existing therapeutic alternatives;

(x) The average patient copay or other cost–sharing for the prescription drug product in the State; and

(xi) Any other factors as determined by the Board in regulations adopted by the Board.

(3) If the Board is unable to determine whether a prescription drug product will produce or has produced challenges to the affordability of the drug for the State health care system, using the factors listed in paragraph (2) of this subsection, the Board may consider the following factors:

(i) The manufacturer's research and development costs, as indicated on the manufacturer's federal tax filing or information filed with the Federal Securities and Exchange Commission for the most recent tax year in proportion to the manufacturer's sales in the State;

(ii) The portion of direct–to–consumer marketing costs eligible for favorable federal tax treatment in the most recent tax year that are specific to the

prescription drug product under review and that are multiplied by the ratio of total manufacturer in–State sales to total manufacturer sales in the United States for the product under review;

(iii) Gross and net manufacturer, pharmacy benefits manager, and wholesale distributor revenues for the prescription drug product under review for the most recent tax year;

(iv) Any additional factors proposed by the manufacturer and appropriate health insurance carriers, health maintenance organizations, managed care organizations, wholesale distributors, and pharmacy benefits managers that the Board considers relevant; and

(v) Any additional factors as established by the Board in regulations.

(c) On or before December 31, 2020, and each December 31 thereafter, the Board shall submit to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, a report that includes:

(1) Price trends for prescription drug products;

(2) The number of prescription drug products that were subject to Board review and the results of the review; and

(3) Any recommendations the Board may have on further legislation needed to make prescription drug products more affordable in the State.

(d) If the Board sets a new upper payment limit, to the extent practicable, the Board shall include in the first report that is required under subsection (c) of this section after the upper payment limit has been in effect for 1 year information on the effects of the upper payment limit, based on available timely data, for the following:

(1) Patient out–of–pocket costs including whether the upper payment limit was associated with increases or decreases in what patients pay for prescription drug products;

(2) Patient health insurance premiums, including whether the upper payment limit is associated with increases or decreases in health insurance costs for patients;

(3) Pharmacies operating in the State, including the impact on reimbursement rates and financial viability of retail and independent pharmacies;

(4) Patient health insurance formularies, including whether the prescription drug product subject to the upper payment limit remained on formularies;

(5) Provider–administered medications subject to the upper payment limit, including whether providers were able to acquire the prescription drug product subject to the upper payment limit at a rate to account for acquisition costs and whether there was an impact on provider reimbursement;

(6) Patient access to the prescription drug product subject to the upper payment limit, which may include:

(i) Whether prescription drug product shortages or other supply disruptions occurred after the upper payment limit took effect;

(ii) Whether formulary placement or plan design changes made the prescription drug product subject to the upper limit more difficult for patients to access, including if insurance plans preferred a prescription drug product without an upper payment limit over a prescription drug product subject to an upper payment limit;

(iii) Whether the distribution and delivery of specialty or rare disease medications from out–of–state pharmacies to providers, pharmacies, or patients was impacted;

(iv) Whether patients in communities of color, patients who are women, patients with a rare disease, or patients in rural areas experienced disproportionate access challenges; and

(v) Whether cost differences as a result of the upper payment limit affected patients, pharmacies, or providers and, if the cost difference resulted in an increase in costs, who was ultimately responsible for bearing the increased cost;

(7) Covered entity providers participating in the 340B drug discount program, including the impact of the upper payment limit on the operations of the providers and their contracted pharmacies; and

(8) The biotechnology industry in the State, including the impact on pharmaceutical research and development, investment, and job growth.

(e) (1) The Board may request information necessary to complete the report required under subsections (c) and (d) of this section from an affected entity.

(2) The entity from which information was requested under paragraph (1) of this subsection shall make a good faith effort to provide the requested information.

§21–2C–10.

(a) All information and data obtained by the Board under this subtitle, that is not otherwise publicly available:

(1) Is considered to be a trade secret and confidential and proprietary information; and

(2) Is not subject to disclosure under the Public Information Act.

(b) Only Board members and staff may access trade secrets and confidential and proprietary data and information obtained under this subtitle that is not otherwise publicly available.

(c) The provisions of Title 11, Subtitle 12 of the Commercial Law Article shall apply to any trade secrets and confidential and proprietary data and information obtained under this subtitle that is not otherwise publicly available.

§21–2C–11.

(a) In this section, "Fund" means the Prescription Drug Affordability Fund.

(b) (1) The Board shall assess and collect an annual fee on:

(i) Manufacturers that sell or offer for sale prescription drug products to persons in the State;

(ii) Pharmacy benefits managers, as defined in § 15–1601 of the Insurance Article;

(iii) Carriers, as defined in § 19–132 of this article; and

(iv) Wholesale distributors, as defined in § 12–6C–01 of the Health Occupations Article, that sell or offer for sale prescription drug products to persons in the State.

(2) The Board shall:

(i) Assess and collect the annual fee under paragraph (1) of this subsection in accordance with criteria established in regulations adopted by the Board; and

(ii) Calculate the annual fee under paragraph (1) of this subsection in a fair and equitable manner.

(3) (i) On or before October 1 each year, each entity assessed a fee under this subsection shall pay the fee assessed by the Board.

(ii) The Board shall allow entities to make partial payments when paying the fee assessed under this subsection.

(iii) Any fee not paid within 30 days after the payment due date may be subject to an interest penalty to be determined and collected by the Board.

(4) The total amount of fees that the Board collects in each calendar year under paragraph (1) of this subsection may not exceed $2,000,000.

(5) The Board shall pay all fees collected under paragraph (1) of this subsection into the Fund.

(c) (1) There is a Prescription Drug Affordability Fund.

(2) The purpose of the Fund is to provide funding for the Board and to carry out the purpose of this subtitle.

(3) The Board shall administer the Fund.

(4) (i) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(ii) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(5) The Fund consists of:

(i) Revenue distributed to the Fund under subsection (b) of this section;

(ii) Money appropriated in the State budget to the Fund;

(iii) Interest earnings; and

(iv) Any other money from any other source accepted for the benefit of the Fund.

(6) The Fund may be used only to provide funding for the Board and for the purposes authorized under this subtitle, including administrative expenses and any costs expended by any State agency to implement this subtitle.

(7) (i) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(ii) Any interest earnings of the Fund shall be credited to the Fund.

(8) Expenditures from the Fund may be made only in accordance with the State budget.

(9) The Fund is subject to audit by the Office of Legislative Audits as provided for under § 2–1220 of the State Government Article.

(10) This subsection may not be construed to prohibit the Fund from receiving funds from any other source.

§21–2C–12.

The Office of the Attorney General may pursue any available remedy under State law when enforcing this subtitle.

§21–2C–13.

(a) If, under § 21–2C–07 of this subtitle, the Board finds that it is in the best interest of the State to establish a process for setting upper payment limits for prescription drug products that it determines have led or will lead to an affordability challenge, the Board, in conjunction with the Stakeholder Council, shall draft a plan of action for implementing the process in accordance with the requirements of this section.

(b) The criteria for setting upper payment limits shall include consideration of:

(1) The cost of administering the prescription drug product;

(2) The cost of delivering the prescription drug product to consumers;

(3) The effect the upper payment limit will have on providers of 340B drugs;

(4) For an upper payment limit on a drug that is designated as a drug for a rare disease or condition, the impact of the upper payment limit on patients with rare diseases; and

(5) Other relevant administrative costs related to the prescription drug product.

(c) (1) If the Board previously set an upper payment limit for a drug that becomes a current shortage, the Board may reconsider the previously set upper payment limit.

(2) The Board may not:

(i) Apply a new upper payment limit to a drug in a current shortage;

(ii) Enforce an upper payment limit against provider or pharmacy reimbursement requirements for Medicare Part C or Part D plans; or

(iii) Count a pharmacy dispensing fee toward or subject a pharmacy dispensing fee to an upper payment limit.

(d) (1) If a plan of action is drafted under subsection (a) of this section, the Board shall submit the plan of action to the Legislative Policy Committee of the General Assembly, in accordance with § 2–1257 of the State Government Article, for its approval.

(2) The Legislative Policy Committee shall have 45 days to approve the plan of action.

(3) If the Legislative Policy Committee does not approve the plan of action, the Board shall submit the plan to the Governor and the Attorney General for approval.

(4) The Governor and the Attorney General shall have 45 days to approve the plan of action.

(5) The Board may not set upper payment limits unless the plan is approved, in accordance with this subsection, by:

(i) The Legislative Policy Committee; or

(ii) 1. The Governor; and

2. The Attorney General.

§21–2C–13. ** CONTINGENCY – NOT IN EFFECT – CHAPTER 692 OF 2019 **

(a) On or after January 1, 2022, the Board may set upper payment limits for prescription drug products that are:

(1) Purchased or paid for by a unit of State or local government or an organization on behalf of a unit of State or local government, including:

(i) State or county correctional facilities;

(ii) State hospitals; and

(iii) Health clinics at State institutions of higher education;

(2) Paid for through a health benefit plan on behalf of a unit of State or local government, including a county, bicounty, or municipal employee health benefit plan; or

(3) Purchased for or paid for by the Maryland State Medical Assistance Program.

(b) The upper payment limits set under subsection (a) of this section shall:

(1) Be for prescription drug products that have led or will lead to an affordability challenge; and

(2) Be set in accordance with the criteria established in regulations adopted by the Board.

(c) (1) The Board shall:

(i) Monitor the availability of any prescription drug product for which it sets an upper payment limit; and

(ii) If there becomes a shortage of the prescription drug product in the State, reconsider whether the upper payment limit should be suspended or altered.

(2) An upper payment limit set under subsection (a) of this section may not be applied to a prescription drug product while the prescription drug product is on the federal Food and Drug Administration prescription drug shortage list.

§21–2C–14.

In accordance with the plan of action approved by the Legislative Policy Committee on October 22, 2024, the Board may set upper payment limits through regulations for prescription drug products that are:

(1) Purchased or paid for by a unit of State or local government or an organization on behalf of a unit of State or local government, including:

(i) State or county correctional facilities;

(ii) State hospitals; and

(iii) Health clinics at State institutions of higher education;

(2) Paid for through a health benefit plan on behalf of a unit of State or local government, including a county, bicounty, or municipal employee health benefit plan; or

(3) Purchased for or paid for by the Maryland State Medical Assistance Program.

§21–2C–15.

(a) A person aggrieved by an upper payment limit set by the Board may request an appeal within 30 days after the Board makes the decision to set the limit.

(b) The Board shall hear the appeal and make a final decision within 60 days after the appeal is requested.

(c) Any person aggrieved by a final decision of the Board issued under subsection (b) of this section may petition for judicial review as provided by the Administrative Procedure Act.

§21–2C–16. ** CONTINGENCY – IN EFFECT – CHAPTERS 610 AND 611 OF 2025 **

(a) (1) The Board, in consultation with the Stakeholder Council, shall determine whether, in addition to setting upper payment limits in accordance with § 21–2C–14 of this subtitle, it is in the best interest of the State for the Board to

establish a process for setting upper payment limits for purchases and payor reimbursements of prescription drug products in the State that the Board determines have led or will lead to an affordability challenge.

(2) When making a determination under paragraph (1) of this subsection, the Board shall consider, if applicable:

(i) Contract and budget data provided to the Board that demonstrates savings to the State or local governments as a result of upper payment limits set in accordance with § 21–2C–14 of this subtitle;

(ii) Success of setting upper payment limits in other states; and

(iii) Expected savings from Medicare Maximum Fair Prices set by the Centers for Medicare and Medicaid Services.

(b) (1) If the Board makes an affirmative determination under subsection (a) of this section, the Board, in consultation with the Stakeholder Council, shall establish a process for setting upper payment limits for purchases and payor reimbursements of prescription drug products in the State that the Board determines have led or will lead to an affordability challenge.

(2) The process established under paragraph (1) of this subsection shall:

(i) To the extent appropriate, use the plan of action approved under § 21–2C–13(d) of this subtitle; and

(ii) Otherwise comply with the requirements for setting upper payment limits established under this subtitle.

(3) Before establishing an upper payment limit that applies to the Maryland Medical Assistance Program, the Board shall confer with the Maryland Medical Assistance Program to approve the application of the upper payment limit by assessing whether the proposed upper payment limit will:

(i) Conflict with the Medicaid Drug Rebates Program, the Covered Outpatient Drug Rule (CMS–2345–FC), or any other federal requirements as applicable; and

(ii) Require additional funding to be allocated to the Maryland Medical Assistance Program budget.

§21–2C–16. ** CONTINGENCY – NOT IN EFFECT – CHAPTERS 610 AND 611 OF 2025 **

(a) (1) The Board, in consultation with the Stakeholder Council, shall determine whether, in addition to setting upper payment limits in accordance with § 21–2C–14 of this subtitle, it is in the best interest of the State for the Board to establish a process for setting upper payment limits for purchases and payor reimbursements of prescription drug products in the State that the Board determines have led or will lead to an affordability challenge.

(2) When making a determination under paragraph (1) of this subsection, the Board shall consider, if applicable:

(i) Contract and budget data provided to the Board that demonstrates savings to the State or local governments as a result of upper payment limits set in accordance with § 21–2C–14 of this subtitle;

(ii) Success of setting upper payment limits in other states; and

(iii) Expected savings from Medicare Maximum Fair Prices set by the Centers for Medicare and Medicaid Services.

(b) (1) If the Board makes an affirmative determination under subsection (a) of this section, the Board, in consultation with the Stakeholder Council, shall establish a process for setting upper payment limits for purchases and payor reimbursements of prescription drug products in the State that the Board determines have led or will lead to an affordability challenge.

(2) The process established under paragraph (1) of this subsection shall:

(i) To the extent appropriate, use the plan of action approved under § 21–2C–13(d) of this subtitle; and

(ii) Otherwise comply with the requirements for setting upper payment limits established under this subtitle.

(3) Before establishing an upper payment limit that applies to the Maryland Medical Assistance Program, the Board shall confer with the Maryland Medical Assistance Program to approve the application of the upper payment limit by assessing whether the proposed upper payment limit will:

(i) Conflict with the Medicaid Drug Rebates Program, the Covered Outpatient Drug Rule (CMS–2345–FC), or any other federal requirements as applicable; and

(ii) Require additional funding to be allocated to the Maryland Medical Assistance Program budget.

(c) (1) Subject to paragraph (2) of this subsection, if the Board establishes a process under subsection (b) of this section, the Board shall set upper payment limits for purchases and payor reimbursements of prescription drug products in the State in accordance with the process.

(2) This subsection does not apply with respect to:

(i) Payor reimbursements under Medicare Part C and D Plans;

(ii) Purchases under the federal 340B Drug Pricing Program; and

(iii) Purchases and payor reimbursements by federal agencies or federal programs that the State is preempted from regulating by federal law.

§21–2D–01.

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

(b) (1) "Retailer" means a person that:

(i) Sells, prepares, or maintains tianeptine products; or

(ii) Advertises, represents, or holds itself out as selling, preparing, or maintaining tianeptine products.

(2) "Retailer" includes a manufacturer, wholesaler, store, restaurant, hotel, catering facility, camp, bakery, delicatessen, supermarket, grocery store, convenience store, gas station, or food or drink company.

(c) "Tianeptine product" means a product that is marketed for human consumption containing any amount of tianeptine sodium or tianeptine sulfate.

§21–2D–02.

(a) A retailer may not distribute, sell, expose for sale, or advertise for sale a tianeptine product to an individual.

(b) A retailer that violates subsection (a) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, imprisonment for not more than 90 days, or both.

(c) In addition to any other penalties under this section, a retailer who violates this section is liable for civil damages sustained by the individual resulting from the violation.

§21–2D–03.

The Department shall adopt regulations to carry out this subtitle.

§21–2E–01.

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

(b) "Kratom product" means a product marketed for human consumption containing any part of the leaf of the plant Mitragyna speciosa.

(c) (1) "Retailer" means a person that:

(i) Sells, prepares, or maintains kratom products; or

(ii) Advertises, represents, or holds itself out as selling, preparing, or maintaining kratom products.

(2) "Retailer" includes a manufacturer, wholesaler, store, restaurant, hotel, catering facility, camp, bakery, delicatessen, supermarket, grocery store, convenience store, gas station, or food or drink company.

§21–2E–02.

(a) (1) A retailer that prepares, distributes, sells, or exposes for sale a kratom product shall disclose on the product label the factual basis on which the representation is made.

(2) A retailer may not prepare, distribute, sell, or expose for sale a kratom product that:

(i) Does not comply with the disclosure requirement established under paragraph (1) of this subsection; or

(ii) Has not been recognized as a dietary ingredient or approved drug by the U.S. Food and Drug Administration.

(b) (1) Subject to paragraph (2) of this subsection, a retailer may not prepare, distribute, sell, or expose for sale any of the following:

(i) A kratom product that is adulterated with a dangerous substance other than kratom;

(ii) A kratom product that is contaminated with a dangerous substance other than kratom;

(iii) A kratom product containing a level of 7–hydroxymitragynine in the alkaloid fraction that is greater than 2% of the alkaloid composition of the product;

(iv) A kratom product containing a synthetic alkaloid, including synthetic mitragynine, synthetic 7–hydroxymitragynine, or any other synthetically derived compound of the kratom plant; or

(v) A product containing kratom that does not include on its package or label the amount of mitragynine and 7–hydroxymitragynine contained in the product.

(2) (i) For the purpose of paragraph (1)(i) of this subsection, a kratom product is adulterated with a dangerous substance other than kratom if:

1. The kratom product is mixed or packed with a substance other than kratom; and

2. That substance affects the quality or strength of the kratom product to a degree as to render the kratom product injurious to a consumer.

(ii) For the purpose of paragraph (1)(ii) of this subsection, a kratom product is contaminated with a dangerous substance other than kratom if the kratom product contains a poisonous or otherwise deleterious ingredient other than kratom, including a drug that is designated as a controlled dangerous substance under Title 5 of the Criminal Law Article.

(c) A retailer may not distribute, sell, or expose for sale a kratom product to an individual under the age of 21 years.

(d) In a prosecution for a violation of this section, it is a rebuttable defense that the defendant relied in good faith on the representations on the manufacturer's label on a kratom product.

(e) A retailer that violates subsection (a)(1) of this section is subject to a civil penalty not exceeding:

(1) $1,000 for a first violation; and

(2) $2,000 for each subsequent violation.

(f) A retailer that violates subsection (a)(2), (b), or (c) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, imprisonment for not more than 90 days, or both.

(g) In addition to any other penalties specified in this section, a retailer who violates this section is liable for any civil damages sustained by the individual resulting from the violation.

§21–2E–03.

(a) A retailer may not directly or indirectly advertise a therapeutic benefit of kratom.

(b) A retailer may not directly or indirectly advertise or market kratom products to minors.

(c) It is a violation of subsection (b) of this section for a retailer to use any of the following in the advertising, promotion, packaging, or labeling of a kratom product:

(1) A cartoon;

(2) A superhero;

(3) A video game reference;

(4) An image of a food product primarily intended for minors;

(5) A trademark that imitates or mimics the trademark of a product that has been advertised or marketed primarily to minors;

(6) A symbol or celebrity that is primarily associated with minors or media primarily directed to minors;

(7) An image of an individual who appears to be under the age of 27 years; and

(8) Other images, graphics, or features or likenesses to images, graphics, or features that are popularly used to advertise to children, including:

(i) Neon colors, signs, or other brightly colored displays;

(ii) Animals;

(iii) Mascots; or

(iv) Statements, artwork, or designs that could reasonably mislead an individual to believe that the package contains anything other than a kratom product.

(d) It is a violation of subsection (b) of this section for a retailer to advertise or promote a kratom product:

(1) In a newspaper, a magazine, a periodical, or any other publication for which individuals under the age of 21 years constitute 15% or more of the total audience, as measured by competent and reliable survey evidence;

(2) At a concert, a stadium, a sporting event, or any other public event for which individuals under the age of 21 years constitute 15% or more of the total audience, as measured by competent and reliable survey evidence; or

(3) By placing an advertisement for kratom on the side of a building or another publicly visible location of any form, including a sign, a poster, a placard, a device, a graphic display, an outdoor billboard, or a freestanding signboard.

(e) A retailer that violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, imprisonment for not more than 90 days, or both.

§21–2E–04.

The Department shall adopt regulations to carry out this subtitle.

§21–2F–01.

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

(b) "Phenibut product" means a product marketed for human consumption containing any beta–phenyl–gamma–aminobutyric acid HCl.

(c) (1) "Retailer" means a person that:

(i) Sells, prepares, or maintains phenibut products; or

(ii) Advertises, represents, or holds itself out as selling, preparing, or maintaining phenibut products.

(2) "Retailer" includes a manufacturer, wholesaler, store, restaurant, hotel, catering facility, camp, bakery, delicatessen, supermarket, grocery store, convenience store, gas station, or food or drink company.

§21–2F–02.

(a) (1) A retailer that prepares, distributes, sells, or exposes for sale a phenibut product shall disclose on the product label the factual basis on which any representations regarding the phenibut product are made.

(2) A retailer may not prepare, distribute, sell, or expose for sale a phenibut product that:

(i) Does not comply with the disclosure requirement established under paragraph (1) of this subsection; or

(ii) Has not been recognized as a dietary ingredient or approved drug by the U.S. Food and Drug Administration.

(b) (1) Subject to paragraph (2) of this subsection, a retailer may not prepare, distribute, sell, or expose for sale any of the following:

(i) A phenibut product that is adulterated with a dangerous substance other than phenibut;

(ii) A phenibut product that is contaminated with a dangerous substance other than phenibut; or

(iii) A product containing phenibut that does not include on its package or label the amount of beta–phenyl–gamma–aminobutyric acid HCl contained in the product.

(2) (i) For the purpose of paragraph (1)(i) of this subsection, a phenibut product is adulterated with a dangerous substance other than phenibut if:

1. The phenibut product is mixed or packed with a substance other than phenibut; and

2. That substance affects the quality or strength of the phenibut product to a degree as to render the phenibut product injurious to a consumer.

(ii) For the purpose of paragraph (1)(ii) of this subsection, a phenibut product is contaminated with a dangerous substance other than phenibut if the phenibut product contains a poisonous or otherwise deleterious ingredient other than phenibut, including a drug that is designated as a controlled dangerous substance under Title 5 of the Criminal Law Article.

(c) A retailer may not distribute, sell, or expose for sale a phenibut product to an individual under the age of 21 years.

(d) In a prosecution for a violation of this section, it is a rebuttable defense that the defendant relied in good faith on the representations on the manufacturer's label on a phenibut product.

(e) A retailer that violates subsection (a)(1) of this section is subject to a civil penalty not exceeding:

(1) $1,000 for a first violation; and

(2) $2,000 for each subsequent violation.

(f) A retailer that violates subsection (a)(2), (b), or (c) of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, imprisonment for not more than 90 days, or both.

(g) In addition to any other penalties specified in this section, a retailer who violates this section is liable for any civil damages sustained by the individual resulting from the violation.

§21–2F–03.

(a) A retailer may not directly or indirectly advertise a therapeutic benefit of phenibut.

(b) A retailer may not directly or indirectly advertise or market phenibut products to minors.

(c) It is a violation of subsection (b) of this section for a retailer to use any of the following in the advertising, promotion, packaging, or labeling of a phenibut product:

(1) A cartoon;

(2) A superhero;

(3) A video game reference;

(4) An image of a food product primarily intended for minors;

(5) A trademark that imitates or mimics the trademark of a product that has been advertised or marketed primarily to minors;

(6) A symbol or celebrity that is primarily associated with minors or media primarily directed to minors;

(7) An image of an individual who appears to be under the age of 27 years; and

(8) Other images, graphics, or features or likenesses to images, graphics, or features that are popularly used to advertise to children, including:

(i) Neon colors, signs, or other brightly colored displays;

(ii) Animals;

(iii) Mascots; or

(iv) Statements, artwork, or designs that could reasonably mislead an individual to believe that the package contains anything other than a phenibut product.

(d) It is a violation of subsection (b) of this section for a retailer to advertise or promote a phenibut product:

(1) In a newspaper, a magazine, a periodical, or any other publication for which individuals under the age of 21 years constitute 15% or more of the total audience, as measured by competent and reliable survey evidence;

(2) At a concert, a stadium, a sporting event, or any other public event for which individuals under the age of 21 years constitute 15% or more of the total audience, as measured by competent and reliable survey evidence; or

(3) By placing an advertisement for phenibut on the side of a building or another publicly visible location of any form, including a sign, a poster, a placard, a device, a graphic display, an outdoor billboard, or a freestanding signboard.

(e) A retailer that violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $5,000, imprisonment for not more than 90 days, or both.

§21–2F–04.

The Department shall adopt regulations to carry out this subtitle.

§21–301.

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

(b) (1) "Bottled water" means any water that is sealed in bottles, packages, or other containers and offered for sale for human consumption, including bottled mineral water.

(2) "Bottled water" does not include:

(i) Soft drinks; or

(ii) A beverage that is labeled "club soda" or "seltzer water".

(b–1) "Cottage food business" means a business that:

(1) Produces or packages cottage food products in a residential kitchen;

(2) Sells the cottage food products in accordance with § 21–330.1 of this subtitle and regulations adopted by the Department; and

(3) Has annual revenues from the sale of cottage food products in an amount not exceeding $100,000.

(b–2) "Cottage food product" means a nonhazardous food, as specified in regulations adopted by the Department, that is sold in the State in accordance with § 21–330.1 of this subtitle and regulations adopted by the Department:

(1) Directly to a consumer from a residence, at a farmer's market, at a public event, by personal delivery, or by mail delivery; or

(2) To a retail food store, including a grocery store, or a food cooperative.

(c) "Crab meat" means the edible meat of steamed or cooked crabs.

(d) "Crab meat plant" means:

(1) A picking plant; or

(2) A place where crab meat is heat–treated to improve the keeping quality of the crab meat.

(e) "Excluded organization" means:

(1) A bona fide nonprofit fraternal, civic, war veterans', religious, or charitable organization or corporation that does not serve food to the public more often than 4 days per week except that once a year an organization may serve food to the public for up to 30 consecutive days; and

(2) A volunteer fire company that does not serve food to the public more often than 4 days per week except that once a year a volunteer fire company may serve food to the public for up to 30 consecutive days.

(f) "Food establishment" means:

(1) A food service facility; or

(2) A food processing plant.

(g) (1) "Food processing plant" means any place used for, or in connection with, the commercial manufacturing, preparing, processing, packaging, canning, freezing, storing, distributing, labeling, or holding of food or drink for human consumption.

(2) "Food processing plant" includes:

(i) A bakery plant;

(ii) A cannery;

(iii) A confectionery plant;

(iv) A crab meat picking plant;

(v) A food manufacturing plant;

(vi) A food warehouse or distribution center;

(vii) A frozen food processing plant;

(viii) An ice manufacturing plant;

(ix) A shellfish plant;

(x) A soft drink manufacturing plant; or

(xi) A bottled water plant.

(3) "Food processing plant" does not include:

(i) A warehouse or distribution center that:

1. Does not process food; and

2. Stores only sealed containers of whole bean, ground or instant coffee, leaf or instant teas, nondairy dehydrated whiteners, sugar, or sugar–free sweeteners; or

(ii) A cottage food business.

(h) (1) "Food service facility" means:

(i) A place where food or drink is prepared for sale or service on the premises or elsewhere; or

(ii) Any operation where food is served to or provided for the public, with or without charge.

(2) "Food service facility" includes a micro market licensed under Title 17, Subtitle 17 of the Business Regulation Article.

(3) "Food service facility" does not include:

(i) A kitchen in a private home where food is prepared at no charge for guests in the home, for guests at a social gathering, or for service to unemployed, homeless, or other disadvantaged populations;

(ii) A food preparation or serving area where food is prepared or served only by an excluded organization;

(iii) A location in a farmer's market or at a public festival or event where raw agricultural products, as defined in § 21–304(d)(1)(iii) of this subtitle, are sold; or

(iv) A cottage food business.

(i) "License" means a license issued by the Department under this subtitle to operate a food establishment.

(i–1) "Mobile food service facility" means a food service facility which is a mechanically, electrically, manually, or otherwise propelled vehicle operating on land or water.

(j) "Picking plant" means a place where:

(1) Crabs are steamed or cooked;

(2) Crab meat is picked from crabs; and

(3) Crab meat is packed for sale.

(j–1) "Public festival or event" means a planned gathering that is open to the public and is regulated by the State or local jurisdiction in which it takes place.

(j–2) (1) "Semipermanent food service facility" means a food service facility that:

(i) Is built at a location other than where it operates;

(ii) Is transported as a complete unit that does not require a building permit to install on the location at which it operates;

(iii) Has no indoor seating for patrons; and

(iv) When serving cooked food, serves only foods cooked for immediate service.

(2) "Semipermanent food service facility" does not include a food service facility that is a mechanically, electrically, manually, or otherwise propelled vehicle operating on land or water that moves as part of its routine operation to:

(i) Change location for sales;

(ii) Obtain food and other supplies;

(iii) Fill potable water supply holding tanks;

(iv) Empty wastewater holding tanks; or

(v) Provide for the cleaning and sanitation of equipment and utensils.

(k) (1) Except as provided under paragraph (2) of this subsection, "soft drink" means any nonalcoholic beverage.

(2) "Soft drink" does not include:

(i) Apple cider;

(ii) Soft drinks that are manufactured on the premises of a soda fountain and used at that soda fountain; or

(iii) Bottled water.

(l) "Surimi" means an intermediate manufactured seafood product derived from minced fish meat, washed to remove water–soluble protein and blood or other undesirable components and mixed with additives to enhance its frozen storage and functional characteristics.

§21–302.

This subtitle does not apply to the manufacture of milk, milk products as defined in § 21–401 of this title, or frozen desserts as defined in § 21–801 of this title.

§21–303.

The purpose of this subtitle is to provide that all food establishments in this State are constructed, operated, and maintained in a manner that assures that all food manufactured, processed, stored, or prepared for human consumption is done so under conditions necessary to protect the public health, safety, and welfare.

§21–304.

(a) (1) The Department shall adopt rules and regulations necessary to carry out the provisions of this subtitle.

(2) For excluded organizations, the Department:

(i) Shall adopt separate regulations that establish minimum standards that:

1. Ensure food integrity and safety;

2. Preserve public health; and

3. Control foodborne illnesses;

(ii) May adopt separate regulations that establish a licensing system, with appropriate standards, that excluded organizations may voluntarily choose to submit to as a rescindable alternative to regulation under item (i) of this paragraph; and

(iii) May adopt regulations governing excluded organizations serving potentially hazardous food prepared in a private kitchen.

(b) Except as provided in subsection (e) of this section, a political subdivision may not adopt a law, ordinance, rule, or regulation that establishes a standard that is less stringent than rules and regulations adopted under this subtitle.

(c) Except as otherwise provided in this section, this subtitle does not limit the power of a home rule or charter county or Baltimore City to adopt and enforce laws, ordinances, and regulations that are consistent with the purposes of this subtitle, including the power to adopt local licensing and enforcement procedures.

(d) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Farmer's market" means a public market in the State where producers of raw agricultural products sell the products directly to the public.

(iii) "Raw agricultural product" includes:

1. Whole, unprocessed grains, flowers, herbs, nuts, fruits, and vegetables supplied directly from the farm on which they were produced; and

2. Any agricultural products the Department identifies in regulation.

(2) A local jurisdiction may not require a license for the sale of raw agricultural products at a farmer's market or at a public festival or event.

(e) (1) The governing body of Frederick County may adopt an ordinance to allow a restaurant with an outdoor dining area to allow a patron's dog to accompany the patron in the outdoor dining area.

(2) An ordinance adopted under paragraph (1) of this subsection shall:

(i) Prohibit a dog from being allowed to travel through an indoor space of a restaurant to enter or exit an outdoor dining area; and

(ii) Contain a provision to ensure that the ordinance does not affect the right of an individual to use a service animal, as defined in § 7–701 of the Human Services Article.

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

(ii) "Base of operations" means a location used by the owner or operator of a mobile food service facility that provides:

1. A source of potable water, potable water hoses, and clean connections;

2. A method for the disposal of sewage;

3. Clean, adequate, and covered trash receptacles;

4. If necessary, refrigerated and dry food storage areas;

5. A storage area for single–serve food items; and

6. If necessary, a utensil washing facility.

(iii) "County of origin" means the county in which the base of operations of a mobile food service facility is located.

(iv) "Mobile food service facility" means a food service facility that:

1. Is a vehicle mechanically, electrically, manually, or otherwise propelled;

2. Operates on land or water; and

3. Changes its location as part of its routine sales operation.

(v) "Mobile reciprocity license" means a license issued under paragraph (3) of this subsection.

(2) This subsection does not apply to a mobile food service facility that operates solely under a temporary food service license in conjunction with fairs, carnivals, or similar events.

(3) A county health department shall issue a mobile reciprocity license to a mobile food service facility that:

(i) Is operating in the county;

(ii) Is operating within 90 miles of its base of operations; and

(iii) Holds a valid license from the county of origin.

(4) A county health department may charge a fee for a mobile reciprocity license in an amount not exceeding $300.

(5) A mobile reciprocity license is valid for a period of 1 year.

(6) If a mobile food service facility has been inspected by the county of origin, a county may not require that the mobile food service facility be inspected before a county health department issues a mobile reciprocity license.

(7) A county health department that issued a mobile reciprocity license may inspect the mobile food service facility while the mobile food service facility is operating in the county.

(8) A mobile food service facility that is issued a mobile reciprocity license shall comply with all applicable State and local laws and regulations.

(9) (i) A county health department may take enforcement action, including the levy of fines, against a mobile food service facility that violates this subtitle or any regulation adopted under this subtitle or any applicable local laws or regulations.

(ii) If a county health department takes enforcement action under subparagraph (i) of this paragraph, the county health department shall notify the county of origin of the action taken.

§21–304.1.

(a) A volunteer fire company that meets the requirements of an excluded organization under § 21-301(e) of this subtitle shall provide written notice to the Department that the volunteer fire company intends to serve food to the public for up to 30 consecutive days.

(b) The written notice shall include the dates on which the food will be prepared, the methods of storing and serving the food, and the methods or procedures to be followed to ensure food safety and security.

§21–304.2.

(a) A restaurant with an outdoor dining area may allow a patron's dog to accompany the patron in the outdoor dining area during the hours designated by the owner of the restaurant.

(b) The owner of a restaurant:

(1) Shall provide written notice to the local health department that the owner intends to allow a patron's dog to accompany the patron in the outdoor dining area of the restaurant not less than 30 days prior to the day on which dogs will be allowed in the outdoor dining area;

(2) May determine the location and the amount of space in the outdoor dining area designated for a patron accompanied by a dog;

(3) May establish limits on the size and type of dogs and any other limitations relating to dogs that may accompany a patron into the outdoor dining area of a restaurant;

(4) May deny entry to the restaurant or eject from the restaurant any patron accompanied by a dog at the discretion of the owner; and

(5) Shall place on permanent display a written notice that is in a typeface that is large enough to be easily legible to the average person from a distance of 8 feet and that is in a location that is plainly visible to the patrons of the restaurant notifying the patrons of the policy of the restaurant allowing dogs in the outdoor dining area.

(c) A patron accompanied by a dog:

(1) May not allow the dog to travel through an indoor space of a restaurant to enter or exit an outdoor dining area;

(2) Shall keep the dog on a leash at all times with the patron at the table at which the patron is seated;

(3) May not leave the dog unattended at any time in the restaurant;

(4) Shall be an adult who is responsible for the behavior of the dog; and

(5) Is liable for any damages caused by the dog to the restaurant or any other patron of the restaurant.

(d) This section does not affect the right of an individual to use a service animal, as defined in § 7–701 of the Human Services Article.

§21–305.

(a) Except as otherwise provided in this subtitle, a person may not operate a food establishment unless the person is licensed by the Department.

(b) (1) A separate license is required for each food establishment that a person owns or operates.

(2) Except in Baltimore City, the provisions of this subsection may require a license for each location where vending machines are operated, but may not require a separate license for each individual vending machine.

(3) Except in Baltimore City, vending machine locations used exclusively for prepackaged and commercially sealed foods that are not potentially hazardous, as defined by regulation, are not required to be licensed.

(4) In Baltimore City, a license may be required for each individual vending machine.

(5) (i) An excluded organization may operate a food establishment without a license unless the excluded organization has been issued a license under § 21–304(a)(2)(ii) of this subtitle.

(ii) If the Department adopts regulations governing excluded organizations serving potentially hazardous foods prepared in a private kitchen, an excluded organization shall meet any requirements in the regulations.

(6) A license is not required for a person who:

(i) Produces shell eggs;

(ii) Sells the shell eggs directly to the public; and

(iii) Is registered with or inspected by the Secretary of Agriculture under § 4–310 or § 4–311.1 of the Agriculture Article.

(7) A license is not required for a person who:

(i) Is licensed by the Department of Natural Resources under § 4–701 or § 4–701.1 of the Natural Resources Article; and

(ii) Harvests and processes finfish on a vessel by ikejime for direct sale to restaurants.

(8) Except as provided in § 21–304 of this subtitle, nothing in this subtitle shall preempt the right of a county to require a permit under the authority provided by a local law, ordinance, or regulation if this subtitle does not require the food establishment to obtain a State license.

(c) A license is not transferable:

(1) Except as provided by regulation for transfer of the license on the death of the licensee from person to person; or

(2) From location to location, except for a producer mobile farmer's market license under § 21–309.1 of this subtitle.

(d) (1) For the purposes of this section a license issued by a county health department under the authority provided by local law, ordinance, or regulation in accordance with § 21-304(b) and (c) of this subtitle shall constitute the license required under this subtitle, unless the Department, after a hearing, determines that the licensee is not in compliance with this subtitle and regulations adopted under this subtitle.

(2) After a determination of noncompliance under paragraph (1) of this subsection, the Department shall act to ensure that the food establishment and

its operator comply with this subtitle and the rules and regulations adopted under this subtitle.

(3) Nothing in this subtitle shall allow the issuance of 2 separate licenses issued solely for the regulation of a food establishment under this subtitle.

(e) In Charles County, an issuance, renewal, or transfer of an off-sale alcoholic beverages license shall not require Department approval.

(f) In Carroll County, a bona fide religious organization that meets the requirements of an excluded organization under § 21–301 of this subtitle or a county–owned and county–operated park or facility that is hosting a public festival may offer for sale or sell the following types of homemade–style food if the food is produced at the organization, park, or facility and meets the appropriate health and safety standards adopted by the Department:

(1) Fruit jellies, jams, and preserves made from apples, apricots, blackberries, blueberries, boysenberries, cherries, cranberries, grapes, nectarines, oranges, peaches, plums, quince, raspberries, red currants, strawberries, or tangerines;

(2) Fruit butter made from apples, apricots, grapes, peaches, plums, prunes, or quince;

(3) Fruit pies made from apples, apricots, blackberries, blueberries, boysenberries, cherries, cranberries, grapes, nectarines, oranges, peaches, plums, quince, raspberries, red currants, strawberries, or tangerines; and

(4) Honey.

§21–306.

(a) To apply for a license, an applicant shall submit an application to the Department on the form that the Department requires.

(b) The application form shall include:

(1) The applicant's name and address;

(2) The location of the food establishment for which application is made;

(3) The type of food establishment that the applicant proposes to operate; and

(4) Any other information the Department requires.

§21–307.

(a) To qualify for a license, an applicant shall:

(1) Comply with the requirements of this subtitle and the rules and regulations adopted under this subtitle;

(2) Agree to permit access to the food establishment for the purpose of any inspection permitted or required under this subtitle; and

(3) Pay the license fee assessed under § 21-308 of this subtitle, unless exempted from the fee under this subtitle or any rule or regulation adopted under this subtitle.

(b) Before issuing a license, the Department may inspect the food establishment identified in the application to determine if the food establishment meets the requirements for a license.

§21–308.

(a) In this section, "on–farm home processing facility" means a home or domestic kitchen located on an individual's farm that manufactures and processes foods for commercial sale.

(b) (1) For any license issued for which the authority to conduct a program under this subtitle has been delegated to a county health department:

(i) A county governing body or the Mayor and City Council of Baltimore City may and the Anne Arundel County Council shall provide for a license fee schedule based on the anticipated cost of licensing, inspecting, and regulating food establishments and may provide for exemptions from the license fee schedule; and

(ii) All license fees shall be paid to the local health department or chief financial officer of the county governing body or Baltimore City.

(2) Except in Anne Arundel County, Baltimore City, Montgomery County, and Prince George's County, a license fee under this subsection may not exceed $70 for a seasonal food processing operation that:

(i) Uses only food that is grown on the property of the licensee; and

(ii) Is in operation for not more than a 3–month continuous period in the calendar year.

(3) A seasonal food processing operation may obtain a food establishment license for a fee of $70 under paragraph (2) of this subsection only twice in a calendar year.

(c) (1) An on–farm home processing facility may obtain an on–farm home processing plant license for a fee established in regulations.

(2) An on–farm home processing facility that obtains an on–farm home processing plant license may manufacture or process only foods provided for in regulations of the Department.

(3) A license or permit is not required to deliver prepackaged foods to fill an order of a customer.

(d) For any other food establishment license, the Secretary shall establish a license fee in accordance with § 2–104 of this article.

(e) Notwithstanding any other provision of this section, a license fee under this section may not exceed $150 annually for a food processing plant that:

(1) Is a bona fide civic or nonprofit organization that processes meat for human consumption; and

(2) Engages in the processing of meat for human consumption no more than three times a year for 5 days or less each time.

§21–309. IN EFFECT

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

(2) "On–farm food service facility" means a food service facility that:

(i) Is located on a farm;

(ii) Serves food as designated by the Department; and

(iii) Operates during a period of time of not more than 30 consecutive days with up to two renewals in a 1–year period.

(3) "Temporary food service facility" means a food service facility that operates during a period of time of not more than 30 consecutive days at a fixed location in conjunction with a fair, carnival, public exhibition, construction project, recreational facility, or similar gathering.

(b) (1) Except as provided in § 10–226 of the State Government Article and in paragraphs (2) and (3) of this subsection, and unless it is renewed for another term, a license expires 1 year from the date of issuance or renewal or as provided by local law, ordinance, or regulation in accordance with § 21–304(b) and (c) of this subtitle.

(2) Except as provided in § 10–226 of the State Government Article, a license to operate a temporary food service facility expires at the conclusion of the underlying event or after 30 consecutive days of operation, whichever is earlier, or as provided by local law, ordinance, or regulation in accordance with § 21–304(b) and (c) of this subtitle.

(3) (i) Except as provided in § 10–226 of the State Government Article, a license to operate an on–farm food service facility expires after 30 consecutive days unless it is renewed in accordance with subparagraph (ii) of this paragraph.

(ii) An on–farm food service facility may renew an on–farm food service facility license up to two times within a 1–year period.

(c) Except in the case of a temporary food service facility, including a mobile food service facility which operates solely as a temporary food service facility, or an on–farm food service facility, at least 1 month before the license expires, the Department shall send to the licensee, by first–class mail to the last known address of the licensee, a renewal notice that states:

(1) The date on which the current license expires; and

(2) The date by which the completed renewal application must be received by the Department for the renewal to be issued and mailed before the license expires.

(d) The Department may renew a license if the licensee:

(1) Has complied with this subtitle and the regulations adopted under this subtitle;

(2) Submits to the Department a completed renewal application on the form the Department requires;

(3) Pays the renewal fee assessed under § 2–104 of this article, unless exempted from the fee under this subtitle or any regulation adopted under this subtitle; and

(4) Agrees to permit access to the food establishment for purposes of any inspection permitted or required under this subtitle.

§21–309. ** TAKES EFFECT JANUARY 31, 2027 PER CHAPTER 189 OF 2026 **

(a) In this section, temporary food service facility" means a food service facility that operates during a period of time of not more than 30 consecutive days at a fixed location in conjunction with a fair, carnival, public exhibition, construction project, recreational facility, or similar gathering.

(b) (1) Except as provided in § 10–226 of the State Government Article and in paragraph (2) of this subsection, and unless it is renewed for another term, a license expires 1 year from the date of issuance or renewal or as provided by local law, ordinance, or regulation in accordance with § 21–304(b) and (c) of this subtitle.

(2) Except as provided in § 10–226 of the State Government Article, a license to operate a temporary food service facility expires at the conclusion of the underlying event or after 30 consecutive days of operation, whichever is earlier, or as provided by local law, ordinance, or regulation in accordance with § 21–304(b) and (c) of this subtitle.

(c) Except in the case of a temporary food service facility, including a mobile food service facility which operates solely as a temporary food service facility, at least 1 month before the license expires, the Department shall send to the licensee, by first–class mail to the last known address of the licensee, a renewal notice that states:

(1) The date on which the current license expires; and

(2) The date by which the completed renewal application must be received by the Department for the renewal to be issued and mailed before the license expires.

(d) The Department may renew a license if the licensee:

(1) Has complied with this subtitle and the regulations adopted under this subtitle;

(2) Submits to the Department a completed renewal application on the form the Department requires;

(3) Pays the renewal fee assessed under § 2–104 of this article, unless exempted from the fee under this subtitle or any regulation adopted under this subtitle; and

(4) Agrees to permit access to the food establishment for purposes of any inspection permitted or required under this subtitle.

§21–309.1.

(a) (1) The Department shall establish a producer mobile farmer's market license.

(2) The fee for a producer mobile farmer's market license:

(i) Shall be based on the anticipated cost of licensing, inspecting, and regulating licensees; and

(ii) May not exceed $100.

(3) A producer mobile farmer's market license shall be valid for a period of 1 year.

(b) A producer mobile farmer's market licensee may transport to and sell at a farmer's market or at a public festival or event:

(1) Products that were produced by the licensee under an on–farm home processing plant license;

(2) Products produced by the licensee, as authorized by the Department in regulation; or

(3) Farm products that have been inspected, licensed, or certified for food safety by the Maryland Department of Agriculture.

(c) (1) A producer mobile farmer's market license is valid in all jurisdictions in the State.

(2) A county or municipality may not require a producer mobile farmer's market licensee to obtain a separate permit or license to sell products authorized for sale under the producer mobile farmer's market license.

(d) The Department shall:

(1) Issue producer mobile farmer's market licenses;

(2) At least once a year, inspect each mobile unit that operates under a producer mobile farmer's market license; and

(3) Adopt regulations to implement this section.

(e) A producer mobile farmer's market license shall be displayed on any mobile unit operating under the license.

(f) (1) A person in violation of this section or a regulation adopted under this section is subject to a fine not to exceed $1,000.

(2) A county health department shall enforce and levy fines for a violation of this section or any regulations adopted under this section.

(3) Fines assessed by a county health department shall be paid to the county in which the violation occurred.

(4) A county health department shall notify the Department of any violations occurring in the county.

§21–309.2.

(a) A county may establish a seasonal farmer's market producer sampling license to be required for a producer of a farm product to prepare and offer samples of the farm product for human consumption at a farmer's market or at a public festival or event.

(b) A county seasonal farmer's market producer sampling license established under this section shall:

(1) Be valid at all farmer's markets in the county;

(2) Be valid at any public festival or event in the county;

(3) Be valid for the entire season for which it is issued; and

(4) Have a single fee as set by the county.

(c) A seasonal farmer's market producer sampling licensee shall use the license only to offer samples of a farm product that has been produced by the licensee.

(d) The Department shall adopt regulations that:

(1) Establish eligibility for the license;

(2) Provide for the authorized uses of the license;

(3) Establish standards and approved methods under which sampling shall be conducted;

(4) Specify the duration of the season during which the license is valid; and

(5) Include other provisions that are necessary to protect public health and control foodborne illnesses.

(e) A county issuing a seasonal farmer's market producer sampling license shall adopt an ordinance that:

(1) Sets the fee for the license;

(2) Provides for the enforcement of provisions of law under which the license is issued; and

(3) Provides penalties for violations of provisions of law under which the license is issued.

§21–309.3. NOT IN EFFECT

** TAKES EFFECT JANUARY 31, 2027 PER CHAPTER 189 OF 2026 **

(a) In this section, "on–farm food service facility" means a food service facility that:

(1) Is located on a farm; and

(2) Serves food as designated by the Department.

(b) There is an on–farm food service facility license.

(c) The fee for an on–farm food service facility license:

(1) Shall be determined by the Department based on the anticipated cost of licensing, inspecting, and regulating licensees; and

(2) May not exceed $100.

(d) (1) An on–farm food service facility license shall be valid for a period of 1 year.

(2) Except as provided in § 10–226 of the State Government Article and unless it is renewed for another term, an on–farm food service facility license expires 1 year from the date of issuance or renewal or as provided by local law, ordinance, or regulation in accordance with § 21–304(b) and (c) of this subtitle.

(e) The Department, in consultation with the Department of the Environment, the Department of Agriculture, and key stakeholders, including the appropriate delegated approval authority and at least one representative of county governments designated by the Maryland Association of Counties, shall adopt regulations for an on–farm food service facility regarding:

(1) Access to water for handwashing and food preparation;

(2) Management of wastewater;

(3) Outdoor cooking and food preparation;

(4) The use of on–farm structures for food preparation and patron seating;

(5) Consistent with § 21–325(d) of this subtitle, toileting facilities; and

(6) Other requirements as necessary for the protection of public health.

(f) In adopting regulations under subsection (e) of this section, the Department may consider:

(1) The number of individuals expected to patronize an on–farm food service facility;

(2) The expected frequency of operation;

(3) How to consider the current or planned physical structures associated with an on–farm food service facility; and

(4) How to assess whether the anticipated operation of an on–farm food service facility is consistent with the continued operation of the farm on which it is located.

(g) This section may not be construed to:

(1) Limit the application of any current or future applicable building codes, zoning codes, land use designations, or public health and safety regulations enacted by a county or other local government to an on–farm food service facility; or

(2) Authorize the Department to:

(i) Conduct or require an assessment of the value of real property;

(ii) Evaluate real property for the purpose of valuation or taxation; or

(iii) Exercise any authority otherwise reserved to the State Department of Assessments and Taxation under the Tax – Property Article.

§21–310.

(a) Within 30 days after the Department receives an application for a license, the Department shall issue a license to any applicant who meets the requirements of this subtitle and all regulations adopted under this subtitle.

(b) While it is effective, a license authorizes the licensee to operate the food establishment identified on the license.

§21–311.

(a) The Department may deny an application for a food establishment license issued under this subtitle if the Department finds that the applicant:

(1) Does not meet the requirements of this subtitle or any rules or regulations adopted under this subtitle; or

(2) Fraudulently or deceptively attempts to obtain a license.

(b) Within 30 days of receipt of the completed application, the Department shall notify the applicant in writing:

(1) That the application has been denied;

(2) The specific reasons for the denial of the application; and

(3) If any, the actions that must be taken by the applicant to qualify for a license.

(c) After a notice of denial is issued, the Department may issue a license to an applicant if the applicant:

(1) Takes all actions specified in the notice of denial; and

(2) Meets the requirements of this subtitle and all rules and regulations adopted under this subtitle.

(d) An applicant who is denied a license is entitled to:

(1) A hearing before the Secretary under § 21-316 of this subtitle; and

(2) Judicial review under § 21-317 of this subtitle.

§21–312.

Each licensee shall display the license conspicuously in the food establishment.

§21–312.1.

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

(2) "Caterer" means a food service facility that offers catering services or identifies itself as a caterer.

(3) "Catering services" means the preparation or provision and the serving of food or drink by a food service facility for service at the provider's premises or elsewhere in connection with a specific event or a business or social function or affair.

(b) A food service facility that offers catering services or that identifies itself as a caterer shall include its food service facility license number, including the identity of the issuer of the license, on:

(1) All advertising on business cards, published print media, flyers, brochures, and any vehicles used in connection with catering services and in telephone directories; and

(2) All contracts for catering services.

(c) A food service facility that is licensed in more than one political subdivision may satisfy the requirements of this section by displaying the food service facility license number of any or all of its licenses issued by one or more of the political subdivisions.

(d) This section does not apply to a person who:

(1) Prepares food in a kitchen of another person's private home for service in that private home; or

(2) Prepares food in a kitchen of a private home or a kitchen of a school, religious or charitable organization, or nonprofit institution for service or sale to benefit a school, religious or charitable organization, or nonprofit institution.

§21–312.2.

(a) This section applies to a semipermanent food service facility that:

(1) Operates in Anne Arundel County; and

(2) Was licensed under § 21–305 of this subtitle on or before December 1, 2010.

(b) An operator of a semipermanent food service facility shall:

(1) Pump out the onboard wastewater holding tank as frequently as required by Anne Arundel County to avoid creating a public health nuisance;

(2) Remove wastewater by:

(i) Hiring a licensed liquid waste hauler to dispose of the wastewater; or

(ii) Disposing of the wastewater at a wastewater disposal facility approved by Anne Arundel County;

(3) Use a food grade hose and an adequate backflow prevention device to maintain a potable water supply; and

(4) Demonstrate compliance with items (1) and (2) of this subsection by quarterly submitting a record of receipts to the issuer of the license.

§21–313.

(a) To enforce this subtitle, a representative of the Department, at any reasonable time, may:

(1) Enter and inspect any food establishment; and

(2) Inspect and sample any item of food that is in a food establishment.

(b) A person may not:

(1) Refuse to grant access to a representative of the Department who requests to enter and inspect a food establishment under this section; or

(2) Interfere with any inspection under this section.

§21–314.

If the Department finds that a food establishment is in violation of this subtitle or any rule or regulation adopted under this subtitle, is in an unsanitary condition, or is not equipped properly, the Secretary shall notify the licensee:

(1) Of the specific findings;

(2) Of a specific, reasonable date by which the licensee shall correct the violations or deficiencies specified in the notice; and

(3) That, if the licensee fails to correct the conditions by the date specified, the Department may suspend or revoke the license issued under this subtitle.

§21–315.

The Department may suspend or revoke a license issued under this subtitle if the licensee:

(1) Violates or fails to meet the requirements of this subtitle or any regulation adopted under this subtitle; or

(2) Fraudulently or deceptively obtains a license.

§21–316.

(a) Except as otherwise provided in Title 10, Subtitles 2 and 3 of the State Government Article, before the Department takes any final action under § 21–311 or § 21–315 of this subtitle, the Secretary shall give the person against whom the action is contemplated an opportunity for a hearing before the Department.

(b) The Department shall give notice and hold the hearing in accordance with Title 10, Subtitle 2 of the State Government Article.

(c) The Department shall send the hearing notice to the applicant or licensee by certified mail, return receipt requested, bearing a postmark from the United States Postal Service.

(d) Within 30 days after the hearing required under this section, the Department shall decide the issue and immediately notify the parties to the hearing.

§21–317.

(a) Any person aggrieved by a final decision of the Department in denying, suspending, or revoking a license issued under this subtitle may take a direct judicial appeal.

(b) The appeal shall be made as provided for judicial review of final decisions in Title 10, Subtitle 2 of the State Government Article.

(c) Either party may appeal the decision of the circuit court to the Appellate Court of Maryland.

§21–318.

(a) If the Department believes that a person is violating any provision of this subtitle or any regulation adopted under this subtitle, the Department may have the person served with a written order that directs the person served to abate the violation within a time specified in the order.

(b) Except as otherwise provided in Title 10, Subtitle 2 of the State Government Article, the Department shall give any person served with an order under this section an opportunity for a hearing before the Department.

(c) After a hearing under this section, the Department may affirm, modify, or withdraw the order.

(d) A person who is served with an order under this section may not violate that order.

§21–321.

(a) Except as provided in subsection (d) of this section, before a food establishment is constructed, remodeled, or materially altered, or before an existing building or structure is converted or remodeled for use as a food establishment, properly prepared plans and specifications for the construction, remodeling, or alteration of a food establishment shall be submitted to:

(1) The Department, if the food establishment is:

(i) A food processing plant; or

(ii) A chain or franchise food service facility planning to construct 2 or more facilities in the State from a single uniform set of plans; or

(2) Except as provided in item (1)(ii) of this subsection, for food service facilities, to the appropriate county health department.

(b) The plans or specifications required under subsection (a) of this section shall include:

(1) Layout and arrangement of work areas;

(2) Construction materials;

(3) The location, size, manufacturer, and model number of equipment and facilities; and

(4) Any other information that may be required for the proper review of the plans and specifications.

(c) Unless the required plans and specifications are approved by the Department, a person may not:

(1) Construct, remodel, or alter a food establishment; or

(2) Convert or remodel an existing building or structure for use as a food establishment.

(d) The provisions of this section do not apply to the construction, remodeling, or alteration of any areas in a food establishment used solely for office space, or recreational areas.

§21–322.

(a) The Maryland Department of Health and the State Department of Agriculture may:

(1) Inspect for wholesomeness any food donated to a nonprofit corporation, organization, or association; and

(2) Establish procedures for handling food donated to any nonprofit corporation, organization, or association.

(b) (1) In this subsection, "person" shall include a nonprofit corporation, organization, or association.

(2) A person shall have the immunity from liability described under § 5–634 of the Courts Article for any act or omission that affects the nature, age, condition, or packaging of the donated food.

§21–323.

(a) In this section, "group home" means a foster home, emergency shelter, or family type residential facility for children that is:

(1) Sponsored by a public or private agency; and

(2) Supervised by foster parents, house parents, or counselors.

(b) Any group home is exempt from any regulation governing food service facilities that is adopted by the Department or a local government, if the group home:

(1) At no time has more than 14 residents including house parents and supervisory, professional, and custodial staff members; and

(2) Has among its resident children only children placed in the group home by a court, a licensed child placement agency, or a government agency, including a local department of social services.

(c) Each group home that is intended for no more than 14 residents shall be registered with the health officer for the county and is subject to State and local health regulations that govern occupancy and use of private family homes.

(d) In each county, the health officer shall inspect each group home that is intended for no more than 14 residents.

§21–323.1.

(a) In this section, "bed and breakfast establishment" means a lodging or rooming house as defined in § 9-201 of the Public Safety Article having eight rooms or fewer for rent.

(b) A bed and breakfast establishment is exempt from any regulation governing food service facilities that is adopted by the Department or a local government relating to the construction or installation of commercial grade kitchen equipment in the bed and breakfast establishment.

(c) Each bed and breakfast establishment that intends to serve hot meals to renters shall be:

(1) Licensed in accordance with § 21–305 of this subtitle; and

(2) Subject to State and local health regulations that govern food safety and contamination.

(d) In each county, the health officer shall inspect each bed and breakfast establishment that intends to serve hot meals to renters for compliance with food safety and contamination regulations in accordance with § 21-313 of this subtitle.

§21–324.

(a) (1) The floors, walls, ceilings, sidewalks, furniture, receptacles, implements, and machinery of or in any food establishment shall be kept in a clean and sanitary condition at all times.

(2) (i) The design and construction of existing equipment in food establishments shall be accepted by the Department, if the existing equipment:

1. Complied with the Department's standards that prevailed at the time of the installation;

2. Accomplishes its intended and required function in the establishment;

3. Is cleanable;

4. Is free of hazardous materials and toxic food contact surfaces; and

5. Is in good repair.

(ii) The Department shall establish guidelines for the replacement of failed existing equipment.

(b) Any vehicle that is used to transport food or from which any food is sold shall be kept in a clean and sanitary condition at all times.

(c) A condition that is unclean and unsanitary exists whenever any of the following occurs:

(1) Any food in the process of manufacture, preparation, packing, canning, freezing, storing, sale, distribution, or transportation is not protected as far as practicable from flies, filth, and any foreign or injurious contamination;

(2) Refuse, dirt, or waste products subject to decomposition and fermentation that are incident to the manufacture, preparation, packing, canning, freezing, storing, sale, distribution, or transportation of food are not removed daily, or at a frequency required by the Department;

(3) Any receptacle, chute, platform, rack, table, shelf, utensil, or machinery used in moving, handling, cutting, chopping, mixing, canning, freezing, or processing food is not kept clean;

(4) The clothing or body of any individual employed in the establishment, place, or vehicle is not kept as clean as the nature of the employment permits;

(5) The food establishment lacks an adequate supply of potable water; or

(6) The food establishment lacks an adequate sewage disposal facility.

§21–324.1.

(a) This section does not apply to an outer door of a food service facility that leads from the kitchen to the outside.

(b) A food service facility may operate with the outer windows or outer doors open unless, while the food service facility is operating with the outer doors or outer windows open, the local health department:

(1) Finds evidence of vermin in food preparation or food storage areas; or

(2) Finds evidence of flying insects in food preparation or food storage areas that pose a significant threat to sanitation or public health.

(c) If a local health department finds that a food service facility is operating in violation of subsection (b) of this section, the food service facility shall take immediate action to eliminate the vermin or flying insects.

(d) A local health department may close a food service facility found to be operating in violation of subsection (b) of this section, or order a temporary closure of the outer windows and outer doors at the food service facility, until the vermin or flying insects are eliminated from the food preparation or food storage areas, or until another action approved by the local health department is taken.

(e) A food service facility found to be operating in violation of subsection (b) of this section on three or more separate occasions shall keep the outer windows and outer doors closed at all times until:

(1) Modifications approved by the local health department are made to the food service facility to effectively protect against the entrance of vermin and flying insects; or

(2) Another action approved by the local health department is taken.

§21–325.

(a) Subject to subsection (d) of this section, each food establishment shall have:

(1) A convenient toilet that is:

(i) Except as provided in subsection (c) of this section, separated from any room in which food is manufactured, prepared, packed, canned, frozen, sold, or distributed;

(ii) Kept in a sanitary condition; and

(iii) Properly ventilated; and

(2) A convenient lavatory that is:

(i) Supplied with soap, water, towels, or other approved hand drying devices;

(ii) Kept in a sanitary condition; and

(iii) Properly ventilated.

(b) (1) This subsection does not apply to a mobile food service facility or a semipermanent food service facility located in Washington County.

(2) Each food service facility which prepares food and provides seating for patrons established after January 1, 1979, shall have available for the public:

(i) A convenient toilet that is kept in a sanitary condition; and

(ii) A convenient lavatory that is:

1. Supplied with soap, water, towels, or other approved hand drying devices;

2. Kept in a sanitary condition; and

3. Properly ventilated.

(c) A room that houses a toilet may be constructed within a larger room in which food is manufactured, prepared, packed, canned, frozen, sold, or distributed.

(d) (1) This subsection applies only to a food establishment that is:

(i) A business that conducts agritourism, as defined in § 4–212 of the Land Use Article;

(ii) A Class 4 limited winery licensed under § 2–206 of the Alcoholic Beverages and Cannabis Article; and

(iii) A Class 8 farm brewery licensed under § 2–210 of the Alcoholic Beverages and Cannabis Article.

(2) A food establishment may comply with the requirement to provide a convenient lavatory by providing a portable toilet that:

(i) Otherwise meets the requirements of subsection (a)(2) or (b)(2)(ii) of this section; and

(ii) Is placed at least 25 feet from a well.

§21–326.

(a) Each food service facility which prepares food and provides seating for patrons shall post a diagram or illustrative directions on the use of manual maneuvers to prevent asphyxiation due to choking.

(b) A person who applies the maneuvers depicted in a diagram posted under this section to remove food lodged in the throat of another is liable only if the person's actions amount to gross negligence.

§21–327.

A person may not sleep in:

(1) Any workroom or food storage room of a food processing plant; or

(2) Any kitchen, dining room, or food storage room of a food service facility.

§21–328.

(a) A person may not knowingly employ any individual to work in any area or capacity in a food establishment in which there is a likelihood of transmission of disease to patrons or other employees of the food establishment if the individual employed:

(1) Has a communicable disease that may be transmitted by food; or

(2) Is a carrier of a communicable disease that may be transmitted by food.

(b) An individual may not knowingly work in any area or capacity in a food establishment in which there is a likelihood of transmission of disease to patrons or other employees of the food establishment if the individual:

(1) Has a communicable disease that may be transmitted by food; or

(2) Is a carrier of a communicable disease that may be transmitted by food.

§21–329.

(a) Unless the packaging of a food product is clearly and conspicuously labeled in accordance with subsection (c) of this section, no food product containing or consisting of surimi may be sold in the State.

(b) Unless all menus and notices advertising a food containing or consisting of surimi are clearly and conspicuously labeled in accordance with subsection (c) of this section, a food service facility may not serve the food in the State.

(c) Labeling for a food product or food containing or consisting of surimi shall include 1 or more of the following terms, as appropriate:

(1) "Imitation crab";

(2) "Imitation lobster";

(3) "Imitation scallops";

(4) "Imitation shrimp";

(5) "Imitation" followed by the name of the seafood imitated;

(6) "Artificial processed seafood";

(7) "Surimi";

(8) "Seafood salad containing imitation" followed by the name of the seafood imitated; or

(9) Other terms approved by the Department.

(d) In addition to the penalties set forth in § 21-1214 of this title, the Secretary may seize or condemn any food product or food sold or served in violation of this section.

§21–330.

(a) A low calorie frozen dessert that contains powders or dry mixes of pasteurized whey, reduced mineral whey, whey protein concentrate, reduced lactose whey, or optional caseinates and is rehydrated with potable water before freezing is not required to be repasteurized.

(b) The wheys, caseinates, or egg ingredients that are used in the formulation of a mixture under subsection (a) of this section shall:

(1) Have been pasteurized before being used in the mixture; and

(2) Contain only those ingredients that:

(i) Are recognized as safe by the United States Food and Drug Administration; or

(ii) Are authorized under regulations adopted under this subtitle.

(c) After the rehydration of a mixture under subsection (a) of this section, the mixture shall be:

(1) Cooled to a maximum temperature of 45 degrees Fahrenheit within 4 hours; and

(2) Frozen within 24 hours.

(d) The Secretary shall adopt regulations that comply with the provisions of this section.

§21–330.1.

(a) This section does not:

(1) Apply to a food establishment that is required to have a license under § 21–305 of this subtitle; or

(2) Exempt a cottage food business from any applicable State or federal tax laws.

(b) A cottage food business is not required to be licensed by the Department if the owner of the cottage food business complies with this section.

(c) The owner of a cottage food business may sell only cottage food products that are:

(1) Stored on the premises of the cottage food business; and

(2) Prepackaged with a label that contains:

(i) The following information:

1. A. The name and address of the cottage food business; or

B. The name and phone number of the cottage food business and the identification number assigned to the cottage food business under subsection (d) of this section;

2. The name of the cottage food product;

3. The ingredients of the cottage food product in descending order of the amount of each ingredient by weight;

4. The net weight or net volume of the cottage food product;

5. Allergen information as specified by federal labeling requirements; and

6. If any nutritional claim is made, nutritional information as specified by federal labeling requirements;

(ii) The following statement printed in 10 point or larger type in a color that provides a clear contrast to the background of the label: "Made by a cottage food business that is not subject to Maryland's food safety regulations."; and

(iii) For a cottage food product offered for sale at a retail food store:

1. The phone number and e–mail address of the cottage food business; and

2. The date the cottage food product was made.

(d) At the request of a cottage food business, the Department shall provide to the cottage food business a unique identification number that the cottage food business may use on the label of a cottage food product under subsection (c) of this section.

(e) The owner of a cottage food business shall comply with all applicable county and municipal laws and ordinances regulating the preparation, processing, storage, and sale of cottage food products.

(f) (1) The Department may investigate any complaint alleging that a cottage food business has violated this section.

(2) On receipt of a complaint, a representative of the Department, at a reasonable time, may enter and inspect the premises of a cottage food business to determine compliance with this section.

(3) The owner of a cottage food business may not:

(i) Refuse to grant access to a representative who requests to enter and inspect the premises of the cottage food business under paragraph (2) of this subsection; or

(ii) Interfere with any inspection under paragraph (2) of this subsection.

(4) An investigation of a cottage food business conducted under this subsection may include sampling of a cottage food product to determine if the cottage food product is misbranded or adulterated.

(g) Before the owner of a cottage food business may sell a cottage food product to a retail food store, the owner shall submit to the Department:

(1) Documentation of the owner's successful completion of a food safety course approved by the Department; and

(2) The label that will be affixed to the cottage food product in accordance with subsection (c)(2) of this section.

(h) Beginning on or before December 30, 2020, and every December 30 thereafter, the Department shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on:

(1) The documentation and labels submitted under subsection (f) of this section; and

(2) Any complaints received by the Department related to a cottage food business or cottage food product.

(i) The Department shall adopt regulations to carry out this section.

§21–330.2.

(a) Beginning March 1, 2014, a food establishment shall display prominently in the staff area of the food establishment a poster relating to food allergy awareness that includes information regarding the risk of an allergic reaction.

(b) On or before January 1, 2014, the Department, in consultation with the Restaurant Association of Maryland and Food Allergy Research and Education, shall create and make available on its website the poster required to be displayed under subsection (a) of this section.

§21–330.3.

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

(2) "Automated external defibrillator (AED)" means a medical heart monitor and defibrillator device that:

(i) Is cleared for market by the federal Food and Drug Administration;

(ii) Recognizes the presence or absence of ventricular fibrillation or rapid ventricular tachycardia;

(iii) Determines, without intervention by an operator, whether defibrillation should be performed;

(iv) On determining that defibrillation should be performed, automatically charges; and

(v) 1. Requires operator intervention to deliver the electrical impulse; or

2. Automatically continues with delivery of the electrical impulse.

(3) "Grocery store" means a store that has:

(i) All major food departments, including produce, meat, seafood, dairy, and canned and packaged goods; or

(ii) 1. At least one of the major food departments; and

2. At least 12,000 square feet of floor space.

(b) This section does not apply to:

(1) A grocery store that has an annual gross income of $10,000,000 or less; or

(2) A restaurant with:

(i) An annual gross income of $1,000,000 or less, exclusive of sales for off–premises consumption; or

(ii) A seating capacity of less than 100 individuals.

(c) Each owner and operator of a grocery store or restaurant shall:

(1) Place an automated external defibrillator in a prominent area, accessible to employees and customers;

(2) Maintain the functionality of the automated external defibrillator; and

(3) Comply with the applicable requirements of the Public Access Automated External Defibrillator Program provided under § 13–517 of the Education Article.

(d) In addition to any other immunities available under statutory or common law:

(1) A grocery store or restaurant is not civilly liable for any act or omission in the provision of automated external defibrillation if the grocery store or restaurant has satisfied the requirements under this section;

(2) An individual is not civilly liable for any act or omission if:

(i) The individual is acting in good faith while rendering automated external defibrillation to another individual who is a victim or reasonably believed by the individual to be a victim of a sudden cardiac arrest;

(ii) The assistance or aid is provided in a reasonably prudent manner; and

(iii) The automated external defibrillation is provided without fee or other compensation; and

(3) A grocery store, restaurant, or individual is not civilly liable for failing to render automated external defibrillation to an individual who is a victim or is reasonably believed to be a victim of a sudden cardiac arrest.

(e) The Department and the Maryland Institute for Emergency Medical Services Systems jointly shall adopt regulations that:

(1) Establish guidelines for periodic inspections and annual maintenance of the automated external defibrillators;

(2) Assist the owner and operator of a grocery store or restaurant in carrying out the provisions of this section; and

(3) Require each grocery store and restaurant subject to this section to register with the Maryland Institute for Emergency Medical Services Systems in order to:

(i) Make its location publicly available to emergency dispatchers; and

(ii) Receive maintenance and recall notices from the Maryland Institute for Emergency Medical Services Systems.

§21–330.4.

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

(2) (i) "Baby food" means food packaged in a jar, pouch, tub, or box sold specifically for babies and children under the age of 2 years.

(ii) "Baby food" does not include infant formula, as defined in 21 U.S.C. § 321(z).

(3) "Manufacturer" includes a food manufacturer, food processor, and food packer.

(4) "Production aggregate" means a quantity of product that is intended to have uniform composition, character, and quality and is produced according to a master manufacturing order.

(5) "Proficient laboratory" means a laboratory that:

(i) Is accredited under the standards of the International Organization for Standardization/International Electrotechnical Commission 17025:2017;

(ii) Uses an analytical method at least as sensitive as the analytical method described in Section 4.7 of the U.S. Food and Drug Administration Elemental Analysis Manual for Food and Related Products; and

(iii) Demonstrates proficiency in quantifying each toxic element to at least 6 micrograms of the toxic element to kilogram of food through an independent proficiency test by achieving a z–score that is less than or equal to plus or minus two.

(6) "QR code" means a machine–readable code, consisting of an array of squares, used for storing an Internet website in order to access a webpage.

(7) "Representative sample" means a sample that consists of a number of units that are drawn based on rational criteria, such as random sampling, and intended to ensure that the sample accurately portrays the material being sampled.

(8) "Toxic heavy metal" means arsenic, cadmium, lead, or mercury.

(b) (1) Except as provided in paragraph (2) of this subsection, on or after January 1, 2025, a person may not sell, distribute, or offer for sale baby food in the State that contains toxic heavy metals that exceed the limits established by the U.S. Food and Drug Administration.

(2) A person may sell, distribute, or offer for sale baby food manufactured before January 1, 2026.

(c) (1) Beginning January 1, 2025, each manufacturer of baby food shall test a representative sample of each production aggregate of the manufacturer's final baby food product for each toxic heavy metal.

(2) The testing required under paragraph (1) of this subsection shall be conducted by a proficient laboratory at least once per month.

(3) A manufacturer may test the final baby food product in accordance with paragraph (1) of this subsection before packaging individual units of baby food for sale or distribution.

(d) On the request of the Department, a manufacturer of baby food shall provide the results of the testing conducted under subsection (c) of this section to an authorized agent of the Department.

(e) Beginning January 1, 2026, each manufacturer of baby food shall:

(1) Make publicly available on the manufacturer's website for each baby food product sold, manufactured, delivered, held, or offered for sale in the State:

(i) The name and level of each toxic heavy metal present in the final baby food product as determined by the testing conducted under subsection (c) of this section;

(ii) Sufficient information, such as the product name, universal product code, or lot or batch number, to enable consumers to identify the final baby food product; and

(iii) A link to the U.S. Food and Drug Administration's website that includes the most recent U.S. Food and Drug Administration guidance and information about the health effects of the toxic heavy metals on children; and

(2) If the baby food is tested for a toxic heavy metal subject to an action level, regulatory limit, or tolerance established by the U.S. Food and Drug Administration under 21 C.F.R. § 109, include on the baby food product label:

(i) The following statement: "For information about toxic element testing on this product, scan the QR code."; and

(ii) A QR code or other machine–readable code that allows consumers to access on the manufacturer's website or the baby food product information page:

1. The test results for the toxic heavy metals; and

2. A link to the webpage on the U.S. Food and Drug Administration website that includes the most recent guidance and information about the health effects of the toxic heavy metal on children.

(f) If a consumer believes, based on information gathered through the use of the code included on the baby food product label under subsection (e)(2) of this section, that baby food is being sold in the State with toxic heavy metals that exceed limits established by the U.S. Food and Drug Administration, the consumer shall report the baby food to the Department.

§21–332.

The Department shall renew, deny, suspend, or revoke a soft drink registration as provided for the renewal, denial, suspension, or revocation of a license under §§ 21-309, 21-311, 21-314, 21-315, 21-316, 21-317, and 21-318 of this subtitle.

§21–333.

In this State, a person may not sell a soft drink manufactured outside of this State unless the soft drink has been registered with the Department.

§21–334.

(a) This section applies to any container that is used to pack, store, distribute, or sell:

(1) A soft drink; or

(2) Bottled water.

(b) Before putting a soft drink or bottled water in a container, a manufacturer shall clean the container in a manner approved by the Department or shall use clean containers.

§21–335.

(a) A person may not sell or offer for sale at retail in this State any metal soft drink container or any composite soft drink container that is designed and constructed with an all metal tab opening device that detaches from the container when the container is opened in a manner which is normally used to empty the contents of the container.

(b) The provisions of this section do not prohibit the sale or offer for sale of:

(1) A beverage container sealed with a laminated tape seal, even if the seal contains aluminum foil, if the seal is not rigid;

(2) Frozen beverage concentrates in all metal containers with detachable metal pull tabs customarily and primarily purchased for dilution and use within the home, or for similar purposes; and

(3) Metal beverage containers with pull tabs for milk-based products, soy-based products, or similar products which require sterilization and pressure in the canning process.

§21–336.

(a) (1) In this section, "approved source" means a source of water that is:

(i) Sampled and found through laboratory analysis to comply with:

1. The microbiological standards adopted by the Department, with testing on a monthly basis; and

2. The chemical and radiological standards adopted by the Department, which shall meet or exceed the standards prescribed by the federal Food and Drug Administration, with testing annually for chemical analyses and once every 4 years for radiological analyses; and

(ii) If applicable, constructed and inspected in accordance with regulations adopted by the Department of the Environment under §§ 9–204, 9–1305, and 9–1306 of the Environment Article.

(2) "Approved source" includes:

(i) An artesian well;

(ii) A drilled well;

(iii) A glacier;

(iv) A public water supply;

(v) A spring; and

(vi) A source of mineral water that complies with the standards specified in paragraph (1) of this subsection but fails to meet the standards with respect to those properties of mineral water related to the limitations on chloride, iron, manganese, sulfate, total dissolved solids, zinc, or any other exemptions listed under 21 C.F.R. 165.110.

(3) The Department may approve a source that does not meet standards regulated by the United States Environmental Protection Agency as a secondary standard if the bottler shows by analysis that a particular treatment used reduces the level of contaminants in the bottled water to a level below the maximum contaminant level.

(b) The requirements of this section are in addition to any other provision of law.

(c) Artesian water, mineral water, natural water, purified water, spring water, well water, and any other type of bottled water shall meet the requirements of the standard of identity for bottled water under 21 C.F.R. 165.110(a).

(d) (1) A person may not bottle water unless the person is licensed by the Department under § 21–305 of this subtitle.

(2) The Department may not issue a license if the Department determines that the water is:

(i) Not from an approved source; or

(ii) In any way injurious to the public health.

(3) To apply for a license to bottle water, a bottler shall:

(i) Submit an application to the Department on the form that the Department requires;

(ii) List on the application form the types of bottled water that the applicant proposes to bottle; and

(iii) Pay to the Department an annual fee established by the Secretary under § 2–104 of this article.

(4) While it is effective, a license to bottle water authorizes a bottler to bottle and sell in the State the types of bottled water identified in the license.

(e) (1) (i) A person who is licensed under this section shall submit to the Department the results of:

1. Annual chemical and radiological analyses of a representative sample of the person's source water and bottled water; and

2. A monthly microbiological analysis of a representative sample of the source water and bottled water.

(ii) The analyses shall demonstrate that the source water and bottled water comply with the chemical, radiological, and microbiological standards adopted by the Department, which shall meet or exceed the standards prescribed by the federal Food and Drug Administration.

(iii) 1. Except as otherwise required by law, mineral water is not subject to the limitations on chloride, iron, manganese, sulfate, total dissolved solids, zinc, or any other exemptions listed under 21 C.F.R. 165.110.

2. Bottled water may not exceed:

A. 10 parts per billion of total trihalomethanes;

B. 5 parts per billion of lead; or

C. 100 parts per billion of chlorine.

(2) (i) Analyses required under this subsection may be performed by a laboratory certified by:

1. A state's Laboratory Certification Program in accordance with the United States Environmental Protection Agency's primacy conditions under the Agency's Public Water System Supervision Program; or

2. The United States Environmental Protection Agency.

(ii) The Department shall accept analyses performed by any laboratory authorized under subparagraph (i) of this paragraph.

(3) A person licensed or registered under this section shall:

(i) For at least 2 years, maintain all inspection and sampling records at the person's principal place of business; and

(ii) Make inspection and sampling records available to the Department upon request.

(4) Notwithstanding the analyses required under paragraph (1) of this subsection, the Department may sample and analyze any bottled water.

(5) The provisions of this subsection do not prevent the Department from prohibiting the use or sale of bottled water in the State, if, in the judgment of the Department:

(i) The water is shown by analysis to be unfit for drinking;

(ii) The water has been misbranded under § 21–210 of this title; or

(iii) Its quality is in any way injurious to the public health.

(f) Bottled water in individual containers shall be marked on each container with a stencil, stamp, or label that clearly indicates:

(1) The identifying batch code for the water; and

(2) In compliance with subsection (g) of this section, the type of water and any additional ingredients.

(g) Labeling of the type of bottled water and any additional ingredients, as required under subsection (f) of this section, shall conform to the labeling requirements for bottled water under 21 C.F.R. 165.110(a).

(h) In accordance with regulations adopted by the Department, a person licensed under this section shall establish written procedures and implement those procedures to:

(1) Prevent contamination during the processing, packaging, transportation, or storage of bottled water; and

(2) Recall bottled water when the person, the Department, or any other government agency determines that a supply is injurious in any way to the public health.

(i) The Department may suspend or revoke a license issued under this section if the licensee:

(1) Violates or fails to satisfy any requirement of this title or any regulation adopted under this title; or

(2) Fraudulently or deceptively obtains a license.

(j) (1) In addition to any other penalty applicable at law, a person who violates any provision of this section shall be liable for a civil penalty of:

(i) Not less than $1,000 and not more than $5,000 for a first offense; and

(ii) Not less than $5,000 and not more than $10,000 for a second offense within 2 years of the first offense.

(2) Each day on which a violation occurs constitutes a separate offense.

(k) By October 1, 2008, the Department shall adopt regulations to implement the provisions of this section.

(l) (1) The Department shall establish a Bottled Water Advisory Committee to advise and assist the Department in the development and adoption of the regulations required under subsection (k) of this section.

(2) The Advisory Committee shall consist of the following representatives:

(i) The Secretary of Health or the Secretary's designee, who shall serve as chairman of the Advisory Committee;

(ii) The Secretary of the Environment or the Secretary's designee;

(iii) A hydrogeologist;

(iv) At least two individuals from the bottled water processing industry;

(v) At least one individual from the bottled water distribution industry;

(vi) At least one individual from the environmental community or consumer advocacy community; and

(vii) At least one consumer of bottled water.

§21–336.1.

(a) Except as permitted under subsection (b) of this section, bottled water shall:

(1) Be obtained from an approved source; and

(2) Undergo:

(i) Ozonation or an equivalent disinfection process approved by the Department; and

(ii) When required by the Department, filtration or any other treatment that is necessary for the water to comply with the standards adopted by the Department under § 21–336(e)(1)(ii) of this subtitle.

(b) The Department may grant to a bottler a waiver of the filtration and disinfection treatment required under subsection (a) of this section if the Department is satisfied that the filtration and disinfection treatment are not necessary to assure that a bottled water product will consistently comply with the microbiological standards under this subtitle.

(c) (1) Based on the bottler's demonstration of long–term baseline microbiological data that monitors the source and the product, the nature and extent of source monitoring, and source protection and bottling sanitation procedures instituted by the bottler, a waiver may be granted if:

(i) The product and source are in compliance with the Codex Alimentarius standard for natural mineral water, CAC/RS 108, as amended, and the requirements under § 21–336(a)(2) and (e) of this subtitle;

(ii) The product and source are in compliance with the Code of Hygienic Practice of the Codex Alimentarius, Alinorm 85/13A, as amended, for the collection, processing, and marketing of natural mineral water; and

(iii) The bottler has submitted a basic hydrogeological survey of the source, a hydrogeological assessment that demonstrates that the source is not under the direct influence of surface water, and an annual sanitary survey, all of which have been prepared by a professionally qualified hydrogeologist and which demonstrate the integrity of the source.

(2) The annual sanitary survey required under paragraph (1)(iii) of this subsection shall include:

(i) Watershed surveillance that includes an inspection of those portions of the drainage area necessary to identify and evaluate actual and probable sources of contamination;

(ii) Evaluation of source construction and protection, and, when appropriate, intake structures and transmission facilities; and

(iii) Evaluation of finished water storage facilities.

(d) Once a waiver has been granted under this section:

(1) A bottler shall renew the waiver of the filtration and disinfection treatment provided under subsection (b) of this section on an annual basis if a continuation of operations is desired by submitting a letter of compliance with subsection (c) of this section from a representative of the bottler to the Department.

(2) The representative of the bottler shall certify under personal knowledge and penalty of perjury that the conditions under subsection (c) of this section on which the waiver was granted have not changed.

(3) The representative of the bottler shall have a continuing obligation to notify the Department of any change of a condition under subsection (c) of this section not later than 5 days from the date of the change.

(4) The product shall be bottled:

(i) In an enclosed filling room or chamber that is under positive pressure of filtered purified air; and

(ii) At a facility and with good manufacturing practices that comply with the requirements of 21 C.F.R. Part 129.

(e) If a bottled water product is not in compliance with any requirement under subsection (c) or (d) of this section:

(1) The Department shall revoke the waiver; and

(2) The product shall be subject to the filtration and disinfection treatment requirements under subsection (a) of this section.

(f) Except for filtration and disinfection treatment, this section may not be construed to waive any requirement that is applicable under this subtitle to a bottled water product.

§21–339.

(a) In this section, "repack crab meat" means to take or remove crab meat from any container or package, when the crab meat has been picked from a crab at another location, and place that crab meat in another container or package.

(b) Each container of crab meat shall be marked plainly with the information required by this section.

(c) (1) Each container of crab meat shall be marked by:

(i) Embossing;

(ii) Imprinting;

(iii) Lithography; or

(iv) Subject to paragraph (2) of this subsection, any other method that the Department approves.

(2) Unless approved by the Secretary, a container of crab meat may not be stamped with ink.

(d) (1) Each container of crab meat shall be marked with:

(i) A description of the product in the container;

(ii) Subject to the requirements of paragraph (2) of this subsection, the name and address of the picking plant or the distributor;

(iii) If a chemical is added to the crab meat, a statement to that effect;

(iv) The license number of the crab meat plant preceded by the State abbreviation applicable to the picking plant;

(v) The net weight of the contents of the container; and

(vi) Any other information that the Department requires.

(2) If a container of crab meat is marked with the name of the distributor, the name of the distributor shall be:

(i) Preceded by the words "packed for" or "distributed by"; or

(ii) Followed by the word "distributor".

(e) A person may not put any false or misleading statement on a container of crab meat.

(f) (1) A person may not repack crab meat or change crab meat containers or container lids with the intent to sell the crab meat except as provided by the Department.

(2) (i) A person may not possess more than 12 empty crab meat containers or container lids unless the person:

1. Is a manufacturer of containers or lids;

2. Is a licensed crab meat packer and the containers or lids are the same as used by the packer in the ordinary course of business;

3. Has removed the crab meat from the containers and lids for consumption on the premises; or

4. Is in possession of the containers or lids as provided for by the Department.

(ii) Possession of empty containers or crab meat container lids in violation of this section shall be presumptive evidence of intent to repack crab meat in violation of this Part VI of this subtitle.

(iii) Possession of crab meat containers or crab meat container lids from which the crab meat has been consumed or cooked for consumption and which have been properly disposed of may not constitute presumptive evidence of intent to repack or change crab meat containers for sale.

(g) (1) Notwithstanding any other provision of law, each container of crab meat sold in the State containing crab meat picked from a crab, packed, repacked, or processed outside of the United States shall be marked with the words "This product contains crab meat from (name of country of origin)".

(2) The marking required by paragraph (1) of this subsection shall be prominently displayed in letters not smaller than 12-point type on the principal display panel of the container so as to be easily read by the consumer.

§21–340.

All crab meat sold in this State, whether processed in a crab meat plant in this State or in a crab meat plant outside this State, shall comply with this subtitle and meet the standards set by the regulations adopted under this subtitle.

§21–341.

(a) A person may not process, sell, or keep for sale, as crab meat, anything that is not crab meat.

(b) A person may not process or sell for human consumption crab meat that:

(1) Contains any filthy, putrid, or decomposed substance or is otherwise unfit for human consumption;

(2) Has been packed or pasteurized in violation of this subtitle; or

(3) Has been packed, prepared, or held under conditions that may have allowed the crab meat to become:

(i) Contaminated with filth; or

(ii) Injurious to health.

(c) (1) A licensee may not possess, with intent to sell for human consumption, any crab meat, the processing or sale of which would be a violation of this section.

(2) Possession by a licensee of any crab meat, the processing or selling of which would be a violation of this section, is presumptive evidence of intent to sell the crab meat for human consumption.

§21–343.

The Secretary shall seize and condemn any crab meat that does not comply with this subtitle.

§21–346.

Except for shellstock that is imported into this State for replanting under the direction of the Department of Natural Resources, or commercially sterile shellfish or shellfish products, a person may not import shellfish into this State unless the shellfish is from a source certified by the appropriate agency responsible for interstate shellfish shipment.

§21–347.

(a) Unless the shellfish contained in the food comes from a source certified by the appropriate agency responsible for interstate shellfish shipment, a person may not import into this State any food that contains shellfish.

(b) Each processor of food that contains shellfish that is imported into this State shall:

(1) Keep on file proof that the shellfish is from a source certified by the appropriate agency responsible for interstate shellfish shipment; and

(2) Provide this proof to the Department on request.

§21–348.

A person may not process, sell, or keep for sale any shellfish or any food that contains shellfish if the shellfish involved is from an unknown or uncertified source.

§21–349.

The Department may:

(1) Detain and take any necessary action on any shipment of shellfish or any food that contains shellfish if the shellfish involved is from an unknown or uncertified source; and

(2) Condemn and destroy any shellfish or any food that contains shellfish if the shellfish involved is from an uncertified source.

§21–350.

(a) (1) Any vehicle that is used to transport, store, or sell shellfish for commercial purposes or processed crabs for commercial purposes shall be capable of maintaining the shellfish or processed crabs at a temperature established by the Department.

(2) This subsection does not apply to a licensed harvester of shellfish who delivers the shellfish in a vehicle to a processor, retailer, or wholesaler on the day of harvest.

(b) Any shellfish or processed crabs that are transported by, sold from, or stored in any vehicle for commercial purposes shall be maintained at a temperature established by the Department.

§21–401. IN EFFECT

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

(b) "Bobtailer" means a person who operates or controls a Grade A milk route and distributes Grade A pasteurized milk products that the person buys from a Grade A distributor or a milk processor.

(c) "Bulk milk hauler/sampler" means any person who collects official samples and transports raw milk from a farm or raw milk products or both to or from a milk plant, receiving station, or transfer station and who possesses a permit from any state to sample the milk or raw milk products.

(d) "Certified industry dairy farm inspector" means an individual who is certified by the Secretary under § 21–414 of this subtitle.

(e) "Dairy farm" means a place where at least 1 cow, goat, or other hooved mammal is kept, and from which the milk is sold or offered for sale.

(f) "Departmental inspection area" means the area in which the Department routinely makes inspections under this subtitle.

(g) "Farmstead cheese" means cheese made on a dairy farm:

(1) Using only the raw milk produced by the herd or flock on the dairy farm; and

(2) That meets the definitions and standards of a hard cheese established in 21 C.F.R. 133.

(h) "Grade A distribution station" means any place or vehicle where, for redistribution and sale, Grade A pasteurized milk products routinely are received, stored, or transferred.

(i) "Grade A distributor" means a person who sells a Grade A pasteurized milk product.

(j) (1) "Grade A milk product" means:

(i) Grade A milk;

(ii) Grade A cream; or

(iii) Any other Grade A milk product that the Secretary designates.

(2) "Manufactured grade milk product" means:

(i) Manufactured grade milk;

(ii) Manufactured grade cream; or

(iii) Any other manufactured grade milk product that the Secretary designates.

(k) "Grade A Pasteurized Milk Ordinance" means the recommended Grade "A" Pasteurized Milk Ordinance published by the federal government.

(l) (1) "Milk" means the milk of a cow, goat, or other hooved mammal.

(2) "Grade A milk" means the milk of a cow, goat, or other hooved mammal produced, processed, pasteurized, bottled, packaged, or prepared in accordance with the Grade A Pasteurized Milk Ordinance.

(3) "Manufactured milk" means the milk of a cow, goat, or other hooved mammal which is not Grade A milk and which is produced, processed, pasteurized, bottled, packaged, or prepared in accordance with "Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements".

(m) "Milk fat" means the natural fat of milk.

(n) "Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements" means the Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements published by the U.S. Department of Agriculture.

(o) (1) "Milk plant" means any place where, for distribution, milk products are:

(i) Processed;

(ii) Pasteurized;

(iii) Bottled or packaged; or

(iv) Prepared.

(2) "Milk plant" does not include a place where milk products are sold at retail only.

(p) "Milk processor" means a person who owns, operates, or controls a milk plant.

(q) "Milk producer" means a person who operates a dairy farm.

(r) "Milk tank truck" means a truck and its equipment that are used to transport milk products.

(s) "Milk transportation company" means a person responsible for a milk tank truck.

(t) "Misbranded milk product" means a milk product:

(1) That is in a container that bears or is accompanied by any false or misleading written, printed, or graphic material; or

(2) That is not labeled in accordance with this subtitle.

(u) (1) "Pasteurized" means having undergone the process of uniformly heating each particle of milk product, holding it in the heated state, and cooling it, in approved and properly operated equipment and under the conditions of temperature and time that the Secretary by rule or regulation establishes, to make the milk product safe and free of pathogens.

(2) "Pasteurized" includes having undergone any other process that:

(i) Is recognized by the appropriate federal authority to be equally as effective as the process described in paragraph (1) of this subsection in making milk products safe and free of pathogens; and

(ii) Is approved by the Secretary.

(v) "Permit" means a permit issued by the Secretary under this subtitle that authorizes the holder of the permit to do any act that is within the scope of the permit.

(w) "Raw milk" means unpasteurized milk.

(x) "Receiving station" means any place where, for delivery to a milk plant, raw milk is collected, cooled, and stored.

(y) "Transfer station" means a place where milk is transferred directly from a milk tank truck to another milk tank truck for delivery to a milk plant.

§21–401. ** CONTINGENCY – NOT IN EFFECT – CHAPTER 530 OF 2019 **

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

(b) "Bobtailer" means a person who operates or controls a Grade A milk route and distributes Grade A pasteurized milk products that the person buys from a Grade A distributor or a milk processor.

(c) "Bulk milk hauler/sampler" means any person who collects official samples and transports raw milk from a farm or raw milk products or both to or from a milk plant, receiving station, or transfer station and who possesses a permit from any state to sample the milk or raw milk products.

(d) "Certified industry dairy farm inspector" means an individual who is certified by the Secretary under § 21–414 of this subtitle.

(e) "Dairy farm" means a place where at least 1 cow, goat, or other hooved mammal is kept, and from which the milk is sold or offered for sale.

(f) "Departmental inspection area" means the area in which the Department routinely makes inspections under this subtitle.

(g) "Farmstead cheese" means cheese made on a dairy farm:

(1) Using only the raw milk produced by the herd or flock on the dairy farm; and

(2) That meets the definitions and standards of a hard cheese established in 21 C.F.R. 133.

(h) "Grade A distribution station" means any place or vehicle where, for redistribution and sale, Grade A pasteurized milk products routinely are received, stored, or transferred.

(i) "Grade A distributor" means a person who sells a Grade A pasteurized milk product.

(j) (1) "Grade A milk product" means:

(i) Grade A milk;

(ii) Grade A cream; or

(iii) Any other Grade A milk product that the Secretary designates.

(2) "Manufactured grade milk product" means:

(i) Manufactured grade milk;

(ii) Manufactured grade cream; or

(iii) Any other manufactured grade milk product that the Secretary designates.

(k) "Grade A Pasteurized Milk Ordinance" means the recommended Grade "A" Pasteurized Milk Ordinance published by the federal government.

(l) (1) "Milk" means the lacteal secretion, practically free of colostrum, obtained by the complete milking of one or more healthy hooved mammals, including members of the order Cetartiodactyla, including:

(i) Family Bovidae, including cattle, water buffalo, sheep, goats, and yaks;

(ii) Family Cervidae, including deer, reindeer, and moose; and

(iii) Family Equidae, including horses and donkeys.

(2) "Grade A milk" means the milk of a cow, goat, or other hooved mammal produced, processed, pasteurized, bottled, packaged, or prepared in accordance with the Grade A Pasteurized Milk Ordinance.

(3) "Manufactured milk" means the milk of a cow, goat, or other hooved mammal which is not Grade A milk and which is produced, processed, pasteurized, bottled, packaged, or prepared in accordance with "Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements".

(m) "Milk fat" means the natural fat of milk.

(n) "Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements" means the Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements published by the U.S. Department of Agriculture.

(o) (1) "Milk plant" means any place where, for distribution, milk products are:

(i) Processed;

(ii) Pasteurized;

(iii) Bottled or packaged; or

(iv) Prepared.

(2) "Milk plant" does not include a place where milk products are sold at retail only.

(p) "Milk processor" means a person who owns, operates, or controls a milk plant.

(q) "Milk producer" means a person who operates a dairy farm.

(r) "Milk tank truck" means a truck and its equipment that are used to transport milk products.

(s) "Milk transportation company" means a person responsible for a milk tank truck.

(t) "Misbranded milk product" means a milk product:

(1) That is in a container that bears or is accompanied by any false or misleading written, printed, or graphic material; or

(2) That is not labeled in accordance with this subtitle.

(u) (1) "Pasteurized" means having undergone the process of uniformly heating each particle of milk product, holding it in the heated state, and cooling it, in approved and properly operated equipment and under the conditions of temperature and time that the Secretary by rule or regulation establishes, to make the milk product safe and free of pathogens.

(2) "Pasteurized" includes having undergone any other process that:

(i) Is recognized by the appropriate federal authority to be equally as effective as the process described in paragraph (1) of this subsection in making milk products safe and free of pathogens; and

(ii) Is approved by the Secretary.

(v) "Permit" means a permit issued by the Secretary under this subtitle that authorizes the holder of the permit to do any act that is within the scope of the permit.

(w) "Raw milk" means unpasteurized milk.

(x) "Receiving station" means any place where, for delivery to a milk plant, raw milk is collected, cooled, and stored.

(y) "Transfer station" means a place where milk is transferred directly from a milk tank truck to another milk tank truck for delivery to a milk plant.

§21–402.

The General Assembly finds that statewide laws, rules, and regulations are needed to govern the production, processing, labeling, and distribution of milk products in this State.

§21–403.

This subtitle applies only to milk products that are intended for sale for immediate or eventual human consumption.

§21–404.

(a) A political subdivision may not regulate any milk product that is produced, processed, and manufactured in accordance with this subtitle and the rules and regulations adopted under this subtitle.

(b) Any milk product that is produced, processed, and manufactured in accordance with this subtitle and the rules and regulations adopted under this subtitle may be sold anywhere in this State.

§21–405.

(a) Except as otherwise provided in this subtitle or by a rule or regulation adopted under this subtitle, this subtitle and the rules and regulations adopted under this subtitle shall be interpreted in accordance with the Grade A Pasteurized Milk Ordinance.

(b) For all manufactured milk products and activities, this subtitle and the rules and regulations adopted under this subtitle shall be interpreted in accordance with Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements.

(c) The Secretary shall keep on file a certified copy of the Grade A Pasteurized Milk Ordinance.

(d) The Secretary shall keep on file a certified copy of Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements.

§21–406.

The Secretary shall adopt rules and regulations to carry out the provisions of this subtitle.

§21–407.

The Secretary shall pay all funds collected under this subtitle into the General Fund of this State.

§21–410.

(a) Except as otherwise provided in this section, a person shall obtain a permit with a Grade A or a manufactured grade classification from the Secretary before that person may:

(1) Bring, send, or receive a milk product into this State for sale;

(2) Offer a milk product for sale;

(3) Give a milk product away;

(4) Store a milk product; or

(5) Transport a milk product.

(b) A permit is required to:

(1) Be a bobtailer;

(2) Be a bulk milk hauler/sampler;

(3) Be a certified industry dairy farm inspector;

(4) Be a milk processor;

(5) Be a milk processor – farmstead cheese producer;

(6) Be a milk producer;

(7) Operate a distribution station;

(8) Operate a milk transportation company;

(9) Operate a receiving station; or

(10) Operate a transfer station.

(c) A permit is not required for:

(1) A milk producer who is outside the departmental inspection area if the raw milk from that milk producer is processed by a milk processor who holds a permit issued under this subtitle;

(2) A bulk milk hauler/sampler who receives raw milk from outside the departmental inspection area;

(3) A grocery store, restaurant, soda fountain, or similar establishment where milk products are served or sold at retail if:

(i) The establishment complies with all applicable provisions of this subtitle and all applicable rules or regulations adopted under this subtitle; and

(ii) The milk product is received from a permit holder; or

(4) A bulk milk hauler/sampler who is transporting a sealed tanker and not producers' samples.

(d) The Secretary shall designate all permits with one of the following classifications, as required by rules and regulations:

(1) Grade A milk; or

(2) Manufactured milk.

§21–411.

(a) To qualify for a permit, a person shall comply with the requirements of this subtitle and the rules and regulations adopted under this subtitle.

(b) In addition to the requirements of subsection (a) of this section, to qualify for a certified industry dairy farm inspector permit or a bulk milk hauler/sampler permit, Grade A classification, the applicant shall meet the requirements of the Grade A Pasteurized Milk Ordinance.

(c) In addition to the requirements of subsection (a) of this section, to qualify for a certified industry dairy farm inspector permit or a bulk milk hauler/sampler permit, manufactured milk classification, the applicant shall meet the requirements of Milk for Manufacturing Purposes and Its Production and Processing: Recommended Requirements.

§21–412.

An applicant for a permit shall:

(1) Submit an application to the Secretary on the form that the Secretary provides; and

(2) Pay to the Secretary an annual fee established by the Secretary under § 2-104 of this article.

§21–413.

(a) If the property of the applicant is in the departmental inspection area, before issuing a permit, the Secretary shall inspect the property, buildings, and equipment of an applicant for:

(1) A bobtailer permit;

(2) A distribution station permit;

(3) A milk processor permit;

(4) A milk processor – farmstead cheese producer permit;

(5) A milk producer permit;

(6) A milk transportation company permit;

(7) A receiving station permit; or

(8) A transfer station permit.

(b) Each inspection under this section shall be to determine whether the property, buildings, equipment, and their operation conform to the rules and regulations adopted under this subtitle.

(c) To ensure continued conformity to the rules and regulations adopted under this subtitle, the Secretary from time to time shall reinspect the property, buildings, and equipment of each permit holder for whom an initial inspection is required under this section.

§21–414.

(a) The Secretary shall certify industry personnel as certified industry dairy farm inspectors.

(b) Each certified industry dairy farm inspector shall cooperate with the Secretary in carrying out the provisions of this subtitle and the rules and regulations adopted under this subtitle for the supervision of dairy farms.

(c) A certified industry dairy farm inspector may inspect a dairy farm to determine whether the dairy farm complies with this subtitle and the rules and regulations adopted under this subtitle for dairy farms.

(d) A certified industry dairy farm inspector may not:

(1) Take punitive action; or

(2) Make an inspection for the issuance or reinstatement of a permit.

(e) Each certified industry dairy farm inspector shall send to the Secretary a report of each inspection that the certified industry dairy farm inspector makes.

§21–415.

(a) The Secretary shall issue the appropriate permit to any applicant who meets the requirements of this subtitle and the rules and regulations adopted under this subtitle for that permit.

(b) A separate permit shall be issued for each place of operation that meets the requirements of this subtitle.

§21–416.

(a) While it is effective, a bobtailer permit authorizes the holder, on a Grade A milk route that the holder operates or controls, to distribute Grade A pasteurized milk products that the holder purchased from a Grade A distributor or a Grade A milk processor.

(b) While it is effective, a certified industry dairy farm inspector permit authorizes the holder to inspect dairy farms in accordance with this subtitle.

(c) While it is effective, a distribution station permit authorizes the holder, for redistribution and sale, whether from a fixed location or from a vehicle:

(1) To receive Grade A pasteurized milk products;

(2) To store Grade A pasteurized milk products; and

(3) To transfer Grade A pasteurized milk products for redistribution and sale.

(d) (1) While it is effective, a milk processor permit authorizes the holder:

(i) To collect raw milk;

(ii) To handle raw milk;

(iii) To process raw milk;

(iv) To pasteurize raw milk;

(v) To store pasteurized milk;

(vi) To bottle or package pasteurized milk;

(vii) To prepare pasteurized milk for distribution; and

(viii) To distribute pasteurized milk.

(2) While it is effective, a milk processor – farmstead cheese producer permit authorizes the holder:

(i) To perform all the functions set forth in paragraph (1) of this subsection; and

(ii) To produce farmstead cheese.

(e) While it is effective, a milk producer permit authorizes the holder:

(1) To operate a dairy farm; and

(2) To sell raw milk from the dairy farm to:

(i) A receiving station;

(ii) A transfer station; or

(iii) A milk plant.

(f) While it is effective, a bulk milk hauler/sampler permit authorizes the holder, while operating a milk tank truck:

(1) To receive raw milk products from a milk producer, milk plant, receiving station, or transfer station;

(2) To transport raw milk products that have been received from a milk producer, milk plant, receiving station, or transfer station; and

(3) To deliver raw milk products that have been received from a milk producer, milk plant, receiving station, or transfer station.

(g) While it is effective, a receiving station permit authorizes the holder:

(1) To collect raw milk;

(2) To cool raw milk;

(3) To process raw milk;

(4) To store raw milk; and

(5) To prepare raw milk for delivery to a milk plant.

(h) While it is effective, a transfer station permit authorizes the holder to operate a place where raw milk is transferred between milk tank trucks for eventual delivery to a milk plant.

(i) A permittee authorized to perform a function under this subtitle shall only exercise that authority as to the classification for which it is designated, except that:

(1) Unless otherwise specified in this subtitle, a milk producer permittee with a Grade A classification authorized to perform a function under this subtitle may exercise that authority for manufactured milk; and

(2) A milk processor, receiving station, or transfer station with a manufactured milk classification may exercise that authority using Grade A raw milk.

(j) While it is effective, a milk transportation company permit authorizes the holder to operate one or more milk tank trucks.

§21–416.1.

(a) The Secretary may establish a farmstead cheese program after the Secretary:

(1) Adopts regulations to implement the program; and

(2) Issues a milk processor – farmstead cheese producer permit to a qualified applicant.

(b) Subject to the availability of sufficient inspection and testing staff, equipment, and other resources, the Secretary may issue milk processor – farmstead cheese producer permits under the program.

(c) To qualify for a milk processor – farmstead cheese producer permit the applicant shall meet any requirements established by the Department by regulation.

§21–417.

(a) (1) Except for a milk producer permit, a permit expires on the first anniversary of its effective date, unless the permit is renewed for a 1–year term as provided in this section.

(2) A milk producer permit does not expire.

(b) Except for a milk processor – farmstead cheese producer permit, before the permit expires, its holder may renew it for an additional 1–year term, if the holder:

(1) Otherwise is entitled to a permit;

(2) Pays to the Secretary a renewal fee equal to the fee for an original permit of the same type; and

(3) Submits to the Secretary a renewal application on the form that the Secretary requires.

(c) (1) Except for a milk processor – farmstead cheese producer permit, the Secretary shall renew the permit of each applicant for renewal who meets the requirements of this section.

(2) Subject to the ongoing availability of sufficient inspection and testing staff, equipment, and other resources, the Secretary may renew a milk processor – farmstead cheese producer permit for an additional 1–year term if the holder meets the requirements established by regulation.

(d) A permit is not transferable.

§21–418.

(a) Subject to the hearing provisions of § 21-419 of this subtitle, the Secretary shall suspend a permit issued under this subtitle if:

(1) The holder of the permit has obtained the permit fraudulently or deceptively;

(2) The holder of the permit has violated this subtitle or a rule or regulation adopted under this subtitle;

(3) A violation of this subtitle or a rule or regulation adopted under this subtitle exists at the place for which the permit has been issued under this subtitle;

(4) A health hazard exists at the place for which the permit has been issued or exists as to the individual who holds the permit; or

(5) The holder of the permit has interfered with the Secretary in the performance of the Secretary's duties.

(b) (1) Except as otherwise provided in this section, before suspending a permit, the Secretary shall give to the holder of the permit notice of intent to suspend.

(2) The notice shall:

(i) Specify with particularity the condition or violation that the Secretary believes to justify the suspension; and

(ii) State that the holder has an opportunity to correct the condition or violation before a time that is:

1. At least 48 hours after the holder receives the notice of intent to suspend; and

2. Agreed on by the parties or set by the Secretary.

(c) The Secretary is not required to give notice of intent to suspend a permit if:

(1) The violation creates an imminent hazard to public health; or

(2) The holder of the permit has willfully refused to permit an authorized inspection.

(d) If a permit has been suspended more than once, the Secretary may revoke the permit.

§21–419.

(a) Except as otherwise provided in this subtitle and in the Administrative Procedure Act, before the Secretary denies an application for a permit or takes any action under § 21–418 of this subtitle, the Secretary shall give the person against whom the action is contemplated an opportunity for a hearing before the Secretary.

(b) Except as otherwise provided in this section, the Secretary shall give notice and hold the hearing in accordance with the Administrative Procedure Act.

(c) (1) Within 48 hours after the person receives notice of the Secretary's action, a person whose permit has been suspended or who has received a notice that the Secretary intends to suspend the permit may request a hearing.

(2) Within 72 hours after receiving the request for a hearing, the Secretary shall hold the hearing.

(d) If after due notice the person for whom the hearing is held fails or refuses to appear, nevertheless the Secretary may hear and determine the matter.

(e) A person aggrieved by a final decision of the Secretary in a contested case, as defined by the Administrative Procedure Act, may take a direct judicial appeal.

§21–422.

(a) The raw milk that a milk producer sells shall be raw milk that:

(1) Is obtained by the complete milking of a healthy cow or goat;

(2) Is unadulterated, whole, and unadjusted; and

(3) Is practically free of colostrum.

(b) The pasteurized milk products that a distributor, bobtailer, or milk processor sells shall:

(1) Be pasteurized; and

(2) Meet all definitions and standards of identity established by federal law and regulation.

§21–424. IN EFFECT

After the milk product has been processed, each milk product shall be labeled with:

(1) The description of that milk product under this subtitle or the rules and regulations adopted under this subtitle; and

(2) Any other information that the Secretary requires by rule or regulation.

§21–424. ** CONTINGENCY – NOT IN EFFECT – CHAPTER 530 OF 2019 **

(a) After the milk product has been processed, each milk product shall be labeled with:

(1) The description of that milk product under this subtitle or the rules and regulations adopted under this subtitle; and

(2) Any other information that the Secretary requires by rule or regulation.

(b) (1) This subsection does not apply to human breast milk.

(2) A person may not state on a label of a food product that the product is milk unless the product meets the definition of "milk" established in § 21–401 of this subtitle.

(c) The Department shall establish and implement a plan to enforce the prohibition in subsection (b) of this section, including notice of the Department's

intent to implement a ban on all products that do not meet the requirements of subsection (b) of this section, including plant–based products mislabeled as milk.

§21–425.

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

(2) "Condensed milk" includes sweetened condensed milk and evaporated milk.

(3) "Condensed skimmed milk" includes sweetened condensed skimmed milk and evaporated skimmed milk.

(4) "Dry milk solids" includes dry buttermilk, dry cream, dry whole milk, and nonfat dry milk solids.

(b) (1) Condensed milk:

(i) Shall be manufactured from pure and wholesome milk;

(ii) Shall contain at least 25.5 percent milk solids and at least 7.5 percent milk fat;

(iii) Shall contain, within the limits of good manufacturing practice, at least 25 international units of vitamin D per fluid ounce; and

(iv) May contain any optional ingredient that is authorized under federal law.

(2) Condensed skimmed milk:

(i) Shall be manufactured from pure and wholesome skimmed milk;

(ii) Shall contain at least 20 percent milk solids and not more than 0.5 percent fat;

(iii) Shall contain, within the limits of good manufacturing practice, at least 25 international units of vitamin D per fluid ounce; and

(iv) May contain any optional ingredient that is authorized under federal law.

(3) Dry milk solids:

(i) Shall be manufactured from pure and wholesome milk, skimmed milk, buttermilk, or cream; and

(ii) May not contain any substance foreign to milk.

(c) (1) Each package or container in which condensed milk, condensed skimmed milk, or dry milk solids are sold or delivered shall be labeled clearly and accurately to show the exact type of product in the package.

(2) The label shall be in letters not smaller or less distinct than any other letters on the package or container except letters used for the brand or trade name.

(d) A person may not manufacture, sell, exchange, deliver, advertise, label, or expose for sale, under a distinctive name or otherwise, any milk product for which a standard is set under this section unless the milk product conforms to that standard.

§21–426.

(a) In this section, "sell-by period" means the length of time a Grade A milk product may be kept for sale.

(b) (1) After a public hearing, the Secretary shall adopt rules and regulations that establish a method for conspicuously marking, on the Grade A milk product container, the last date on which the product may be sold.

(2) Each Grade A milk product container shall be marked as required by rules and regulations adopted under this subtitle.

(c) The Secretary shall adopt regulations that establish the sell-by period for a Grade A milk product that is cooled to, packaged, and stored at 45 degrees Fahrenheit or less before it is purchased by or delivered to the ultimate consumer.

§21–427.

(a) Unless the transfer occurs on a dairy farm or in a receiving station, transfer station, or milk plant, a person may not transfer a milk product from a container or milk tank truck to another.

(b) (1) This subsection does not apply to milk for a mixed drink that requires less than 8 ounces of milk.

(2) Except as otherwise provided in this subsection, a person may not sell or serve any fluid milk product unless it:

(i) Is in the individual, original container that was sealed in the milk plant in which the milk product was pasteurized; or

(ii) Is served or sold from a bulk milk dispenser approved by the Secretary.

(3) A person may serve cream, whipped cream, or half and half from other than the original container or an approved bulk milk dispenser, if the cream, whipped cream, or half and half:

(i) Is served for consumption at the place of sale; or

(ii) Is served from an original container of not more than one-half gallon capacity or from a bulk dispenser.

(c) (1) In this subsection, "consumer container" means a container that:

(i) Contains a milk product; and

(ii) Is intended for delivery to the ultimate consumer of the milk product.

(2) A person may not store a consumer container in water.

(3) A person may not store a consumer container in ice unless the person drains the water from the melting ice properly.

(d) Except as approved by the Secretary, a person may not use or permit the use of any apparatus, equipment, utensil, or container that is intended for use in the processing and packaging of a milk product for any other purpose.

§21–428.

(a) (1) The Secretary shall impound a milk product that the Secretary determines is a threat to public health.

(2) For purposes of this subsection, a threat to public health exists if a milk product intended for consumption:

(i) Is handled improperly;

(ii) Is not kept at the required temperature;

(iii) Is injurious to health if consumed; or

(iv) Is otherwise unsafe.

(b) If the Secretary impounds a milk product under subsection (a) of this section, the Secretary may issue an order to dispose of the milk product, make the milk product unusable for consumption, or impose a civil monetary penalty in accordance with the health laws and regulations of the State.

(c) (1) The owner of the milk product that is disposed of or otherwise made unusable under subsection (b) of this section may bring an action for damages against the Secretary.

(2) The Secretary shall have the immunity from liability described in § 5-633 of the Courts Article in any action brought under this subsection.

(d) (1) An order of the Secretary that imposes a civil monetary penalty under subsection (b) of this section shall state the basis on which the order is made, the amount of the penalty, and the manner in which the amount of the penalty is calculated as specified by regulations adopted by the Secretary in accordance with paragraph (2) of this subsection.

(2) The regulations adopted under paragraph (1) of this subsection shall provide for how the civil money penalty will be adjusted according to the volume of milk found to be unusable for consumption.

(3) A person subject to a civil monetary penalty imposed under subsection (b) of this section may appeal the order that imposes the penalty in accordance with Title 10, Subtitle 2 of the State Government Article.

(e) Subsections (a), (b), (c), and (d) of this section do not apply to a retail establishment.

(f) If a retail establishment repeatedly fails to handle and maintain milk products properly, the Secretary, after due notice, may order that retail establishment to stop selling milk products until the establishment shows that it can and will handle and keep its milk products properly.

§21–429.

(a) If a Grade A milk product is from a place outside the departmental inspection area, a person may sell the Grade A milk product in this State if:

(1) The person holds a permit issued under this subtitle; and

(2) The Grade A milk product:

(i) To the extent produced, processed, or pasteurized outside the departmental inspection area, is produced, processed, and pasteurized under requirements that are substantially equivalent to the requirements of this subtitle and of rules and regulations adopted under this subtitle; and

(ii) Is from an establishment that has a current individual United States Public Health Service rating of at least 90 from a State milk sanitation rating officer who is certified by the appropriate federal authority and listed in the interstate milk shippers report published by the appropriate federal authority.

(b) (1) The Secretary may inspect the property, buildings, or equipment of any permit holder whose Grade A milk product has been produced, processed, or pasteurized outside the departmental inspection area.

(2) The person inspected shall pay the cost of the inspection.

(3) The Department shall bill and collect the cost of the inspection.

(c) A person may not sell in this State any Grade A milk product produced by a dairy farm, milk plant, or frozen dessert manufacturer that is in a jurisdiction that does not authorize milk products or frozen desserts to be imported from this State.

§21–430.

(a) In this section, "milk emergency":

(1) Means a general and acute shortage of milk from Grade A dairy farms; and

(2) Does not include a simple shortage of milk from Grade A dairy farms that affects only a small number of distributors.

(b) (1) In a milk emergency, the Secretary may authorize the sale of a pasteurized milk product that has not been certified as Grade A pasteurized milk.

(2) A person who sells a milk product under this subsection shall label the milk product as the Secretary requires.

§21–433.

A person may not violate any provision of this subtitle or any rule or regulation adopted under this subtitle.

§21–434.

Except for sale of raw milk by a holder of a milk producer permit to a holder of a milk processor permit or the sale of a farmstead cheese, a person may not sell raw milk for human consumption.

§21–435.

(a) (1) An individual who has a communicable disease or is a carrier of a communicable disease may not work, in any capacity that brings that individual into contact with the production, handling, storage, or transportation of milk products, containers, equipment, or utensils, at:

(i) A dairy farm;

(ii) A milk plant;

(iii) A receiving station; or

(iv) A transfer station.

(2) A person who operates a dairy farm, transfer station, receiving station, or milk plant may not employ any individual:

(i) Who, if employed, would violate paragraph (1) of this subsection; or

(ii) Whom the employer reasonably believes would violate paragraph (1) of this subsection if employed.

(b) Each holder of a permit for a receiving station, transfer station, or as a distributor, milk processor, or milk producer shall notify the Secretary immediately if:

(1) A communicable disease affects any individual on that person's dairy farm, distribution station, receiving station, transfer station, or milk plant; or

(2) That person suspects that any employee of that person has contracted a communicable disease or has become a carrier of a communicable disease.

(c) An individual who has an infected cut or lesion on a hand or arm may not handle any milk product, milk container, or milk equipment.

(d) (1) The Secretary may make or require a reasonable medical and biological examination of an individual who is suspected of having any communicable disease.

(2) An examination under this subsection may include examination of the bodily discharges of the individual.

§21–436.

(a) In this section, "labeled milk can" means any milk can, cream can, or case that:

(1) Belongs to an owner, dealer, or shipper of milk or cream who ships the milk or cream to any place in this State; and

(2) Has the name or initials of the owner, dealer, or shipper stamped, marked, or fastened on it.

(b) A person may not:

(1) Use, sell, dispose of, buy, or traffic in labeled milk cans, without the consent of the owner, dealer, or shipper;

(2) Willfully change the name or initials of the owner, dealer, or shipper stamped, marked, or fastened on the labeled milk can without the consent of the owner, dealer, or shipper; or

(3) Place in any labeled milk can any substance other than milk or cream, without the consent of the owner, dealer, or shipper.

§21–801.

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

(b) "Frozen dessert" means:

(1) Ice cream and frozen custard;

(2) Ice milk;

(3) Mellorine;

(4) Sherbet;

(5) Water ice;

(6) Goat milk ice cream and goat milk frozen custard;

(7) Goat milk ice milk;

(8) Quiescently frozen confection;

(9) Quiescently frozen dairy confection; or

(10) (i) Any frozen food product that is similar in appearance, odor, or taste to any of the products listed in this subsection;

(ii) Any frozen food product that is prepared or frozen in the same way as any of the products listed in this subsection; or

(iii) The mix that is used in any of the products listed in this subsection.

(c) "License" means a license issued by the Secretary to manufacture in this State a frozen dessert or a mix for a frozen dessert.

§21–802.

(a) If there is an outside container or wrapper for a frozen dessert or a mix for a frozen dessert, then, in order to comply with any requirement under this subtitle that a word, statement, or any other information appear on the label of the frozen dessert or mix, the word, statement, or other information also shall:

(1) Be placed on the outside container or wrapper; or

(2) Be legible through the outside container or wrapper.

(b) For purposes of the construction and enforcement of this subtitle, an act or omission of any officer, agent, employee, or any other person employed by any corporation, company, or association, shall be considered to be the act or omission of the corporation, company, society, or association, as well as of the person.

§21–803.

(a) The Secretary shall provide a copy of this subtitle:

(1) To the extent possible, to every person who in this State manufactures or sells, at wholesale or retail, any frozen dessert or mix for a frozen dessert; and

(2) To any person who requests it.

(b) The Secretary may:

(1) Publish summaries of judgments, decrees, or court orders issued under this subtitle; and

(2) Otherwise collect, report, or illustrate the results of any investigation conducted under this subtitle.

§21–804.

(a) To prevent deception in the sale of frozen desserts and to safeguard the health and welfare of consumers, the Secretary shall adopt rules and regulations that:

(1) Provide definitions and set standards of identity for frozen desserts and the mixes used in the manufacture of frozen desserts;

(2) Set packaging, labeling, and sanitary requirements for frozen desserts; and

(3) Govern any other condition that relates to the manufacture, processing, distribution, or sale of frozen desserts, whether manufactured or processed in a regular manufacturing plant, in a counter freezer, or otherwise.

(b) So far as practicable, the Secretary may conform any rule or regulation adopted under this subtitle to the rules and regulations adopted under the federal act.

(c) (1) The Secretary may not adopt a rule or regulation under this section unless the requirements of this subsection and the Administrative Procedure Act are met.

(2) A public hearing shall be held on any rule or regulation that the Secretary considers under this section. Based on the record of the hearing, the Secretary shall issue a proposed decision on the rule or regulation.

(3) The Secretary shall provide any interested party an opportunity to file exceptions to the proposed decision based on the hearing record.

(4) When issuing a final decision regarding a rule or regulation, the Secretary also shall:

(i) Rule on any exception to the Secretary's proposed decision; and

(ii) State the reasons for the ruling.

§21–807.

(a) A person shall be licensed by the Secretary before the person may manufacture a frozen dessert or a frozen dessert mix for sale in this State.

(b) A separate license is required for each manufacturing plant that a person operates.

§21–808.

(a) An applicant for a license shall:

(1) Submit an application to the Secretary on the form that the Secretary requires; and

(2) Pay to the Secretary an application fee established by the Secretary under § 2-104 of this article.

(b) The application fee under this section shall be based on:

(1) If the applicant has a manufacturing facility located in this State, the annual production of any frozen dessert or frozen dessert mix in this State; and

(2) If the applicant has a manufacturing facility not located in this State, the annual sales of any frozen dessert or frozen dessert mix in this State.

(c) For each license for which a person applies, the person shall submit a separate application and pay a separate application fee.

(d) The application:

(1) Shall be on the form that the Secretary requires; and

(2) Shall include:

(i) The location of the manufacturing plant at which the frozen dessert or frozen dessert mix is manufactured; and

(ii) Any brand name under which the frozen dessert or frozen dessert mix is to be sold.

§21–809.

(a) If an application is submitted for a license for a manufacturing plant that is in this State, before issuing the license, the Secretary shall inspect the property, buildings, and equipment of the plant to determine whether the plant meets the requirements for a license.

(b) (1) To determine whether the plant meets the requirements for a license, the Secretary may inspect a manufacturing plant that is outside of this State.

(2) If the Secretary does not inspect a plant outside of this State, the Secretary may not issue a license for the plant unless the applicant satisfies the Secretary that:

(i) The plant and the frozen desserts or frozen dessert mixes produced in the plant conform to the laws of the jurisdiction in which the plant is located; and

(ii) Those laws, rules, and regulations are at least as stringent as those that apply under this subtitle.

§21–810.

The Secretary shall issue a license to any applicant who meets the requirements of this subtitle.

§21–811.

While it is effective, a license authorizes the licensee to manufacture frozen desserts and frozen dessert mixes at the manufacturing plant identified in the license.

§21–812.

(a) A license expires on the first anniversary of its effective date, unless the license is renewed for a 1-year term as provided in this section.

(b) At least 1 month before the license expires, the Secretary shall send to the licensee, by first-class mail to the last known address of the licensee, a renewal notice that states:

(1) The date on which the current license expires;

(2) The date by which the renewal application must be received by the Secretary for the renewal to be issued and mailed before the license expires; and

(3) The amount of the renewal fee.

(c) Before a license expires, the licensee periodically may renew it for an additional 1-year term, if the licensee:

(1) Otherwise is entitled to a license;

(2) Pays to the Secretary a renewal fee established by the Secretary under § 2-104 of this article; and

(3) Submits to the Secretary:

(i) A renewal application on the form that the Secretary requires; and

(ii) Satisfactory evidence of compliance with the requirements of this section for renewal.

(d) The renewal fee under this section shall be based on:

(1) If the licensee has a manufacturing facility located in this State, the annual production of any frozen dessert or frozen dessert mix in this State; and

(2) If the licensee has a manufacturing facility not located in this State, the annual sales of any frozen dessert or frozen dessert mix in this State.

(e) The Secretary shall renew the license of each licensee who meets the requirements of this section.

(f) A license is not transferable.

§21–813.

(a) If the Secretary finds that a licensee has violated any of the provisions of this subtitle or that a violation has occurred on any premises for which a license has been issued, the Secretary immediately shall give written notice to the licensee. The notice shall set forth the nature of the violation and direct that it be stopped.

(b) If a licensee fails to comply with a notice given under this section, the Secretary may suspend or revoke the license of the licensee.

§21–814.

(a) Except as otherwise provided in the Administrative Procedure Act, before the Secretary suspends or revokes a license under § 21-813 of this subtitle or denies a license to any applicant, the Secretary shall give the individual against whom the action is contemplated an opportunity for a hearing before the Secretary.

(b) The Secretary shall give notice and hold the hearing in accordance with the Administrative Procedure Act.

§21–815.

(a) Any applicant who has been denied a license and any licensee aggrieved by the suspension or revocation of a license under § 21–813 of this subtitle may take a judicial appeal.

(b) The appeal shall be made in accordance with the provisions for judicial review of final decisions in contested cases in the Administrative Procedure Act.

(c) Either party may appeal the decision of the circuit court to the Appellate Court of Maryland.

§21–818.

A person may not manufacture for sale in this State a frozen dessert or a frozen dessert mix unless the person holds a license for the plant in which the frozen dessert or mix is manufactured.

§21–819.

(a) A person may not manufacture for sale in this State a frozen dessert or a frozen dessert mix:

(1) While the license for the plant in which the frozen dessert or mix is manufactured is suspended; or

(2) After the license:

(i) Has expired; or

(ii) Has been revoked.

(b) The Secretary may sue to enjoin a person from repeating a violation of this section.

§21–820.

(a) A person may not sell any frozen dessert or frozen dessert mix that was manufactured at a plant for which a license was not then held.

(b) The Secretary may sue to enjoin a person from repeating a violation of this section.

§21–821.

(a) Any frozen dessert manufacturer licensed by the State of Maryland and desiring to sell a product for which a frozen dessert standard has not been set shall file with the Secretary a written request for authorization.

(b) Any authorization granted under this section shall not exceed a period of 1 year.

§21–1110.

(a) This section does not apply to cosmetics, infant formula, or baby food if:

(1) The cosmetics, infant formula, or baby food are being sold in a single lot at a charity auction; and

(2) The total value of the cosmetics, infant formula, or baby food in the lot is $100 or less.

(b) A person may not sell any drug, medicine, cosmetic, pharmaceutical preparation, medicinal preparation, or infant formula or baby food that is subject to dating requirements by the United States Food and Drug Administration at any auction sale unless the person notifies the Secretary in writing of the proposed auction at least 7 days before the date of the auction.

(c) (1) The Secretary may:

(i) Inspect any drugs, medicines, cosmetics, pharmaceutical preparations, medicinal preparations, infant formula, or baby food that a person proposes to sell by auction sale; and

(ii) Issue an order that prohibits the sale of any of these if, in the opinion of the Secretary, they are unfit for human use or consumption.

(2) A person may not hold an auction sale of any drug, medicine, cosmetic, pharmaceutical preparation, medicinal preparation, infant formula, or baby food in violation of an order issued under this section.

§21–1111.

(a) This section does not apply to any:

(1) Surgical or dental instrument;

(2) Physical therapy equipment;

(3) X–ray apparatus; or

(4) Component part or accessory of any of these items.

(b) A person may not:

(1) Sell, distribute, or otherwise dispose of any drug, medicine, pharmaceutical preparation, or medicinal preparation by means of any public exhibition, entertainment, performance, or carnival, commonly known as a "medicine show" or "patent medicine show"; or

(2) Put or cause to be put, in any way, any package, parcel, or sample of any drug or medicine:

(i) In or on any part of any house, building, or yard without the consent of the owner or occupant; or

(ii) On any street or public highway.

§21–1112.

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

(2) "Authorized prescriber" means a licensed dentist, licensed physician, licensed podiatrist, licensed veterinarian, certified nurse midwife to the extent permitted under § 8–601 of the Health Occupations Article, certified nurse practitioner to the extent permitted under § 8–508 of the Health Occupations Article, or other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

(3) "Board" means a health occupation licensing board authorized to issue a permit, license, or certificate under the Health Occupations Article.

(4) (i) "Controlled dangerous substance" means a drug, substance, or immediate precursor listed in Schedule I through Schedule V in Title 5 of the Criminal Law Article.

(ii) "Controlled dangerous substance" does not include tobacco or a distilled spirit, wine, or malt beverage.

(5) "Drug" means a prescription or nonprescription drug.

(6) "Nonprescription drug" means a drug which may be sold without a prescription and which is labeled for consumer use in accordance with the requirements of the laws and regulations of this State and the federal government.

(7) "Permit holder" means a holder of, or applicant for:

(i) A pharmacy permit or distributor's permit issued by the State Board of Pharmacy under Title 12 of the Health Occupations Article;

(ii) A dispensing permit issued by a board under the authority of § 12–102(c)(2) of the Health Occupations Article; or

(iii) A controlled dangerous substances registration issued by the Office of Controlled Substances Administration under § 5–301(a)(1) of the Criminal Law Article.

(8) "Prescription drug" means a drug that under § 21–220 of this title may be dispensed only on the prescription of a health practitioner who is authorized by law to prescribe the drug.

(b) (1) The Department may issue an order of impoundment and immediately impound drugs, bulk powders and chemicals, or prescription records of a permit holder or an authorized prescriber if:

(i) A permit holder's permit or authorized prescriber's license has expired or has been revoked or suspended;

(ii) An application for a permit or license has been denied;

(iii) A board has:

1. Determined that the permit holder or authorized prescriber failed to comply with a board order, letter of surrender, or law regarding the disposition of drugs, bulk powders and chemicals, or prescription records; and

2. Requested that the Department impound the drugs, bulk powders and chemicals, or prescription records;

(iv) The drugs or bulk powders and chemicals pose an imminent threat to the public health, safety, or welfare; or

(v) The confidentiality of the prescription records is in imminent danger of being compromised.

(2) The Department may not impound the drugs, bulk powders and chemicals, or prescription records of a permit holder or authorized prescriber who is in compliance with a board order or law specifically providing for the manner of the disposition of drugs, bulk powders and chemicals, or prescription records.

(c) (1) Except as otherwise provided in paragraph (2) of this subsection, the Department shall:

(i) Attempt to serve written notice of an impoundment on the permit holder or authorized prescriber;

(ii) Provide the permit holder or authorized prescriber with an opportunity to avoid impoundment by allowing the permit holder or authorized prescriber to dispose of the drugs, bulk powders and chemicals, or prescription records in a manner acceptable to the Department;

(iii) Provide the permit holder or authorized prescriber with an opportunity prior to impoundment to review the nature, type, and amount of information upon which the Department issued the impoundment order; and

(iv) Provide the permit holder or authorized prescriber with an opportunity to avoid impoundment by providing the Department with information upon which the Department could reasonably conclude that the impoundment is not warranted.

(2) If drugs or bulk powders and chemicals pose an imminent threat to the public health, safety, or welfare, or if the confidentiality of prescription records is in imminent danger of being compromised, the Department may:

(i) Issue an impoundment order; and

(ii) Immediately impound drugs, bulk powders and chemicals, or prescription records without prior notice to the permit holder or authorized prescriber.

(d) An order of impoundment constitutes a final order subject to judicial review under the State Administrative Procedure Act.

(e) The Department shall provide the permit holder or authorized prescriber with a list of all drugs, bulk powders and chemicals, and prescription records impounded.

(f) The Department may charge reasonable fees to recover the costs of the collection, storage, and disposition of drugs, bulk powders and chemicals, or prescription records.

(g) The Department shall adopt regulations governing the disposition of impounded drugs, bulk powders and chemicals, and prescription records.

(h) Prior to issuing an order of impoundment, the Department, with the approval of the Board of Pharmacy, shall develop regulations concerning:

(1) The nature, type, and amount of information upon which the Department may rely to issue an order of impoundment;

(2) The level of investigation the Department must pursue to verify the information upon which the order of impoundment was based under subsection (b)(1)(iv) or (v) or (c)(2) of this section; and

(3) The measures the Department must pursue to attempt service on the permit holder or authorized prescriber prior to impoundment under subsection (c) of this section.

(i) Prior to destroying or transferring impounded drugs, bulk powders and chemicals, or prescription records, the Department shall publish a notice once a week for 2 consecutive weeks in a newspaper that is circulated locally:

(1) Stating the date that the drugs, bulk powders and chemicals, or prescription records will be destroyed or transferred; and

(2) Designating a date, time, and location where the drugs, bulk powders and chemicals, or prescription records may be retrieved by the permit holder or authorized prescriber if certain conditions are met.

(j) A board shall immediately notify the Office of Controlled Substances Administration of the surrender, suspension, or revocation of a permit holder's permit or an authorized prescriber's license.

§21–1113.

In any action brought by the Attorney General under § 11–209 of the Commercial Law Article, a person that sells, distributes, or otherwise disposes of any drug, medicine, cosmetic, food, food additive, or commercial feed, as defined in § 6–101 of the Agriculture Article, or medical device:

(1) May not assert as a defense that the person did not deal directly with the person on whose behalf the action is brought; and

(2) May prove, as a partial or complete defense against a damage claim, in order to avoid duplicative liability, that all or any part of an alleged overcharge ultimately was passed on to another person by a purchaser or seller in the chain of manufacture, production, or distribution who paid the alleged overcharge.

§21–1202.

(a) A person who violates any provision of § 21-436 of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50.

(b) Half of any fine collected under this section shall be paid to the school board of the county where the violation occurred.

§21–1203.

A person who violates any provision of Subtitle 4, except §§ 21-425 and 21-436 of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100.

§21–1204.

(a) A person who violates any provision of § 21–820 of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100.

(b) For purposes of this section, each day that a violation continues constitutes a separate offense.

§21–1205.

(a) A person who violates § 21-819 of this title is guilty of a misdemeanor and on conviction is subject to:

(1) For a first offense, a fine not exceeding $300; or

(2) For a subsequent offense, a fine not exceeding $500.

(b) For purposes of this section, each day that a violation continues constitutes a separate offense.

§21–1206.

A person who violates any provision of the following sections of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500:

(1) § 21-818 of this title; and

(2) § 21-1110 of this title.

§21–1210.

A person who violates any provision of § 21-425 of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 or imprisonment not exceeding 30 days or both.

§21–1212.

A person who violates any provision of § 21–1111 of this title is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 or imprisonment not exceeding 1 year or both.

§21–1214.

(a) (1) Except as provided in paragraph (2) of this subsection, any person who violates any provision of Subtitle 3 of this title or any rule or regulation adopted under Subtitle 3 of this title is guilty of a misdemeanor and on conviction is subject to:

(i) For a first offense, a fine not exceeding $1,000 or imprisonment not exceeding 90 days, or both; and

(ii) For a second offense, a fine not exceeding $2,500 or imprisonment not exceeding 1 year, or both.

(2) A person who violates § 21–330.1 of this title is not subject to paragraph (1) of this subsection.

(b) In addition to any criminal penalties imposed under this section, a person who violates any provision of Subtitle 3 of this title or any rule or regulation adopted under Subtitle 3 of this title or any term, condition, or limitation of any license or registration issued under Subtitle 3 of this title:

(1) Is liable for a civil penalty not exceeding $5,000, to be collected in a civil action in the District Court for any county; and

(2) May be enjoined from continuing the violation.

(c) Each day on which a violation occurs is a separate violation under this section.

§21–1215.

(a) This section does not apply to a violation of § 21–220(b)(4), § 21–228, or § 21–259.3 of this title.

(b) A person who violates any provision of Subtitle 2 of this title or any regulation adopted under Subtitle 2 of this title is guilty of a misdemeanor and on conviction is subject to:

(1) A fine not exceeding $10,000 or imprisonment not exceeding 1 year or both; or

(2) If the person has been convicted once of violating Subtitle 2 of this title, a fine not exceeding $25,000 or imprisonment not exceeding 3 years or both.

(c) In addition to any criminal penalties imposed under this section, a person who violates any provision of Subtitle 2 of this title, any rule or regulation adopted under Subtitle 2 of this title, or any term, condition, or limitation of any license or registration issued under Subtitle 2 of this title:

(1) Is subject to a civil penalty not exceeding $5,000, in an action in any District Court; and

(2) May be enjoined from continuing the violation.

(d) Each day on which a violation occurs is a separate violation under this section.

§22–201.

(a) A person may not sell or otherwise provide bichloride of mercury in a tablet that contains more than one-tenth of a grain of bichloride of mercury unless the tablet:

(1) Has the word "Poison" impressed or embossed on it;

(2) Is triangular, diamond, square, oblong, or irregular in shape;

(3) Is blue, green, or purple in color; and

(4) Is contained in a bottle that has the word "Poison" blown in one side of the bottle and a label on the opposite side that bears the word "Poison" in conspicuous letters.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100 or imprisonment in jail not exceeding 3 months, or both.

§22–202.

(a) (1) In this section, "caustic or corrosive substance" means:

(i) Hypochlorous acid, either free or combined, and any compound or mixture that contains hypochlorous acid in a concentration so as to yield 10 percent or more by weight of available chlorine;

(ii) Potassium hydroxide and any compound or mixture that contains, in a concentration of 10 percent or more, free or chemically unneutralized potassium hydroxide, including caustic potash and vienna paste;

(iii) Sodium hydroxide and any compound or mixture that contains, in a concentration of 10 percent or more, free or chemically unneutralized sodium hydroxide, including caustic soda and lye; or

(iv) Ammonia water and any compound or mixture that yields, in a concentration of 5 percent or more, free or chemically uncombined ammonia, including ammonium hydroxide and hartshorn.

(2) In this section, "caustic or corrosive substance" does not include:

(i) Calx chlorinata;

(ii) Bleaching powder; or

(iii) Chloride of lime.

(b) A person may not sell, exchange, receive, hold, pack, or display or offer for sale or exchange any caustic or corrosive substance for household use unless the container of the caustic or corrosive substance meets the labeling requirements of subsection (c) of this section.

(c) In addition to any other requirement of law, the container of any caustic or corrosive substance shall bear a plainly written, conspicuous label that includes:

(1) The common name of the caustic or corrosive substance;

(2) The name and business address of the manufacturer, packer, seller, or distributor;

(3) Directions for treatment in case of accidental personal injury from the caustic or corrosive substance, except on shipping containers used for shipment by manufacturers or wholesalers for other than household use; and

(4) The word "Poison":

(i) Parallel with the main body of print on the label;

(ii) On a plain, clear background of a distinctly contrasting color; and

(iii) Printed in uncondensed gothic capital letters of a size that is:

1. Not less than 24 point; or

2. If there is no other print that is 24 point or larger, not smaller than the largest type on the label.

(d) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100.

§22–301.

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

(b) "Child resistant packaging" means packaging that is designed so that the average child under the age of 5 years finds it significantly difficult to open the package or to obtain a harmful amount of the contents of the package within a reasonable time, and so that it is not difficult for a normal adult to open or use.

(c) "Household substance" means any substance that is customarily used or stored by individuals in or about the household and that is:

(1) A hazardous substance as defined in the Federal Hazardous Substances Act;

(2) A pesticide as defined in the Federal Insecticide, Fungicide, and Rodenticide Act;

(3) A food, drug, or cosmetic as defined in the Federal Food, Drug, and Cosmetic Act; or

(4) A fuel that is:

(i) Intended for use in the heating, cooking, or refrigeration system of a house; and

(ii) Stored in a portable container.

(d) "Labeling" means any label or other written or graphic matter that is on or accompanies a household substance or its package.

(e) (1) "Package" means the immediate container or wrapping of a household substance or the outer container or wrapping used in displaying a household substance to retail consumers.

(2) "Package" does not include any container or wrapping that is used only for:

(i) Transportation of a household substance in bulk or quantity to a manufacturer, packer, processor, or wholesale or retail distributor; or

(ii) Shipment or delivery of a household substance to a retail consumer, unless the container or wrapping is the only package or wrapping of the household substance.

(f) "State adopted federal regulation" means any rule or regulation adopted by the federal government under the federal Poison Prevention Packaging Act that becomes a rule or regulation of this State by automatic adoption under § 22-303 of this subtitle.

§22–302.

Compliance with the federal standards set by rule or regulation under the federal Poison Prevention Packaging Act is sufficient compliance with this subtitle.

§22–303.

(a) (1) Any rule or regulation adopted by the federal government under the federal Poison Prevention Packaging Act automatically is adopted as a rule or regulation of this State.

(2) The Secretary may adopt rules and regulations to set standards for labeling and child resistant packaging of any household substance, if the Secretary finds that:

(i) The potential hazard to children from access to the household substance requires child resistant packaging to protect children from serious personal injury or serious illness as the result of handling, using, or ingesting the household substance; and

(ii) Child resistant packaging of the household substance is technically feasible, practicable, and appropriate.

(b) So far as practicable, the Secretary may conform any rule or regulation adopted under this section to the rules and regulations adopted under the federal Poison Prevention Packaging Act.

(c) If, under rules and regulations adopted under this subtitle, a dangerous household substance is required to meet child resistant packaging standards, the Secretary, by rule or regulation, also may prohibit its being packaged in a manner that the Secretary finds is unnecessarily attractive to children.

(d) The standards set under this subtitle for child resistant packaging of a dangerous household substance may not require specific:

(1) Packaging designs;

(2) Product content;

(3) Package quantity; or

(4) Except as provided in § 22-310 of this subtitle, labeling.

§22–304.

In setting any standard for labeling and child resistant packaging of any dangerous household substance, the Secretary shall consider:

(1) The nature and use of the dangerous household substance;

(2) The reasonableness of the standard;

(3) Available scientific and engineering information about child resistant packaging;

(4) Available medical information about personal injury to and illness of children from accidental access to dangerous household substances; and

(5) Manufacturing practices of industries affected by this subtitle.

§22–305.

(a) Except for a State adopted federal regulation, the Secretary may not adopt any rule or regulation under this subtitle unless the requirements of this subtitle and the Administrative Procedure Act are met.

(b) If the Secretary proposes to set a standard for child resistant packaging of a dangerous household substance, the Secretary shall publish:

(1) The findings made by the Secretary under § 22-303 of this subtitle;

(2) The reasons for the proposed standard; and

(3) The citation of each statutory provision that authorizes the action.

§22–306.

(a) Unless a written protest is filed with the Secretary, a State adopted federal regulation takes effect in this State on the date that it becomes effective as a federal rule or regulation.

(b) Any person who may be affected adversely by a State adopted federal regulation may:

(1) File a protest against the State adopted federal regulation not more than 30 days after its effective date; and

(2) Request a hearing.

(c) A protest under this section stays the effect of the State adopted federal regulation as a rule or regulation of this State.

§22–307.

(a) Unless a written protest is filed with the Secretary, a rule or regulation proposed by the Secretary under this subtitle takes effect on the date the Secretary designates but not earlier than 90 days after publication.

(b) Any person who may be affected adversely by a rule or regulation that is proposed by the Secretary under this subtitle may:

(1) File a protest within 30 days after publication of the proposed rule or regulation; and

(2) Request a hearing.

§22–308.

(a) The Secretary shall give notice of and hold any hearing authorized or required by this subtitle in accordance with the Administrative Procedure Act.

(b) If a written protest against a rule or regulation is filed in accordance with § 22-306 or § 22-307 of this subtitle, the Secretary shall provide an opportunity for a public hearing:

(1) To receive evidence on the issues raised by the protest; and

(2) To hear any interested person.

§22–309.

(a) (1) As soon as practicable after a hearing on a protest against a rule or regulation under § 22-308 of this subtitle, the Secretary shall:

(i) Act on the protest by issuing an order; and

(ii) Send a copy of the order to each protester by certified mail, return receipt requested, bearing a postmark from the United States Postal Service.

(2) Each order issued under this section shall be based on substantial evidence in the record of the hearing.

(b) An order issued by the Secretary under this section may:

(1) Reinstate, rescind, or modify a State adopted federal regulation as a rule or regulation of this State; or

(2) As to any other rule or regulation proposed under this subtitle:

(i) Withdraw the proposal;

(ii) Modify the proposal and set an effective date for the modified proposal that is at least 60 days after publication of the order; or

(iii) Set a new effective date for the original proposal that is at least 60 days after publication of the order.

§22–310.

(a) Except as otherwise provided in this section, a dangerous household substance that is subject to a child resistant packaging standard may be provided in single size conventional packages designed for easy opening by elderly individuals or individuals with disabilities if:

(1) Elderly individuals or individuals with disabilities would be unable to use the dangerous household substance if packaged in accordance with the child resistant packaging standard;

(2) The dangerous household substance is at the same time provided in packages that meet the child resistant packaging standards adopted under this subtitle; and

(3) The single size conventional package of the dangerous household substance bears a conspicuous label on which is printed:

(i) "This Package for Households Without Young Children"; or

(ii) If the package is too small for that statement, a substitute statement as required by rule or regulation.

(b) (1) If the Secretary finds that a dangerous household substance offered in a single size conventional package under subsection (a) of this section is not offered at the same time in a popular size package that conforms to the child resistant packaging standards, the Secretary may notify the manufacturer or packer of the dangerous household substance of the violation and of a time period within which the violation is to be corrected.

(2) If the violation remains uncorrected at the end of the specified time period, the Secretary, after giving the manufacturer or packer an opportunity for a hearing, may order the manufacturer or packer to package the dangerous household substance only in packages that conform to the child resistant packaging standards.

§22–311.

A dangerous household substance dispensed under the prescription of an authorized prescriber may be provided in a package that does not meet the child resistant packaging standards adopted under this subtitle if the noncomplying package is:

(1) Required by the prescription; or

(2) Requested by the purchaser.

§22–312.

(a) At any reasonable time, a representative of the Secretary may enter and inspect any establishment in which the Secretary reasonably believes a dangerous household substance is being manufactured, repacked, or relabeled.

(b) On entering any establishment to make an inspection under this section, the representative of the Secretary shall present appropriate credentials to the owner, operator, or agent in charge.

(c) During any inspection under this section, the representative of the Secretary may obtain a sample of any product, package, or labeling in any reasonable manner.

§22–401.

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

(b) "Guaranty" means a guaranty that the product, fabric, or related material covered by the guaranty has been tested for flammability under the rules and regulations adopted by the Department under this subtitle.

(c) "Product" means any mattress, mattress pad, sleepwear, or other clothing.

§22–402.

The Department shall adopt the federal rules and regulations that:

(1) Are adopted under the federal Flammable Fabrics Act of 1967; and

(2) Relate to products, fabrics, or related materials.

§22–403.

(a) At any reasonable time, a representative of the Department may enter any factory, warehouse, or establishment in which a product is manufactured, processed, packaged, or stored and inspect any pertinent equipment, labeling, or finished or unfinished products.

(b) On entering any factory, warehouse, or establishment to make an inspection under this section, the representative of the Department shall present appropriate credentials to the owner, operator, or agent in charge.

(c) (1) During any inspection under this section, the representative of the Department may obtain a sample of any product, package, or labeling.

(2) When obtaining a sample under this section, the representative of the Department shall:

(i) Pay or offer to pay for the sample; and

(ii) Give the owner, operator, or agent in charge a receipt that describes the sample obtained.

§22–404.

(a) The Department shall determine whether any chemical used as a fire retardant in a product is a known carcinogen.

(b) If the Department determines that a chemical is a known carcinogen, the Department shall:

(1) Inform the public of this determination; and

(2) Give the public any directions that could reduce the danger from the chemical.

§22–405.

If a product is manufactured, processed, packaged, held, or sold in violation of this subtitle or any rule or regulation adopted under this subtitle, on petition of the Secretary, the circuit court for the county in which the product is located may grant an injunction forbidding all or any one of the following:

(1) Manufacturing the product;

(2) Processing the product;

(3) Packaging the product;

(4) Selling the product;

(5) Transferring the product; or

(6) Moving the product.

§22–406.

(a) A guaranty under this section may be:

(1) A separate guaranty that specifically designates the product, fabric, or related material; or

(2) A continuing guaranty that:

(i) Is given by a seller to a buyer;

(ii) Applies to any product, fabric, or related material sold to the buyer; and

(iii) Is in the form the Department approves.

(b) A person may not manufacture, sell, or hold with intent to sell any new or unused product that does not comply with the flammability requirements of this subtitle.

(c) A person may not give a false guaranty.

(d) This section does not apply to a person who:

(1) Receives in good faith a product, fabric, or related material that is covered by a guaranty that is signed by and contains the name and address of the person who manufactured the product, fabric, or related material or from whom it was received;

(2) Has not altered the flammability of the product, fabric, or related material covered by the guaranty; and

(3) Reasonably and in good faith relies on the guaranty.

§22–407.

A person who willfully violates any provision of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 6 months or both.

§22–501.

(a) In this subtitle, "hazardous material" means:

(1) Any substance that may cause substantial personal injury or substantial illness from customary or reasonably foreseeable handling or use, or ingestion by children, and is:

(i) Toxic;

(ii) Corrosive;

(iii) Flammable or combustible;

(iv) An irritant;

(v) A strong sensitizer; or

(vi) A substance that generates pressure by decomposition, heat, or other means; or

(2) Any other substance that the Secretary declares to be hazardous material under § 22-502 of this subtitle.

(b) In this subtitle, "hazardous material" does not include:

(1) Any food, drug, or cosmetic that is subject to the Federal Food, Drug, and Cosmetic Act or Title 21, Subtitle 2 of this article;

(2) A fuel that is a household substance as defined in § 22-301 of this title; or

(3) A pesticide that is subject to the Federal Insecticide, Fungicide, and Rodenticide Act unless the pesticide is contained in an article that, because it contains the pesticide, is as hazardous as any substance described in subsection (a) of this section.

§22–502.

(a) In accordance with the Administrative Procedure Act, for the protection of the public health and safety, the Secretary may adopt rules and regulations that:

(1) Declare to be a hazardous material any substance that the Secretary finds:

(i) Meets the standards for being a hazardous material;

(ii) Is a toy or other substance intended for use by children that presents an electrical, mechanical, or thermal hazard; or

(iii) Needs to be declared a hazardous material to remove any uncertainty as to whether it is hazardous material;

(2) Set requirements for labeling hazardous material; and

(3) Declare any hazardous material to be a banned hazardous material and require its removal from commerce if the Secretary finds that:

(i) The hazardous material is a danger to the public health and safety; and

(ii) Proper labeling cannot protect the public health and safety adequately.

(b) To the extent the Secretary finds to be consistent with protecting the public health and safety adequately, the Secretary shall adopt rules and regulations that exempt or partially exempt hazardous material from the labeling requirements if compliance with labeling requirements is impractical or unnecessary:

(1) Because of the size of the package that contains the hazardous material;

(2) Because the hazard is minor; or

(3) For other good reason.

§22–503.

Hazardous material is considered to be misbranded if the hazardous material:

(1) Is intended or packaged in a form suitable for use in the home or by children; and

(2) Fails to meet the labeling requirements established by the rules and regulations adopted under this subtitle.

§22–504.

(a) Notwithstanding the provisions of the Administrative Procedure Act, if the Secretary believes that a toy or other article presents an imminent electrical, mechanical, or thermal hazard to the public health and that proper labeling cannot correct the hazard, the Secretary shall issue a temporary rule or regulation, effective immediately, that:

(1) Declares the toy or other article to be a banned hazardous material; and

(2) Requires its immediate removal from commerce.

(b) Immediately after the Secretary issues a temporary rule or regulation under subsection (a) of this section, the Secretary shall:

(1) Give notice of and hold a hearing on the temporary rule or regulation; and

(2) As promptly as possible, complete proceedings under § 22-502 of this subtitle for adoption of the rule or regulation.

(c) The Secretary shall give notice and hold the hearing in accordance with the Administrative Procedure Act.

§22–505.

(a) Any person who may be affected adversely by a rule or regulation adopted by the Secretary under this subtitle may take an appeal in the manner provided for judicial review of final decisions in contested cases in the Administrative Procedure Act.

(b) A person who seeks judicial review under this section shall file a petition with the court within 60 days after publication of the rule or regulation.

(c) If a petition for judicial review of a rule or regulation is filed under this section:

(1) The clerk of the court shall send to the Secretary a copy of the petition; and

(2) On receipt of the copy of the petition, the Secretary shall file with the court the record of the proceedings that relate to the rule or regulation that is the subject of the judicial review.

§22–506.

(a) To enforce this subtitle, the Secretary or a representative of the Secretary at any reasonable time may:

(1) Enter and inspect any factory, warehouse, or establishment in which the Secretary believes hazardous material is manufactured, processed, packaged, or stored; and

(2) Enter and inspect any vehicle that is used to transport or hold hazardous materials in commerce.

(b) As part of any inspection under subsection (a) of this section, the Secretary may inspect any pertinent equipment, labeling, or finished or unfinished substance or toy.

(c) Before entering to make an inspection under this section, the Secretary or representative of the Secretary shall present appropriate credentials to the owner, operator, or agent in charge.

(d) (1) During an entry and inspection under this section, the Secretary or representative of the Secretary may obtain a sample of any substance, toy, package, or labeling.

(2) When obtaining a sample under this subsection, the Secretary or representative of the Secretary shall:

(i) Pay or offer to pay for the sample; and

(ii) Give the owner, operator, or agent in charge a receipt that describes the sample obtained.

§22–507.

(a) The Secretary may collect, report, and illustrate the results of any investigation by the Department that relates to hazardous material.

(b) The Secretary may:

(1) Publish summaries of judgments, decrees, or court orders issued under this subtitle; and

(2) If there is an imminent danger to public health, publish information about any hazardous material.

§22–508.

The results of any investigation made by the Department shall be available as evidence in any civil or criminal proceeding that is instituted against the manufacturer or retailer of hazardous material by any person who is injured in any manner by contact with the hazardous material.

§22–601. IN EFFECT

** CONTINGENCY – CHAPTER 606 OF 2011 **

(a) A person may not sell or offer to sell any engine coolant or antifreeze that contains more than 10% ethylene glycol unless the coolant or antifreeze includes not less than 30 parts per million nor more than 50 parts per million denatonium benzoate.

(b) The provisions of this section do not apply to the sale of:

(1) A motor vehicle that contains engine coolant or antifreeze at the time of sale;

(2) A wholesale container of engine coolant or antifreeze designed to contain 55 gallons or more of engine coolant or antifreeze;

(3) Engine coolant or antifreeze reformulated through on–site recycling; or

(4) Engine coolant or antifreeze purchased in accordance with military specifications.

(c) (1) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $100.

(2) Each day that a violation continues shall constitute a separate offense.

§24–101.

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

(b) "Distribute" includes:

(1) Offering for sale;

(2) Selling;

(3) Bartering; and

(4) Giving away.

(c) "Exotic bird" means a bird that is not native to this State.

(d) "Permit" means a permit issued by the Secretary to import, distribute, and breed exotic birds.

§24–102.

(a) A person shall hold a permit issued by the Secretary before the person may import, distribute, or breed any exotic bird in this State.

(b) A permit is not required for a person:

(1) Legally to acquire and keep an exotic bird as a household pet; or

(2) To import, distribute, or breed any bird that is regulated by any program of the Department of Natural Resources.

(c) A separate permit is required for each facility where a person keeps an exotic bird.

§24–103.

A permit expires on the July 1 after its effective date, unless it is renewed for a 1-year term.

§24–104.

Each permit shall be displayed conspicuously in the facility for which it is issued.

§24–105.

Each permit holder shall keep in a sanitary condition the facility for which the permit is issued.

§24–106.

(a) On a form approved by the Secretary, each permit holder shall keep a record of the following information for each exotic bird received or disposed of by the permit holder or an agent of the permit holder:

(1) At the time of receipt:

(i) The exotic bird's species;

(ii) The date of receipt and the number of exotic birds received; and

(iii) The name and address of the former owner; and

(2) At the time of transfer:

(i) The exotic bird's species;

(ii) The date of transfer; and

(iii) The name and address of the new owner.

(b) Each permit holder shall keep for at least 1 year, at the facility for which the permit is issued, any record required under this section.

§24–107.

(a) If a bird dies while in the possession of a permit holder, the permit holder shall freeze the bird immediately.

(b) The Secretary of Health shall specify the methods for handling, treating, and destroying any bird that:

(1) Dies while in the possession of a permit holder; or

(2) In a case that involves psittacosis or any other disease that is contagious to human beings:

(i) Has the disease;

(ii) Is suspected of having the disease;

(iii) Is suspected of being a carrier of the disease;

(iv) Has been exposed to the disease; or

(v) Is kept at the same facility where the disease is discovered or suspected.

(c) In a case that involves velogenic visertrophic Newcastle disease or any other disease that is contagious to domestic animals or poultry, the State Secretary of Agriculture shall specify the methods for handling, treating, and destroying any bird that:

(1) Has the disease;

(2) Is suspected of having the disease;

(3) Is suspected of being a carrier of the disease;

(4) Has been exposed to the disease; or

(5) Is kept at the same facility where the disease is discovered or suspected.

§24–108.

(a) The Secretary of Health or a representative of the Secretary of Health may inspect the facilities of any permit holder.

(b) On request, any permit holder or the Secretary of Health shall make available to the State Secretary of Agriculture any record, specimen, or other material necessary to diagnose or trace any infectious disease that:

(1) Occurs in an exotic bird; and

(2) Is contagious to domestic animals or poultry.

§24–109.

Except as otherwise provided in this subtitle, a person may not import, distribute, or breed in this State any exotic bird, unless the person holds a permit issued by the Secretary.

§24–110.

A person who violates any provision of this subtitle or any rule, regulation, or order adopted or issued by the Secretary of Health or the State Secretary of Agriculture under this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

§24–202.

(a) At all times during business hours, each privately owned and commercially operated indoor racket sports facility shall have on the premises personnel who are certified to administer cardiopulmonary resuscitation.

(b) This section may not be construed as creating any civil or criminal liability.

§24–205.

(a) In this section, "smoking" means the act of smoking or carrying a burning:

(1) Cigar;

(2) Cigarette;

(3) Pipe; or

(4) Other tobacco product of any kind.

(b) Every director of a nursing home, health clinic, or physician's office shall make and carry out a plan that adequately protects the health of nonsmoking patients by regulating the smoking of tobacco products on the premises.

(c) (1) An individual may not smoke in any area of a hospital.

(2) The hospital director shall provide for the posting and placement of conspicuous signs that clearly indicate that smoking is not permitted in the hospital.

(d) (1) Notwithstanding the provisions of § 24–504 of this title, this section does not apply to patients who are:

(i) In a facility for the treatment of mental disorders as defined in § 10–101(g) of this article;

(ii) In a facility where the average patient stay is more than 30 days; or

(iii) In an acute care hospital and the attending physician authorizes smoking, in writing, as part of the care for the patient.

(2) Smoking permitted under this section shall be in designated areas that are considered safe and provide nonsmoking patients, family members, and employees protection from tobacco smoke.

(3) Smoking may not be permitted where nonsmoking patients sleep.

§24–206.

Each movie house, theater, bar, or similar commercial establishment that uses strobe lighting shall keep posted conspicuously at the entrance of the establishment a warning that strobe lighting:

(1) Is used in the establishment; and

(2) May be harmful to an individual who is susceptible to epileptic or similar seizures.

§24–207.

(a) The Department shall adopt rules and regulations to carry out the provisions of this section, including:

(1) Standards for marking transparent glass doors; and

(2) Definitions of "business establishment", "public building", and "commercial building or structure".

(b) In each business establishment, public building, or commercial building or structure, each door that has a surface area of at least 80 percent transparent glass shall be marked so that it warns any individual nearing it that a glass door is present.

(c) A person who violates any provision of this section or any rule or regulation adopted under this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50.

§24–208.

(a) To assure the cost-free operation of toilets in any public or private building required by any State, county, or municipal law, rule, or regulation to have public toilets, and to end any discriminatory effect based on sex related to the use of coin-operated pay toilets, in any public or private building required by State, county, or municipal law, rule, or regulation to have public toilets, a fee or charge may not be imposed for the use of any toilet required by law, rule, or regulation to be installed in any public or private building. However, any number of toilets greater than the number required by law, rule, or regulation may be coin-operated.

(b) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $50.

§24–209.

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

(2) "Customer" means an individual who is lawfully on the premises of a retail establishment.

(3) "Eligible medical condition" means:

(i) Crohn's disease, ulcerative colitis or any other inflammatory bowel disease, or any other medical condition that requires immediate access to a toilet facility; or

(ii) A condition that requires the use of an ostomy device.

(b) At the request of a customer during normal business hours, and where a public restroom is not readily available, each retail establishment that has a toilet facility for its employees shall allow the customer to use the facility if:

(1) Three or more employees of the retail establishment are working at the time the customer requests use of the facility; and

(2) The customer suffers from an eligible condition that is documented with a signed statement by the customer's health care provider on an identification card that has been prepared by the Maryland Department of Health in accordance with subsection (c) of this section.

(c) The Maryland Department of Health shall develop a standard identification card that is available on the Department's website to be printed and signed by a health care provider as evidence of the existence of an eligible medical condition.

(d) Notwithstanding any provision of this section, an employee toilet facility is not to be considered a public restroom.

§24–210.

A retail establishment and any employee of a retail establishment shall have the immunity from liability described under § 5-635 of the Courts and Judicial Proceedings Article.

§24–211.

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

(2) "Place of public entertainment" means any establishment that:

(i) Accommodates more than 100 individuals; and

(ii) Is included under § 302.0 Use Group A, Assembly Uses, of the Building Officials and Code Administrators Model Performance Code as adopted by regulation by the Department of Housing and Community Development.

(3) "Public restroom" means a public sanitary facility that contains more than one sanitary fixture.

(4) "Sanitary fixture" means a toilet, urinal, or lavatory placed in a public sanitary facility.

(b) In any place of public entertainment required by a State, county, or municipal law, rule, or regulation to have a public restroom, sanitary fixtures shall be distributed so that the number of toilets provided in a public restroom for women shall be no less than the combined number of toilets and urinals provided in a public restroom for men.

(c) The provisions of this section shall apply to any place of public entertainment for which a construction permit is issued after May 1, 1993.

(d) This section does not apply to:

(1) Restoration or renovation of structures, including restoration or renovation which involves 100% of the previously existing structure; or

(2) An addition to any structure.

§24–212.

(a) The proprietor of a building containing any elevator whose use is available to the general public shall post a sign prohibiting the smoking of tobacco products in that elevator. The sign shall state "Smoking in This Elevator Is Illegal and Subject to a Penalty Not to Exceed $25.00".

(b) A person may not smoke tobacco products in any area prohibited under subsection (a) of this section.

(c) The Commissioner of Labor and Industry may promulgate rules and regulations in furtherance of the provisions of this section.

(d) Any person who violates any provision of this section is subject to a civil penalty not to exceed $25.

§24–301.

(a) The Department shall adopt rules and regulations that establish safety requirements for eyeglass and sunglass lenses and frames.

(b) A person may not sell or dispense any eyeglasses or sunglasses that do not meet the safety requirements established by the Department.

(c) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

§24–301.1.

(a) Subject to subsection (d) of this section, the Department shall adopt regulations that govern the selling and dispensing of plano and zero-powered contact lenses and plano and zero-powered replacement contact lenses.

(b) A person may not knowingly sell or dispense contact lenses or replacement contact lenses without a valid and unexpired prescription or replacement contact lens prescription.

(c) A person who violates any provision of this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000.

(d) This section does not limit the right of the State Board of Examiners in Optometry to regulate an optometrist who knowingly sells or dispenses contact lenses or replacement contact lenses without a valid and unexpired prescription or replacement contact lens prescription.

§24–302.

(a) A person may not knowingly manufacture, sell, rent, or offer for sale any toy that is designed to depict torture or to resemble any instrument that is designed specifically for torture.

(b) This section does not apply to:

(1) Any toy gun; or

(2) Any model of an aircraft, ship, motor vehicle, railroad engine, car, rocketship or other spacecraft, or any part of the model.

§24–303.

(a) A person may not sell methyl methacrylate liquid monomer to a beauty salon, as defined in § 5-101 of the Business Occupations and Professions Article.

(b) A person that violates any provision of this section or any regulation adopted by the Secretary under this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 for each violation.

§24–304.

(a) (1) In this section, "child care article" means an empty bottle or cup to be filled with food or liquid that is designed or intended by a manufacturer to be used by a child under the age of 4 years.

(2) If a federal law regulating the use of bisphenol–A in child care articles is enacted, "child care article" shall be defined as specified in the federal law.

(b) On or after January 1, 2012, a person may not manufacture, knowingly sell, or distribute in commerce any child care article containing bisphenol–A.

(c) Except as provided in subsection (g) of this section, on or after July 1, 2014:

(1) The State may not purchase infant formula in containers containing more than 0.5 parts per billion of bisphenol–A; and

(2) A person may not manufacture, knowingly sell, or distribute in commerce a container of infant formula containing more than 0.5 parts per billion of bisphenol–A.

(d) In complying with subsections (b) and (c) of this section, a person:

(1) Shall use a safe and legal alternative when replacing bisphenol–A; and

(2) May not replace bisphenol–A with:

(i) Carcinogens rated by the United States Environmental Protection Agency as Group A, B, or C carcinogens; or

(ii) Reproductive toxicants that cause birth defects, reproductive harm, or developmental harm as identified by the United States Environmental Protection Agency.

(e) A person that violates this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $10,000 for each violation.

(f) On or before January 1, 2012, the Department shall adopt regulations to carry out subsection (b) of this section.

(g) If the Secretary certifies that the safety concerns for bisphenol–A are resolved by additional research or if implementation of subsection (c) of this section would adversely affect the health or well–being of children or adults, the Secretary may suspend implementation of subsection (c) of this section.

§24–305.

(a) This section does not apply to a tobacco product that is regulated under Title 16 of the Business Regulation Article.

(b) (1) Subject to paragraph (3) and except as provided in paragraph (2) of this subsection, a person may not:

(i) Sell, distribute, or offer for sale to an individual under the age of 21 years an electronic smoking device, as defined in § 16.7–101(c) of the Business Regulation Article;

(ii) Display electronic smoking devices, as defined in § 16.7–101(c) of the Business Regulation Article, for sale unless the electronic smoking devices are located behind a counter in an area accessible only to the person and employees of the person; or

(iii) Except as provided in paragraph (4) of this subsection, sell electronic smoking devices, as defined in § 16.7–101(c) of the Business Regulation Article, unless the person verifies that the individual is at least 21 years old.

(2) This subsection does not apply to an electronic smoking device that contains or delivers nicotine intended for human consumption if the device has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product and is being marketed and sold solely for this purpose.

(3) Subject to paragraph (4) of this subsection, a person may verify an individual's age only:

(i) By means of a government–issued photo identification containing the individual's date of birth; and

(ii) In a direct face–to–face exchange including the assistance of any electronic or mechanical device.

(4) A person is not required to verify the age of an individual at least 30 years old.

(c) (1) A person that violates this section is subject to a civil penalty not exceeding:

(i) $300 for a first violation;

(ii) $1,000 for a second violation occurring within 24 months after the first violation; and

(iii) $3,000 for each subsequent violation occurring within 24 months after the preceding violation.

(2) Issuance of a civil citation for a violation of this section precludes prosecution under § 10–107 of the Criminal Law Article arising out of the same violation.

(3) If a violation is committed by a person acting on behalf of a retailer, the civil penalty imposed under paragraph (1) of this subsection shall be paid by the retailer.

(d) In a prosecution for a violation of this section, it is a defense that the defendant examined the purchaser's or recipient's driver's license or other valid identification issued by a government unit that positively identified the purchaser or recipient as at least 21 years of age.

(e) (1) In this subsection, "designee" means a retired sworn law enforcement officer employed by the Department or a county health officer or an employee of the Department or a local health department trained in civil enforcement.

(2) The Secretary, the Secretary's designee, a sworn law enforcement officer, a county health officer, or a designee of a county health officer may issue a civil citation for a violation of this section.

(3) A citation issued under this section shall include:

(i) The name and address of the person charged;

(ii) The nature of the violation;

(iii) The location and time of the violation;

(iv) The amount of the civil penalty;

(v) The manner, location, and time in which the civil penalty may be paid;

(vi) A notice stating the person's right to elect to stand trial for the violation; and

(vii) A warning that failure to pay the civil penalty or to contest liability in a timely manner in accordance with the citation:

1. Is an admission of liability; and

2. May result in entry of a default judgment that may include the civil penalty, court costs, and administrative expenses.

(4) The Secretary, Secretary's designee, county health officer, or county health officer's designee shall retain a copy of the citation issued under this section.

(5) (i) 1. A person who receives a citation from the Secretary, the Secretary's designee, a county health officer, or a county health officer's designee under this section may elect to stand trial for the violation by filing a notice of intention to stand trial with the county health officer or designee at least 5 days before the date set in the citation for the payment of the civil penalty.

2. After receiving a notice of intention to stand trial under subsubparagraph 1 of this subparagraph, the Secretary, Secretary's designee, county health officer, or county health officer's designee shall forward the notice and a copy of the citation to the District Court.

(ii) A person who receives a citation from a sworn law enforcement officer under this section may elect to stand trial for the violation by filing a notice of intention to stand trial and a copy of the citation with the District Court at least 5 days before the date set in the citation for payment of the civil penalty.

(6) (i) After receiving a citation and notice under this section, the District Court shall schedule the case for trial and notify the defendant of the trial date.

(ii) In a proceeding before the District Court, a violation of this section shall be prosecuted in the same manner and to the same extent as a municipal infraction under §§ 6–108 through 6–115 of the Local Government Article.

(7) The District Court shall remit any penalties collected for a violation of this section to the county in which the violation occurred.

(8) Adjudication of a violation of this section is not a criminal conviction for any purpose.

§24–306.

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

(2) (i) "Child care product" means a consumer product intended for use by a child under the age of 3 years.

(ii) "Child care product" includes a baby product, toy, and car seat.

(iii) "Child care product" does not include a product regulated under § 24–306.1 of this subtitle.

(3) "TCEP" means (tris (2–chloroethyl) phosphate).

(4) "TDCPP" means (tris (1, 3–dichloro–2–propyl) phosphate).

(b) This section does not apply to the sale or distribution of a child care product that is resold, offered for resale, or distributed by a consumer for consumer use.

(c) A person may not import, sell, or offer for sale any child care product that:

(1) Contains more than one–tenth of 1% of TCEP or TDCPP by mass; and

(2) Is intended for use by a child under the age of 3 years.

(d) (1) A person that violates this section is subject to:

(i) For a first violation, a civil penalty not exceeding $1,000; and

(ii) For any subsequent violation, a civil penalty not exceeding $2,500 for each violation.

(2) In addition to the civil penalties provided in paragraph (1) of this subsection, a court may enjoin an action prohibited by this section.

(e) The Secretary may suspend implementation of subsection (c) of this section if the Secretary determines that the fire safety benefits of TCEP or TDCPP are greater than the health risks associated with TCEP or TDCPP.

(f) On or before June 1, 2021, the Department shall adopt regulations to carry out this section.

§24–306.1.

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

(2) "Adult mattress" means any mattress other than a toddler mattress, a crib mattress, or any other infant sleep product.

(3) "Flame–retardant chemical" means a chemical that:

(i) Is used to resist or inhibit the spread of fire or act as a synergist to chemicals that resist or inhibit the spread of fire, including any chemical for which the term "flame retardant" appears on a safety data sheet developed in accordance with 29 C.F.R. 1910.1200(g); and

(ii) 1. Contains one or more halogen elements, including fluorine, chlorine, bromine, or iodine;

2. Contains one or more carbon elements and one or more phosphorus elements;

3. Contains one or more carbon elements and one or more nitrogen elements; or

4. Is a nanoscale chemical.

(4) (i) "Juvenile product" means a consumer product intended for use by a child under the age of 12 years.

(ii) "Juvenile product" includes a bassinet, a booster seat, a changing pad, a children's nap mat, a floor playmat, a high chair, a high chair pad, an infant bouncer, an infant carrier, an infant seat, an infant swing, an infant walker, a nursing pad, a nursing pillow, a playpen side pad, a play yard, a portable hook–on chair, and a stroller.

(iii) "Juvenile product" does not include:

1. A product that is not primarily intended for use in the home, including a product that is, or is a component part of, a motor vehicle, a watercraft, an aircraft, or any other vehicle;

2. A product regulated under 49 C.F.R. Part 571;

3. A consumer electronic product; or

4. A product regulated under § 24–306 of this subtitle.

(5) "Mattress" has the meaning stated in 16 C.F.R. § 1632.1.

(6) "Reupholstered furniture" means furniture for which the original fabric, padding, decking, barrier material, foam, or other resilient filling has been replaced and that has not been sold since the time of replacement.

(7) "Upholstered furniture" means furniture that includes filling materials, barrier materials, decking materials, or cover fabrics.

(b) This section does not apply to the sale or distribution of a juvenile product, mattress, upholstered furniture, or reupholstered furniture that is resold, offered for resale, or distributed by a consumer for consumer use.

(c) (1) This subsection does not apply to:

(i) An electronic component, or the casing for an electronic component, of a juvenile product, mattress, upholstered furniture, or reupholstered furniture;

(ii) A component of upholstered or reupholstered furniture other than cover fabric, barrier material, resilient filling material, and decking material;

(iii) Thread or fiber when used for stitching mattress components together; or

(iv) Except for foam, a component of an adult mattress.

(2) A person may not import, sell, or offer for sale any juvenile product, mattress, upholstered furniture, or reupholstered furniture that contains more than 0.1% of flame–retardant chemicals by mass.

(d) (1) Subject to paragraph (2) of this subsection, if a person willfully violates this section, the Secretary may assess a civil penalty:

(i) For a first violation, not exceeding $2,500;

(ii) For a second violation, not exceeding $5,000;

(iii) For a third violation, not exceeding $7,500; and

(iv) For any subsequent violation, not exceeding $10,000 for each violation.

(2) In determining the amount of a penalty under paragraph (1) of this subsection, the Secretary shall consider:

(i) The nature and severity of the violation;

(ii) The good faith of the person;

(iii) The history of violations by the person; and

(iv) The extent to which the person cooperated with any investigation by the Department.

(e) On or before June 1, 2021, the Department shall adopt regulations to carry out this section.

§24–307.

(a) (1) This section does not apply to the distribution of a coupon that is redeemable for a tobacco product if the coupon is:

(i) Contained in a newspaper, a magazine, or any other type of publication in which the coupon is incidental to the primary purpose of the publication; or

(ii) Sent through the mail.

(2) This section does not apply to the distribution of a tobacco product or tobacco paraphernalia to an individual under the age of 21 years who is acting solely as the agent of the individual's employer if the employer distributes tobacco products or tobacco paraphernalia for commercial purposes.

(b) (1) A person who distributes tobacco products for commercial purposes, including a person licensed under Title 16, Title 16.5, Title 16.7, or Title 16.9 of the Business Regulation Article, may not:

(i) Distribute to an individual under the age of 21 years:

1. A tobacco product;

2. Tobacco paraphernalia; or

3. A coupon redeemable for a tobacco product;

(ii) Display tobacco products for sale unless the tobacco products are located behind a counter in an area accessible only to the person and employees of the person; or

(iii) Except as provided in paragraph (3) of this subsection, sell tobacco products unless the person verifies that the individual is at least 21 years old.

(2) A person who distributes tobacco products may verify an individual's age only:

(i) By means of a government–issued photo identification containing the individual's date of birth; and

(ii) In a direct face–to–face exchange including the assistance of any electronic or mechanical device.

(3) A person who distributes tobacco products is not required to verify the age of an individual at least 30 years old.

(c) (1) A person who violates subsection (b) of this section is subject to a civil penalty not exceeding:

(i) $300 for a first violation;

(ii) $1,000 for a second violation occurring within 24 months after the first violation; and

(iii) $3,000 for each subsequent violation occurring within 24 months after the preceding violation.

(2) The local health departments shall report violations of subsection (b) of this section to the Executive Director of the Alcohol, Tobacco, and Cannabis Commission.

(3) Issuance of a civil citation for a violation of this section precludes prosecution under § 10–107 of the Criminal Law Article arising out of the same violation.

(4) If a violation is committed by a person acting on behalf of a retailer, the civil penalty imposed under paragraph (1) of this subsection shall be paid by the retailer.

(d) In a prosecution for a violation of subsection (b) of this section, it is a defense that the defendant examined the purchaser's or recipient's driver's license or other valid identification issued by a governmental unit that positively identified the purchaser or recipient as at least 21 years old.

(e) (1) In this subsection, "designee" means a retired sworn law enforcement officer employed by the Secretary or a county health officer or an employee of a local health department trained in civil enforcement.

(2) The Secretary, the Secretary's designee, a sworn law enforcement officer, a county health officer, or a designee of a county health officer may issue a civil citation for a violation of subsection (b) of this section.

(3) A citation issued under this subsection shall include:

(i) The name and address of the person charged;

(ii) The nature of the violation;

(iii) The location and time of the violation;

(iv) The amount of the civil penalty;

(v) The manner, location, and time in which the civil penalty may be paid;

(vi) A notice stating the person's right to elect to stand trial for the violation; and

(vii) A warning that failure to pay the civil penalty or to contest liability in a timely manner in accordance with the citation:

1. Is an admission of liability; and

2. May result in entry of a default judgment that may include the civil penalty, court costs, and administrative expenses.

(4) The Secretary, Secretary's designee, county health officer, or designee shall retain a copy of the citation issued under this subsection.

(5) (i) A person who receives a citation from the Secretary, the Secretary's designee, a county health officer, or designee under this subsection may elect to stand trial for the violation by filing a notice of intention to stand trial with the county health officer or designee at least 5 days before the date set in the citation for the payment of the civil penalty.

(ii) After receiving a notice of intention to stand trial under subparagraph (i) of this paragraph, the county health officer or designee shall forward the notice and a copy of the citation to the District Court.

(6) (i) After receiving a citation and notice under this subsection, the District Court shall schedule the case for trial and notify the defendant of the trial date.

(ii) In a proceeding before the District Court, a violation of subsection (b) of this section shall be handled in the same manner as a municipal infraction under §§ 6–108 through 6–115 of the Local Government Article.

(7) The District Court shall remit any penalties collected for a violation of subsection (b) of this section to the county in which the violation occurred.

(8) Adjudication of a violation of subsection (b) of this section is not a criminal conviction for any purpose.

(f) (1) The Maryland Department of Health, in collaboration and consultation with the Executive Director of the Alcohol, Tobacco, and Cannabis Commission, local health departments, and local law enforcement agencies, shall develop ongoing strategies for enforcement of § 10–107 of the Criminal Law Article.

(2) On or before October 1 each year, the Department shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(i) The development of enforcement strategies required under paragraph (1) of this subsection; and

(ii) Training and assistance to tobacco retailers to improve compliance with § 10–107 of the Criminal Law Article.

§24–501.

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

(b) "Cannabis" has the meaning stated in § 1–101 of the Alcoholic Beverages and Cannabis Article.

(c) "Electronic smoking device" has the meaning stated in § 16.7–101 of the Business Regulation Article.

(d) "Employee" has the meaning stated in § 5–101 of the Labor and Employment Article.

(e) "Employer" has the meaning stated in § 5–101 of the Labor and Employment Article.

(f) "Environmental smoke" means:

(1) The complex mixture formed from the escaping smoke of a burning tobacco, cannabis, or hemp product or smoke exhaled by the smoker; or

(2) The complex mixture formed from the escaping aerosol of an electronic smoking device or exhaled as electronic smoking device aerosol.

(g) "Hemp" has the meaning stated in § 14–101 of the Agriculture Article.

(h) "Indoor area open to the public" means:

(1) An indoor area or a portion of an indoor area accessible to the public by either invitation or permission; or

(2) An indoor area of any establishment licensed or permitted under the Alcoholic Beverages and Cannabis Article for the sale or possession of alcoholic beverages.

(i) "Place of employment" has the meaning stated in § 5–101 of the Labor and Employment Article.

(j) "Smoking" means the burning of a lighted cigarette, cigar, pipe, or any other matter or substance containing, wholly or in part, tobacco, cannabis, or hemp.

(k) "Tobacco product" has the meaning stated in § 13–1001 of this article.

(l) "Vaping" means the use of:

(1) An electronic smoking device; or

(2) Any device through which the user inhales aerosol containing tobacco, cannabis, or hemp.

§24–502.

It is the intent of the General Assembly that the State protect the public and employees from involuntary exposure to environmental smoke in indoor areas open to the public, indoor places of employment, and certain designated private areas.

§24–503.

The purpose of this subtitle is to preserve and improve the health, comfort, and environment of the people of the State by limiting exposure to environmental smoke.

§24–504.

Except as provided in § 24–505 of this subtitle, beginning on February 1, 2008, a person may not smoke or vape in:

(1) An indoor area open to the public;

(2) An indoor place in which meetings are open to the public in accordance with Title 3 of the General Provisions Article;

(3) A government–owned or government–operated means of mass transportation including buses, vans, trains, taxicabs, and limousines; or

(4) An indoor place of employment.

§24–505.

This subtitle does not apply to:

(1) Private homes, residences, including residences used as a business or place of employment, unless being used by a person who is licensed or registered under Title 5, Subtitle 5 of the Family Law Article to provide child care, and private vehicles, unless being used for the public transportation of children, or as part of health care or child care transportation;

(2) A hotel or motel room rented to one or more guests as long as the total percent of hotel or motel rooms being so used does not exceed 25%;

(3) A retail tobacco business that is a sole proprietorship, limited liability company, corporation, partnership, or other enterprise, in which:

(i) The primary activity is the retail sale of tobacco products and accessories; and

(ii) The sale of other products is incidental;

(4) Any facility of a manufacturer, importer, wholesaler, or distributor of tobacco products or of any tobacco leaf dealer or processor in which employees of the manufacturer, importer, wholesaler, distributor, or processor work or congregate; or

(5) A research or educational laboratory for the purpose of conducting scientific research into the health effects of environmental smoke.

§24–506.

(a) Signs that state "Smoking or Vaping Permitted in This Room" shall be prominently posted and properly maintained where smoking or vaping is allowed under § 24–505(2) of this subtitle.

(b) Signs that state "No Smoking or Vaping" shall be conspicuously posted and properly maintained in each indoor area open to the public and each public entrance to an indoor area where smoking or vaping is prohibited under this subtitle.

(c) The signs shall be posted and maintained by the owner, operator, manager, or other person having control of the area.

(d) The letters on the signs shall be at least 1 inch in height.

§24–507.

(a) The Department shall adopt regulations that prohibit environmental smoke in indoor areas open to the public.

(b) On or before September 30 of each year, the Department shall report, in accordance with § 2–1257 of the State Government Article, to the General Assembly on:

(1) The enforcement efforts of the Department to eliminate environmental smoke in indoor areas open to the public during the prior year; and

(2) The results of these enforcement efforts.

§24–508.

(a) Subject to subsection (c) of this section and except as provided in subsection (d) of this section, a person who violates a provision of this subtitle or a regulation adopted under § 24–507(a) of this subtitle:

(1) For a first violation, shall be issued a written reprimand by the Secretary or the Secretary's designee;

(2) For a second violation, is subject to a civil penalty of $100; and

(3) For each subsequent violation, is subject to a civil penalty of not less than $250.

(b) The Secretary may waive a penalty established under subsection (a) of this section, giving consideration to factors that include:

(1) The seriousness of the violation; and

(2) Any demonstrated good faith measures to comply with the provisions of this subtitle.

(c) (1) This subsection does not apply to an alleged violation of subsection (d) of this section.

(2) It is an affirmative defense to a complaint brought against a person for a violation of a provision of this subtitle or a regulation adopted under this subtitle that the person or an employee of the person:

(i) Posted a "No Smoking or Vaping" sign as required under § 24–506 of this subtitle;

(ii) Removed all ashtrays and other smoking or vaping paraphernalia from all areas where smoking is prohibited; and

(iii) If the violation occurred in a bar, tavern, or restaurant:

1. Refused to seat or serve any individual who was smoking or vaping in a prohibited area; and

2. If the individual continued to smoke or vape after an initial warning, asked the individual to leave the establishment.

(d) An employer who discharges or discriminates against an employee because that employee has made a complaint, has given information to the Department in accordance with this subtitle, has caused to be instituted or is about to cause to be instituted a proceeding under this subtitle, or has testified or is about to testify in a proceeding under this subtitle, shall be deemed in violation of this subtitle and shall be subject to a civil penalty of at least $2,000 but not more than $10,000 for each violation.

(e) (1) An employee may not:

(i) Make a groundless or malicious complaint under this subtitle to the Secretary or an authorized representative of the Secretary;

(ii) In bad faith, bring an action under this subtitle; or

(iii) In bad faith, testify in an action under this subtitle or a proceeding that relates to the subject of this subtitle.

(2) The Secretary may bring an action for injunctive relief and damages against a person who violates the provisions of paragraph (1) of this subsection.

(f) A penalty collected by the Secretary under this section shall be paid to the Cigarette Restitution Fund established under § 7–317 of the State Finance and Procurement Article.

§24–509.

Nothing in this subtitle shall be construed to preempt a county or municipal government from enacting and enforcing more stringent measures to reduce involuntary exposure to environmental smoke.

§24–510.

This subtitle may be cited as the Clean Indoor Air Act.

§24–601.

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

(b) "Facility" means:

(1) A public community mental health facility, addiction facility, or developmental disabilities facility that is wholly owned by and operated under the authority of a county or a municipal corporation, or both; or

(2) A nonprofit community mental health facility, addiction facility, or developmental disabilities facility that is wholly owned by and operated under the authority of a nonprofit organization.

(c) "Nonprofit organization" means:

(1) A bona fide religious organization, no part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of the facility, the purchase of equipment to be used in the facility, or the expansion of the facility; or

(2) An organization:

(i) That is chartered as a nonprofit corporation and classified by the Internal Revenue Service as nonprofit; and

(ii) No part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of the facility, the purchase of equipment to be used in the facility, or the expansion of the facility.

(d) "Wholly owned" includes leased, if:

(1) (i) The lease is for a minimum term of 30 years following project completion; or

(ii) The lease agreement extends the right of purchase to the lessee; and

(2) (i) The lessor consents to the recording, in the land records of the political subdivision in which the facility is located, of a notice of the State's right of recovery, as provided under § 24-606 of this subtitle; or

(ii) The lease agreement is with the State for a State-owned building or State-owned property.

§24–602.

The Board of Public Works, upon recommendation of the Secretary of the Department, may make grants to qualified applicants for the construction, acquisition, renovation, and equipping of community mental health facilities, addiction facilities, and developmental disabilities facilities, including the plans, specifications, site improvements, surveys, and applicable architects' and engineers' fees.

§24–603.

(a) (1) Any county, municipal corporation, or nonprofit organization sponsoring a project involving the construction, acquisition, renovation, or equipping of a facility in the State may apply to the Department for a State grant to be applied toward the cost of that project.

(2) The application shall be directed to the Secretary of the Department.

(3) On approval of a project and the project plans by the Department, the Secretary shall promptly report the application to the Board of Public Works, together with the Secretary's recommendation that the Board make funds available as provided in this subtitle.

(b) Before the Department approves any project, the applicant shall file with the Department:

(1) A statement listing the personnel employed or to be employed at the facility and showing all remuneration and perquisites for personal services and all other expenses paid or to be paid to these personnel, as well as all other expenses incurred or to be incurred in operating the facility; and

(2) The schedule of rates charged or to be charged for services rendered.

§24–604.

(a) The allocation and use of State funds under this subtitle are subject to the following terms and conditions.

(b) (1) State funds may be used only for the construction, acquisition, renovation, and equipping of facilities including the reports, plans, specifications, site improvements, surveys, and other related programs.

(2) Any federal grant that is available for this purpose shall be applied first to the cost of construction, acquisition, renovation, or equipping of a facility.

(3) A State grant shall provide up to 75% of the eligible cost remaining after the federal grant has been applied.

(4) For projects designated under federal regulations, State plans, or the departmental regulations as eligible for poverty area funding, State grants shall amount to up to 90% of the eligible cost remaining after the federal grant has been applied.

(5) For purposes of this subtitle, community development block grant funds shall be considered as local matching funds and may not be considered as federal grant funds.

(c) The amount of the State grant for any project shall be determined after consideration of all eligible applications, the total of unallocated State funds available at the time the application is received, and the priorities of area need as may be established by the Department.

(d) (1) No portion of the proceeds of a State grant may be used:

(i) For the furtherance of sectarian religious instruction; or

(ii) In connection with the design, acquisition, or construction of any building used or to be used as a place of sectarian religious worship or instruction, or in connection with any program or department of divinity for any religious denomination.

(2) On the request of the Board of Public Works, the applicant shall submit evidence satisfactory to the Board that none of the proceeds of the grant have been or are being used for a purpose prohibited by this subtitle.

§24–605.

(a) The Board of Public Works shall make allocations from funds available under this subtitle in accordance with this subtitle.

(b) The Board shall certify the allocations to the proper State officers, and the Treasurer shall make payments to the applicant, when needed, for the construction, acquisition, renovation, or equipping of a facility.

(c) The Board may adopt regulations for receiving and considering applications and for disbursing funds to applicants.

§24–606.

(a) In accordance with this section, the State:

(1) Shall have the right to recover funds disbursed under this subtitle; and

(2) May not:

(i) Recover funds disbursed under this subtitle from the federal government if the federal government is the lessor of real property on which a project is constructed or a facility is operated; or

(ii) Create a lien against real property that is leased from the federal government on which a project is constructed or a facility is operated.

(b) Subject to subsection (a)(2) of this section, in the event of failure to complete a project or failure to commence operation of a facility, the State may recover from the recipient of the funds disbursed for the project or facility or the owner of the property an amount equal to the amount of State funds disbursed for the project, together with all costs and reasonable attorneys' fees incurred by the State in the recovery proceedings.

(c) Subject to subsection (a)(2) of this section, if, within 30 years after completion of a project, a community mental health facility, addiction facility, or developmental disabilities facility with respect to which funds have been paid under this subtitle is sold or transferred to any person, agency, or organization that would not qualify as an applicant under this subtitle, or that is not approved as a transferee by the Board of Public Works, or if, within the same period, a community mental health facility, addiction facility, or developmental disabilities facility ceases to be a "facility" as defined in this subtitle, then the State may recover from either the transferor or transferee or, in the case of a community mental health facility, addiction facility, or developmental disabilities facility that has ceased to be a "facility" as defined in this subtitle, from the owner, an amount bearing the same ratio to the then current fair market value of so much of the property as constituted an approved project as the amount of the State participation bore to the total eligible cost of the approved project, together with all costs and reasonable attorneys' fees incurred by the State in the recovery proceedings.

(d) (1) The Department shall cause notice of the State's right of recovery to be recorded in the land records of the county or Baltimore City in which the

property is located before the State makes any funds available for the approved project.

(2) The recording of the notice shall not create any lien against the property; however, subject to subsection (a)(2) of this section, it shall constitute notice to any potential transferee, potential creditor, or other interested party of the possibility that the State may obtain a lien under this subtitle.

(e) (1) In the event of a failure to complete the project or commence operations of the facility as described in subsection (b) of this section, or in the event of an alleged sale or transfer as described in subsection (c) of this section, or in the event that a property is alleged to have ceased to be a "facility" as defined in this subtitle, the Secretary of the Board of Public Works may authorize the Department to file, in the circuit court of the county or Baltimore City in which the property is located, a claim under this subtitle (styled as a civil action against the owner of the property and any other interested parties, including any transferor that the State wishes to make a party), together with a sworn affidavit stating facts on which the allegations of default are based, as well as a detailed justification of the amount claimed.

(2) If the circuit court determines from the State's initial filing that there is probable cause to believe that a default has occurred, the court shall authorize a temporary lien on the property, in the amount of the State's claim, plus any additional amount estimated to be necessary to cover the costs and reasonable attorney's fees incurred by the State, or other amounts as the court determines to be reasonable, pending full determination of the State's claim.

(3) The temporary lien takes effect on the date of the court's authorization if the State records a notice of temporary lien in the land records of the county or Baltimore City in which the property is located within 10 days thereafter; otherwise, the temporary lien takes effect on the date a notice of temporary lien is recorded. While the temporary lien is in effect, neither the owner nor any person who acquired an interest in the property after the State first made funds available in connection with the property under this subtitle may take any action that would affect the title to the property or institute any proceedings to enforce a security interest or other similar rights in the property, without the prior written consent of the State.

(4) The owner of the property or any other interested party may obtain release of this temporary lien at any time by filing with the court a bond securing the payment in full of the State's claim any additional amount necessary to cover the costs and reasonable attorneys' fees incurred by the State. The owner or other interested party may cause the release to be recorded in the land records.

(f) (1) Proceedings to determine the State's right to recover and the amount of its recovery under this subtitle shall have priority over other civil proceedings in the circuit courts.

(2) At the conclusion of full adversary proceedings on the issue of default and on any disputes over the amount of the State's recovery, the circuit court shall, if it finds that a default has occurred, issue a final judgment for the amount it finds to be recoverable by the State. All parties involved in the default, including in every case the owner of the property, shall be held jointly and severally liable to the State for the amount of the judgment. This amount, if it remains unpaid after the expiration of 30 days following the court's final order, shall be a lien on the property, superior (except as the State may by written subordination agreement provide otherwise) to the lien or other interest of any mortgagee, pledgee, purchaser, or judgment creditor whose interest became perfected against third persons after the State first made funds available in connection with the property under this subtitle.

(3) This lien takes effect on the 31st day following the court's final order if the State records a notice of lien in the land records of the county or Baltimore City in which the property is located on or before the 41st day following the final order; otherwise, the lien takes effect on the date a notice of lien is recorded. At the time this lien takes effect, any temporary lien then in effect shall be automatically and fully released, and the recorded notice of this lien shall constitute notice of the release of the temporary lien.

(4) This lien may be enforced and foreclosed in accordance with the procedures prescribed in the Maryland Rules, except that neither the State nor any agent appointed by the State to sell the property need file a bond.

(5) The owner or any other interested party may obtain release of this lien at any time by paying the State the full amount of the judgment rendered by the circuit court, together with interest from the date of judgment. On payment in full, the State shall cause a release to be recorded in the land records.

(6) If the circuit court finds that there has been no default or if the full amount of the court's judgment is paid to the State within 30 days after the court's final order, any temporary lien then in effect shall be released immediately and the State shall cause a release to be recorded in the land records.

(g) (1) All funds recovered as a result of the State's right of recovery shall be deposited in the Annuity Bond Fund and applied to the debt service requirements of the State.

(2) The Board of Public Works may waive the State's right of recovery if the Board determines that there is good cause for releasing the transferor, transferee, or owner from this obligation.

§24–607.

(a) The Department shall adopt regulations to implement the provisions of this subtitle.

(b) The regulations shall include requirements for annual financial statements from each facility for at least the term of the bond used to finance any project at the facility.

§24–701.

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

(b) "Adult day care center" means a nonresidential center that:

(1) Serves the elderly, medically handicapped adults, or victims of Alzheimer's disease and related disorders;

(2) Meets the definition in § 14-201(b) or § 14-301(b) of this article; and

(3) Is licensed by the Department.

(c) "Facility" means an adult day care center that is wholly owned by and operated under the authority of:

(1) A county or a municipal corporation; or

(2) A nonprofit organization.

(d) "Nonprofit organization" means:

(1) A bona fide religious organization, no part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of the facility, the purchase of equipment to be used in the facility, or the expansion of the facility; or

(2) An organization:

(i) That is chartered as a nonprofit corporation and classified by the Internal Revenue Service as nonprofit; and

(ii) No part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of the facility, the purchase of equipment to be used in the facility, or the expansion of the facility.

(e) "Wholly owned" includes leased, if:

(1) (i) The lease is for a minimum term of 30 years following project completion; or

(ii) The lease agreement extends the right of purchase to the lessee; and

(2) The lessor consents to the recording, in the land records of the county or Baltimore City in which the facility is located, of a notice of the State's right of recovery, as provided under § 24-706 of this subtitle.

§24–702.

Upon the recommendation of the Secretary, the Board of Public Works may make grants to counties, municipal corporations, and nonprofit organizations for:

(1) The conversion of public buildings or parts of buildings to adult day care centers;

(2) The acquisition of existing buildings or parts of buildings for use as adult day care centers;

(3) The renovation of adult day care centers;

(4) The purchase of capital equipment for adult day care centers; or

(5) The planning, design, and construction of adult day care centers.

§24–703.

(a) Any county, municipal corporation, or nonprofit organization sponsoring a project involving work specified in § 24–702 of this subtitle may apply to the Department for a State grant to be applied toward the cost of that project.

(b) (1) The application shall be directed to the Secretary of Health.

(2) On approval of a project and the project plans by the Department, the Secretary shall promptly report the application to the Board of Public Works, together with the Secretary's recommendation that the Board make funds available as provided in this subtitle.

§24–704.

(a) The allocation and use of State funds under this subtitle are subject to the following terms and conditions.

(b) State funds may be used to acquire an existing building or part of a building for use as an adult day care center, or to plan, design, and construct an adult day care center, only if the local government and the Department certify to the Board of Public Works that no surplus school building or other public building appropriate for use as an adult day care center exists in the area where it is desired to locate a center.

(c) Any federal or other grant that is received for an eligible project shall be applied first to the cost of the project.

(d) Except as provided in subsections (e) and (f) of this section, a State grant may not exceed $400,000 or 50 percent of the cost of eligible work remaining unpaid after all federal and other grants have been applied, whichever is less.

(e) At the discretion of the Board of Public Works, a State grant may exceed 50 percent of the cost of eligible work remaining unpaid after all federal and other grants have been applied, if:

(1) The project involves the conversion of a public building or part of a building to an adult day care center, the renovation of an adult day care center, or the planning, design, and construction of an adult day care center;

(2) The value of real property and improvements made available by the local government, or the value of the center to be renovated, equals or exceeds the amount of the State grant;

(3) No State funds have been used for the acquisition, construction, or maintenance of any real property and improvements made available by the local government or any building to be converted or renovated; and

(4) The State is not responsible for any bonded indebtedness in connection with any real property and improvements made available by the local government or any building to be converted or renovated.

(f) For a project designated under federal regulations, State plans, or departmental regulations as eligible for poverty area funding, a State grant may cover up to 75 percent of the cost of eligible work remaining unpaid after all federal and other grants have been applied.

(g) The amount of the State grant for any project shall be determined after consideration of all eligible applications, the total of unallocated State funds available at the time the application is received, and the priorities of area need as may be established by the Department.

(h) No portion of the proceeds of a State grant may be used for the furtherance of sectarian religious instruction, or in connection with the design, acquisition, or construction of any building used or to be used as a place of sectarian religious worship or instruction, or in connection with any program or department of divinity for any religious denomination. Upon the request of the Board of Public Works, the applicant shall submit evidence satisfactory to the Board that none of the proceeds of the grant have been or are being used for a purpose prohibited by this subtitle.

§24–705.

(a) The Board of Public Works shall make allocations from funds available under this subtitle in accordance with this subtitle.

(b) The Board shall certify the allocations to the proper State officers, and the Treasurer shall make payments to or on behalf of the applicant, when needed, for the approved project.

(c) The Board of Public Works may adopt regulations to implement this section.

§24–706.

(a) If, within 30 years after completion of a project, a property with respect to which funds have been paid under this subtitle is sold or transferred to any person, agency, or organization that would not qualify as an applicant under this subtitle, or that is not approved as a transferee by the Board of Public Works, or if, within the same period, the property ceases to be a "facility" as defined in this subtitle, then the State may recover from either the transferor or transferee or, in the case of a property that has ceased to be a "facility" as defined in this subtitle, from the owner, an amount bearing the same ratio to the then-current value of so much of the property as constituted an approved project as the amount of the State participation bore to the

total eligible cost of the approved project, together with all costs and reasonable attorneys' fees incurred by the State in the recovery proceedings.

(b) (1) Before the State makes any funds available for an approved project, the Department shall cause a notice of this right of recovery to be recorded in the land records of the county or Baltimore City in which the property is located.

(2) The recording of the notice:

(i) Does not create any lien against the property; but

(ii) Shall constitute notice to any potential transferee, potential transferor, potential creditor, or other interested party of the possibility that the State may obtain a lien under this subtitle.

(c) (1) In the event of an alleged sale or transfer as described in subsection (b) of this section, or in the event that a property is alleged to have ceased to be a "facility" as defined in this subtitle, the Secretary of the Board of Public Works may file, in the circuit court for the county or Baltimore City in which the property is located, a claim under this subtitle (styled as a civil action against the owner of the property and any other interested parties, including any transferor that the State wishes to make a party), together with sworn affidavits stating facts on which the allegations of default are based, as well as a detailed justification of the amount claimed.

(2) If the circuit court determines from the State's initial filing that there is probable cause to believe that a default has occurred, the court shall authorize a temporary lien on the property, in the amount of the State's claim (plus any additional amount estimated to be necessary to cover the costs and reasonable attorneys' fees incurred by the State) or in other amounts as the court determines to be reasonable, pending full determination of the State's claim.

(3) The temporary lien shall take effect on the date of the court's authorization if the Secretary of the Board of Public Works records a notice of temporary lien in the land records of the county or Baltimore City in which the property is located within 10 days thereafter, otherwise, the temporary lien shall take effect on the date a notice of temporary lien is recorded. While the temporary lien is in effect, neither the owner nor any person who acquired an interest in the property after the State first made funds available in connection with the property under this subtitle, may take any action that would affect the title to the property or institute any proceedings to enforce a security interest or other similar rights in the property, without the prior written consent of the State.

(4) The owner of the property or any other interested party may obtain release of this temporary lien at any time by filing with the court a bond securing the payment in full of the State's claim and any additional amount necessary to cover the costs and reasonable attorneys' fees incurred by the State. The owner or other interested party may cause the release to be recorded in the land records.

(d) (1) Proceedings to determine the State's right to recover and the amount of its recovery under this subtitle shall have priority over other civil proceedings in the circuit courts.

(2) At the conclusion of full adversary proceedings on the issue of default and on any disputes over the amount of the State's recovery, the circuit court shall, if it finds that a default has occurred, issue a final judgment for the amount it finds to be recoverable by the State. All parties involved in the default, including in every case the owner of the property, shall be held jointly and severally liable to the State for the amount of the judgment. This amount, if it remains unpaid after the expiration of 30 days following the court's final order, shall be a lien on the property, superior (except as the State may by written subordination agreement provide otherwise) to the lien or other interest of any mortgagee, pledgee, purchaser, or judgment creditor whose interest became perfected against third persons after the State first made funds available in connection with the property under this subtitle.

(3) This lien takes effect on the 31st day following the court's final order if the Secretary of the Board of Public Works records a notice of lien in the land records of the county or Baltimore City in which the property is located on or before the 41st day following the final order, otherwise, the lien takes effect on the date a notice of lien is recorded. At the time this lien takes effect, any temporary lien then in effect shall be automatically and fully released, and the recorded notice of this lien shall constitute notice of the release of the temporary lien.

(4) This lien may be enforced and foreclosed in accordance with the procedures prescribed in the Maryland Rules, except that neither the State nor any agent appointed by the State to sell the property need file a bond.

(5) The owner or any other interested party may obtain release of this lien at any time by paying to the State the full amount of the judgment rendered by the circuit court, together with interest from the date of judgment. On payment in full, the Secretary of the Board of Public Works shall cause a release to be recorded in the land records.

(6) If the circuit court finds that there has been no default or if the full amount of the court's judgment is paid to the State within 30 days after the court's final order, any temporary lien then in effect shall be released immediately and the

Secretary of the Board of Public Works shall cause the release to be recorded in the land records.

(e) (1) All funds recovered as a result of this right of recovery shall be deposited in the Annuity Bond Fund and applied to the debt service requirements of the State.

(2) The Board of Public Works may waive the State's right of recovery if the Board determines that there is good cause for releasing the transferor, transferee, or owner from this obligation.

§24–707.

The Department shall adopt regulations to implement the provisions of this subtitle.

§24–801.

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

(b) "Commissioner of Health" means the Baltimore City Commissioner of Health.

(c) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome (AIDS).

(d) "Participant" means an individual who has registered with the Program.

(e) "Program" means the HIV Prevention Syringe Services Program.

(f) "Residue" means the dried remains of a controlled dangerous substance attached to or contained within a hypodermic needle or syringe.

§24–802.

(a) There is an HIV Prevention Syringe Services Program in the Baltimore City Health Department.

(b) The Program shall:

(1) Distribute syringes and provide for the exchange by participants of used hypodermic needles and syringes for sterile hypodermic needles and syringes as needed; and

(2) Operate in accordance with the procedures approved, with the advice and approval of the oversight committee, by the Commissioner of Health.

§24–803.

The Program shall:

(1) Be designed and maintained to provide security measures and processes required to safely distribute hypodermic needles and syringes and account for the number of hypodermic needles and syringes exchanged and distributed by the Baltimore City Health Department and the number of hypodermic needles and syringes in storage;

(2) Be operated to allow participants to exchange used hypodermic needles and syringes at available mobile syringe services sites;

(3) Include appropriate levels of staff expertise in working with injecting drug users and adequate staff training in providing community service provider referrals, counseling, and preventive education;

(4) Provide for the dissemination of other preventive means for decreasing the risk of HIV transmission;

(5) Provide referrals to drug counseling and treatment services, and follow–up to those referrals to assure that participants receive the treatment they desire;

(6) Educate injecting drug users on the risk of transmitting HIV or the hepatitis B virus through high–risk needle–sharing practices and sexual behaviors;

(7) Include policies and procedures for the screening of applicants to the Program in order to preclude noninjecting drug users from participating in the Program; and

(8) Implement procedures for identifying Program participants that are consistent with the confidentiality provisions of this subtitle.

§24–804.

(a) The Mayor of Baltimore City shall appoint an oversight committee for the Program.

(b) The oversight committee shall consist of:

(1) One representative from academia who specializes in public health issues;

(2) One representative from law enforcement;

(3) One representative from the Maryland Department of Health;

(4) One representative of a Baltimore City community group;

(5) One representative of an HIV advocacy group;

(6) One addiction treatment counselor;

(7) One recovering injecting drug user; and

(8) Up to three other individuals whom the Baltimore City Health Department determines to be appropriate for appointment to the oversight committee.

(c) The oversight committee shall:

(1) Provide advice to the Commissioner of Health and the Program Director on developing and revising as necessary:

(i) Program operating procedures for the distribution and exchange of hypodermic needles and syringes to injecting drug users;

(ii) A plan for community outreach and education;

(iii) A protocol for providing referrals for Program participants to addiction treatment and rehabilitation; and

(iv) A plan for evaluating the Program; and

(2) Provide ongoing oversight of the Program and make recommendations to the Program Director or the Commissioner of Health regarding any aspect of Program procedures, operation, or evaluation.

§24–805.

(a) The Commissioner of Health shall appoint a Director for the Program.

(b) With the advice of the oversight committee, the Director shall develop and revise as necessary:

(1) Program operating procedures for the distribution and exchange of hypodermic needles and syringes to injecting drug users;

(2) A community outreach and education program; and

(3) A protocol for providing referrals for Program participants to substance use treatment and rehabilitation.

(c) The Director shall submit the operating procedures, the plan for a community outreach and education program, and the substance use treatment referral protocol to the Commissioner of Health or the Commissioner's designee for approval prior to the implementation of revised procedures.

§24–806.

(a) The Baltimore City Health Department shall include in its Program operating procedures measures to collect the following data:

(1) The number of participants served by the Program;

(2) The length of time a participant is served by the Program;

(3) Demographic profiles of participants served by the Program that include:

(i) Age;

(ii) Sex;

(iii) Race; and

(iv) Zip code of residence;

(4) The number of hypodermic needles and syringes exchanged;

(5) The number of participants referred to addiction treatment; and

(6) The number of referrals made by the Program for addiction treatment for people who inject drugs.

(b) With the advice of the oversight committee, the Baltimore City Health Department shall develop and implement a plan for Program evaluation that shall include the following issues:

(1) The estimated prevalence and incidence of HIV among Program participants;

(2) The strengths and weaknesses of the Program; and

(3) The advisability of continuing the Program.

(c) As part of its plans for data collection and Program evaluation described under subsections (a) and (b) of this section, the Baltimore City Health Department shall develop and implement a methodology to collect returned needles and syringes and send them to the Rapid Analysis of Drugs program operated by the Center for Harm Reduction at the Maryland Department of Health.

(d) On or before December 31 of each year, the Baltimore City Health Department shall report to the oversight committee, the Governor, and, in accordance with § 2–1257 of the State Government Article, the General Assembly, on the number of hypodermic needles and syringes exchanged as part of the Program.

§24–807.

(a) (1) Each Program participant shall be issued an identification card with an identification number.

(2) The identification number shall be cross-indexed to a confidential record containing pertinent data on the participant.

(b) Any information obtained by the Program that would identify Program participants, including Program records, is:

(1) Confidential;

(2) Not open to public inspection or disclosure; and

(3) Not discoverable in any criminal or civil proceeding.

(c) (1) Notwithstanding the provisions of subsection (b) of this section, upon the written consent of a Program participant, information obtained by the Program that identifies the Program participant may be released or disclosed to a person or agency participating in the Program.

(2) In addition to the provisions of paragraph (1) of this subsection, if a Program participant raises the issue of participation in the Program either as a subject matter or legal defense in an administrative, civil, or criminal proceeding, the Program participant waives the confidentiality as to identity provided under subsection (b)(1) of this section.

§24–808.

No Program staff member or Program participant may be found guilty of violating § 5–601, § 5–619, § 5–620, § 5–902, or § 5–904 of the Criminal Law Article for possessing or distributing controlled paraphernalia or drug paraphernalia whenever the possession or distribution of the controlled paraphernalia or drug paraphernalia is a direct result of the employee's or participant's activities in connection with the work of the Program authorized under this subtitle.

§24–809.

Except for violations of any laws that could arise from residue attached to or contained within hypodermic needles or syringes being returned or already returned to the Program, this subtitle does not provide immunity to a Program staff member or Program participant from criminal prosecution for a violation of any law prohibiting or regulating the use, possession, dispensing, distribution, or promotion of illicit drugs.

§24–901.

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

(b) "Community–based organization" means a public or private organization that is representative of a community or significant segments of a community and provides educational, health, or social services to individuals in the community.

(c) "Drug" has the meaning stated in § 8–101 of this article.

(d) "HIV" means the human immunodeficiency virus that causes acquired immune deficiency syndrome (AIDS).

(e) "Participant" means an individual who has registered with a Program.

(f) "Program" means an Opioid–Associated Disease Prevention and Outreach Program.

(g) "Residue" means the remains of a controlled dangerous substance attached to or contained within a hypodermic needle or syringe.

(h) "Substance–related disorder" has the meaning stated in § 7.5–101 of this article.

(i) "Viral hepatitis" means inflammation of the liver caused by the hepatitis A, B, C, D, and E viruses.

§24–902.

(a) (1) A Program may be established by a local health department or a community–based organization, subject to the provisions of this subtitle.

(2) (i) A county may cooperate with another county to establish a Program.

(ii) A community–based organization may establish a multicounty Program.

(3) This subtitle does not apply to the AIDS Prevention Sterile Needle and Syringe Exchange Pilot Program established under Subtitle 8 of this title.

(b) (1) (i) A local health department or community–based organization shall apply to the Department and a local health officer for authorization to operate a Program.

(ii) A local health department or community–based organization may apply at any time for authorization to operate a Program under subparagraph (i) of this paragraph.

(2) The Department and a local health officer jointly shall issue an authorization determination based on the ability of a Program to meet the requirements of this subtitle.

(3) The Department and a local health officer shall:

(i) Approve or deny an application for authorization to operate a Program within 60 days after receiving a complete application; and

(ii) Provide to the applicant a written explanation of the decision of the Department and local health officer.

(4) (i) A local health department or community–based organization may appeal an adverse decision by the Department and a local health officer to the Secretary or the Secretary's designee.

(ii) The Secretary or the Secretary's designee shall:

1. Grant or deny an appeal within 60 days after receiving an appeal; and

2. Provide a written explanation of the Secretary's or the Secretary's designee's decision to the local health department or community–based organization.

(c) If established under subsection (a) of this section, a Program shall:

(1) Provide for substance use outreach, education, and linkage to treatment services to participants, including distribution and collection of hypodermic needles and syringes; and

(2) Operate in accordance with:

(i) The technical assistance of the Standing Advisory Committee; and

(ii) The procedures, plans, and protocols approved by:

1. The local health officer for each county in which a Program is established; and

2. The Department.

§24–903.

(a) A Program shall:

(1) Be designed and maintained to provide security of Program locations and equipment, in accordance with regulations adopted by the Department;

(2) Be operated to allow participants to obtain and return hypodermic needles and syringes at any Program location, if more than one location is available;

(3) Include appropriate levels of staff expertise in working with individuals who inject drugs;

(4) Include adequate staff training in providing community referrals, counseling, and preventive education;

(5) Provide for the dissemination of other preventive means for curtailing the spread of HIV and viral hepatitis;

(6) Provide linkage to additional services, including:

(i) Substance–related disorder counseling, treatment, and recovery services;

(ii) Testing for HIV, viral hepatitis, and sexually transmitted diseases;

(iii) Reproductive health education and services;

(iv) Wound care; and

(v) The services of an overdose response program under Title 13, Subtitle 31 of this article;

(7) Educate participants on the dangers of contracting HIV and viral hepatitis;

(8) Provide overdose prevention education and access to naloxone, or a referral for a participant to obtain naloxone;

(9) Establish procedures for identifying Program participants that are consistent with the confidentiality provisions of this subtitle;

(10) Establish a method of identification and authorization for Program staff members and Program volunteers who have access to hypodermic needles, syringes, or Program records; and

(11) Develop a plan for data collection and Program evaluation in accordance with regulations adopted by the Department.

(b) A Program may offer additional services, including:

(1) Substance–related disorder counseling, treatment, and recovery services;

(2) Testing for HIV, viral hepatitis, and sexually transmitted diseases;

(3) Reproductive health education and services;

(4) Wound care; and

(5) The services of an overdose response program under Title 13, Subtitle 31 of this article.

(c) With the technical assistance of the Standing Advisory Committee, a Program shall develop:

(1) Program operating procedures for the distribution, collection, and safe disposal of hypodermic needles and syringes;

(2) A community outreach and education plan; and

(3) A protocol for linking Program participants to substance–related disorder treatment and recovery services.

(d) After receiving technical assistance from the Standing Advisory Committee, a Program shall submit the operating procedures, plan for community outreach and education, and protocol for linking Program participants to substance–related disorder treatment and recovery services developed under subsection (c) of this section for approval to:

(1) The local health officer for each county in which a Program is established; and

(2) The Department.

§24–904.

(a) The Department shall appoint a Standing Advisory Committee on Opioid–Associated Disease Prevention and Outreach Programs.

(b) The Standing Advisory Committee shall consist of:

(1) The Secretary or the Secretary's designee;

(2) One individual from academia who specializes in public health issues related to substance–related disorders or infectious diseases;

(3) One representative from law enforcement, nominated by the Executive Director of the Governor's Office of Crime Prevention and Policy;

(4) One individual with expertise in the prevention of HIV or viral hepatitis;

(5) One health care practitioner with experience providing services to individuals who inject drugs;

(6) One individual with substance use experience;

(7) One family member of an individual who injects or has injected drugs;

(8) One representative of local law enforcement;

(9) One local health officer;

(10) One representative of a local or regional hospital;

(11) One individual with experience in syringe services programs; and

(12) Any additional members recommended by the Department.

(c) The Secretary or the Secretary's designee shall serve as chair of the Standing Advisory Committee.

(d) The Standing Advisory Committee shall:

(1) Provide technical assistance to each Program on developing:

(i) Program operating procedures for collection and distribution of hypodermic needles and syringes;

(ii) A plan for community outreach and education; and

(iii) A protocol for linking Program participants to substance–related disorder treatment and recovery services; and

(2) Make recommendations to a Program regarding any aspect of Program procedures or operation.

§24–905.

(a) The Department shall:

(1) Adopt regulations for the implementation of this subtitle, in consultation with the Standing Advisory Committee and the Maryland Association of County Health Officers; and

(2) Ensure the provision of technical assistance to a Program about best practices, best practice protocols, and other subject areas.

(b) The regulations adopted under subsection (a)(1) of this section shall establish:

(1) Procedures for ensuring the security of Program locations and equipment;

(2) An appeals process for appeals authorized by § 24–902(b)(4) of this subtitle, including the standard of review that the Secretary or the Secretary's designee must apply when reviewing a decision of the Department and a local health officer; and

(3) Procedures for data collection and Program evaluation.

§24–906.

(a) (1) Each Program participant shall be issued a unique identification card with a unique identification number.

(2) The unique identification number may not be cross–indexed to any personal identifying data on the participant.

(b) Any information obtained by a Program that identifies Program participants, including Program records, is:

(1) Confidential;

(2) Not open to public inspection or disclosure; and

(3) Not discoverable in any criminal or civil proceeding.

(c) (1) Notwithstanding the provisions of subsection (b) of this section, on the written consent of a Program participant, information obtained by a Program that identifies the Program participant may be released or disclosed to an individual or agency for purposes of linking to services under § 24–903(a)(6) of this subtitle.

(2) In addition to the provisions of paragraph (1) of this subsection, if a Program participant raises the issue of participation in a Program either as a subject matter or legal defense in an administrative, civil, or criminal proceeding, the Program participant waives the confidentiality as to identity provided under subsection (b) of this section.

(3) Substance–related treatment records requested or provided under this section are subject to any additional limitations on disclosure or re–disclosure of a medical record developed in connection with the provision of substance–related treatment services under State law or 42 U.S.C. § 290dd–2 and 42 C.F.R. Part 2.

§24–907.

A Program shall collect and report at least annually the following data to the Department:

(1) The number of participants served by the Program;

(2) The number of new participants registered by the Program during the reporting period;

(3) Demographic profiles of participants served by the Program, including:

(i) Age;

(ii) Gender;

(iii) Race;

(iv) Zip code; and

(v) Types of drugs used;

(4) The number of hypodermic needles and syringes distributed and collected;

(5) Each location at which hypodermic needles and syringes were distributed; and

(6) The number of linkages provided to participants under § 24–903(a)(6) of this subtitle.

§24–908.

(a) A Program staff member, Program volunteer, or Program participant may not be arrested, charged, or prosecuted for violating § 5–601, § 5–619, § 5–620, or § 5–902(c) or (d) of the Criminal Law Article for possessing or distributing controlled paraphernalia or drug paraphernalia whenever the possession or distribution of the controlled paraphernalia or drug paraphernalia is a direct result of the employee's, volunteer's, or participant's activities in connection with the work of a Program authorized under this subtitle.

(b) Notwithstanding the provisions of subsection (a) of this section, a Program staff member, Program volunteer, or Program participant is not immune from criminal prosecution for any activities not authorized or approved by a Program.

§24–909.

Except for violations of any laws that could arise from residue attached to or contained within hypodermic needles or syringes being returned or already returned to a Program, nothing in this subtitle provides immunity to a Program staff member, Program volunteer, or Program participant from criminal prosecution for a violation of any law prohibiting or regulating the use, possession, dispensing, distribution, or promotion of controlled dangerous substances, dangerous drugs, detrimental drugs, or harmful drugs or any conspiracy or attempt to commit any of those offenses.

§24–1001.

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

(b) "Assisted living facility" means a residential facility or facility-based program that:

(1) Meets the definition in § 19-1801 of this article; and

(2) Is licensed by the Department.

(c) "Facility" means an assisted living facility that is wholly owned by and operated under the authority of:

(1) A county;

(2) A municipal corporation; or

(3) A nonprofit organization.

(d) "Nonprofit organization" means:

(1) A bona fide religious organization, no part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of a facility, the purchase of equipment to be used in a facility, or the expansion of a facility; or

(2) An organization:

(i) That is chartered as a nonprofit corporation and classified by the Internal Revenue Service as nonprofit; and

(ii) No part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of a facility, the purchase of equipment to be used in a facility, or the expansion of a facility.

(e) "Wholly owned" includes leased, if:

(1) (i) The lease is for a minimum term of 30 years following project completion; or

(ii) The lease agreement extends the right of purchase to the lessee; and

(2) The lessor consents to the recording in the land records of the county or Baltimore City in which the facility is located, of a notice of the State's right of recovery as provided under § 24-1006 of this subtitle.

§24–1002.

On the recommendation of the Secretary, the Board of Public Works may make grants to counties, municipal corporations, and nonprofit organizations for:

(1) The conversion of public buildings or parts of buildings to assisted living facilities;

(2) The acquisition of existing buildings or parts of buildings for use as assisted living facilities;

(3) The renovation of assisted living facilities;

(4) The purchase of capital equipment for assisted living facilities; or

(5) The planning, design, and construction of assisted living facilities.

§24–1003.

(a) Any county, municipal corporation, or nonprofit organization sponsoring a project involving work specified in § 24-1002 of this subtitle may apply to the Secretary for a State grant to be applied toward the cost of that project.

(b) On approval of a project and the project plans by the Department, the Secretary shall promptly report the application to the Board of Public Works, together with the Secretary's recommendation that the Board make funds available as provided in this subtitle.

§24–1004.

(a) The allocation and use of State funds under this subtitle are subject to the following terms and conditions.

(b) If the local government and the Department certify to the Board of Public Works that a surplus public building appropriate for use as an assisted living facility does not exist in the area in which the facility is to be located, State funds may be used to:

(1) Acquire an existing building or part of a building for use as an assisted living facility; or

(2) Plan, design, and construct an assisted living facility.

(c) Any federal or other grant that is received for an eligible project shall be applied first to the cost of the project.

(d) Except as provided in subsections (e) and (f) of this section, a State grant may not exceed 50% of the cost of eligible work remaining unpaid after all federal and other grants have been applied.

(e) At the discretion of the Board of Public Works, a State grant may exceed 50% of the cost of eligible work remaining unpaid after all federal and other grants have been applied, if:

(1) The project involves the conversion of a public building or part of a building to an assisted living facility, the renovation of an assisted living facility, or the planning, design, and construction of an assisted living facility;

(2) The value of real property and improvements made available by the local government, or the value of the center to be renovated, equals or exceeds the amount of the State grant;

(3) State funds have not been used for the acquisition, construction, or maintenance of any real property and improvements made available by the local government or any building to be converted or renovated; and

(4) The State is not responsible for any bonded indebtedness in connection with any real property and improvements made available by the local government or any building to be converted or renovated.

(f) For a project designated as eligible for poverty area funding under federal regulations, State plans, or departmental regulations, a State grant may cover up to 75% of the cost of eligible work remaining unpaid after all federal and other grants have been applied.

(g) The amount of the State grant for any project shall be determined after consideration of:

(1) All eligible applications;

(2) The total of unallocated State funds available at the time the application is received; and

(3) The priorities of area need established by the Department.

(h) (1) No portion of the proceeds of a State grant may be used:

(i) To further sectarian religious instruction;

(ii) In connection with the design, acquisition, or construction of any building to be used as a place of sectarian religious worship or instruction; or

(iii) In connection with any program or department of divinity for any religious denomination.

(2) On the request of the Board of Public Works, the applicant shall submit evidence satisfactory to the Board that the proceeds of the grant are not being used for a purpose prohibited under this subsection.

§24–1005.

(a) The Board of Public Works shall make allocations from funds available under this subtitle in accordance with this subtitle.

(b) The Board shall certify the allocations to the proper State officers, and the Treasurer shall make payments to or on behalf of the applicant, when needed, for the approved project.

(c) The Board of Public Works may adopt regulations to implement this section.

§24–1006.

(a) The State may recover from either the transferor or transferee or, in the case of a property that has ceased to be a "facility", from the owner, an amount bearing the same ratio to the then current value of so much of the property as constituted an approved project as the amount of the State participation bore to the total eligible cost of the approved project, together with all costs and reasonable attorney's fees incurred by the State in the recovery proceedings, if, within 30 years after completion of a project, a property for which funds have been paid under this subtitle:

(1) Is sold or transferred to any person, agency, or organization that would not qualify as an applicant under this subtitle, or that is not approved as a transferee by the Board of Public Works; or

(2) Ceases to be a "facility" as defined in this subtitle.

(b) (1) Before the State makes any funds available for an approved project, the Department shall cause a notice of this right of recovery to be recorded in the land records of the county or Baltimore City in which the property is located.

(2) The recording of the notice:

(i) Does not create a lien against the property; but

(ii) Shall constitute notice to any potential transferee, potential transferor, potential creditor, or other interested party of the possibility that the State may obtain a lien under this subtitle.

(c) (1) (i) The Secretary of the Board of Public Works may file a civil claim under subsection (b) of this section, in the circuit court for the county or Baltimore City in which the property is located, against the owner of the property and any other interested parties, including any transferor that the State wishes to make a party.

(ii) The claim shall be filed with:

1. Sworn affidavits stating facts on which the allegations of default are based; and

2. A detailed justification of the amount claimed.

(2) If the circuit court determines from the State's initial filing that there is probable cause to believe that a default has occurred, pending full determination of the State's claim, the court shall authorize a temporary lien on the property:

(i) In the amount of the State's claim plus any additional amount estimated to be necessary to cover the costs and reasonable attorney's fees incurred by the State; or

(ii) In other amounts that the court determines to be reasonable.

(3) (i) A temporary lien shall take effect:

1. On the date of the court's authorization, if the Secretary of the Board of Public Works records a notice of temporary lien in the land records of the county or Baltimore City in which the property is located within 10 days after the court's authorization; or

2. On the date a notice of temporary lien is recorded.

(ii) While the temporary lien is in effect, neither the owner nor any person who acquired an interest in the property after the State first made funds available in connection with the property may without the prior written consent of the State:

1. Take any action that would affect the title to the property; or

2. Institute any proceedings to enforce a security interest or other similar rights in the property.

(4) (i) The owner of the property or any other interested party may obtain release of a temporary lien at any time by filing with the court a bond securing the payment in full of the State's claim and any additional amount necessary to cover the costs and reasonable attorney's fees incurred by the State.

(ii) The owner or other interested party may cause the release to be recorded in the land records.

(d) Proceedings to determine the State's right to recover and the amount of its recovery under this subtitle shall have priority over other civil proceedings in the circuit courts.

(e) (1) (i) At the conclusion of full adversary proceedings on the issue of default and of any disputes over the amount of the State's recovery, the circuit court shall, if it finds that a default has occurred, issue a final judgment for the amount it finds to be recoverable by the State.

(ii) All parties involved in the default, including in every case the owner of the property, shall be held jointly and severally liable to the State for the amount of the judgment.

(2) (i) Except as the State may otherwise provide by a written subordination agreement, if the amount of the final judgment remains unpaid after 30 days following the court's final order, the final judgment shall constitute a lien on the property, superior to the lien or other interest of a mortgagee, pledgee, purchaser, or judgment creditor whose interest became perfected against third persons after the State first made funds available under this subtitle.

(ii) 1. Except as provided in item 2 of this item, a lien takes effect on the date a notice of lien is recorded.

2. A lien takes effect on the 31st day following the court's final order if the Secretary of the Board of Public Works records a notice of lien in the land records of the county or Baltimore City in which the property is located on or before the 41st day following the final order.

(iii) 1. At the time that a lien takes effect, any temporary lien then in effect shall be automatically and fully released.

2. The recorded notice of a lien shall constitute notice of the release of a temporary lien.

(iv) A lien imposed under this subsection may be enforced and foreclosed in accordance with the procedures prescribed in the Maryland Rules, except that neither the State nor any agent appointed by the State to sell the property need file a bond.

(3) (i) The owner or any other interested party may obtain release of a lien at any time by paying to the State the full amount of the judgment rendered by the circuit court, together with interest from the date of judgment.

(ii) On payment in full, the Secretary of the Board of Public Works shall cause a release to be recorded in the land records.

(4) If the circuit court finds that there has been no default or if the full amount of the court's judgment is paid to the State within 30 days after the court's final order, a temporary lien then in effect shall be released immediately and the Secretary of the Board of Public Works shall cause the release to be recorded in the land records.

(f) (1) All funds recovered as a result of this right of recovery shall be deposited in the Annuity Bond Fund and applied to the debt service requirements of the State.

(2) If the Board determines that there is good cause for releasing the transferor, transferee, or owner from the obligation imposed under this subtitle, the Board of Public Works may waive the State's right of recovery under this subtitle.

§24–1007.

The Department shall adopt regulations to implement the provisions of this subtitle.

§24–1101.

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

(b) "Proceeds" means the gross proceeds minus the costs associated with the sale, lease, or disposition of property and equipment, as determined by the Department of General Services.

(c) "Trust Fund" means the Community Services Trust Fund.

§24–1102.

(a) There is a Community Services Trust Fund in the Office of the Treasurer.

(b) The purpose of the Trust Fund is to receive and hold the proceeds from the sale or long–term lease of property and equipment of a Developmental Disabilities Administration facility or a Behavioral Health Administration facility.

§24–1103.

(a) The Trust Fund is a continuing, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.

(b) (1) The Treasurer shall hold the Trust Fund and the Comptroller shall account for the Trust Fund.

(2) (i) The Trust Fund shall be invested and reinvested in the same manner as other State funds.

(ii) Any investment earnings of the Trust Fund shall be paid into the Trust Fund.

(3) The Treasurer shall deposit funds into the two accounts of the Trust Fund in accordance with § 24-1104 of this subtitle.

§24–1104.

(a) The Trust Fund consists of two accounts.

(b) (1) One account holds the proceeds from the sale or long–term lease of property and equipment resulting from the sale or long–term lease of Developmental Disabilities Administration facilities.

(2) One account holds the proceeds from the sale or long–term lease of property and equipment resulting from the sale or long–term lease of Behavioral Health Administration facilities.

§24–1105.

(a) The Trust Fund may only be used in accordance with this section.

(b) In accordance with an appropriation approved by the General Assembly in the State budget, the Comptroller shall transfer:

(1) The investment earnings of the Developmental Disabilities Administration account of the Trust Fund into the Waiting List Equity Fund established under § 7–205 of this article; and

(2) The proceeds and investment earnings of the Behavioral Health Administration account of the Trust Fund into the Mental Health Community–Based Services Fund established under § 10–208 of this article.

(c) For fiscal year 2026 only, the Developmental Disabilities Administration may use money in the Trust Fund for provider reimbursements.

§24–1201.

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

(b) "Health and Human Services Referral System" means a coordinated system for health and human service resources accessible to all State residents through 2–1–1 and other designated technology systems.

(c) "2–1–1" means the abbreviated dialing code assigned by the Federal Communications Commission for consumer access to community information and referral services.

(d) "2–1–1 Maryland" means the Maryland Information Network, 2–1–1 Maryland, a 501(c)(3) corporation in the State that administers the 2–1–1 system.

(e) "2–1–1 Maryland call center" means a nonprofit agency or organization designated by 2–1–1 Maryland to provide 2–1–1 services.

§24–1202.

(a) The General Assembly:

(1) Recognizes the importance of a statewide information and referral system for health and human services;

(2) Recognizes that an integrated technology system would provide access to a single source for information and referral to health and human services, community preparedness, and behavioral health care coordination and could be accessed toll free from anywhere in Maryland, 24 hours a day, 365 days a year;

(3) Acknowledges that the three–digit number, 2–1–1, is a nationally recognized and applied telephone number which may be used for information and referral and eliminates delays caused by lack of familiarity with health and human services numbers and by understandable confusion in circumstances of crisis; and

(4) Recognizes a demonstrated need for an easy to remember, easy to use telephone number that will enable individuals in need to be directed to available community resources.

(b) The purpose of this subtitle is to establish the three–digit number, 2–1–1, as the primary information and referral telephone number for health and human services in the State.

§24–1203.

(a) Except as provided in subsection (c) of this section, an agency or organization shall be approved by 2–1–1 Maryland as a 2–1–1 Maryland call center in order to provide 2–1–1 services in the State.

(b) When approving a 2–1–1 service provider, 2–1–1 Maryland shall consider:

(1) The ability of the proposed 2–1–1 service provider to meet the national 2–1–1 standards recommended by:

(i) The Alliance of Information and Referral Systems and adopted by the National 2–1–1 Collaborative; or

(ii) An equivalent entity;

(2) The financial stability of the proposed 2–1–1 service provider;

(3) Any community support for the proposed 2–1–1 service provider;

(4) Any experience that the proposed 2–1–1 service provider has with other information and referral services;

(5) The degree to which the county in which the proposed call center is to be located has dedicated substantial resources to the establishment of a single telephone source for non–emergency inquiries regarding county services; and

(6) Any other criteria that 2–1–1 Maryland considers appropriate.

(c) If an agency of the State that provides health and human services establishes a public information telephone line or hotline, the agency shall consult with 2–1–1 Maryland about using the 2–1–1 system to provide public access to information.

§24–1204.

(a) The Department shall, in consultation with 2–1–1 Maryland, as appropriate:

(1) Maintain public information available from State agencies, programs, and departments that provide health and human services;

(2) Support projects and activities that further the development of 2–1–1 Maryland;

(3) Examine and make recommendations to maximize the use of information technology in making 2–1–1 services available throughout the State; and

(4) Make recommendations to 2–1–1 Maryland regarding the establishment of an opt–in mental health services phone call program that:

(i) Requires a call center to call individuals who have opted in to the mental health services phone call program on a periodic basis, as determined by 2–1–1 Maryland; and

(ii) Attempts to connect individuals to a provider of mental health services if the individual requests to speak to a mental health provider during a call with 2–1–1 Maryland.

(b) The Governor may include in the annual budget bill an appropriation to the Department in an amount sufficient to carry out subsection (a)(4) of this section.

(c) On or before December 31, 2005, and every year thereafter, the Department, in consultation with 2–1–1 Maryland, shall report to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly on the activities performed under subsection (a) of this section.

§24–1205.

Funding for the Department's implementation of this subtitle is subject to:

(1) The availability of appropriated funds; and

(2) Audit by the Office of Legislative Audits under § 2–1220 of the State Government Article.

§24–1301.

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

(b) "Federally qualified health center" means a health center that is:

(1) Designated as a federally qualified health center under § 330 of the federal Public Health Service Act, 42 U.S.C. § 254b; and

(2) Wholly owned by and operated under the authority of a county, municipal corporation, or nonprofit organization.

(c) "Nonprofit organization" means:

(1) A bona fide religious organization, no part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of a facility, the purchase of equipment to be used in a facility, or the expansion of a facility; or

(2) An organization:

(i) That is chartered as a nonprofit corporation and classified by the Internal Revenue Service as nonprofit; and

(ii) No part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of a facility, the purchase of equipment to be used in a facility, or the expansion of a facility.

(d) "Wholly owned" includes leased, if:

(1) (i) The lease is for a minimum term of 15 years following project completion; or

(ii) The lease agreement extends the right of purchase to the lessee; and

(2) The lessor consents to the recording, in the land records of the county or Baltimore City where the facility is located, of a notice of the State's right of recovery as provided under § 24–1306 of this subtitle.

§24–1302.

(a) There is a Federally Qualified Health Centers Grant Program.

(b) On the recommendation of the Secretary, the Board of Public Works may make grants to counties, municipal corporations, and nonprofit organizations for:

(1) The conversion of public buildings or parts of public buildings to federally qualified health centers;

(2) The acquisition of existing buildings or parts of buildings for use as federally qualified health centers;

(3) The renovation of federally qualified health centers;

(4) The purchase of capital equipment for federally qualified health centers;

(5) The planning, design, and construction of federally qualified health centers; or

(6) The acquisition of land for the construction or use of a federally qualified health center.

§24–1303.

(a) Any county, municipal corporation, or nonprofit organization sponsoring a project involving work specified in § 24-1302 of this subtitle may apply to the Secretary for a State grant to be applied toward the cost of that project.

(b) The application for a grant shall include:

(1) Project plans for the work to be carried out;

(2) A statement listing the personnel employed or to be employed at the federally qualified health center, including all remuneration and perquisites for personal services and all other expenses paid or to be paid to the personnel;

(3) All other expenses incurred or to be incurred in operating the federally qualified health center; and

(4) The schedule of rates charged or to be charged for services rendered.

(c) On approval of a project and the project plans, the Secretary shall promptly report the application to the Board of Public Works, together with the Secretary's recommendation that the Board make funds available as provided in this subtitle.

§24–1304.

(a) The allocation and use of State funds under this subtitle are subject to the terms and conditions set forth in this section.

(b) State funds may only be used for the purposes listed under § 24–1302 of this subtitle and approved by the Secretary under § 24–1303 of this subtitle.

(c) The allocation and use of State funds under this subtitle are subject to the following terms and conditions:

(1) Any federal or other grant that is received for an eligible project shall be applied first to the cost of the project;

(2) Except as provided in subsection (d) of this section, a State grant may not exceed 75% of the cost of eligible work remaining unpaid after all federal grants have been applied; and

(3) For purposes of this subtitle, community development block grant funds shall be considered as local matching funds and may not be considered as federal grant funds.

(d) For a project designated as eligible for poverty area funding under federal regulations, State plans, or departmental regulations, a State grant may cover up to 90% of the cost of eligible work remaining unpaid after all federal grants have been applied.

(e) The amount of the State grant recommended to the Board of Public Works for any project shall be determined after consideration of:

(1) All eligible projects;

(2) The total of unallocated State funds available at the time the grant recommendation is made to the Board of Public Works; and

(3) The priorities of area need established by the Department.

(f) (1) No portion of the proceeds of a State grant may be used:

(i) To further sectarian religious instruction;

(ii) In connection with the design, acquisition, or construction of any building to be used as a place of sectarian religious worship or instruction; or

(iii) In connection with any program or department of divinity for any religious denomination.

(2) On the request of the Board of Public Works, the applicant shall submit evidence satisfactory to the Board that the proceeds of the grant are not being used for a purpose prohibited under this subsection or under applicable federal law.

(g) Beginning in fiscal year 2007 and continuing every fiscal year thereafter, the Governor shall include an appropriation in the State capital budget to be distributed and managed in accordance with this subtitle.

§24–1305.

(a) The Board of Public Works shall make allocations from funds available under this subtitle in accordance with this subtitle.

(b) The Board shall certify the allocations to the proper State officers, and the Treasurer shall make payments to or on behalf of the applicant, when needed, for the approved project.

(c) The Board of Public Works may adopt regulations to implement this section.

§24–1306.

(a) (1) Except as provided in paragraph (2) of this subsection, the State may recover from either the transferor or transferee or, in the case of a property that has ceased to be a federally qualified health center, from the owner, an amount bearing the same ratio to the then current value of so much of the property as constituted an approved project as the amount of the State participation bore to the total eligible cost of the approved project, together with all costs and reasonable attorneys' fees incurred by the State in the recovery proceedings, if a property for which funds have been paid under this subtitle:

(i) Is sold or transferred to any person, agency, or organization that would not qualify as an applicant under this subtitle, or that is not approved as a transferee by the Board of Public Works; or

(ii) Ceases to be a federally qualified health center as defined in this subtitle.

(2) The State may not recover under paragraph (1) of this subsection:

(i) If the property was leased by the federally qualified health center, more than 15 years after completion of the project; or

(ii) If the property was owned by the federally qualified health center, more than 30 years after completion of the project.

(b) (1) Before the State makes any funds available for an approved project, the Department shall cause a notice of this right of recovery to be recorded in the land records of the county or Baltimore City where the property is located.

(2) The recording of the notice:

(i) Does not create a lien against the property; but

(ii) Shall constitute notice to any potential transferee, potential transferor, potential creditor, or other interested party of the possibility that the State may obtain a lien under this subtitle.

(c) (1) (i) The Secretary of the Board of Public Works may file a civil complaint under subsection (b) of this section, in the circuit court for the county or Baltimore City where the property is located, against the owner of the property and any other interested parties, including any transferor that the State wishes to make a party.

(ii) The complaint shall be filed with:

1. Sworn affidavits stating facts on which the allegations of default are based; and

2. A detailed justification of the amount claimed.

(2) If the circuit court determines from the State's initial filing that a default has occurred, pending full determination of the State's claim, the court shall authorize a temporary lien on the property:

(i) In the amount of the State's complaint plus any additional amount estimated to be necessary to cover the costs and reasonable attorneys' fees incurred by the State; or

(ii) In other amounts that the court determines to be reasonable.

(3) (i) A temporary lien shall take effect:

1. On the date of the court's authorization, if the Secretary of the Board of Public Works records a notice of temporary lien in the land

records of the county or Baltimore City where the property is located within 10 days after the court's authorization; or

2. On the date a notice of temporary lien is recorded.

(ii) While the temporary lien is in effect, neither the owner nor any person who acquired an interest in the property after the State first made funds available in connection with the property may, without the prior written consent of the State:

1. Take any action that would affect the title to the property; or

2. Institute any proceedings to enforce a security interest or other similar rights in the property.

(4) (i) The owner of the property or any other interested party may obtain release of a temporary lien at any time by filing with the court a bond securing the payment in full of the State's claim and any additional amount necessary to cover the costs and reasonable attorneys' fees incurred by the State.

(ii) The owner or other interested party may cause the release to be recorded in the land records.

(d) Proceedings to determine the State's right to recover and the amount of its recovery under this subtitle shall have priority over other civil proceedings in the circuit courts.

(e) (1) (i) At the conclusion of full adversary proceedings on the issue of default and of any disputes over the amount of the State's recovery, the circuit court shall, if it finds that a default has occurred, issue a final judgment for the amount it finds to be recoverable by the State.

(ii) All parties involved in the default, including in every case the owner of the property, shall be held jointly and severally liable to the State for the amount of the judgment.

(2) (i) Except as the State may otherwise provide by a written subordination agreement, if the amount of the final judgment remains unpaid after 30 days following the court's final order, the final judgment shall constitute a lien on the property, superior to the lien or other interest of a mortgagee, pledgee, purchaser, or judgment creditor whose interest became perfected against third persons after the State first made funds available under this subtitle.

(ii) 1. Except as provided in subsubparagraph 2 of this subparagraph, a lien takes effect on the date a notice of lien is recorded.

2. A lien takes effect on the 31st day following the court's final order if the Secretary of the Board of Public Works records a notice of lien in the land records of the county or Baltimore City where the property is located on or before the 41st day following the final order.

(iii) 1. At the time that a lien takes effect, any temporary lien then in effect shall be automatically and fully released.

2. The recorded notice of a lien shall constitute notice of the release of a temporary lien.

(iv) A lien imposed under this subsection may be enforced and foreclosed in accordance with the procedures prescribed in the Maryland Rules, except that neither the State nor any agent appointed by the State to sell the property need file a bond.

(3) (i) The owner or any other interested party may obtain release of a lien at any time by paying to the State the full amount of the judgment rendered by the circuit court, together with interest from the date of judgment.

(ii) On payment in full, the Secretary of the Board of Public Works shall cause a release to be recorded in the land records.

(4) If the circuit court finds that there has been no default or if the full amount of the court's judgment is paid to the State within 30 days after the court's final order, a temporary lien then in effect shall be released immediately and the Secretary of the Board of Public Works shall cause the release to be recorded in the land records.

(f) (1) All funds recovered as a result of this right of recovery shall be deposited in the Annuity Bond Fund and applied to the debt service requirements of the State.

(2) If the Board determines that there is good cause for releasing the transferor, transferee, or owner from the obligation imposed under this subtitle, the Board of Public Works may waive the State's right of recovery under this subtitle.

§24–1307.

The Department shall adopt regulations to implement the provisions of this subtitle.

§24–1401.

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

(b) "Facility" means:

(1) (i) A public nursing facility that is wholly owned by and operated under the authority of a county or a municipal corporation, or both; or

(ii) A nonprofit nursing facility that is wholly owned by and operated under the authority of a nonprofit organization;

(2) A facility that meets the definition of § 19–1401 of this article; and

(3) A facility that is licensed by the Department.

(c) "Nonprofit organization" means:

(1) A bona fide religious organization, no part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of the facility, the purchase of equipment to be used in the facility, or the expansion of the facility; or

(2) An organization:

(i) That is chartered as a nonprofit corporation and classified by the Internal Revenue Service as nonprofit; and

(ii) No part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of the facility, the purchase of equipment to be used in the facility, or the expansion of the facility.

(d) "Wholly owned" includes leased, if:

(1) (i) The lease is for a minimum term of 30 years following project completion; or

(ii) The lease agreement extends the right of purchase to the lessee; and

(2) The lessor consents to the recording, in the land records of the political subdivision in which the facility is located, of a notice of the State's right of recovery, as provided under § 24–606 of this title; or

(3) The lease agreement is with the State for a State–owned building or State–owned property.

§24–1402.

The Board of Public Works, upon recommendation of the Secretary of the Department, may make grants to qualified applicants for the purpose of converting nursing facility beds to other health care services deemed appropriate by the Department, including the plans, specifications, site improvement, surveys, and applicable architects' and engineers' fees.

§24–1403.

(a) Any county, municipal corporation, or nonprofit organization sponsoring a project under this subtitle may apply to the Department for a State grant to be applied toward the cost of that project.

(b) The application shall be directed to the Secretary of the Department.

(c) On approval of a project and the project plans by the Department, the Secretary shall promptly report the application to the Board of Public Works, together with the Secretary's recommendation that the Board of Public Works make funds available as provided in this subtitle.

§24–1404.

(a) The allocation and use of State funds under this subtitle are subject to the following terms and conditions:

(1) State funds may be used only for projects approved by the Secretary under this subtitle.

(2) (i) Any federal grant that is available for this purpose shall be applied first to a project approved under this subtitle; or

(ii) In this subtitle, community development block grants shall be considered as local matching funds and may not be considered as federal grant funds.

(b) A State grant shall provide up to 50% of the eligible cost remaining after the federal grant has been applied, except as provided in subsection (c) of this section.

(c) For projects designated under federal regulations, State plans, or departmental regulations as eligible for poverty area funding, a State grant may cover up to 75% of the eligible cost remaining after any federal grants have been applied.

(d) The amount of the State grant for any project shall be determined after consideration of:

(1) All eligible applications;

(2) The total amount of unallocated State funds available at the time the application is received; and

(3) The priorities of area need established by the Department.

(e) (1) No portion of the proceeds of a State grant may be used:

(i) To further sectarian religious instruction; or

(ii) In connection with the design, acquisition, or construction of any buildings used or to be used as a place of sectarian religious worship or instruction.

(2) Upon the request of the Board of Public Works, the applicant shall submit evidence satisfactory to the Board of Public Works that none of the proceeds of the grant have been or are being used for a purpose prohibited by this subtitle.

§24–1405.

(a) The Board of Public Works shall make allocations from funds available under this subtitle in accordance with this subtitle.

(b) The Board of Public Works shall certify the allocations to the proper State officers, and the Treasurer shall make payments to the applicant, when needed, for the construction, acquisition, renovation, or equipping of a facility.

(c) The Board of Public Works may adopt regulations for receiving and considering applications and for disbursing funds to applicants.

§24–1406.

(a) In accordance with this section, the State shall have the right to recover funds disbursed under this subtitle.

(b) In the event of failure to complete a project or failure to commence operation of a facility, the State may recover from the recipient of the funds disbursed for the project or facility or from the owner of the property an amount equal to the amount of State funds disbursed for the project, together with all costs and reasonable attorneys' fees incurred by the State in the recovery proceedings.

(c) The State may recover from either the transferor or transferee or, in the case of a property that has ceased to be a facility, from the owner, an amount bearing the same ratio to the then current value of so much of the property as constituted an approved project as the amount of the State participation bore to the total eligible cost of the approved project, together with all costs and reasonable attorneys' fees incurred by the State in the recovery proceedings, if, within 30 years after completion of a project, a property for which funds have been paid under this subtitle:

(1) Is sold or transferred to any person, agency, or organization that would not qualify as an applicant under this subtitle, or that is not approved as a transferee by the Board of Public Works; or

(2) Ceases to be a facility as defined in this subtitle.

(d) (1) Before the State makes any funds available for an approved project, the Department shall cause a notice of this right of recovery to be recorded in the land records of the county or Baltimore City in which the property is located.

(2) The recording of the notice:

(i) Does not create a lien against the property; but

(ii) Shall constitute notice to any potential transferee, potential transferor, potential creditor, or other interested party of the possibility that the State may obtain a lien under this subtitle.

(e) (1) (i) The Secretary of the Board of Public Works may authorize the Department to file a civil claim, in the circuit court for the county or Baltimore City in which the property is located, against the owner of the property and any other interested parties, including any transferor that the State wishes to make a party if:

1. A failure to complete the project or commence operations of the facility as described in subsection (b) of this section has occurred;

2. An alleged sale or transfer as described in subsection (c) of this section has occurred; or

3. A property is alleged to have ceased to be a facility as defined in this subtitle;

(ii) The claim shall be filed with:

1. Sworn affidavits stating facts on which the allegations of default are based; and

2. A detailed justification of the amount claimed.

(2) If the circuit court determines from the State's initial filing that there is probable cause to believe that a default has occurred, pending full determination of the State's claim, the court shall authorize a temporary lien on the property:

(i) In the amount of the State's claim plus any additional amount estimated to be necessary to cover the costs and reasonable attorneys' fees incurred by the State; or

(ii) In other amounts that the court determines to be reasonable.

(3) (i) A temporary lien shall take effect:

1. On the date of the court's authorization, if the Secretary of the Board of Public Works records a notice of temporary lien in the land records of the county or Baltimore City in which the property is located within 10 days after the court's authorization; or

2. On the date a notice of temporary lien is recorded.

(ii) While the temporary lien is in effect, the owner or any person who acquired an interest in the property after the State first made funds available in connection with the property may not without the prior written consent of the State:

1. Take any action that would affect the title to the property; or

2. Institute any proceedings to enforce a security interest or other similar rights in the property.

(4) (i) The owner of the property or any other interested party may obtain release of a temporary lien at any time by filing with the court a bond securing the payment in full of the State's claim and any additional amount necessary to cover the costs and reasonable attorneys' fees incurred by the State.

(ii) The owner or other interested party may cause the release to be recorded in the land records.

(f) Proceedings to determine the State's right to recover and the amount of its recovery under this subtitle shall have priority over other civil proceedings in the circuit courts.

(g) (1) (i) At the conclusion of full adversary proceedings on the issue of default and of any disputes over the amount of the State's recovery, the circuit court shall, if it finds that a default has occurred, issue a final judgment for the amount it finds to be recoverable by the State.

(ii) All parties involved in the default, including in every case the owner of the property, shall be held jointly and severally liable to the State for the amount of the judgment.

(2) (i) Except as the State may otherwise provide by a written subordination agreement, if the amount of the final judgment remains unpaid after 30 days following the court's final order, the final judgment shall constitute a lien on the property, superior to the lien or other interest of a mortgagee, pledgee, purchaser, or judgment creditor whose interest became perfected against third persons after the State first made funds available under this subtitle.

(ii) 1. Except as provided in subsubparagraph 2 of this subparagraph, a lien takes effect on the date a notice of lien is recorded.

2. A lien takes effect on the 31st day following the court's final order if the Secretary of the Board of Public Works records a notice of lien in the land records of the county or Baltimore City in which the property is located on or before the 41st day following the final order.

(iii) 1. At the time that a lien takes effect, any temporary lien then in effect shall be automatically and fully released.

2. The recorded notice of a lien shall constitute notice of the release of a temporary lien.

(iv) A lien imposed under this subsection may be enforced and foreclosed in accordance with the procedures prescribed in the Maryland Rules, except that neither the State nor any agent appointed by the State to sell the property need file a bond.

(3) (i) The owner or any other interested party may obtain release of a lien at any time by paying to the State the full amount of the judgment rendered by the circuit court, together with interest from the date of judgment.

(ii) On payment in full, the Secretary of the Board of Public Works shall cause a release to be recorded in the land records.

(4) If the circuit court finds that there has been no default or if the full amount of the court's judgment is paid to the State within 30 days after the court's final order, a temporary lien then in effect shall be released immediately and the Secretary of the Board of Public Works shall cause the release to be recorded in the land records.

(h) (1) All funds recovered as a result of this right of recovery shall be deposited in the Annuity Bond Fund and applied to the debt service requirements of the State.

(2) If the Board of Public Works determines that there is good cause for releasing the transferor, transferee, or owner from the obligation imposed under this subtitle, the Board of Public Works may waive the State's right of recovery under this subtitle.

§24–1407.

(a) A temporary delicensure of licensed bed capacity of a facility under this subtitle does not require a certificate of need review.

(b) The Maryland Health Care Commission shall retain the bed capacity of a facility on its inventory for up to 2 years, provided that the owner or licensed operator of the facility provides written notice to the Commission at least 30 days before the proposed temporary delicensure.

§24–1408.

The Department, in consultation with the Maryland Health Care Commission and the nursing home industry, shall adopt regulations to implement the provisions of this subtitle.

§24–1501.

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

(b) "Care coordination services" means an active, ongoing process of assisting an individual to identify, access, and use community resources and coordinating services to meet the individual's needs.

(c) "Fund" means the Maryland Prenatal and Infant Care Grant Program Fund established under § 24–1502(a) of this subtitle.

(d) "Hospital" has the meaning stated in § 19–301 of this article.

(e) "Provider of prenatal care" means a health care provider who is authorized to provide prenatal services under the Health Occupations Article.

§24–1502.

(a) There is a Maryland Prenatal and Infant Care Grant Program Fund.

(b) The purpose of the Fund is to make grants to:

(1) Counties and municipalities to provide care coordination services to low–income pregnant and postpartum women and to children from birth to 3 years old; and

(2) Federally qualified health centers, hospitals, and providers of prenatal care to increase access to prenatal care, which may include behavioral and oral health services necessary for maintaining a healthy pregnancy.

(c) The Secretary shall:

(1) Award grants from the Fund; and

(2) Oversee the operation of the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund;

(2) Investment earnings of the Fund; and

(3) Any other money from any other source accepted for the benefit of the Fund.

(f) (1) In fiscal years 2021 and 2022, the Governor shall include in the annual budget an appropriation of $100,000 for the Fund.

(2) The Governor shall include in the annual budget bill appropriations in the following amounts for the Fund:

(i) $1,100,000 for fiscal year 2023;

(ii) $2,100,000 for fiscal year 2024; and

(iii) $3,100,000 for fiscal year 2025 and each fiscal year thereafter.

(g) The Fund may be used only to provide grants to:

(1) Counties and municipalities to provide care coordination services to low–income pregnant and postpartum women and children from birth to 3 years old; and

(2) Federally qualified health centers, hospitals, and providers of prenatal care to provide and promote prenatal care to women who would otherwise not receive prenatal care.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund, including interest earnings under subsection (e) of this section.

(i) Expenditures from the Fund may be made only in accordance with the State budget.

(j) Money expended from the Fund for grants under this subtitle is supplemental to and is not intended to take the place of funding that otherwise would be appropriated for care coordination services.

(k) The Fund is subject to audit by the Office of Legislative Audits as provided in § 2–1220 of the State Government Article.

§24–1503.

(a) Any county or municipality may apply to the Secretary for a grant from the Fund to be applied toward a program that provides care coordination services to low–income pregnant and postpartum women and to children from birth to 3 years old.

(b) An application for a grant from the Fund shall include, at minimum:

(1) Evidence that the county's or municipality's care coordination services will be a collaborative effort involving:

(i) The appropriate public service agencies; and

(ii) Community–based providers; and

(2) A plan for the establishment of a database that collects data from the program to ensure that the services are provided to the families with the highest need.

§24–1504.

(a) (1) Subject to paragraphs (2) and (3) of this subsection, the Secretary shall establish procedures for the distribution of money from the Fund.

(2) In establishing procedures for awarding grants under § 24–1503 of this subtitle, the Secretary shall consult with the members of the Children's Cabinet.

(3) In establishing procedures for awarding grants under § 24–1506 of this subtitle, including the procedure by which a federally qualified health center, hospital, or provider of prenatal care may apply for a grant, the Secretary shall consult with the Maternal and Child Health Bureau in the Department.

(b) Priority on awarding grants under § 24–1503 of this subtitle shall be given to proposals from a county or municipality that:

(1) Has:

(i) A high number of births to women enrolled in Medicaid;

(ii) High rates of infant mortality;

(iii) High rates of preterm births; and

(iv) High rates of infants with low birthweight; and

(2) Demonstrates that the program will be coordinated with community–based service providers.

(c) Priority on awarding grants under § 24–1506 of this subtitle shall be given to proposals from federally qualified health centers, hospitals, or providers of prenatal care that propose to serve communities that have:

(1) A high number of births to women enrolled in the Maryland Medical Assistance Program;

(2) High rates of infant mortality;

(3) High rates of preterm births; and

(4) High rates of infants with low birthweight.

§24–1505.

A county or municipality awarded a grant from the Fund shall submit annually to the Secretary and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report that includes data describing:

(1) The services provided;

(2) The number of individuals receiving services;

(3) Outcomes for individuals receiving services; and

(4) An assessment of the funded activities' ability to scale.

§24–1506.

(a) (1) (i) The Secretary shall, in coordination with the Maternal and Child Health Bureau in the Department, award competitive grants to federally qualified health centers, hospitals, and providers of prenatal care that propose a program to increase accessibility to prenatal care in communities with members who would otherwise not receive prenatal care, including women who cannot obtain prenatal care due to their immigration status.

(ii) A federally qualified health center, hospital, or provider of prenatal care that receives a grant under this paragraph may use the funding to promote and market the proposed program.

(2) The Secretary may require an applicant to provide matching funds or in–kind contributions as a condition of receiving a grant under this section.

(3) The Secretary shall distribute at least the following totals in grants under this section:

(i) $1,000,000 in fiscal year 2023;

(ii) $2,000,000 in fiscal year 2024; and

(iii) $3,000,000 in fiscal year 2025 and each fiscal year thereafter.

(b) The Secretary shall ensure that grants awarded under this section are used for the purposes of:

(1) Improving the health outcomes of pregnant women in the community served using the grant funds; and

(2) Collecting sufficient data to determine how to expand successful elements of the program to other communities in the State.

(c) On or before December 1 each year, beginning in 2023, the Secretary shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, to the General Assembly a report on the grants distributed under this section for the most recent closed fiscal year, including:

(1) The total number of grants distributed; and

(2) Information about grant recipients and the programs and services provided using the grant funding.

§24–1601.

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

(b) (1) "Community dental clinic" means a nonprofit organization that provides dental services and is:

(i) A health care center or program that offers dental services:

1. Free of cost or on a sliding scale fee schedule; and

2. Without regard to an individual's ability to pay; and

(ii) Wholly owned and operated under the authority of a county, municipal corporation, or nonprofit organization.

(2) "Community dental clinic" does not include a federally qualified health center or a federally qualified health center look–alike.

(c) "Nonprofit organization" means:

(1) A bona fide religious organization, no part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of a facility, the purchase of equipment to be used in a facility, or the expansion of a facility; or

(2) An organization:

(i) That is chartered as a nonprofit corporation and classified by the Internal Revenue Service as nonprofit; and

(ii) No part of the earnings of which inures to the benefit of any individual or is used for any purpose other than the maintenance and operation of a facility, the purchase of equipment to be used in a facility, or the expansion of a facility.

(d) "Wholly owned" includes leased, if:

(1) (i) The lease is for a minimum term of 15 years following project completion; or

(ii) The lease agreement extends the right of purchase to the lessee; and

(2) The lessor consents to the recording, in the land records of the county or Baltimore City where the facility is located, of a notice of the State's right of recovery as provided under § 24–1606 of this subtitle.

§24–1602.

(a) There is a Community Dental Clinics Grant Program.

(b) On the recommendation of the Secretary, the Board of Public Works may make grants to counties, municipal corporations, and nonprofit organizations for the purpose of supporting the provision of dental services by community dental clinics through:

(1) The conversion of public buildings or parts of public buildings to community dental clinics;

(2) The acquisition of existing buildings or parts of buildings for use as community dental clinics;

(3) The renovation of community dental clinics;

(4) The purchase of capital equipment for community dental clinics; or

(5) The planning, design, and construction of community dental clinics.

§24–1603.

(a) Any county, municipal corporation, or nonprofit organization sponsoring a project involving work specified in § 24–1602 of this subtitle may apply to the Secretary for a State grant to be applied toward the cost of that project.

(b) The application for a grant shall include:

(1) Project plans for the work to be carried out;

(2) A statement listing the personnel employed or to be employed at the community dental clinic, including all remuneration and perquisites for personal services and all other expenses paid or to be paid to the personnel;

(3) All other expenses incurred or to be incurred in operating the community dental clinic; and

(4) The schedule of rates charged or to be charged for services rendered.

(c) On approval of a project and the project plans, the Secretary promptly shall report the application to the Board of Public Works, together with the Secretary's recommendation that the Board make funds available as provided in this subtitle.

§24–1604.

(a) The allocation and use of State funds under this subtitle are subject to the terms and conditions set forth in this section.

(b) State funds may be used only for the purposes listed under § 24–1602 of this subtitle and approved by the Secretary under § 24–1603 of this subtitle.

(c) The allocation and use of State funds under this subtitle are subject to the following terms and conditions:

(1) Any federal or other grant that is received for an eligible project shall be applied first to the cost of the project;

(2) Except as provided in subsection (d) of this section, a State grant may not exceed 75% of the cost of eligible work remaining unpaid after all federal grants have been applied; and

(3) For purposes of this subtitle, community development block grant funds shall be considered as local matching funds and may not be considered as federal grant funds.

(d) For a project designated as eligible for poverty area funding under federal regulations, State plans, or departmental regulations, a State grant may cover up to 90% of the cost of eligible work remaining unpaid after all federal grants have been applied.

(e) The amount of the State grant recommended to the Board of Public Works for any project shall be determined after consideration of:

(1) All eligible projects;

(2) The total of unallocated State funds available at the time the grant recommendation is made to the Board of Public Works; and

(3) The priorities of area need established by the Department.

(f) (1) No portion of the proceeds of a State grant may be used:

(i) To further sectarian religious instruction;

(ii) In connection with the design, acquisition, or construction of any building to be used as a place of sectarian religious worship or instruction; or

(iii) In connection with any program or department of divinity for any religious denomination.

(2) On the request of the Board of Public Works, the applicant shall submit evidence satisfactory to the Board that the proceeds of the grant are not being used for a purpose prohibited under this subsection or under applicable federal law.

(g) Beginning in fiscal year 2021 and each fiscal year thereafter, the Governor shall include an appropriation in the State operating budget bill or capital budget bill to be distributed and managed in accordance with this subtitle.

§24–1605.

(a) The Board of Public Works shall make allocations from funds available under this subtitle in accordance with this subtitle.

(b) The Board of Public Works shall certify the allocations to the proper State officers, and the State Treasurer shall make payments to or on behalf of the applicant, when needed, for the approved project.

(c) The Board of Public Works may adopt regulations to implement this section.

§24–1606.

(a) The State may recover from either the transferor or transferee or, in the case of a property that has ceased to be a community dental clinic, from the owner, an amount bearing the same ratio to the then current value of so much of the property as constituted an approved project as the amount of the State participation bore to the total eligible cost of the approved project, together with all costs and reasonable attorney's fees incurred by the State in the recovery proceedings, if, within 30 years after completion of a project, a property for which funds have been paid under this subtitle:

(1) Is sold or transferred to any person, agency, or organization that would not qualify as an applicant under this subtitle, or that is not approved as a transferee by the Board of Public Works; or

(2) Ceases to be a community dental clinic as defined in this subtitle.

(b) (1) Before the State makes any funds available for an approved project, the Department shall cause a notice of this right of recovery to be recorded in the land records of the county or Baltimore City where the property is located.

(2) The recording of the notice:

(i) Does not create a lien against the property; but

(ii) Shall constitute notice to any potential transferee, potential transferor, potential creditor, or other interested party of the possibility that the State may obtain a lien under this subtitle.

(c) (1) (i) The Secretary of the Board of Public Works may file a civil complaint authorized under subsection (a) of this section, in the circuit court for the county or Baltimore City where the property is located, against the owner of the property and any other interested parties, including any transferor that the State wishes to make a party.

(ii) The complaint shall be filed with:

1. Sworn affidavits stating facts on which the allegations of default are based; and

2. A detailed justification of the amount claimed.

(2) If the circuit court determines from the State's initial filing that a default has occurred, pending full determination of the State's claim, the court shall authorize a temporary lien on the property:

(i) In the amount of the State's complaint plus any additional amount estimated to be necessary to cover the costs and reasonable attorney's fees incurred by the State; or

(ii) In other amounts that the court determines to be reasonable.

(3) (i) A temporary lien shall take effect:

1. On the date of the court's authorization, if the Secretary of the Board of Public Works records a notice of temporary lien in the land records of the county or Baltimore City where the property is located within 10 days after the court's authorization; or

2. On the date a notice of temporary lien is recorded.

(ii) While the temporary lien is in effect, neither the owner nor any person that acquired an interest in the property after the State first made funds

available in connection with the property may, without the prior written consent of the State:

1. Take any action that would affect the title to the property; or

2. Institute any proceedings to enforce a security interest or other similar rights in the property.

(4) (i) The owner of the property or any other interested party may obtain release of a temporary lien at any time by filing with the court a bond securing the payment in full of the State's claim and any additional amount necessary to cover the costs and reasonable attorney's fees incurred by the State.

(ii) The owner or other interested party may cause the release to be recorded in the land records.

(d) Proceedings to determine the State's right to recover and the amount of the State's recovery under this subtitle shall have priority over other civil proceedings in the circuit courts.

(e) (1) (i) At the conclusion of full adversary proceedings on the issue of default and of any disputes over the amount of the State's recovery, the circuit court shall, if it finds that a default has occurred, issue a final judgment for the amount the circuit court finds to be recoverable by the State.

(ii) All parties involved in the default, including in every case the owner of the property, shall be held jointly and severally liable to the State for the amount of the judgment.

(2) (i) Except as the State may otherwise provide by a written subordination agreement, if the amount of the final judgment remains unpaid after 30 days following the court's final order, the final judgment shall constitute a lien on the property, superior to the lien or other interest of a mortgagee, pledgee, purchaser, or judgment creditor whose interest became perfected against third persons after the State first made funds available under this subtitle.

(ii) 1. Except as provided in subsubparagraph 2 of this subparagraph, a lien takes effect on the date a notice of lien is recorded.

2. A lien takes effect on the 31st day following the court's final order if the Secretary of the Board of Public Works records a notice of lien in the land records of the county or Baltimore City where the property is located on or before the 41st day following the final order.

(iii) 1. At the time that a lien takes effect, any temporary lien then in effect shall be automatically and fully released.

2. The recorded notice of a lien shall constitute notice of the release of a temporary lien.

(iv) A lien imposed under this subsection may be enforced and foreclosed in accordance with the procedures prescribed in the Maryland Rules, except that neither the State nor any agent appointed by the State to sell the property need file a bond.

(3) (i) The owner or any other interested party may obtain release of a lien at any time by paying to the State the full amount of the judgment rendered by the circuit court, together with interest from the date of judgment.

(ii) On payment in full, the Secretary of the Board of Public Works shall cause a release to be recorded in the land records.

(4) If the circuit court finds that there has been no default or if the full amount of the court's judgment is paid to the State within 30 days after the court's final order, a temporary lien then in effect shall be released immediately and the Secretary of the Board of Public Works shall cause the release to be recorded in the land records.

(f) (1) All funds recovered as a result of this right of recovery shall be deposited in the Annuity Bond Fund and applied to the debt service requirements of the State.

(2) If the Board of Public Works determines that there is good cause for releasing the transferor, transferee, or owner from the obligation imposed under this subtitle, the Board of Public Works may waive the State's right of recovery under this subtitle.

§24–1607.

The Department shall adopt regulations to implement the provisions of this subtitle.

§24–1701.

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

(b) "Education loan" means any loan that is obtained for tuition, educational expenses, or living expenses for undergraduate or graduate study leading to practice as a physician or physician assistant.

(c) "Fund" means the Maryland Loan Assistance Repayment Program Fund.

(d) "Primary care" includes:

(1) Primary care;

(2) Family medicine;

(3) Internal medicine;

(4) Obstetrics;

(5) Pediatrics;

(6) Geriatrics;

(7) Emergency medicine;

(8) Women's health;

(9) Psychiatry; and

(10) Preventative medicine.

(e) "Program" means the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants.

§24–1702.

(a) (1) There is a Maryland Loan Assistance Repayment Program Fund in the State.

(2) The Fund is a continuing, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(4) The Fund shall be invested and reinvested in the same manner as other State funds.

(5) Any investment earnings of the Fund shall be paid into the Fund.

(b) The Fund consists of:

(1) Revenue generated through a permanent funding structure recommended to the General Assembly by a stakeholder workgroup convened by the Department; and

(2) Any other money from any other source accepted for the benefit of the Fund.

(c) Expenditures from the Fund shall be made by an appropriation in the annual State budget or by an approved budget amendment as provided under § 7–209 of the State Finance and Procurement Article.

(d) The money in the Fund shall be used by the Department to administer the Program.

§24–1703.

There is a Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants in the State.

§24–1704.

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

(2) (i) "Eligible field of employment" means employment by an organization, institution, association, society, or corporation that is exempt from taxation under § 501(c)(3) or (4) of the Internal Revenue Code of 1986.

(ii) "Eligible field of employment" includes employment by the State or any local government in the State.

(3) "Physician" includes a part–time physician.

(4) "Physician assistant" includes a part–time physician assistant.

(b) (1) The Department shall assist in the repayment with the funds transferred to the Department by the Comptroller under § 14–207(d) of the Health

Occupations Article of the amount of education loans owed by a physician or physician assistant who:

(i) 1. Practices primary care in an eligible field of employment in a geographic area of the State that has been federally designated; or

2. Is a medical resident specializing in primary care who agrees to practice for at least 2 years as a primary care physician in an eligible field of employment in a geographic area of the State that has been federally designated; and

(ii) Meets any other requirements established by the Department.

(2) The Department may establish prorated loan repayment assistance for a part–time physician or part–time physician assistant participating in the Program.

(c) Any unspent portions of the money that is transferred to the Department for use under this subtitle from the Board of Physicians Fund may not be transferred to or revert to the General Fund of the State, but shall remain in the Fund maintained by the Department to administer the Program.

§24–1705.

(a) In addition to the assistance provided under § 24–1704 of this subtitle, the Department may, subject to the availability of money in the Fund, assist in the repayment of an education loan owed by a physician or physician assistant who:

(1) Practices a medical specialty that has been identified by the Department as being in shortage in the geographic area of the State where the physician or physician assistant practices that specialty; and

(2) Commits to practicing in the area for a period of time determined by the Department.

(b) The Department shall prioritize funding for the repayment of education loans through the Program in the following order:

(1) Physicians and physician assistants that meet the requirements under § 24–1704(b) of this subtitle;

(2) Physicians and physician assistants practicing primary care in a geographic area where the Department has identified a shortage of primary care physicians or physician assistants; and

(3) Physicians and physician assistants practicing a medical specialty other than primary care in a geographic area where the Department has identified a shortage of that specialty.

§24–1706.

The Department shall adopt regulations to implement the provisions of this subtitle, including:

(1) Establishing the maximum number of participants in the Program each year in each priority area described under § 24–1705 of this subtitle; and

(2) Establishing the minimum and maximum amount of loan repayment assistance awarded under this subtitle in each priority area described under § 24–1705 of this subtitle.

§24–1707.

On or before October 1, 2021, and each October 1 thereafter, the Department shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(1) The eligible physicians, physician assistants, and medical residents who applied for the Program, including information on:

(i) The specialty of the physician, physician assistant, or medical resident;

(ii) The type and location of the site in which the physician, physician assistant, or medical resident provided services; and

(iii) The geographic area served by the physician, physician assistant, or medical resident; and

(2) The physicians, physician assistants, and medical residents who participated in the Program, including information on:

(i) The amount of assistance provided to each participant;

(ii) The specialty of the participant;

(iii) The type and location of the site in which the participant provided services; and

(iv) The geographic area served by the participant.

§24–1708.

(a) In this section, "Council" means the Maryland Loan Assistance Repayment Program Advisory Council for Physicians and Physician Assistants.

(b) There is a Maryland Loan Assistance Repayment Program Advisory Council for Physicians and Physician Assistants.

(c) The Council consists of the following members:

(1) The Chair of the Health Services Cost Review Commission, or the Chair's designee;

(2) The Chair of the Maryland Health Care Commission, or the Chair's designee;

(3) The President of the Maryland Hospital Association, or the President's designee;

(4) The Dean of the University of Maryland School of Medicine, or the Dean's designee;

(5) The Dean of the Johns Hopkins School of Medicine, or the Dean's designee;

(6) The President of MedChi, or the President's designee;

(7) One representative of the Primary Care Office in the Office of Population Health Improvement;

(8) One representative of the State Board of Physicians;

(9) One representative of the Maryland Academy of Physician Assistants; and

(10) Any other members as determined necessary by the Secretary.

(d) (1) The members of the Council shall select the chair of the Council.

(2) A member of the Council:

(i) May not receive compensation as a member of the Council; but

(ii) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(3) The Council shall meet at least three times a year.

(e) The Department shall provide staff for the Council.

(f) The Council shall:

(1) Seek permanent and diverse revenue sources to aid in the stability and further development of the Program;

(2) Help ensure maximum use of federal funds;

(3) Use available data and information to help direct funding to priority areas;

(4) Monitor similar loan programs in other states and ensure that the Program remains competitive;

(5) Assist the Department in the administration of the Program;

(6) Help market and raise awareness of the Program through educational institutions and other appropriate entities as an incentive to health care providers to practice in underserved areas; and

(7) Make recommendations to the Governor and the General Assembly on any necessary changes to the Program.

(g) On or before October 1, 2028, and every 3 years thereafter, the Council shall report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on the activities and recommendations of the Council.

§24–1801.

(a) In this section, "Fund" means the Maryland AIDS Drug Assistance Program Fund.

(b) There is a Maryland AIDS Drug Assistance Program Fund.

(c) The purpose of the Fund is to support the administration, operation, and activities of the Maryland AIDS Drug Assistance Program.

(d) The Department shall administer the Fund.

(e) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(f) The Fund consists of:

(1) Except as provided in subsection (j) of this section, rebates received by the Department from the Maryland AIDS Drug Assistance Program;

(2) Money appropriated in the State budget to the Fund;

(3) Interest earnings of the Fund; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(g) The Fund may be used only to fund:

(1) The Maryland AIDS Drug Assistance Program;

(2) The Maryland AIDS Drug Assistance Program Plus (MADAP–Plus); and

(3) Any other services to eligible individuals as authorized under Part B of the federal Ryan White HIV/AIDS Program.

(h) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(i) (1) Expenditures from the Fund may be made only in accordance with the State budget.

(2) The Fund shall have its own program code within the State budget.

(j) Notwithstanding subsection (f) of this section, the Department shall:

(1) Deposit any rebates from a source other than a federal source received by the Department from the Maryland AIDS Drug Assistance Program into an account within the Fund; and

(2) Use the funds in the account under item (1) of this subsection only to fund State–identified priorities for HIV prevention, surveillance, and care services.

(k) The Secretary shall adopt regulations establishing income and other eligibility criteria for the receipt of HIV prevention and care services funded under subsection (j) of this section.

§24–1901. IN EFFECT

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

(b) "Education loan" means any loan that is obtained for tuition, educational expenses, or living expenses for State certification, undergraduate, or graduate study leading to practice as a nurse or nursing support staff.

(c) "Fund" means the Maryland Loan Assistance Repayment Program Fund for Nurses and Nursing Support Staff.

(d) "Nurse" includes:

(1) An advanced practice registered nurse, as defined in § 8–101(b) of the Health Occupations Article certified to practice as a nurse midwife or clinical nurse specialist;

(2) A licensed practical nurse, as defined in § 8–101(h) of the Health Occupations Article;

(3) A nurse anesthetist, as defined in § 8–101(k) of the Health Occupations Article;

(4) A registered nurse, as defined in § 8–101(p) of the Health Occupations Article; and

(5) A registered nurse practitioner, as defined in § 8–101(q) of the Health Occupations Article.

(e) "Nursing support staff" includes:

(1) A certified medication technician, as defined in § 8–6A–01(j) of the Health Occupations Article;

(2) A certified medicine aide, as defined in § 8–6A–01(k) of the Health Occupations Article;

(3) A certified nursing assistant, as defined in § 8–6A–01(l) of the Health Occupations Article; and

(4) A geriatric nursing assistant, as defined in § 8–6A–01(o) of the Health Occupations Article.

(f) "Program" means the Maryland Loan Assistance Repayment Program for Nurses and Nursing Support Staff.

§24–1901. ** TAKES EFFECT APRIL 1, 2026 PER CHAPTER 416 OF 2025 **

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

(b) "Education loan" means any loan that is obtained for tuition, educational expenses, or living expenses for State certification, undergraduate, or graduate study leading to practice as a nurse or nursing support staff.

(c) "Fund" means the Maryland Loan Assistance Repayment Program Fund for Nurses and Nursing Support Staff.

(d) "Nurse" includes:

(1) An advanced practice registered nurse, as defined in § 8–101(b) of the Health Occupations Article certified to practice as a nurse midwife or clinical nurse specialist;

(2) A licensed practical nurse, as defined in § 8–101(h) of the Health Occupations Article;

(3) A nurse anesthetist, as defined in § 8–101(k) of the Health Occupations Article;

(4) A registered nurse, as defined in § 8–101(p) of the Health Occupations Article; and

(5) A registered nurse practitioner, as defined in § 8–101(q) of the Health Occupations Article.

(e) "Nursing support staff" includes:

(1) A certified medication technician, as defined in § 8–6A–01 of the Health Occupations Article;

(2) A certified medicine aide, as defined in § 8–6A–01 of the Health Occupations Article; and

(3) A certified nursing assistant, as defined in § 8–6A–01 of the Health Occupations Article.

(f) "Program" means the Maryland Loan Assistance Repayment Program for Nurses and Nursing Support Staff.

§24–1902.

(a) (1) There is a Maryland Loan Assistance Repayment Program Fund for Nurses and Nursing Support Staff.

(2) The Fund is a continuing, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(4) The Fund shall be invested and reinvested in the same manner as other State funds.

(5) Any investment earnings of the Fund shall be paid into the Fund.

(b) The Fund consists of:

(1) Revenue generated through a permanent funding structure recommended to the General Assembly by a stakeholder workgroup convened by the Department;

(2) Any available federal funds;

(3) Interest earnings; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(c) Expenditures from the Fund shall be made by an appropriation in the annual State budget or by an approved budget amendment as provided under § 7–209 of the State Finance and Procurement Article.

(d) The money in the Fund shall be used by the Office of the Comptroller to administer the Program.

§24–1903.

There is a Maryland Loan Assistance Repayment Program for Nurses and Nursing Support Staff.

§24–1904.

(a) (1) In this section, "eligible field of employment" means:

(i) Employment by an organization, an institution, an association, a society, or a corporation that is exempt from taxation under § 501(c)(3) or (4) of the Internal Revenue Code of 1986; or

(ii) For–profit employment in an area of the State identified by the Department as having a health care workforce shortage or public health need.

(2) "Eligible field of employment" includes employment by the State or a local government in the State.

(b) The Department shall use the Fund to assist in the repayment of the amount of education loans owed by a nurse or nursing support staff who:

(1) Practices in an eligible field of employment; or

(2) Meets any other requirements established by the Department.

(c) Any unspent portions of the money that is transferred to the Department for use under this subtitle may not be transferred to or revert to the General Fund of the State, but shall remain in the Fund maintained by the Department to administer the Program.

§24–1904.1.

(a) In addition to the assistance provided under § 24–1904 of this subtitle, the Department may, subject to the availability of money in the Fund, assist in the repayment of an education loan owed by a nurse or nursing support staff who:

(1) Practices a medical specialty that has been identified by the Department as being in shortage in the geographic area of the State where the nurse practices that specialty; and

(2) Commits to practicing in the area for a period of time determined by the Department.

(b) The Department shall prioritize funding for the repayment of education loans through the Program in the following order:

(1) Nurses or nursing support staff who meet the requirements under § 24–1904(b)(1) of this subtitle;

(2) Nurses or nursing support staff practicing in primary care in a geographic area where the Department has identified a shortage of nurses or nursing support staff; and

(3) Nurses or nursing support staff practicing in a medical specialty other than primary care in a geographic area where the Department has identified a shortage of that specialty.

§24–1905.

The Department shall adopt regulations to carry out the provisions of this subtitle, including regulations that:

(1) With advice from a stakeholder workgroup convened by the Department, establish priorities for funding the repayment of education loans through the Program;

(2) Establish the maximum number of participants in the Program each year in each priority area established under item (1) of this section; and

(3) Establish the minimum and maximum amount of loan repayment assistance awarded under this subtitle in each priority area established under item (1) of this section.

§24–1906.

On or before October 1, 2023, and each October 1 thereafter, the Department shall report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on:

(1) The eligible nurses and nursing support staff who applied for the Program, including information on:

(i) The practice of the nurse or nursing support staff;

(ii) The type and location of the site in which the nurse or nursing support staff provided services; and

(iii) The geographic area served by the nurse or nursing support staff; and

(2) The nurses and nursing support staff who participated in the Program, including information on:

(i) The amount of assistance provided to each participant;

(ii) The practice of the participant;

(iii) The type and location of the site in which the participant provided services; and

(iv) The geographic area served by the participant.

§24–2001.

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

(b) "Mayor" means the Mayor of Baltimore City.

(c) "Review team" means the Baltimore City Behavioral Health Crisis Incident Review Team established under this subtitle.

§24–2002.

(a) There is a Baltimore City Behavioral Health Crisis Incident Review Team in Baltimore City.

(b) The membership of the review team shall be established by the Mayor to reflect a variety of organizations, agencies, and areas of expertise and shall include:

(1) The Mayor, or the Mayor's designee;

(2) The Police Commissioner of Baltimore City, or the Commissioner's designee;

(3) The Baltimore City Commissioner of Health, or the Commissioner's designee; and

(4) The President of the local behavioral health authority for Baltimore City, or the President's designee.

(c) The Mayor shall designate a chair or cochairs from among the members of the review team.

(d) The review team may establish subcommittees to carry out the work of the review team.

(e) The Mayor shall establish requirements and procedures applicable to the review team, including:

(1) Requirements for meetings of the review team and any subcommittees established by the review team;

(2) Confidentiality requirements; and

(3) Procedures related to the collection, utilization, sharing, and disclosure of information collected by the review team.

§24–2003.

The purpose of the review team is to:

(1) Review behavioral health crisis incidents involving law enforcement in Baltimore City;

(2) Identify root causes and patterns within and across public systems that result in behavioral health crises involving law enforcement;

(3) Provide recommendations based on identified factors that contribute to behavioral health crises involving law enforcement for quality and performance improvement;

(4) Facilitate coordination and collaboration among entities involved in the behavioral health and law enforcement systems; and

(5) Assist in the implementation of procedural, logistical, and clinical changes to minimize the need for law enforcement involvement in behavioral health crises.

§24–2004.

(a) On request of the review team and as necessary to carry out the purpose and duties of the review team, the review team shall be provided with access to:

(1) Public behavioral health system data, records of service utilization history, and clinical information relevant to a behavioral health crisis involving law enforcement under review; and

(2) Information and records maintained by a State or local government agency, including death certificates, law enforcement investigative information, medical examiner investigative information, parole and probation information and records, and information and records of a social services agency, if the agency provided services to an individual whose interaction with law enforcement during a behavioral health crisis is being reviewed by the review team.

(b) Substance abuse treatment records requested or provided under this section are subject to any additional limitations on disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290DD–2 and 42 C.F.R. Part 2.

§24–2005.

(a) Meetings of the review team shall be closed to the public and are not subject to the Open Meetings Act when the review team is discussing individual behavioral health crises or incidents involving law enforcement interaction.

(b) Except as provided in subsection (c) of this section, meetings of the review team shall be open to the public and are subject to the Open Meetings Act when the review team is not discussing individual behavioral health crises or incidents involving law enforcement interaction.

(c) (1) During a public meeting, information may not be disclosed that identifies:

(i) A deceased individual;

(ii) An individual who has experienced a behavioral health crisis;

(iii) A family member, guardian, or caretaker of a deceased individual or an individual who has experienced a behavioral health crisis; or

(iv) An individual convicted of a crime or adjudicated as having committed a delinquent act.

(2) During a public meeting, information may not be disclosed about the involvement of any agency with:

(i) A deceased individual;

(ii) An individual who experienced a behavioral health crisis;

(iii) A family member, guardian, or caretaker of a deceased individual or an individual who experienced a behavioral health crisis; or

(iv) An individual convicted of a crime or adjudicated as having committed a delinquent act.

(d) This section does not prohibit the review team from requesting the attendance at a team meeting of a person who has information relevant to the review team's exercise of its purpose and duties.

§24–2006.

(a) Subject to subsection (b) of this section, all information and records acquired by the review team in the exercise of its purpose and duties under this subtitle:

(1) Are confidential and exempt from disclosure under the Public Information Act; and

(2) May be disclosed only as necessary to carry out the review team's purpose and duties.

(b) (1) Mental health records are subject to the additional limitations under § 4–307 of this article for disclosure of a medical record developed primarily in connection with the provision of mental health services.

(2) Substance abuse treatment records are subject to any additional limitations for disclosure or redisclosure of a medical record developed in connection with the provision of substance abuse treatment services under State law or 42 U.S.C. § 290DD–2 and 42 C.F.R. Part 2.

(c) Statistical compilations of data that do not contain any information that would allow the identification of any person to be ascertained are public records.

(d) Reports of the review team that do not contain any information that would allow the identification of any person to be ascertained are public information.

(e) Except as necessary to carry out the review team's purpose and duties, members of the review team and persons attending the review team meeting may not disclose:

(1) What transpired at a meeting that is not public under § 24–2005 of this subtitle; or

(2) Any information the disclosure of which is prohibited by this section.

(f) (1) Members of the review team, individuals attending the review team meeting, and individuals who present information to the review team may not be questioned in any civil or criminal proceeding about information presented in or opinions formed as a result of a meeting.

(2) This subsection does not prohibit an individual from testifying to information that is obtained independently of the review team or that is public information.

(g) (1) Except as provided in paragraph (2) of this subsection, information, documents, or records of the review team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

(2) Information, documents, or records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of the review team or are maintained by the review team.

§24–2007.

An individual who violates § 24–2005 or § 24–2006 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 90 days or both.

§24–2101.

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

(b) "Alternative therapies" includes hyperbaric oxygen therapy and psychedelics including 3,4–Methylenedioxymethamphetamine (MDMA), psilocybin, and ketamine.

(c) "Fund" means the Post–Traumatic Stress Disorder and Traumatic Brain Injury Alternative Therapies Fund.

§24–2102.

(a) There is a Post–Traumatic Stress Disorder and Traumatic Brain Injury Alternative Therapies Fund.

(b) The purpose of the Fund is to support the Department in studying the effectiveness of and improving access to alternative therapies for post–traumatic stress disorder and traumatic brain injuries in veterans.

(c) The Department shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund; and

(2) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only for:

(1) Studying the use of alternative therapies for veterans with post–traumatic stress disorder and traumatic brain injuries;

(2) Providing cost–free access to alternative therapies for veterans with post–traumatic stress disorder and traumatic brain injuries;

(3) Any uses determined by the Department under subsection (i) of this section; and

(4) Administrative expenses of the Department in administering the Fund.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the General Fund of the State.

(h) Expenditures from the Fund may be made only in accordance with the State budget.

(i) The Department periodically shall consult with the Department of Veterans and Military Families, The Johns Hopkins University, the University of Maryland, Sheppard Pratt, Walter Reed National Military Medical Center, and BrainFutures to determine:

(1) The effectiveness of and a method for improving access to alternative therapies for treating post–traumatic stress disorder and traumatic brain injuries in veterans; and

(2) Appropriate uses of the Fund that further the Fund's purpose under subsection (b) of this section.

(j) On or before December 1 each year, beginning in 2024, the Department shall submit to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly a report on the use of the Fund during the immediately preceding fiscal year.

§24–2201.

For fiscal year 2024, and for each fiscal year thereafter, the Governor shall provide an appropriation in the State budget to fund the operations of the Mid Shore Health Improvement Coalition.

§24–2401. NOT IN EFFECT

** TAKES EFFECT JULY 1, 2025 PER CHAPTERS 798 AND 799 OF 2024 **

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

(b) "Birthing facility" means a freestanding birthing center or a hospital that provides obstetric care.

(c) "Freestanding birthing center" has the meaning stated in § 19–3B–01 of this article.

(d) "Hospital" has the meaning stated in § 19–301 of this article.

(e) "Report card" means the Maryland Report Card for Birthing Facility Maternity Care developed under § 24–2402 of this subtitle.

§24–2402. NOT IN EFFECT

** TAKES EFFECT JULY 1, 2025 PER CHAPTERS 798 AND 799 OF 2024 **

(a) Subject to subsections (b) and (c) of this section, the Secretary, in collaboration with the Maryland Health Care Commission, shall:

(1) Develop a Maryland Report Card for Birthing Facility Maternity Care; and

(2) Collect the necessary information to complete an annual report card for each birthing facility in the State.

(b) The report card shall include the following information for each birthing facility, disaggregated by race and age in accordance with best practices for data suppression:

(1) The number and rate of vaginal deliveries performed;

(2) The number and rate of cesarean deliveries performed;

(3) The age–adjusted rate of complications and the total number of complications experienced by a patient receiving obstetric care for:

(i) A vaginal delivery at the birthing facility, including maternal hemorrhage, laceration, infection, or any other complication as required by the Secretary; or

(ii) A cesarean delivery at the birthing facility, including maternal hemorrhage, infection, operative complication, or any other complication as required by the Secretary; and

(4) Qualitative measures based on patient input regarding the patient's receipt of respectful obstetric care.

(c) The report card score shall be balanced for the risks associated with the level of acuity care provided for obstetric patients served by the birthing facility.

(d) The Department shall include the most recent report card on the Department's website.

(e) (1) At least once every 3 years, the Secretary shall:

(i) Review the criteria evaluated in the report card; and

(ii) Revise the complications or other factors to be included in the report card.

(2) The Secretary shall consider expert guidance when reviewing the criteria evaluated in the report card.

§24–2501.

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

(b) "Collection entity" means any individual, partnership, corporation, trust, estate, cooperative, association, government or government subdivision, agency, or other entity that purchases medical debt or collects medical debt on behalf of another.

(c) "Medical debt" has the meaning stated in § 14–1213 of the Commercial Law Article.

§24–2502.

(a) A person whose primary business is providing medical services, products, or devices, or the person's agent or assignee:

(1) May not disclose any portion of a medical debt to a consumer reporting agency; and

(2) Shall include in any contract entered into with a collection entity for the purchase or collection of medical debt a provision prohibiting the disclosure of any portion of the medical debt to a consumer reporting agency.

(b) A contract entered into on or after October 1, 2025, that does not include the provision required under subsection (a)(2) of this section is void and unenforceable.

§24–2601.

In this subtitle, "school health and wellness personnel" includes:

(1) Counselors;

(2) Dental hygienists;

(3) Occupational therapists;

(4) Occupational therapy assistants;

(5) Physical therapists;

(6) School counselors;

(7) School nurses;

(8) School psychologists;

(9) School social workers; and

(10) Speech–language pathologists.

§24–2602.

(a) The Department and the State Department of Education jointly shall conduct an assessment of the school health and wellness personnel workforce in the State each year to:

(1) Identify the ratio of school health and wellness personnel to students and schools by jurisdiction;

(2) Obtain information from each local school system and local health department regarding vacancy rates for each type of provider of school health and wellness services; and

(3) Obtain feedback from each local school system, each local health department, associations of school health and wellness professionals, and other stakeholders on strategies to improve the recruitment and retention of school health and wellness personnel.

(b) On or before December 1, 2027, and each December 1 thereafter, the Department and the State Department of Education jointly shall:

(1) Submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on the findings of the assessment conducted under this section; and

(2) Publish the report on the website of each agency.

§24–2701.

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

(b) (1) "Health care facility" means a facility or an office where health care is provided to patients by a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(2) "Health care facility" includes:

(i) A hospital, as defined in § 19–301 of this article;

(ii) A freestanding medical facility, as defined in § 19–3A–01 of this article;

(iii) A nursing facility;

(iv) A residential treatment center;

(v) A rehabilitation facility; and

(vi) A facility operated by the Department, the Behavioral Health Administration, or a health officer.

(c) "Service member" has the meaning stated in § 9–901 of the State Government Article.

(d) "Service member community member" means:

(1) A service member;

(2) A veteran;

(3) The spouse of a service member or veteran;

(4) A child of a service member or veteran; or

(5) A stepchild of a service member or veteran.

(e) "Veteran" has the meaning stated in § 9–901 of the State Government Article.

§24–2702.

(a) Each health care facility may screen each patient for information on the patient's eligibility as a service member community member and include in the patient's medical record whether the patient is a service member community member.

(b) For the purpose of improving health care equity for service member community members, each health care facility may identify service member community members as a vulnerable population and comply with the standards associated with the National Patient Safety Goal to Improve Health Care Equity established by The Joint Commission.

§24–2801.

In this subtitle, "Fund" means the Public Health Workforce Development Fund.

§24–2802.

(a) There is a Public Health Workforce Development Fund.

(b) The purpose of the Fund is to support the education and training of the public health workforce.

(c) The Maryland Community Health Resources Commission shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

(1) Money appropriated in the State budget to the Fund;

(2) Interest earnings of the Fund;

(3) Any money transferred from the Population Health Improvement Fund under § 13–5602 of this article; and

(4) Any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only to support the education and training of the public health workforce.

(g) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any interest earnings of the Fund shall be credited to the Fund.

(h) Expenditures from the Fund may be made only in accordance with the State budget.