TITLE 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article §§ 15-601, 19-207, 19-210-214, 19-214.1, 19.214.2, 19.214.3, 19-216, 19-217, 19-219 and 19-222; Insurance Article, §§14-501 and 14-504; State Government Article, §10-304(b); Annotated Code of Maryland

.01 Definitions.

A. "Burden of proof" means the burden of persuasion by the preponderance of the evidence.

B. "Commission" means the Health Services Cost Review Commission.

C. "Executive Director" means the Executive Director of the Commission, or in his absence, the Commission staff member designated to act in his stead.

D. "Opinion" means a written statement setting forth the reasons and grounds why the writer of the statement believes that certain actions should be taken or decisions or recommendations made.

E. "Order Nisi" means an order of the Commission that certain actions shall be taken or that certain matters are approved as of a future date, thereby permitting parties affected by the Order Nisi to make any objections they may have known to the Commission.

F. Partial Rate Application.

(1) “Partial rate application” means a request by a hospital for the amendment or establishment of a singe approved rate.

(2) “Partial rate application” includes, but is not limited to, those requests enumerated in Regulation .03B(4) of this chapter.

G. "Publish" means the insertion of a public notice concerning proposed actions, including but not limited to public hearings, in a newspaper or newspapers in general circulation in

the community in which the hospital affected is located, and, if the public notice relates to a public hearing, in the *Maryland Register* at least 15 days before the date of the public hearing.

H. "Rate application" and "application" mean a hospital application for rate approval, to be submitted as specified in these regulations.

I. "Recommendation" means a written statement from the Commission's staff to the Commission, advocating a resolution of issues or approval, disapproval, or modification of certain hospital rates and procedures for evaluating the rates.

J. "Regression analysis" means a statistical technique used to measure and control for the effect of selected independent variables (for example, percentage of Medicaid revenue) on one dependent variable (for example, bad debts).

K. "Uncompensated care" means care provided for which compensation is not received (that is, any combination of bad debts and charity care), and as more fully described in the Commission's Accounting and Budget Manual for Fiscal and Operating Management which is incorporated by reference in COMAR 10.37.01.02.

L. “Value of the substantial, available, and affordable coverage (SAAC) differential” means the difference between the amount paid out by SAAC-approved nonprofit health service plans, health insurers, and health maintenance organizations on behalf of SAAC enrollees to hospitals, and what they would have paid to hospitals absent the differential.

.01-1 Incorporation by Reference.

The Alternative Rate Setting Method (ARM) Manual (1998) is hereby incorporated by reference.

.02 Rate Review System.

A. The rate review system, otherwise known as the Accounting and Budget Manual for Fiscal and Operating Management, shall consist of:

(1) The rate review forms; and
(2) Instructions for completion of the forms.

B. The rate review system is incorporated by reference in COMAR 10.37.01.02.

C. A hospital's rate review system and a schedule of published rates shall be filed by the last day of the third month after the close of the hospital's fiscal year.

.03 Regular Rate Applications.

A. A hospital may not file a regular rate application with the Commission until November 1, 2008, or until such earlier date as designated by the Commission. During this interim period of time, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission law, regulation, or policy. As of November 1, 2008, or as of the earlier date if so designated by the Commission, a hospital may file a regular rate application with the Commission at any time if:

(1) The rates being requested are not subject of a hospital-instituted case pending before the Commission; or

(2) The subject hospital has not obtained permanent rates through the issuance of a Commission rate order with an effective date falling within the last 90 days.

B. Full Rate Application.

(1) "Full rate application" means a regular rate application which requests the amendment of more than one previously approved rate.

(2) In order for a full rate application to be docketed, it shall comply with a template for such applications as prescribed by the Commission and shall:

(a) Enumerate the services for which new rates are being requested, listing present and proposed rates;

(b) Be accompanied by appropriate supporting documents:

(c) Include a complete description of what is requested; and

(d) Include specific detail and substantiation of any circumstances the applicant hospital cites as unique to its facility that would require revenue in excess of the amount resulting from use of the ICC methodology set forth in Regulation .04-1 of this chapter.

(3) Requests for special consideration of a full rate application shall be accompanied by supporting documentation in the format of applicable reports under COMAR 10.37.01.03H.

(4) The provisions of §B(2) and (3) of this regulation may be waived by staff if the application applies only to:

(a) A request filed as a requirement of COMAR 10.37.03.06 (Hospital-based physician compensation source);

(b) A request for a change in the applicant's uncompensated care allowance;

(c) A request for rates to cover government mandated or similar action affecting more than one previously approved rate for which the staff believes the provisions of §B(2) and (3) of this regulation are not necessary; or

(d) A request for rates associated with a Certificate of Need – approved capital project.

C. Uncompensated Care Policy.

(1) The Commission's rate-setting methodology shall include in the rates of each hospital a provision for a reasonable level of uncompensated care provided at the hospital. The Commission may use a regression analysis or other statistical method to establish the reasonable level of uncompensated care.

(2) In establishing a reasonable level of uncompensated care in a full rate review, the Commission shall consider for each hospital the:

(a) Amount of uncompensated care actually incurred;
(b) Predicted amount of uncompensated care; and
(c) The hospital's requested amount.

(3) A hospital may request a change in its approved provision of uncompensated care to the predicted amount by means of a partial rate application provided the request is revenue neutral.

D. Uncompensated Care Policy - Medicaid Day Limits.

(1) A hospital may request a change in its approved provision of uncompensated care by means of a partial rate application in response to action taken by the Secretary of Mental Health and Hygiene to establish hospital day limits under the Medical Assistance Program.

(2) In evaluating such a request, the Commission shall consider the following factors before deciding whether to approve, deny, or modify the hospital's request:

(a) The hospital's actual uncompensated care and estimated uncompensated care from the Commission's most recent uncompensated care regression analysis;

(b) The hospital's cash position, operating margin, and net margin as shown on its latest audited financial statements and its most recent unaudited FS Schedules submitted to the Commission;

(c) Any other financial considerations that are presented to the Commission with the partial rate application;

(d) The hospital's position on the Commission's most recent Reasonableness of Charges analysis;

(e) Whether changing a hospital's approved provision of uncompensated care in response to the establishment of hospital day limits places the Medicare waiver in potential jeopardy; and

(f) Whether implementing such a change to a hospital's approved provision of uncompensated care is in the public interest.

(3) The review of a hospital's request for additional revenue in its approved provision of uncompensated care related to Medicaid's day limits shall be completed by the Commission as soon as practicable.

(4) Any action taken by the Commission on such a request shall not be considered a final decision in a contested case under the Administrative Procedure Act, and a hospital retains the right to file a full rate application in accordance with Commission law and regulation.

(5) Any additional revenue approved by the Commission under such a request shall be removed from approved rates prospectively upon the expiration of the hospital day limits established by the Medical Assistance Program.

.03-1 Partial Rate Application.

A. The provisions of Regulation .03B(2) and (3) of this chapter may be waived by staff in the review of a partial rate application.

B. A hospital may file a partial rate application with the Commission at any time, consistent with the provisions of Regulations .03A of this chapter. The moratorium provisions associated with Regulations .03A apply only to partial rate applications associated with a capital project. A partial rate application is not a contested case under the provisions of the Administrative Procedure Act.

C. The Commission shall act on a docketed partial rate application within the time frames established for a full rate application that does not involve a public hearing, consistent with Commission law and regulation.

D. A hospital that has been denied its request for a partial rate change may file a full rate application with the Commission in accordance with Commission law and regulation.

.04 Commission Review of Established Rates.

A. The Commission may order a review of a hospital's established rates at any time, as it deems necessary and proper.

B. This order, provided it orders the review of any rate or charge, may constitute a Commission initiated rate proceeding.

.04-1 ICC Methodology.

A. In evaluating the reasonableness of a hospital’s permanent rate structure, the Commission may use its Interhospital Cost Comparison (ICC) methodology as a benchmark for reasonableness. Thus, the results of an ICC analysis do not constitute an absolute rule, and the Commission shall consider the individual circumstances of the subject hospital in determining the appropriate rate structure. The ICC methodology begins by establishing costs for the target hospital and its peer group. Under the methodology, costs are determined by calculating the hospitals’ charges and then removing markup and profits. The methodology then compares the subject hospital’s costs to the average costs of its peer group after adjusting for factors for which the hospital is not held accountable. These factors include, but need not be limited to, casemix, labor market cost differences, reasonable medical education costs, and special grants awarded by the Commission.

B. Commission shall fully describe and publicly disseminate the technical provisions of the methodology used to evaluate a hospital’s permanent rate structure. Any Commission approved updates or changes to these provisions shall similarly be described and disseminated.

C. The final rates that are approved by the Commission for a nonprofit hospital’s permanent rate structure shall allow the hospital to charge reasonable rates that will permit it to provide, on a solvent basis, effective and efficient service that is in the public interest.

D. The final rates that are approved by the Commission for a proprietary profit-making hospital’s permanent rate structure shall allow the hospital to charge reasonable rates that will permit it to provide effective and efficient service that is in the public interest and include enough allowance for and provide a fair return to the owner of the hospital.

.04-2 Case Target Methodology.

A. Effective July 1, 2000, the Commission shall implement its case target methodology (CTM) for the purpose of establishing reasonable rates for Maryland's general acute hospitals. Effective July 1, 2008, the Commission shall expand its case target methodology to include outpatient services. This methodology is prospective in nature and designates a charge-per-admission target and a charge-per-visit target for each hospital.

B. In setting individual targets, the Commission shall take into account the following factors:

(1) The case severity of the patients;
(2) The historical charges of the hospital;
(3) The statutory requirement regarding the reasonable relationship between costs and charges;
(4) The payor mix;
(5) The reasonable uncompensated care of the hospital;
(6) Graduate medical education
(7) The screening position of the hospital;
(8) Appropriate adjustments associated with exceptional or outlier cases as defined by the Commission;
(9) The annual update factor; and
(10) Appropriate adjustments associated with the hospital's relative adjusted charge per case.

C. The CTM shall be implemented through an agreement entered into by the Commission and each individual general acute hospital. This agreement, which shall be annual, shall set forth all relevant provisions for achieving the target established, including, but not limited to, performance corridors, interim rate adjustments, the exclusion of certain cases, and the penalties associated with failure to comply with the terms of the agreement. A hospital that is a party to this agreement shall submit a signed copy of the agreement to the Commission's offices within 60 days of the issuance of the annual unit rate and charge-per-case target update rate order. Following the receipt of its inpatient charge-per-case agreement, a hospital will receive an addendum to the agreement that establishes the charge-per-visit target. The addendum, which shall be annual, shall set forth all relevant provisions for achieving the charge-per-visit target established, including but not limited to, interim rate adjustments, the exclusion of certain cases, and the penalties associated with failure to comply with the agreement. A hospital that is a party to the addendum shall submit a signed copy of the addendum to the Commission's offices within 60 days of the issuance of the charge-per-visit target addendum. Failure to submit either the signed agreement or the signed addendum in a timely manner may subject the hospital to penalties under COMAR 10.37.01.03N. A hospital that disagrees with a proposed target may file a full rate application with the Commission in

accordance with Regulation .03 of this chapter.

D. In lieu of a CTM agreement, a hospital may request that it be permitted to enter into a total patient revenue (TPR) agreement with the Commission. A TPR agreement establishes a revenue cap for qualifying hospitals. A qualifying hospital is one that typically is located in a rural area and has a well-defined catchment area with a stable population.

.04-3 Case Target Update Mechanism.

A. For purposes of this regulation, the following definitions apply:

(1) "Factor cost inflation" means increases in the costs of goods, services, wages, and salaries experienced by the hospitals as calculated by the Commission for the most recent period for which data are available preceding the year for which the Commission calculates case target updates.

(2) "Hospital update" means the amount by which an individual hospital's charge per admission may increase in a rate year (that is, July 1 - June 30).

(3) "National growth allowance" means one-half of the amount, if any, by which national growth in net revenue per adjusted admission exceeds factor cost inflation growth in any rate year.

(4) "National growth reduction" means the amount, if any, by which factor cost inflation growth exceeds the growth in national net revenue per adjusted admission in any rate year.

(5) "Annual update factor" means the amount by which total State charge per admission may increase in a rate year.

B. Annual Update Factor:

(1) On or before April 1 of each year, the Commission shall establish an annual update factor for the purpose of adjusting the rates of each individual hospital. The annual update factor shall be calculated on the basis of projected factor cost inflation adjusted by any national growth allowance or national growth reduction.

(2) If Maryland hospitals exceed the annual update factor established by the Commission for a given year, the annual update factor shall be reduced in future years to recoup the excess revenue growth. Similarly, if Maryland hospitals fall below the annual update factor for a given year, the annual update factor shall be adjusted accordingly in future years.

(3) If Maryland hospitals accrue a national growth reduction for 2 consecutive years, in the following year the annual update factor shall be reduced by the first of the 2-year national growth reduction. Except as provided for in §D of this regulation, the annual update may not be less than 1 percent.

C. The technical provisions of the methodology used to convert the annual update factor into the hospital update for the next rate year shall be fully described and publicly disseminated on or before July 1 of each year, allowing sufficient time for comment and implementation.

D. Corrective Action. If, at any time, the Commission estimates that the relative Medicare waiver test cushion is established to be 5 percent or less (based on modeling using the Health Care Financing Administration actuary's most recent projections and Health Services Cost Review Commission casemix data adjusted for the historical relationship between charges and payments), the Commission may take immediate corrective action, as it deems necessary and proper, to restore the minimum waiver cushion and to reverse any further deterioration. The Commission shall provide sufficient notice and opportunity for comment before taking corrective action. This comment opportunity does not constitute a contested case within the meaning of the Administrative Procedure Act. Any reductions implemented to preserve the waiver are not subject to the limitation requiring the annual update factor to be at least 1 percent.

E. The provisions of this regulation shall apply to all Maryland's general acute care hospitals from July 1, 2000, and after that.

F. Compliance and Penalties. CTM compliance shall be monitored during the agreement period. Penalties shall be assessed prospectively at the beginning of the next period. Penalties shall be based on the corridors specified in the Agreement.

.05 Application for Temporary Change in Rates.

A. The Commission may issue a general notice setting forth circumstances under which a hospital may obtain a temporary change in rates. The rates, if approved or modified, shall be effective before the rate review procedure set forth in these regulations, but not before the date of application.

B. A hospital may apply at any time for a temporary change in rates provided that one of the following conditions is satisfied:

(1) A decline in the hospital's experienced or projected net revenues, due to factors beyond the hospital's control, requiring funds beyond those normally available;

(2) An increase in the hospital's experienced or projected expenses, due to factors beyond the hospital's control, requiring funds beyond those normally available; or

(3) A hospital's expenses from regulated services exceed its revenues from regulated services, or the hospital's financial integrity is otherwise jeopardized (for example, for breaching its bond covenants).

C. The Commission and its staff shall review the application and consult with the hospital as to the necessity for the temporary change in rates and the amount of the change required. Designated interested parties shall have 6 working days from the filing of the application to submit comments to the Commission.

D. Within 12 working days from the filing of the application, the Commission shall issue its order:

(1) Denying the temporary change in rates and stating the grounds therefor; or

(2) Granting a temporary change in rates, stating:

(a) The amount of the temporarily changed rates, which may or may not be the same as the rates set forth in the hospital's application;

(b) The necessity for the temporary change in rates;

(c) That a regular rate review proceeding on the proposed rates will be conducted by the Commission as soon as practicable;

(d) The availability of copies of the order at the offices of the Commissioner; and

(e) The availability of the record of the temporary rate application for inspection at the Commission's office during ordinary business hours.

E. The Commission order denying or granting the temporary change in rates shall be published and copies forwarded to:

(1) The hospital;

(2) Designated interested parties; and

(3) Persons writing to the Commission requesting a copy of the order.

F. A temporary change in rates may not, absent extraordinary circumstances, result in a hospital's screening position being higher than 2 percent below the Statewide average on the regression-adjusted inpatient screen. Outpatient rates resulting from a temporary rate increase may not exceed the median, adjusted for mark-up and labor market.

G. A temporary change in rates is subject to the Commission's final rate order in the regular rate review proceeding, which may be effective as of the date of the temporary rate order.

.06 Application for Alternative Method of Rate Determination.

A. At any time on or after July 1, 1974, a hospital may file a written application with the Commission requesting an alternative method for submitting or reviewing any or all of its rates and charges, specifying the reasons for and details of the alternative methods.

B. If warranted by the circumstances set forth in the application, the Executive Director may grant a temporary approval of an alternative method of rate determination.

C. The procedure for submitting and reviewing an application under an alternative method of rate determination shall follow as closely as possible the procedure for a regular rate application, except that the time periods and limitations set forth in these regulations do not apply to an application for an alternative method of rate determination.

D. At anytime after the approval of an alternative method of rate review by the Executive Director, the Commission may initiate further proceedings to determine the hospital's continuing qualification for the alternative method of rate determination.

E. ARM System.

(1) The Commission may implement a system providing for alternative rate setting methods (ARM) which would permit hospitals to accept financial risk for the provision of hospital services under certain conditions and circumstances.

(2) The implementation of an ARM system shall be consistent with the principles of equity and access embodied in the Commission's all-payer rate setting system.

(3) The ARM Manual shall set forth the process and requirements associated with the ARM system.

F. Required Reports under ARM System.

(1) A hospital granted approval for an alternative method of charging under this regulation is required to file quarterly reports and annual reports, to include but not be limited to those listed below in this section, in order to determine that the hospital continues to qualify for the alternative method of rate determination.

(2) Quarterly Reports. The following reports shall be completed in the form prescribed by the Commission and submitted to the Commission within 30 days after the end of each hospital's calendar quarter:

(a) Statistical Data Summary - Each Capitation or Risk-Sharing Contract;
(b) Statistical Data Summary - Each Fixed-Price Contract;
(c) Statistical Data Summary - Other;
(d) Revenue Summary - Each Capitation or Risk-Sharing Contract;
(e) Revenue Summary - Each Fixed-Price Contract; and
(f) Revenue Summary - Other.

(3) Annual Reports. The following annual reports shall be completed in the form prescribed by the Commission and submitted to the Commission within 90 days after the end of the appropriate fiscal year:

(a) Statement of Revenue and Expense - Each Capitation or Risk-Sharing Contract;
(b) Statement of Revenue and Expense - Each Fixed-Price Contract;
(c) Statement of Revenue and Expense - Other;
(d) Audited Statement of Revenue and Expense - Contracting Entity; and
(e) Audited Balance Sheet - Contracting Entity.

(4) Filing of Reports/Extension.

(a) A hospital required to file the reports in this section may request a reasonable extension of time for filing, if the extension request is:

(i) Made in writing to the attention of the Executive Director;
(ii) Supported by sufficient justification; and
(iii) Made at a reasonable time before the due date of a required report.

(b) The Executive Director shall respond promptly in writing to the requesting hospital upon receipt of the request by either approving or disapproving the request.

(c) Extensions will be granted only for valid reasons.

(d) Any required report submitted by a hospital that is substantially incomplete or inaccurate shall be considered untimely filed.

(5) Time for Filing. An application for an alternative rate application shall be filed at least 30 days before the proposed effective date of the alternative rate.

(6) Penalties.

(a) The Commission may impose penalties of up to $250 per day for failing to file reports as required in this section.

(b) The Commission may refuse to grant a rate increase to a hospital that does not file a report as required under this section.

(c) A fine assessed for failure to file an alternative rate application on a timely basis shall begin as of the date the application should have been filed.

G. Funding for Health Information Technology.

(1) The Commission may adjust a hospital's rates for health information technology (HIT) projects in conjunction with action taken by the Maryland Health Care commission (MHCC) under COMAR 10.25.13.

(2) Upon receipt of a recommendation for funding from the MHCC, the Commission's staff shall:

(a) Review the information presented;

(b) Consult with appropriate parties; and

(c) Recommend to the Commission approval, denial, or modification of the MHCC recommendation.

(3) In deciding the course of action to follow on an MHCC HIT project recommendation, the Commission and its staff shall consider, among other things, the following criteria:

(a) The basis for the MHCC recommendation;

(b) The applicant's statement of purpose, mission, vision, goals, and measurable objectives of the project;

(c) The planned approach, including:

(i) An explanation of how the project's goals and objectives will be met;

(ii) The technical strategy of the project;

(iii) What activities will be used;

(iv) What personnel will be needed; and

(v) How that personnel will be utilized;

(d) How the project will be evaluated, as well a specific measurement strategies;

(e) A timeline that includes the start and end dates of the project and a schedule of activities;

(f) The credentials of the entity and participating individuals, including information that demonstrates their background and ability to carry out the project successfully;

(g) The potential of the project to enhance the value of health care in Maryland, such as improving health care outcomes and reducing health care costs;

(h) Information that demonstrates why the project is needed; and

(i) A budget that details cost projections for the project that is specific, reasonable, realistic, accurate, and flexible.

(4) Decision.

(a) Based on its consideration of the above-stated criteria and staff's recommendation, the Commission shall decide on the nature, extent, terms and conditions of any rate adjustment approved.

(b) The decision of the Commission on an MHCC recommendation for HIT funding is final.

(c) A request for funding under this section is not a contested case under the Administrative Procedure Act.

.07 Rate Applications by New Hospitals or Existing Hospitals with Expanded Facilities or New Revenue Centers.

A. At least 60 days before the operational opening of a new hospital, a revenue center, or a new service within a hospital whose projected annual operating cost exceeds $100,000, the hospital shall file a rate application for the requested rates. This application shall be supported by financial data presented in the format of the Commission's rate review system.

B. If an existing hospital expands its operations so that the number of in-patient beds is increased by 20 percent or more, and if a rate application is filed pertaining to the expanded facilities and providing for an occupancy rate for the expanded facilities of the hospital at an amount below the target occupancy established by the Commission, the Commission may require the filing of additional information projecting the hospital's expanded facilities' activity levels for the first 5 years of their operation.

.07-1 Outpatient Services – At the Hospital Determination.

A. Definition. In this regulation, “at the hospital” means a service provided in a building on the campus of a hospital in which hospital services are provided.

B. A service at the hospital is:

(1) Presumed to be an outpatient service; and

(2) Subject to rate regulation.

C. In accordance with Health-General Article, § 19-201, Annotated Code of Maryland, the Commissioner’s rate-setting jurisdiction extends to outpatient services provided at the hospital.

D. A hospital that desires an exception to the presumption stated under § C of this regulation must receive a determination under the provisions of this regulation.

E. Commission Approval.

(1) A hospital may not charge a Commission-approved rate for an outpatient service without prior Commission or Commission staff approval.

(2) A hospital may not open a new outpatient service, relocate an existing outpatient service, or convert an existing outpatient service from regulated or unregulated status without a prior determination from the Commission's staff as to whether the service is being provided at the hospital.

F. Upon request for an exception under § D of this regulation, the Commission's staff shall:

(1) Review the information presented;

(2) Consult with appropriate parties;

(3) Visit the site of the service as it considers necessary; and

(4) Notify the hospital of its determination as soon as practicable.

G. In deciding whether an outpatient service is at the hospital, the Commission staff may consider, among other things, the following criteria:

(1) Location of the entrances:

(2) Location and signage of parking;

(3) Location and language of signage at entrances, within buildings, on the campus, and in parking areas effectively altering the public that a given building or service is either at the hospital or not at the hospital;

(4) Location of registration, changing, and waiting areas;

(5) Whether billing reflects clearly that the service is rate regulated or not rate regulated;

(6) Whether any physical connection from an unregulated facility to the hospital, such as tunnels, hallways, covered walkways, elevators, or connecting bridges, will be restricted to hospital staff and physician use in order to ensure that patients and visitors do not have access to the unregulated facility from the hospital;

(7) Whether there is any duplication of an unregulated service within the hospital in order to avoid inappropriate patient steering;

(8) Whether there is any inappropriate mixing of regulated and unregulated services in the same building, which would tend to have the effect of confusing patients about the regulated or nonregulated status of a given service being provided; and

(9) Whether any Medicare Part B physician's service being provided in an unregulated building also includes components of a Medicare Part A hospital service that would be reasonably expected by a patient to fall under Commission rate-setting jurisdiction.

H. Based on consideration of the criteria stated in § G of this regulation, the Commission's staff shall make its determination on the request made under § E of this regulation.

I. A hospital that fails to obtain or violates a staff determination on the at the hospital status of a given service may be subject to fines for inaccurate reporting under COMAR 10.37.01.03N and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained or adhered to.

J. A request for a determination under this regulation is not a contested case under the Administrative Procedure Act.

.08 Content.

Each rate application shall include a list of services for which new rates are being requested, a list of the present and requested rates, and shall be based on the currently filed or required rate review system.

.09 Method of Filing.

The application may be filed by private messenger at the Offices of the Commission, or may be filed by registered mail, return receipt requested, at the following address:

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

.10 Docketing and Receipt.

A. Docketing.

(1) When a valid rate application is received, as per the above regulations, it shall be entered on the Commission docket and a file opened.

(2) Each rate application shall be given an annual docket number and a consecutive page number in the docket.

(3) Each rate application shall be given a consecutive file number.

(4) A regular rate application file number shall be noted "R".

(5) The file number of an order authorizing Commission investigation and review of established rates shall be noted "C".

(6) A temporary rate application file number shall be noted "T".

(7) An alternative method of rate determination application file number shall be noted "A".

(8) A rate application file number by a new hospital or a hospital with expanded facilities or new revenue centers shall be noted "N".

(9) The date of receipt of the rate application shall be noted on the docket and on the file.

B. Upon request of the hospital, the Commission shall give the hospital a receipt for the rate application filing, showing the docket, page, and file numbers, and the date of receiving the rate application.

C. The hospital shall file an original and three copies of each rate application and its supporting documents, if any. In addition, the hospital shall file with each rate application a certificate of service indicating that the application and supporting documents have been mailed or served upon all designated parties to that proceeding and upon the Commission at its offices.

.11 Recommendations of the Commission's Staff to the Commission.

A. A rate application review shall be completed and the recommendation given to the Commission as soon as possible.

B. The recommendation shall include a specification of those areas of costs which the staff believes should be reviewed. When practicable, the recommendation shall also include the amounts challenged by the staff.

C. Any of four actions may be recommended to the Commission. If two or more actions are recommended, the issues and rates to be evaluated in each action shall be set forth clearly. These four actions are as follows:

(1) The Commission should hold a public hearing on rates;

(2) The Commission should grant tentative approval or modify all or some of the rates and publish notice of an order nisi;

(3) The Commission should hold a general hearing on rates;

(4) The Commission should deny the application in which case it shall state the grounds for the denial.

D. A copy of the recommendation shall be placed in the file and a copy shall be forwarded to each Commission member, the hospital, and each interested party.

E. The Commission may not call for the effective date of an Order Nisi or call for a public hearing for 30 days after the Commission acts on the staff's recommendation.

F. Before a staff recommendation or public hearing, the staff may hold conferences with hospital representatives and interested parties in an attempt to clarify or resolve potential issues.

.12 Preliminary Commission Order.

A. The Commission shall consider the staff recommendation and, within 20 days of the date of the recommendation, issue its preliminary order adopting or modifying the recommendation, or referring the recommendations back to the staff for further review and subsequent recommendations.

B. Order Nisi.

(1) If the Commission issues a preliminary order granting tentative approval of any rates, it shall publish notice of the order nisi and the rates.

(2) In addition, the Commission shall forward copies of the order nisi and the rates to the hospital and interested parties.

(3) The order nisi shall state:

(a) The name and address of the hospital; the names of the designated interested parties; the docket, page, and file numbers of the rate application proceeding and the date the application was filed with the Commission.

(b) An enumeration of services and the proposed representative rates to be charged;

(c) That the Commission has approved the rates as of a date to be specified, with a provision that the order may be suspended if reasonable cause is shown within 15 days of the date of the order nisi;

(d) That objections to the tentatively approved rates shall be submitted (in person or by mail) to the Commission in writing; that designated interested parties shall submit copies of their objections, identifying the proceeding and Order Nisi to which objections are made to the hospital, and nine copies to the Commission office; and

(e) That the file, which may contain supporting documents from the hospital, the Commission staff recommendation, the Accounting and Reporting reports and the Rate Review System of the hospital, is available at the Commission offices during regular business hours for public inspection.

C. If the Commission issues an order for a public hearing, it shall forward copies of the Order and public notice of the hearing to the hospital and the designated interested parties and shall publish a public notice of the hearing. The notice shall state:

(1) The name and address of the hospital; the names of the designated interested parties; the docket, page, and file numbers of the rate application proceeding; the date the application was filed with the Commission; and the time, date, and place of the hearing;

(2) A description of the issues to be presented at the public hearing;

(3) That any person interested in the matter may attend the public hearing;

(4) That all persons wishing to present relevant testimony or a statement at the public hearing shall forward copies to the hospital, each designated interested party, and nine copies to the Commission office; that the hospital and members of the public shall forward their testimony at least 8 days before the hearing; that the designated interested parties shall forward their testimony at any time before the close of the first session.

D. Written testimony will not be considered unless the person submitting the testimony makes himself available for cross-examination unless stipulated to the contrary.

E. If the Commission issues an order for a general hearing by the Commission, it shall forward copies of the order and public notice of the hearing to the hospital and the designated interested parties and publish a public notice of the hearing.

.13 Public Hearing Before the Commission.

A. Testimony shall be in writing and may not be delivered orally, except as set forth in Regulation .14K, below.

B. Presenting Direct Testimony.

(1) Any person who wishes to present direct testimony at the public hearing shall forward copies to the hospital and to every designated interested party, and shall file nine copies at the Commission's office.

(2) If the public hearing is the result of a hospital rate application pursuant to Regulation .03, the applicant shall file its testimony at least 20 days before the date of the hearing. The staff of the Commission and members of the public shall file their testimony at least 10 days before the date of the hearing.

(3) If the public hearing is the result of a Commission-initiated review of the rates of a hospital pursuant to Regulation .04, the Commission staff shall file its testimony at least 20 days before the date of the hearing. The hospital and members of the public shall file their testimony at least 10 days before the date of the hearing.

(4) The designated interested parties shall file their testimony before the close of the first hearing session.

C. The written direct testimony shall set forth the conclusions of the person submitting it and the arguments and facts supporting these conclusions. This testimony shall specifically pertain to the issues set forth in the public notice.

D. Written direct testimony shall be verified either by:

(1) Appearing before an officer or other persons authorized to administer an oath; or

(2) Signing the documents containing the statements required to be under oath and including the following representation:

> I do solemnly declare and affirm under the penalties of perjury that the facts set forth in the foregoing testimony are true and correct to the best of my knowledge, information and belief.

E. Copies of written direct testimony shall be forwarded by the person submitting them to the hospital and the designated interested parties.

F. All written direct testimony shall pertain solely to the proposed rates and be relevant to that subject. The presiding officer shall separate irrelevant material from the remainder of the record and keep that material apart. Parts of the body of the written direct testimony judged irrelevant by the presiding officer shall be so marked and may not be considered by the Commission in its deliberations.

G. Persons submitting written testimony shall make themselves available for cross-examination and may give redirect and rebuttal testimony, orally or in writing, as directed or permitted by the presiding officer.

H. All testimony at public hearings shall be filed in a timely manner. Requests for hearing postponements shall be made at a reasonable time before the hearing. These requests will only be granted for valid reasons, at the discretion of the Commission. If a hospital requests a postponement of an initial hearing session after the staff has already submitted its testimony, the Commission may require the hospital to file its testimony within the time frame of the original hearing date.

.14 Conduct of Public Hearing.

A. The Chairman of the Commission shall preside at the public hearing, which may be called to order when the presiding officer is in attendance. If the Chairman is absent or has been disqualified, the Vice-Chairman or another Commissioner shall preside.

B. The Commission may direct that a hearing officer preside at the public hearing. In this case, the hearing officer may exercise all powers given to a presiding Commissioner in these regulations during all sessions of the public hearing.

C. At the discretion of the Commission, the specific duties of the hearing officer may include the following:

(1) Making all rulings as to evidence, testimony, and official notice;
(2) Setting the order for the examination and cross-examination of witnesses;
(3) Administering oaths and affirmations;
(4) Preparing both written and oral summaries of cases heard;
(5) Preparing a recommendation for the Commission consisting of a written report with findings of fact and conclusions of law.

D. The presiding officer may adjourn a hearing to a specified time, date, and place.

E. All public hearings shall be recorded and testimony shall be under oath. A transcript of the record of the hearing shall be placed in the file of the proceeding. If the hospital or any other party desires a copy of the transcript, that party shall make arrangements with the stenographer.

F. All direct testimony shall be submitted in writing and in an issue-by-issue format. The hearing shall begin with the examination of the representative of the hospital and any witnesses which the hospital may desire to have testify on its behalf. Whenever practicable, the testimony of witnesses shall proceed on an issue-by-issue basis.

G. The Commission's staff member assigned to the proceeding shall be the next witness to be examined on the issue in question. In a Commission initiated review, the staff member assigned to the proceeding shall be examined before the hospital witness.

H. Representatives of the other interested parties who have submitted written testimony shall be examined in the order set by the presiding officer.

I. The Commission may examine witnesses at any time during the course of the proceeding. Commission staff and representatives of the hospitals and interested parties may also examine witnesses.

J. All testimony and examination shall be relevant to the subject of the proposed rates. Redundant and irrelevant testimony and examinations shall be prohibited or stricken by the presiding officer. In addition, all interested parties may move the Commission to strike redundant and irrelevant testimony.

K. At the presiding officer's discretion, he may allow direct oral testimony if a person attending the hearing demonstrates good cause for not submitting the testimony in written form before the hearing. Witnesses giving direct oral testimony shall be subject to cross-examination in the same manner as other witnesses. Anyone denied an opportunity to testify may appeal in writing to the full Commission within 7 days from this denial.

L. To preserve his rights on appeal or otherwise, it is not necessary for a party objecting to a Commission ruling or decision to state the grounds of his objection, unless specifically requested to do so by a member of the Commission.

M. At the Commission's reasonable discretion, it may permit the filing of post hearing briefs by the hospital, the Commission staff member or any interested party. Those parties submitting briefs shall file copies within a reasonable time designated by the presiding officer to the hospital, the designated interested parties, the Commission office and to each Commission member.

N. A Commission member shall remove himself from participation in a public hearing as a Commission member if he decides that a conflict of interest may appear to prejudice his evaluation of the issues considered at the public hearing. Challenges to a Commission member's participation in a public hearing as a Commission member shall be considered by the Commission, the decision made by a majority vote, excluding the member objected to. Challenges shall be made by motion, at least 7 days before the public hearing.

O. Except as otherwise provided, all decisions required during the conduct of the public hearing shall be made by the presiding officer.

.15 Decision and Opinions of the Commission.

A. The decision and the opinions of the Commission shall be based solely on the testimony, examination, and evidence presented at the public hearing, on the briefs filed, if any, on the evidence incorporated into the record of the proceeding by reference, on information and data in the record of the proceeding, and on matters as to which the Commission has taken official notice, which matters shall be made known to the parties to the proceedings.

B. The deliberations of the Commission may be held in private executive session.

C. The decision shall be made by a majority of the Commission members attending all sessions of the public hearing, or having read the record of hearings they did not attend.

D. The decision shall be in writing and shall be based on a written majority or unanimous opinion stating the reasons and grounds for the Commission's decision. If a majority of Commissioners who are to render the final decision have not heard the evidence, the decision, if adverse to a party to the proceeding other than the Commission itself, may not be made until a proposal for decision, including findings of fact and conclusions of law, has been served upon the parties, and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to a majority of the Commissioners who are to render the decision, who shall personally consider the whole record or those portions of it as may be cited by the parties.

E. At the discretion of a Commission member (or members) who agrees with the decision reached by the majority of the Commission, but who does not agree with the majority opinion, or any part of it, the Commission member (or members) may file a written concurring opinion.

F. A Commission member (or members) who does not agree with the decision or any part of it reached by the majority of the Commission may, at his discretion, file a written dissenting opinion.

G. The Commission's decision and the opinion (or opinions) shall be filed promptly and the Commission's staff then shall forward copies of the Commission's decision and the opinion (or opinions) to the hospital, to the designated interested parties, and to those parties who submitted written direct testimony before the public hearing.

H. The Commission shall then publish:

(1) An order approving, modifying, or disapproving the rates under review in the proceeding;

(2) A notice that copies of the Commission's decision and the opinion (or opinions) may be obtained by written request to the Commission offices; and

(3) A notice that the record of the complete proceeding is open for public inspection at the Commission offices during regular business hours.

.16 General Hearing Before the Commission.

A. To obtain general information from the region and community in which a hospital is located, the Commission, at its discretion, may hold a general hearing during the course of any rate proceeding.

B. A general hearing shall be supplementary to other methods of rate review and may not replace them.

C. A general hearing shall be held in the region in which the hospital whose rates are being reviewed is located.

D. The public notice of a general hearing may state:

(1) The name and address of the hospital; the designated interested parties; the docket, page, and file numbers of the application; and the time, date, and place of the hearing;

(2) A description of the issues to be considered at the general hearing;

(3) That any party interested in the matter may attend and present written or oral statements concerning the announced issues; and

(4) That presentations may be limited as to time and that the number of spokespersons representing any group or organization may be limited.

E. The general hearing shall be conducted by a hearing officer, any member of the Commission, a senior member of the Commission staff or its legal counsel.

F. Persons attending the general hearing may present written or oral statements concerning the issues and rates set forth in the notice, which statements need not be verified. The presiding officer, within his discretion, may limit the number of spokespersons representing a group or organization and may limit the time allowed for oral statements.

G. The conduct of the general hearing shall be recorded and the transcript shall be placed in the file of the proceedings. Any person may purchase a transcript of the hearing from the stenographer.

H. The presiding officer may ask questions of the spokespersons. Within the discretion of the presiding officer, examination or questions of the spokespersons by other persons may be permitted.

I. A transcript of the oral statements and copies of the written statements shall be placed in the Commission's file of the particular rate review proceeding.

.17 Forms.

The following forms are illustrative of pleadings and papers commonly used by parties in rate review proceedings and should be used wherever possible and, if necessary, adapted to the facts in the proceeding and the needs of the party using the forms:

A. Rate Application.

IN RE: THE RATE APPLICATION OF	*	BEFORE THE MARYLAND
________________________ (Hospital)	*	HEALTH SERVICES COST
(City or County), Maryland	*	REVIEW COMMISSION
	*	Docket: ____________________ Folio: ______________________
	*	Proceeding No.:_______________

* * * * * * * * * * * * * * * * *

B. Public Notice of Rate Proceeding.

HEALTH SERVICES COST REVIEW COMMISSION
PUBLIC NOTICE
RATE PROCEEDING OF
(specify type of application)

(name of hospital)
(reference to proceeding)

PUBLIC NOTICE is hereby given that (specify type of application) has been filed (by-concerning) (name of hospital) before the Health Services Cost Review Commission in regard to the following rates or rate components:

(Specify services and old and new rates or rate components.)

Further notice shall be given when or if a public or general hearing is held.

The file of this application is available for public inspection at the offices of the Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, during regular business hours.

HEALTH SERVICES COST REVIEW
COMMISSION

C. Notice of Public Hearing.

NOTICE OF PUBLIC HEARING
HEALTH SERVICES COST REVIEW COMMISSION
RATE PROCEEDING OF

(specify type of application)

(name of hospital)
(reference to proceeding)

Pursuant to regulations of the Commission, the public notice is hereby published of a public hearing before (the Commission) at (location), at (time) A.M. or P.M., on (date), to consider the following issues and/or rates of (name of hospital):

(Set forth issues and/or rates.)

The designated interest parties participating in this proceeding are: Provider Reimbursement Department of Blue Cross of Maryland, Inc.; Medical Care Programs Administration of the Maryland Department of Health and Mental Hygiene (Medicaid); Division of Provider Reimbursement and Accounting Policy, Bureau of Health Insurance, Social Security Administration, Department of Health, Education and Welfare of the United States (Medicare); and (list other designated interested parties, if any, for the hospital in question.)

Any person interested in this proceeding may attend the hearing.

All persons wishing to present relevant testimony or a statement at this public hearing shall forward copies to the hospital, each designated interested party and nine copies to the Commission office. The hospital and members of the public shall forward their testimony at least 8 days before the hearing. The designated interested parties shall forward their testimony at any time before the close of the first session. The office of the Commission is as follows:

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Addresses of designated interested parties may be obtained at the Commission's office at (410) 764-2605.

All testimony and statements shall identify the proceeding to which they pertain, setting forth the name of the hospital and the docket, file and proceeding number, and must be signed by the person submitting the testimony or statement or by a representative of a group submitting testimony or a statement.

D. Notice of General Hearing.

HEALTH SERVICES COST REVIEW COMMISSION
PUBLIC NOTICE OF GENERAL HEARING
CONCERNING RATE PROCEEDING OF
(specify type of application)

(name of hospital)
(reference to proceeding)

Pursuant to rules of procedure of the Commission, public notice is hereby given of a general hearing in the above proceeding at (location), at (time) A.M., or P.M., on (date) concerning the following rates or rate components of (hospital):

(Specify services and old and new rates or rate components.)

Any person, group or organization interested in this matter may attend this hearing and present written or oral statements concerning the above rates or rate components.

Presentations may be limited as to time and the number of spokespersons representing any group or organization may be limited.

The file in the above proceeding is available at the offices of the Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215.

HEALTH SERVICES COST REVIEW COMMISSION

E. Notice of Orders Nisi.

PUBLIC NOTICE AS TO ORDERS NISI
HEALTH SERVICES COST REVIEW COMMISSION

Pursuant to regulations of the Commission, public notice is hereby given of the following Order Nisi of the Commission: (Order Nisi is to be set forth in full, including tentatively approved rates and issues.)

Motions raising objections to the above tentatively approved rates and/or issues shall be submitted (in person or by mail) to the hospital, and nine copies to the Commission's office in legibly written or typed copies, within the above deadline, ___________________, 20 __, identifying the proceeding and Order Nisi to which objections are made.

A copy of the Commission's decision and opinions, if any, may be obtained by written request to the Commission's office as follows:

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Addresses of designated interested parties may be obtained at the Commission's office at (410) 764-2605.

The record of the complete proceeding in which the above Order Nisi was passed is open for public inspection at the above Commission's office during regular business hours.

HEALTH SERVICES COST REVIEW
COMMISSION

F. Order Nisi.

ORDER NISI

Upon (open public hearing) (recommendation of Commission staff, etc.), it is this day of _________________, 20___, by the Maryland Health Services Cost Review Commission,

ORDERED, that (the following rates of ___________________ hospital be and they hereby are approved), (whatever actions are to occur or whatever issues are to be resolved, etc.), as of the __ day of _______________, 20 ___, unless reasonable cause to the contrary is shown on or before the ____ day of __________________, 20 ___.

MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

____

A majority of the Commissioners have concurred in the above Order Nisi.

G. Orders.

ORDER

Upon (consideration of Motion to _______________________________) (recommendation of Commission's staff, (consideration of, etc.), it is, this ______ day of ____________, 20 ___, by the Maryland Health Services Cost Review Commission,

ORDERED, that (requested action) be and it hereby is (approved, disapproved, etc.).

MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

____

A majority of the Commissioners have concurred in the above Order.

10.37.10.17I

H. Motions.

MOTION

(Name of movant) hereby moves that the Health Services Cost Review Commission (describe action to be taken or question to be answered) and as reasons therefore states:

(Set forth reasons, authorities, citations, etc.)

(date) (signature of movant)

(Type name, title, if any, and address and
telephone number of movant.)

I. Service.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT on this ____ day of _________________, 20___, I (mailed or caused to be mailed) (served or caused to be served) a copy of the above (describe pleading) upon (state name and address of party (parties) or attorney (attorneys) upon whom a copy of the pleading was served.)

Date: _______________, 20

____

(Signature of party filing pleading)

J. Subpoena Duces Tecum for Rate Review.

WRIT OF SUBPOENA DUCES TECUM

TO: (Name and address of person subpoenaed.)

You are hereby summoned to appear in person at the Commission's offices, 4160 Patterson Avenue, Baltimore, Maryland 21215 on (date) at (time) to give testimony under oath concerning the above proceeding.

You are also commanded then and there to produce the following documents and records:

__________________Date ____________________________________
HEALTH SERVICES COST REVIEW COMMISSION

K. Summons for Rate Review.

WRIT OF SUMMONS

TO: (Name and address of person summoned.)

You are hereby summoned to appear in person at the Commission's offices, 4160 Patterson Avenue, Baltimore, Maryland 21215 on (date) at (time) to give testimony under oath concerning the above proceeding.

__________________Date ____________________________________
HEALTH SERVICES COST REVIEW COMMISSION

L. Summons for Hearing.

WRIT OF SUMMONS

TO: (Name and address of person summoned.)

You are hereby summoned to appear in person at a public hearing before (the Commission), at (location) on (date) at (time) to testify under oath therein.

__________________Date

HEALTH SERVICES COST REVIEW COMMISSION

M. Subpoena Duces Tecum for Hearing.

WRIT OF SUBPOENA DUCES TECUM

TO: (Name and address of person subpoenaed)

You are hereby summoned to appear in person at a public hearing before the (Commission) in the above proceeding at (location) on (date) at (time) to testify under oath thereat.

You are also commanded then and there to produce the following documents and records:

__________________Date ______________________________________

HEALTH SERVICES COST REVIEW COMMISSION

.18 Format.

A. All pleadings, motions, and other papers filed in a Commission proceeding shall be typed or legibly written on sheets of bond paper not more than 11 inches long or 8½ inches wide, and each paper shall have a left margin of at least 1 inch and a top margin of at least 1½ inches.

B. All pleadings, motions, and other papers, excluding exhibits appended to the pleadings, shall contain a heading at the top of the first page and, excluding appended exhibits and written direct testimony for a public hearing, a certificate of service at the bottom of the last page.

.19 Filing of a Rate Application.

A. A rate application filed by private messenger at the offices of the Commission shall be deemed to be filed on the date the application is received during normal working hours in the Commission's office.

B. A rate application sent by registered mail shall be deemed to be filed 3 days after the application is placed in the U. S. Postal Service, these days to exclude Saturdays, Sundays, and holidays on which mail is not delivered to the Commission. The rate application's file date shall be entered on the docket of the proceeding.

.20 Service.

An original and three copies of all other pleadings, documents, testimony, or motions to be considered by the Commission shall be filed at the office of the Commission during regular business hours. All pleadings, documents, testimony, or motions shall contain a Certificate of Service indicating that the pleading, document, testimony, or motion has been mailed or served upon all designated parties to that proceeding and upon the Commission at its offices.

.21 Computations of Time Periods and Extensions.

A. In computing any period of time prescribed by these regulations, by order of the Commission or by any applicable statute, the day of the action or default initiating the designated period of time may not be included. The last day of the period so computed is to be included unless it is a day on which the office of the Commission is closed, in which event that period runs until the end of the next day on which the office of the Commission is open. When the period of time allowed is more than 5 days, intermediate Saturdays, Sundays, and legal holidays shall be considered in the same manner as other days, but if the period of time allowed is 5 days or less, intermediate Saturdays, Sundays, and legal holidays may not be counted in computing the period of time.

B. At the discretion of the Executive Director or his designee and, upon reasonable cause being shown by the submitting party, a period of time to submit a document or perform any other act permitted or prescribed by these regulations may be extended for a reasonable period of time.

.22 Motions.

A. Motions shall be in writing, except when made at a hearing or conference and shall state concisely the question which the Commission is called upon to determine, or the action the movant desires the Commission to take. It shall state all reasons, authorities, and citations in the body of the motion or in a supporting memorandum. A Certificate of Service, setting forth all parties upon whom a copy of the motions was served, shall be attached to the motion.

B. The following actions shall be taken by motion:

(1) Objections to actions of the Commission, or the Commission's staff; motions for clarification or reconsideration may not stay the orders of the Commission;
(2) Demands for actions which the movant desires the Commission, or the Commission’s staff to take;
(3) Showing reasonable cause why an Order Nisi should not become effective;
(4) Presenting a proper and justifiable question to the Commission;
(5) Objections to the introduction of statements or other evidence by another party during a proceeding;
(6) Challenges to members of the Commission;
(7) Proposals for stipulations;
(8) Answers to prior motions; and
(9) All other actions which might be initiated properly or undertaken by a party to a proceeding and which are not otherwise provided for in these regulations.

C. The motion shall be filed with the Commission and a copy shall be served on each affected party.

D. A motion need not be verified unless it is based upon facts not apparent from the record or documents filed in the proceeding.

E. Any affected party may answer an initial motion.

F. The method of considering the motion, whether by executive communication, private hearing, or public hearing shall be determined by the Chairman of the Commission.

G. The Commission shall decide upon the question presented or action demanded in the motion in an equitable manner and as soon as practicable.

H. Except when a motion is made at a conference or a hearing, the order granting or denying the motion shall be in writing and shall be entered on the record of the proceeding and copies of the order shall be served upon the moving party and all affected parties.

I. The decision expressed in the order shall be decided pursuant to these regulations, if provision is made. If no provision is made, the motion shall be decided by a majority of the Commission. However, motions made in the course of a private conference or at a public hearing shall be decided by the presiding officer or a majority of the Commission attending the session of the conference or hearing at which the motion was made, as provided elsewhere in these regulations. Motions made in the course of a general hearing shall be decided by the hearing officer.

.23 Subpoenas.

A. At any time, the Commission may issue subpoenas directing a designated person to do the following:

(1) Appear to testify at a hearing or private pre-hearing conference conducted by the Commission;

(2) Appear at a specified time and date at the Commission offices or any designated place within the State, and, under oath or otherwise, give testimony and answer questions of the Commission or its authorized representatives; or

(3) Produce documents, reports, or records of a particular activity for a specific period of time if he has custody of, or access to, the documents, reports, or records; the records may be in any reasonable form; the production shall be made at a specified time, date, and place.

B. A subpoena shall be in whatever form is prescribed by the Commission and shall include:

(1) The name, title, if any, and address of the person upon whom it is to be served and the address at which it is to be served;

(2) The name(s), title(s), or position(s) of the witness(es) who shall appear and the time, date and place of their appearance.

(3) A reasonable specification of the documents, reports and/or records, if any, to be produced at the designated time, date and place.

C. Subpoenas shall be served at least 7 days before any public hearing or private or pre-hearing conference or executive session of the Commission at which the witness or witnesses are directed to appear, and shall be served at least 3 days before a private appointment.

D. Subpoenas shall be served in person by a person designated by the executive director or, at his discretion, by registered or certified mail, return receipt requested. A signed return of the service or the return receipt shall be entered in the file and noted on the docket of the proceeding.

E. A witness or a party with whom he is associated or affiliated may move to quash or modify the subpoena directed to him at any time before the date set for his appearance by filing with the Commission a motion to quash or modify the subpoena as provided in that section which pertains to motions in general.

F. Failure to appear or to produce documents in accordance with a subpoena shall subject the witness or the party with which he is affiliated or associated to a finding of contempt by the Commission and other penalties provided by law or these regulations.

.24 Effective Date and Suspensions.

A. The effective date of rates applied for in a rate application shall be 30 days from the date of the filing of the rate application with the Commission and shall be specified in the rate application.

B. The Commission's staff may recommend the suspension of the effective date of the rates under review.

C. At any time during a rate review, the Commission may order a suspension of the effective date of the rates under review, within the time specifications of Health-General Article, §19-219, Annotated Code of Maryland, and shall state the grounds for its action.

.25 Evidence, Testimony, and Official Notice.

A. The presiding officer at a public hearing or general hearing shall make all rulings as to evidence, testimony, and official notice and he may call on the legal counsel of the Commission for guidance in his rulings.

B. All evidence and testimony shall be relevant and pertain solely to the issues being considered in a particular proceeding.

C. Redundant evidence or testimony may not be permitted at public or general hearings or in the records of proceedings.

D. Non-expert opinion testimony may be considered at a hearing and documentary opinion evidence may be entered in the record of a proceeding if the testimony or evidence is based on facts and matters admissible into evidence and the facts and matters are within the personal knowledge of the submitter of the document.

E. Qualification as an expert shall be within the discretion of the presiding officer of the public or general hearing at which the proposed expert may proffer testimony or evidence or, if evidence is proffered at a time other than at a public hearing, within the discretion of the Chairman of the Commission considering the proceeding. The expert qualification need not be based upon academic degrees or learning; reasonably extensive practical experience with the subject may be sufficient for an expert qualification.

F. Subject to the provisions of these regulations, legal rules of evidence shall be followed as far as practicable at public and general hearings.

G. Reliable and probative documents previously filed with or compiled by the Commission or its staff or consultants that are relevant to issues being considered by the Commission may be incorporated by reference into the record of a proceeding by the Commission or, by leave of the presiding officer, by a party to the proceeding.

H. In the course of a proceeding, the Commission may take official notice of facts and matters in the same manner as the courts of the State take judicial notice of facts and matters and, additionally, may take notice, without meeting formal evidentiary rules, of general, technical, or scientific facts within the specialized knowledge of a member of the Commission. However, any party to the proceeding is entitled, on timely request, to an opportunity to show that the Commission should not take official notice of specific facts and matters or that the fact or matter to be officially noticed is inapplicable to the proceeding or is incorrect or misunderstood by the Commission.

I. In reviewing a hospital's rate structure, the Commission may consider or take official notice of any public document, including, but not limited to, any filing made with the Maryland Health Resources Planning Commission relative to a Certificate of Need application, including all projections of volumes, revenues, rates, and feasibility studies, as well as any public document concerning the financing of a project approved pursuant to a Certificate of Need.

.26 Differentials.

A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy;

(b) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(c) 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 is authorized representative in order to understand:

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill;

(iii) How to apply for free and reduced-cost care; and

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(d) Provides contact information for the Maryland Medical Assistance Program; and

(e) Includes a statement that physician charges are not included in the hospital bill and are billed separately.

(2) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before discharge;

(b) With the hospital bill; and

(c) On request.

(3) The hospital bill shall include a reference to the information sheet.

(4) The Commission shall:

(a) Establish uniform requirements for the information sheet; and

(b) Review each hospital's implementation of and compliance with the requirements of this section.

A-1. Hospital Credit and Collection Policies.

(1) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(2) The policy shall:

(a) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(b) Prohibit the hospital from selling any debt;

(c) Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

(d) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(e) Describe the hospital's procedures for collecting any debt; and

(f) Describe the circumstances in which the hospital will seek a judgment against a patient.

(3) The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of § A-1(2) of this regulation.

B. Working Capital Differentials--Payment of Charges.

(1) A third-party payer may obtain a discount in rates established by the Commission if it provides current financing monies in accordance with the following terms:

(a) A third-party payer that provides current financing equal to the average amount of outstanding charges for bills from the end of each regular billing period and for discharged patients shall be entitled to a 2-percent discount. For purposes of this regulation, a regular billing period shall be based on a 30-day billing cycle. The current financing provided in here corresponds to a third party's paying on discharge.

(b) A third party payer that provides current financing equal to the average amount of outstanding charges for discharged patients plus the average daily charges times the average length of stay, shall be entitled to a 2.25-percent discount. The current financing provided in here corresponds to a third party's paying on admission.

(c) Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third party payer's processing and payment time.

(d) Upon request from an applicant, the Commission may approve an alternative method of calculating current financing monies.

(e) The third party payer shall adjust the current financing advance to reflect Commission rate orders and changes in volume associated with the particular payer and hospital. This adjustment shall be made within 45 days of a rate order or at such other time as circumstances warrant. In the absence of a rate order, the adjustment shall be made at least annually.

(2) The third party payer shall promptly provide the Commission with a verified record of the detailed calculation of the current financing and of each recalculated balance as adjustments are made. The detailed calculations shall become a part of the public record. The Commission may, at any time, evaluate the amount of current financing monies provided to a hospital to assure that it meets the discount of requirements specific in §B(1), above. If the Commission finds that the amount of current financing is inconsistent with the requirements of §B(1), the Commission may, at its sole discretion, require an adjustment to the working capital advance or to the discount.

(3) A payer or self-paying patient, who does not provide current financing under §B(1)(a) - (e) of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers a not subject to Insurance Article, § 15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(4) Hospital Billing Responsibilities.

(a) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(b) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and excepting arithmetic errors, represent the full charge for the patient's care. In addition, a notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts mentioned above.

(c) The bill and the notice shall state that the:

(i) Charge is due within 60 days of the discharge or dismissal; and

(ii) Patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days; and

(iii) Payers not subject to Insurance Article, § 15-1005, Annotated Code of Maryland, may be subject to interest or late payment charges at a rate of 1 percent per month beginning on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(5) Hospital Financial Assistance Responsibilities.

(a) On or before June 1, 2009, each hospital shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage. The financial assistance policy shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level; and

(ii) Reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital.

(b) A hospital whose current financial assistance policy, that is, as of May 8, 2009, provides for free or reduced-cost medical care to patients at an income threshold higher than that set forth in § B(5)(a) of this regulation may not reduce that income threshold.

(c) A hospital that believes that an increase to the income thresholds as set forth in §B(5)(a) of this regulation may result in undue financial hardship to it may file a written request with the Commission that it be exempted from the increased threshold. In evaluating the hospital's request for exemption, the Commission shall consider the hospital's:

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

(d) Based on staff's evaluation of the written request for an exemption, the Executive Director shall respond in writing within a reasonable period of time approving or disapproving the hospital's exemption request.

(e) A hospital denied an exemption shall be afforded an opportunity to address the Commission at a public meeting on its request. Based on arguments made at the public meeting, the Commission may approve, disapprove, or modify the Executive Director's decision on the exemption request.

(f) A notice shall be posted in conspicuous places throughout the hospital including the billing office, describing the financial assistance policy and how to apply for free and reduced-cost care.

(g) Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost care.

(h) Each hospital shall establish a mechanism to provide the Uniform Financial Assistance Application to patients who do not indicate public or private health care coverage.

C. GME Discounts. In those instances where a teaching hospital is reimbursed separately for the costs associated with the provision of graduate medical education (GME), the Commission shall calculate the percentage of the hospitals's rates that these GME payments represent and provide notice of the amounts that may be credited toward the payment for services rendered. At all times, total payment received by the teaching hospital shall be in accordance with Commission-approved rates.

.26-1 Maryland Health Insurance Plan (MHIP) Assessment.

A. The Commission shall determine and assess those funds necessary to operate and administer the MHIP. The Commission shall adjust hospital rates to implement the revenue neutral assessment.

B. Beginning July 1, 2008, the Commission shall assess each hospital 1 percent of its net patient revenue to operate and administer the MHIP.

C. Beginning on September 5, 2003, each hospital whose rates have been approved by the Commission shall remit monthly, by the 5th of each month, 1/12 of its total share of the annual funding assessment determined by the Commission to be owed by the hospital to the Maryland Health Insurance Plan Fund as established under Insurance Article, Title 14, Subtitle 5, Annotated Code of Maryland.

D. A hospital that fails to remit its funding assessment due in a timely manner may be subject to an annualized interest charge of 3 percentage points above the most recent average prime rate of interest, as published in the "Money Rates" section of The Wall Street Journal, on the unpaid balance. In addition, the Commission may impose penalties of up to 5 percent of the amount of any underpayment made by the hospital.

.26-2 Assessment for Savings in Averted Uncompensated Care.

A. Beginning July 1, 2008, the Commission shall assess annually a uniform, broad-based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care resulting from the expansion of health care coverage under Ch. 7, Acts of 2007 Special Session.

B. Given the prospective nature of the rate system, the Commission shall ensure that the assessment amount does not exceed the savings projected in averted hospital uncompensated care from the health care coverage expansion. The Commission shall notify hospitals annually of the amount to be assessed by July 1 of each year, to be effective July 1.

C. Beginning September 2008, on or before the 5th business day of each month, each hospital assessed in accordance with Health-General Article § 19-214, Annotated Code of Maryland, and the provisions of this regulation shall make payment into the Health Care Coverage Fund established under Health-General Article, § 15-701, Annotated Code of Maryland.

D. A hospital that fails to remit its monthly funding assessment in a timely manner may be subject to an annualized interest charge of 3 percentage points above the most recent average prime rate of interest, as published in the "Money Rates" section of the Wall Street Journal, on the unpaid balance. In addition, the Commission may impose penalties of up to 5 percent of any underpayment made by the hospital.

.27 Designated Interested Parties.

A. Designated interested parties for a specific rate review proceeding may include:

(1) Those community oriented groups which the Commission determines have a significant interest in the hospital and its rate application;

(2) Those third party payors or their representatives who have been designated by the Commission as interested parties for this proceeding;

(3) The hospital whose rates are being reviewed;

(4) Maryland Health and Higher Educational Facilities Authority for rate review proceedings concerning hospitals with capital financing through the Authority;

(5) Group Hospitalization, Incorporated, for rate review proceedings concerning hospitals with which it has contractual relations; and

(6) Legal Aid Bureau of Baltimore City.

B. Designated interested parties for all rate applications are:

(1) Provider Reimbursement Department, Blue Cross of Maryland, Inc.;

(2) Medical Care Programs Administration of the Department of Health and Mental Hygiene (Medicaid);

(3) Division of Provider Reimbursement and Accounting Policy, Bureau of Health Insurance, Social Security Administration, Department of Health, Education and Welfare of the United States (Medicare); and

(4) Health Insurance Association of America.

.28 Right to Counsel.

A hospital or any other party in a rate review proceeding may be represented by legal counsel at any or all times during the proceeding, but there is no requirement that parties have legal counsel.

.29 Challenges.

A. Any party to a proceeding may challenge the ability of any member of the Commission to consider the rates or issues in that proceeding. Excepting private conferences, this challenge shall be made during the proceeding before its first hearing. Challenges may not be permitted after the first hearing, except in extraordinary circumstances.

B. A challenge shall be verified in writing, specifying the member of the Commission and shall set forth all its reasons. The challenge shall be filed with the Commission and entered upon the record of the proceeding.

C. A copy of the challenge shall be forwarded to the challenged member immediately after it is filed, and he may make whatever response he deems proper and necessary.

D. The challenge shall be denied or allowed by a majority of the Commission, excluding the challenged member. The order based on the decision shall be filed with the Commission, entered in the record of the proceeding and served on the challenged member and the challenging party.

E. If a challenge to a Commission member is allowed, he immediately shall cease all participation in the proceeding in question as a Commission member.

F. The allowance of a challenge to a member of the Commission may not, in itself, disqualify him from serving as a Commission member in other matters and proceedings.

.30 Consolidation.

When two or more rate proceedings involve common questions of fact, the Commission, upon a majority vote of its members, may order that the common questions of fact be decided in a consolidated proceeding.

.31 Burden of Proof.

A. In proceedings initiated by a regular, temporary, or new hospital rate application, the burden of proof of the reasonableness, equity, and lack of undue discrimination of the proposed rates shall rest with the hospital.

B. In proceedings initiated by an application for an alternative method of rate determination, the burden of proof of the applicability of the alternative method of rate review to the hospital shall rest with the hospital.

C. In proceedings initiated by an order for Commission review of established rates, the burden of proof of the reasonableness, equity, and lack of undue discrimination of the established rates under review shall rest with the hospital.

.32 Severability.

If any section or provision of these regulations is declared unconstitutional or void by any Court of competent jurisdiction, or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the regulations and the applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these regulations are declared to be severable.

.33 Petition for Promulgation, Amendment, or Repeal of Regulation.

A. Any interested party may file with the Commission a petition for the promulgation, amendment, or repeal of a regulation designed to implement, interpret, or prescribe law, policy, organization, procedure, or practice requirements of the Commission. The petition shall set forth:

(1) The interest of the petitioner and the nature of the relief desired;
(2) Any facts, views, arguments, and data deemed relevant by the petitioner; and
(3) Verification under oath by the party or by a duly authorized officer or agent of the party, whose address and title shall be stated.

B. If the petition is for the promulgation of a regulation, a copy of the proposed regulation shall be attached.

C. If the petition is for the amendment of a regulation, a copy of the amended regulation shall be attached with new matters underlined and matters to be deleted bracketed.

D. In addition to and accompanying the original of the petition filed with the Commission, there shall be 12 copies for use of the Commission and other interested parties.

E. The Commission shall consider the petition as well as all comments relating to it by interested parties. Within 30 days from the filing of the petition, the Commission shall render a decision:

(1) Denying the petition and stating the reasons therefor; or

(2) Submitting the proposed action to the Maryland Register for notice to, and comments by, all interested parties.

.34 Petition for Declaratory Ruling.

A. An interested person may file with the Commission a petition for a declaratory ruling with respect to the manner in which the Commission would apply a statute that the Commission enforces, a regulation of the Commission, or an order of the Commission, to a person or property on the facts set forth in the petition.

B. The petition for a declaratory ruling shall be filed in writing and shall contain a statement describing in detail the interest of the petitioner in making the request, the issues involved, a statement of the facts, a listing of documents or statements, or both, to be considered, and a sworn statement by the petitioner that the facts contained there are true to the best of the person's knowledge and belief.

C. Sixty days from the receipt of the petition the Commission shall inform the petitioner whether the petition will be granted. If the petition is not granted, the Commission shall inform the petitioner in writing of the reasons for the denial. If the petition is granted, the Commission shall inform the petitioner when to expect the declaratory ruling.

.35 Consideration and Disposition.

A. Consideration.

(1) The petition shall be granted whenever the Commission deems issuing a declaratory ruling advisable under the circumstances.

(2) In rendering its declaratory ruling, the Commission:

(a) Shall consider all the materials submitted with the petition; or
(b) May, in its discretion:

(i) Consult individuals or materials outside the corners of the petition, or
(ii) Require argument of the question or permit the introduction of evidence.

B. Disposition.

(1) A declaratory ruling issued shall be in writing, stating the:

(a) Issue;
(b) Conclusion;

(c) Facts upon which the conclusion was based; and
(d) Sources relied upon.

(2) A declaratory relief issued by the Commission shall plainly state on its face that it is a declaratory ruling pursuant to this regulation.
(3) A written answer from the Commission to an inquiry may not be construed as a declaratory ruling unless made in conformity with these regulations.

C. Publication and Inspection. The Commission:

(1) Shall keep a record of each declaratory ruling issued and index all declaratory rulings issued by reference to statute or statues or regulation or regulations involved.
(2) May publish a declaratory ruling of general interest subject to the mandates of the Public Information Act, State Government Article, §10-601, et seq.; Annotated Code of Maryland, and allow inspection of the declaratory rulings subject to the Public Information Act.

D. Denial of a Petition for Declaratory Ruling. A petition may be denied if the:

(1) Request contains incomplete information upon which to base an informed declaratory ruling;
(2) Commission concludes that a declaratory ruling cannot reasonably be given on the matter;
(3) Matter is adequately covered by a prior regulation, declaratory ruling, decision, or legal opinion; or
(4) Commission concludes that a declaratory ruling would not be in the public interest.

.36 Effect and Appeal.

A. Effect.

(1) A declaratory ruling shall be binding upon the Commission and the petitioner on the statement of facts covered in the declaratory ruling and set forth in the petition.

(2) After notice and an opportunity to reply, a declaratory ruling may be reconsidered, amended, altered, or revoked by the Commission.

B. Appeal. A declaratory ruling is subject to review as provided in State Government Article, §10-305, Annotated Code of Maryland.