Health-General Article, § 19-201, et seq.
Annotated Code of Maryland

Subtitle 2. Health Services Cost Review Commission

§ 19-201. Definitions.

(a) *In general.* -- In this subtitle, the following words have the meanings indicated.

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

(c) *Facility*. -- "Facility" means, whether operated for a profit or not:

(1) Any hospital; or

(2) Any related institution.

(d) *Hospital services*. -- (1) "Hospital services" means:

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

(ii) Emergency services, including services provided at:

(1) Freestanding medical facility pilot projects authorized under Subtitle 3A of this title prior to January 1, 2008; and

(2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015;

(iii) Outpatient services provided at the hospital; and

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

(2) "Hospital services" does not include:

(i) Outpatient renal dialysis services; or

(ii) Outpatient services provided at a limited service hospital as defined in § 19-301 of this title, except for emergency services.

(e) *Related institution*. -- (1) "Related institution" means an institution that is licensed by the Department as:

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

(ii) An intermediate care facility—intellectual disability.

(2) "Related institution" includes any institution in paragraph (1) of this subsection, as reclassified from time to time by law. (An. Code 1957, art. 43, §§ 568H, 568-I; 1982, ch. 21, § 2; 1984, ch. 370; 1985, ch. 10, § 3; ch. 112; 1999, ch. 678; ch. 702, § 2; 2003, ch. 349; 2009, ch. 119; 2010, chs. 505, 506.)

§ 19-202. Commission established.

There is a State Health Services Cost Review Commission. The Commission is an independent Commission that functions in the Department. (An. Code 1957, art. 43, § 568-I; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-203. Membership.

(a) *Composition; appointment of members*. -- (1) The Commission consists of 7 members appointed by the Governor.

(2) Of the 7 members, 4 shall be individuals who do not have any connection with the management or policy of any facility.

(b) *Qualifications*. -- Each member shall be interested in problems of health care.

(c) *Tenure; vacancies*. -- (1) The term of a member is 4 years.

(2) The terms of members are staggered as required by the terms provided for members of the Commission on July 1, 1982. The terms of those members end as follows:

(i) 2 in 1983;

(ii) 1 in 1984;

(iii) 2 in 1985; and

(iv) 2 in 1986.

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

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

(5) A member who serves 2 consecutive full 4-year terms may not be reappointed for 4 years after completion of those terms/

(6) When appointing a member to fill a vacancy due to the expiration of a member's term, the Governor shall give consideration to, and make appointments when appropriate, that would promote the racial, gender, and geographic diversity of the Commission. (An. Code 1957, art. 43, § 568J; 1982, ch. 21, § 2; 1999, ch. 702, § 2; 2003, ch. 349.)

§ 19-204. Officers.

Annually, from among the members of the Commission:

(1) The Governor shall appoint a chairman; and

(2) The chairman shall appoint a vice chairman. (An. Code 1957, art. 43, § 568J; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-205. Executive Director.

(a) *Position and appointment*. -- With the approval of the Governor, the Commission shall appoint an Executive Director, who is the chief administrative officer of the Commission.

(b) *Responsibility to Commission*. -- The Executive Director serves at the pleasure of the Commission.

(c) *Duties*. -- Under the direction of the Commission, the Executive Director shall perform any duty or function that the Commission requires. (An. Code 1957, art. 43, § 568L; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-206. Quorum; meetings; compensation; staff.

(a) *Quorum*. -- A majority of the full authorized membership of the Commission is a quorum. However, the Commission may not act on any matter unless at least 4 members in attendance concur.

(b) *Meetings*. -- The Commission shall meet at least 6 times a year, at the times and places that it determines.

(c) *Compensation and reimbursement for expenses*. -- Each member of the Commission is entitled to:

(1) Compensation in accordance with the State budget; and

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

(d) *Staff*. -- (1) The Commission may employ a staff in accordance with the State budget.

(2) The Commission, in consultation with the Secretary, shall determine the appropriate job classification and grades for all staff.

(3) The Deputy Director and each principal section chief of the Commission serve at the pleasure of the Commission.

(4) The Commission, in consultation with the Secretary, may determine the appropriate job classifications and, subject to the State budget, the compensation for the Executive Director, Deputy Director, and each principal section chief of the Commission. (An. Code 1957, art. 43, §§ 568J, 568L; 1982, ch. 21, § 2; 1993, ch. 136; 1999, ch. 702, § 2; 2009, ch. 690.)

§ 19-207. Miscellaneous powers and duties.

(a) *General powers*. -- In addition to the powers set forth elsewhere in this subtitle, the Commission may:

(1) Adopt rules and regulations to carry out the provisions of this subtitle;

(2) Create committees from among its members;

(3) Appoint advisory committees, which may include individuals and representatives of interested public or private organizations;

(4) Apply for and accept any funds, property, or services from any person or government agency;

(5) Make agreements with a grantor or payor of funds, property, or services, including an agreement to make any study, plan, demonstration, or project;

(6) Publish and give out any information that relates to the financial aspects of health care and is considered desirable in the public interest; and

(7) Subject to the limitations of this subtitle, exercise any other power that is reasonably necessary to carry out the purposes of this subtitle.

(b) *General duties*. -- In addition to the duties set forth elsewhere in this subtitle, the Commission shall:

(1) Adopt rules and regulations that relate to its meetings, minutes, and transactions;

(2) Keep minutes of each meeting;

(3) Prepare annually a budget proposal that includes the estimated income of the Commission and proposed expenses for its administration and operation;

(4) Within a reasonable time after the end of each facility's fiscal year or more often as the Commission determines, prepare from the information filed with the Commission any summary, compilation, or other supplementary report that will advance the purpose of this subtitle;

(5) Periodically participate in or do analyses and studies that relate to:

(i) Health care costs;

(ii) The financial status of any facility; or

(iii) Any other appropriate matter.

(6) On or before October 1 of each year, submit to the Governor, to the Secretary, and, subject to § 2-1246 of the State Government Article, to the General Assembly an annual report on the operations and activities of the Commission during the preceding fiscal year, including:

(i) A copy of each summary, compilation, and supplementary report required by this subtitle;

(ii) An update on the status of the State's Medicare waiver;

(iii) Budget information regarding the Health Services Cost Review Commission Fund, including:

1. Any balance remaining in the Fund at the end of the previous fiscal year; and

2. The percentage of the total annual costs of the Commission that is represented by the balance remaining in the Fund at the end of the previous fiscal year;

(iv) A summary of the Commission's role in hospital quality of care activities, including information about the status of any pay for performance initiatives; and

(v) Any other fact, suggestion, or policy recommendation that the Commission considers necessary;

(7) Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Maryland Health Care Commission; and

(8) In consultation with the Maryland Health Care Commission, annually publish each acute care hospital's severity-adjusted average charge per case for the 15 most common inpatient diagnosis-related groups.

(c) *Deadlines for reports*. -- (1) The Commission shall set deadlines for the filing of reports required under this subtitle.

(2) The Commission may adopt rules or regulations that impose penalties for failure to file a report as required.

(3) The amount of any penalty under paragraph (2) of this subsection may not be included in the costs of a facility in regulating its rates.

(d) *Records*. -- Except for privileged medical information, the Commission shall make:

(1) Each report filed and each summary, compilation, and report required under this subtitle available for public inspection at the office of the Commission during regular business hours; and

(2) Each summary, compilation, and report available to any agency on request.

(e) *Contracts*. -- (1) The Commission may contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Commission.

(2) Unless permission is granted specifically by the Commission, a third party hired by the Commission may not release, publish, or otherwise use any information to which the third party has access under its contract. (An. Code 1957, art. 43, §§ 568J, 568L, 568M, 568P to 568T, 568X, 568Y; 1982, ch. 21, § 2; ch. 911, § 12; 1984, ch. 285, § 2; 1997, ch. 635, § 9; ch. 636, § 9; 1999, ch. 702, § 2; 2003, ch.385; 2006, ch. 48; 2007, ch. 628.)

§ 19-207.1. User fees.

Redesignated.

§ 19-207.2. Fee for closed or delicensed hospitals.

Redesignated.

§ 19-207.3. Hospital uncompensated care.

Redesignated.

§ 19-208. Limitations on Secretary.

(a) *Plans, proposals, and projects*. -- The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify any decision or determination that the Commission makes under authority specifically delegated by law to the Commission.

(b) *Staff, functions, and funds*. – (1) The power of the Secretary to transfer by rule, regulation, or written directive, any staff, functions, or funds of units in the Department does not apply to any staff, function, or funds of the Commission

(2) The Secretary may assess an administrative charge on the Commission to fund services provided to the Commission by the Department.

(3) The amount to be paid by the Commission to the Department for administrative costs, not to exceed 18% of the salaries of the Commission, shall be based on indirect costs or services benefiting the Commission, less overhead costs paid directly by the Commission.

(c) *Procurement procedure*. -- 1) The power of the Secretary over the procurement procedure for units in the Department does not apply to the procurement procedure for the Commission.

(2) Subject to the provisions of paragraph (1) of this subsection, any procurement for services to be performed or for supplies to be delivered to the Commission is subject to the purposes and requirements of the State Finance and Procurement Article. (An. Code 1957, art. 41, § 206; 1982, ch. 21, § 2; 1999, ch. 702, § 2; 2004, ch. 430, § 4; 2005, ch. 444, §1; 2006, ch. 107; 2007, ch. 628.)

§19-209. Health information exchange pilot project.

Abrogated on June 30, 2010.

§19-210.

Reserved.

Part II. Health Care Facility Rate Setting.

§ 19-211. Jurisdiction of Commission.

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

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

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

(b) *Ratesetting restricted.* -- The Commission may not set rates for related institutions until:

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

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

(c) *Ratesetting. – Freestanding medical facilities.* -- The Commission shall set rates for hospital services provided at:

(1) A freestanding medical facility pilot project authorized under Subtitle 3A of this title prior to January 1, 2008; and

(2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015. (An. Code 1957, art. 43, §§ 568-I, 568-U; 1982, ch. 21, § 2; 1985 ch. 112; 1986, ch. 5, § 1; 1999, ch. 702, § 2; 2010, chs. 505, 506.)

§ 19-212. Financial status.

The Commission shall:

(1) Require each facility to disclose publicly:

(i) Its financial position; and

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

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

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

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

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

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

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

(iii) Rates are set equitably among all purchasers of services without undue discrimination. (An. Code 1957, art. 43, § 568H; 1982, ch. 21, § 2; 1983, ch. 583, § 2; 1985, ch. 112; 1999, ch. 702, § 2.)

§ 19-212.1. Notification of certain financial transactions, contracts or agreements required.

Redesignated.

§ 19-213. User fees.

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

(2) "Facilities" means hospitals and related institutions whose rates have been approved by the Commission.

(b) *Assessment and collection authorized*. -- The Commission shall assess and collect user fees on facilities as defined in this section.

(c) *Limitation on amount and use of user fees*. -- (1) The total fees accessed by the Commission may not exceed $5,5000,000.

(2) The total user fees assessed by the Commission may not exceed the Special Fund appropriation for the Commission by more than 20%.

(3) The user fees assessed by the Commission shall be used exclusively to cover the actual documented direct costs of fulfilling the statutory and regulatory duties of the Commission in accordance with the provisions of this subtitle and any administrative costs for services to the Commission provided by the Department.

(4) The Commission shall pay all funds collected from fees assessed in accordance with this section into the Health Services Cost Review Commission Fund.

(5) The user fees assessed by the Commission may be expended only for purposes authorized by the provisions of this subtitle.

(6) The amount specified in paragraph (1) of this subsection limits only the total user fees the Commission may assess in a fiscal year.

(d) *Health Services Cost Review Commission Fund*. -- (1) There is a Health Services Cost Review Commission Fund.

(2) The Fund is a special continuing, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.

(3) The Treasurer shall separately hold, and the Comptroller shall account for, the Fund.

(4) The Fund shall be invested and reinvested in the same manner as other State funds.

(5) Any investment earnings shall be retained to the credit of the Fund.

(6) The Fund shall be subject to an audit by the Office of Legislative Audits as provided for in § 2-1220 of the State Government Article.

(7) This section may not be construed to prohibit the Fund from receiving funds from any other source.

(8) The Fund shall be used only to provide funding for the Commission and for the purposes authorized under this subtitle. The costs of the Commission include the administrative costs incurred by the Department on behalf of the Commission.

(e) *Powers of Commission*. -- The Commission shall:

(1) Assess user fees for each facility equal to the sum of:

(i) The amount equal to one half of the total user fees times the ratio of admissions of the facility to total admissions of all facilities; and

(ii) The amount equal to one half of the total user fees times the ratio of gross operating revenue of each facility to total gross operating revenues of all facilities;

(2) Establish minimum and maximum assessments; and

(3) Assess each facility on or before June 30 of each year.

(f) *Payment*. -- On or before September 1 of each year, each facility assessed under this section shall make payment to the Commission. The Commission shall make provision for partial payments.

(g) *Interest penalty*. -- Any bill not paid within 30 days of an agreed payment date may be subject to an interest penalty to be determined by the Commission.

(h) *Termination of section*. -- (1) This section shall terminate and be of no effect on the first day of July following the cessation of a waiver by law or agreement for Medicare and Medicaid between the State of Maryland and the federal government.

(2) If notice of intent to terminate is made by the federal government to this State prior to the first day of an intervening session of the Maryland General Assembly, this section shall expire June 30 of the following calendar year. However, under no circumstances shall less than seven calendar months occur between notice of termination and expiration of this section. (1983, ch. 132; 1986, ch. 684; 1988, ch. 391; 1991, ch. 169; 1992, ch. 18; 1993, ch. 136; 1995, ch. 319; 1997, ch. 238; ch 635, § 9; ch. 636, § 9; 1999, ch. 613; ch. 702, § 2; 2000, ch. 375; 2001, ch. 498; 2004, ch. 430, § 4; 2005, ch. 444, § 1; 2006, ch. 107; 2007, ch. 628; 2008, ch. 641.)

§ 19-214. Hospital uncompensated care [Amendment subject to contingent abrogation].

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

(1) Reduce uncompensated care; and

(2) Assure the integrity of the payment system.

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

(1) Are in the public interest;

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

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

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

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

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

(d) *Annual assessment for savings in averted uncompensated care*. – (1) Each year, the Commission shall assess a uniform, broad-based, and reasonable amount in hospital rates to:

(i) Reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly; and

(ii) Operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.

(2) (i) For the portion of the assessment under paragraph (1)(i) of this subsection:

1. The Commission shall ensure that the assessment amount does not exceed the savings realized in averted hospital uncompensated care from the health care coverage expansion; and

2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15-701 of this article.

(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1)(i) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.

(3) For the portion of the assessment under paragraph (1)(ii) of this subsection:

(i) The Commission shall ensure that the assessment:

1. Shall be included in the reasonable costs of each hospital when establishing the hospital's rates;

2. May not be considered in determining the reasonableness of rates or hospital financial performance under Commission methodologies; and

3. May not be less as a percentage of net patient revenue than the assessment of 0.8128% that was in existence on July 1, 2007; and

(ii) Each hospital shall remit monthly one-twelfth of the amount assessed under paragraph (1)(ii) of this subsection to the Maryland Health Insurance Plan Fund established under Title 14, Subtitle 5 of the Insurance Article, for the purpose of operating and administering the Maryland Health Insurance Plan.

(4) The assessment authorized under paragraph (1) of this subsection may not exceed 3% in the aggregate of any hospital's total net regulated patient revenue.

(5) Funds generated from the assessment under this subsection may be used only as follows:

(i) To supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008;

(ii) To provide funding for the operation and administration of the Maryland Health Insurance Plan, including reimbursing the Department for subsidizing the plan costs of members of the Maryland Health Insurance Plan under a Medicaid Waiver Program; and

(iii) Any funds remaining after expenditures under items (i) and (ii) of this paragraph have been made may be used for the general operations of the Medicaid program.

(e) *Annual report.* – On or before January 1 each year, the Commission shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly the following information:

(1) The aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the General Assembly of the 2007 Special Session; and

(2) The number of individuals who enrolled in Medicaid as a result of the change in eligibility standards under § 15-103(a)(2)(ix) and (x) of this article and the expenses associated with the utilization of hospital inpatient care by these individuals. (1992, ch. 375, § 1; 1999, ch. 702, § 2; 2007, ch. 5, § 7; 2007 Sp. Sess., ch. 7, § 1; 2008, ch. 36, § 6; chs. 244, 245; 2009, chs. 310, 211; ch. 487, § 1, 2010, ch. 72.)

§ 19-214.1. Financial assistance policy.

(a) *Definitions.* -- (1) In this section the following words have the meanings indicated:

(2) *"Financial hardship"* means medical debt, incurred by a family over a 12-month period, that exceeds 25% of family income.

(3) *"Medical debt"* means out-of-pocket expenses, excluding co-payments, coinsurance, and deductibles, for medical costs billed by a hospital.

(b) *In general.* – (1) The Commission shall require each acute care hospital and each chronic care hospital in the State under the jurisdiction of the Commission to develop a financial assistance policy for providing free and reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

(2) The financial assistance police shall provide, at a minimum:

(i) Free medically necessary care to patients with family income at or below 150% of the federal poverty level; and

(ii) Reduced-cost medically necessary care to low-income patients with family income above 150% of the federal poverty level, in accordance with the mission and service area of the hospital.

(3) (i) The Commission by regulation may establish income thresholds higher than those under paragraph (2) of this subsection.

(ii) In establishing income thresholds that are higher than those under paragraph (2) of this subsection for a hospital, the Commission shall take into account:

1. The patient mix of the hospital;
2. The financial condition of the hospital;
3. The level of bad debt experienced by the hospital; and
4. The amount of charity care provided by the hospital.

(4) (i) Subject to subparagraphs (ii) and (iii) of this paragraph, the financial assistance policy required under this subsection shall provide reduced-cost medically necessary care to patients with family income below 500% of the federal poverty level who have a financial hardship.

(ii) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under subparagraph (i) of this paragraph.

(iii) In establishing a family income threshold that is different than the family income threshold under subparagraph (i) of this paragraph, the Commission shall take into account:

1. The median family income in the hospital's service area;
2. The patient mix of the hospital;
3. The financial condition of the hospital;
4. The level of bad debt experienced by the hospital;
5. The amount of charity care provided by the hospital; and
6. Other relevant factors.

(5) If a patient is eligible for reduced-cost medically necessary care under paragraphs (2)(ii) and (4) of this subsection, the hospital shall apply the reduction that is most favorable to the patient.

(6) If a patient has received reduced-cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.

(c) *Posting notice of policy throughout hospitals.* – A hospital shall post a notice in conspicuous places throughout the hospital, including the billing office, informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(d) *Duties of Commission.* – The Commission shall:

(1) Develop a uniform financial assistance application; and

(2) Require each hospital to use the uniform financial assistance application to determine eligibility for free and reduced-cost care under the hospital's financial assistance policy.

(e) *Application*. – The uniform financial assistance application:

(1) Shall be written in simplified language; and

(2) May not require documentation that presents an undue barrier to a patient's receipt of financial assistance.

(f) *Information sheet*. -- (1) Each hospital shall develop an information sheet that:

(i) Describes the hospital's financial assistance policy;
(ii) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;
(iii) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

1. The patient's hospital bill;
2. The patient's rights and obligations with regard to the hospital bill;
3. How to apply for free and reduced-cost care; and

4. How to apply for the Maryland Medical Assistance Program and and other programs that may help pay the bill;

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

(v) 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:

(i) Before discharge;
(ii) With the hospital bill; and
(iii) On request.

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

(i) Establish uniform requirements for the information sheet; and
(ii) Review each hospital's implementation of and compliance with the requirements of this subsection.

(g) *Availability of Staff.* – Each hospital shall ensure the availability of staff who are trained to work with the patient, the patient's family, and the patient's authorized representative in order to understand:

(1) The patient's hospital bill;

(2) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost medically necessary care due to a financial hardship;

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

(4) How to contact the hospital for additional assistance. (2005, ch. 280, § 2; 2009, chs. 310, 311; 2010, chs. 60, 61.)

§ 19-214.2. Debt Collection Policy.

(a) *Submission to Commission.* -- 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.

(b) *Contents.* -- The policy shall:

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

(2) Prohibit the hospital from selling any debt;

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

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

(5) Describe the hospital's procedures for collecting a debt;

(6) Describe the circumstances in which the hospital will seek a judgment against a patient;

(7) In accordance with subsection (c) of this section, provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care on the date of service;

(8) If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care on the date of the service for which the judgment was awarded or the adverse information as reported, require the hospital to seek to vacate the judgment or strike the adverse information; and

(9) Provide a mechanism for a patient to:

(i) Request the hospital to reconsider the denial of free or reduced-cost care; and

(ii) File with the hospital a complaint against the hospital or an outside collection agency used by the hospital regarding the handling of the patient's bill.

(c) *Refund; reduction of period.* – (1) Beginning October 1, 2010, a hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service.

(2) A hospital may reduce the 2-year period under paragraph (1) of this subsection to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free care at the time of

service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the requested information.

(3) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital services, a hospital's refund policy shall provide for a refund that complies with the terms of the patient's plan.

(d) *Report to consumer reporting agency or commencement of civil action.* – (1) For at least 120 days after issuing an initial patient bill, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill.

(2) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(e) *Sale or foreclosure of patient's primary residence prohibited.* – (1) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill.

(2) If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

(f) *Delegation to outside collection agency.* – If a hospital delegates collection activity to an outside collection agency, the hospital shall:

(1) Specify the collection activity to be performed by the outside collection agency through an explicit authorization or contract;

(2) Require the outside collection agency to abide by the hospital's credit and collection policy;

(3) Specify procedures the outside collection agency must follow if a patient appears to qualify for financial assistance; and

(4) Require the outside collection agency to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the outside collection agency regarding the handling of the patient's bill; and

(ii) Forward the complaint to the hospital if a patient files a complaint with the collection agency.

(g) *Review and approval of policies.* – (1) The board of directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital at least every 2 years.

(2) A hospital may not alter its financial assistance or debt collection policies without approval by the board of directors.

(h) The Commission shall review each hospital's implementation of and compliance with the hospital's policies and the requirements of this section. (2009, chs. 310, 311; 2010, chs. 60, 61.)

§ 19-214.3. Violations of § 19-214.1 or § 19-214.2.

(a) Fine. – If a hospital knowingly violates any provision of § 19-214.1 or § 19-214.2 of this subtitle or any regulation adopted under this subtitle, the Commission may impose a fine not to exceed $50,000 per violation.

(b) Considerations. – Before imposing a fine, the Commission shall consider the appropriateness of the fine in relation to the severity of the violation. (2009, chs. 310, 311.)

§ 19-215. Uniform accounting and financial reporting system.

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

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

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

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

(b) *Modification of system.* -- In conformity with this subtitle, the Commission may allow and provide for modifications in the uniform accounting and financial reporting system to reflect correctly any differences among facilities in their type, size, financial structure, or scope or type of service. (An. Code 1957, art. 43, § 568-O; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-216. Required reports of facilities.

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

(1) A balance sheet that details its assets, liabilities, and net worth;
(2) A statement of income and expenses; and

(3) The most recent Form 990 that the facility filed with the Internal Revenue Service; and

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

(b) *Form*. -- (1) A report under this section shall:

(i) Be in the form that the Commission requires;
(ii) Conform to the uniform accounting and financial reporting system adopted under this subtitle; and

(iii) Be certified as follows:

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

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

(2) If the Commission requires, responsible officials of a facility also shall attest that, to the best of their knowledge and belief, the report has been prepared in conformity with the uniform accounting and financial reporting system adopted under § 19-211 of this subtitle. (An. Code 1957, art. 43, § 568P; 1982, ch. 21, § 2; 1985, ch. 109, § 2; 1999, ch. 702, § 2; 2009, ch. 398,)

§ 19-217. Notification of certain financial transactions, contracts or agreements required.

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

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

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

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

(c) *Exception.* -- The provisions of this section do not apply to any financial transaction, contract, or other agreement made by a facility with any issuer of tax-exempt bonds, including the Maryland Health and Higher Education Facilities Authority, the State, or any county or municipal corporation of the State, if a notice of the proposed issuance of revenue bonds that meets the requirements of § 147 (f) of the Internal Revenue Code has been published. (1991, ch. 555; 1999, ch. 702, § 2; 2009, ch. 60, § 5.)

§ 19-218. Additional information.

(a) *In general.* -- The Commission shall require each facility to give the Commission information that:

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

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

(3) Includes the effect of any proposal made, under Subtitle 1 of this title, on comprehensive health planning; and

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

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

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

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

(3) The State Board of Physicians. (An. Code 1957, art. 43, § 568R; 1982, ch. 21, § 2; 1985, ch. 112; 1988, ch. 6, § 1; 1989, ch. 5, § 1; 1999, ch. 702, § 2; 2003, ch. 252, § 10.)

§ 19-219. Review and approval of rates and costs. [Amendment subject to contingent abrogation].

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

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

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

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

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

(2) A facility shall charge for services only at a rate set in accordance with this subtitle.

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

(c) Alternate ratesetting methods. – to promote the most efficient and effective use of health care facility services and, if it is in the public interest and consistent with this subtitle, the Commission may promote and approve alternate methods of rate determination and payment that are of an experimental nature.

(d) Determination and collection of funds. – (1) In this subsection, “base hospital rates” means the aggregate value to participating commercial health insurance carriers of the substantial, available, and affordable coverage purchaser differential as determined by the Commission for the calendar year 2002.

(2) The Commission, in accordance with this subsection, shall calculate the amount of funds necessary to operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.

(3) (i) The Commission shall determine the percentage of total net patient revenue received in calendar year 2002 by all hospitals for which the Commission approved hospital rates that is represented by the base hospital rate.

(ii) The percentage under subparagraph (i) of this paragraph shall be determined by dividing the base hospital rate by the total net patient revenue received in calendar year 2002 by all hospitals for which the Commission approved hospital rates.

(4) On or before May 1 of each year, the Commission shall:

(i) Determine the amount of funding to allocate to the Maryland Health Insurance Plan by multiplying the percentage determined under paragraph (3) of this subsection by the value of the total net patient revenues received in the immediately preceding State fiscal year by all hospitals for which rates were approved by the Commission; and

(ii) Determine the share of total funding owed by each hospital for which rates have been approved by the Commission proportionate to the percentage of the base hospital rate attributable to each hospital.

(5) Each hospital shall remit monthly one-twelfth of the amount determined under paragraph (4)(ii) of this subsection to the Maryland Health Insurance Plan Fund.

(e) Adjustment of rates. – (1) The Commission shall adjust hospital rates to ensure that the assessment collected under subsection (d) of this section is revenue neutral to each hospital.

(2) The Commission may not consider the assessment required under subsection (d) of this section in determining:

(i) The reasonableness of rates under this section; or

(ii) Hospital financial performance.

(An. Code 1957, art. 43, § 568U; 1982, ch. 21, § 2; 1984, ch. 470; 1985, ch. 10, § 3; ch. 112; 1999, ch. 702, § 2; 2002, ch. 153, § 4; 2003, ch. 1; 2008, chs. 244, 245).

§ 19-220. Rate review and approval procedures.

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

(2) The information shall include:

(i) Necessary operating expenses;

(ii) Appropriate expenses that are incurred in providing services to

patients who cannot or do not pay;

(iii) Incurred interest charges; and

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

(b) *Definition of regulated rates*. -- The Commission shall define, by regulation, the types and classes of charges that may not be changed, except as specified in § 19-222 of this subtitle.

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

(d) *Reasonableness of rates*. -- The Commission shall:

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

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

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

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

(e) *Consideration of certain costs*. -- In the determination of reasonable rates for each facility, as specified in this section, the Commission shall take into account all of the cost of complying with recommendations made, under Subtitle 1 of this title, on comprehensive health planning.

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

(g) *Executive sessions*. -- Except as otherwise provided by law, in reviewing rates or charges or considering a request for changes in rates or charges, the Commission may not hold executive sessions. (An. Code 1957, art. 43, § 568V; 1982, ch. 21, § 2; 1985, ch. 112; 1988, ch. 6, § 1; 1999, ch. 702, § 2.)

§ 19-221. Accounting principles for rate determinations.

The Commission shall use any reasonable, relevant, or generally accepted accounting principles to determine reasonable rates for each facility. (An. Code 1957, art. 43, § 568VA; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-222. Change of rate structures or charges.

(a) *Filing of notice; effective date*. -- (1) A facility may not change any rate schedule or charge of any type or class defined under § 19-220(b) of this subtitle, unless the facility files with the Commission a written notice of the proposed change that is supported by any information that the facility considers appropriate.

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

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

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

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

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

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

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

(5) The Commission:

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

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

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

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

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

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

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

(2) Accept any benefits under that decision.

(e) *Refund of funds collected pending delay or appeal*. -- If a change in any rate or charge increase becomes effective because a final determination is delayed because of an appeal or otherwise, the Commission may order the facility:

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

(i) Funds received because of the change; and

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

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

(i) To refund the funds with interest; or

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

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

(g) *Incentives for merger or consolidation*. -- (1) The State Health Services Cost Review Commission shall provide incentives for merger, consolidation, and conversion and for the implementation of the institution-specific plan developed in accordance with § 19-119 of this title.

(2) Notwithstanding any of the provisions in this section, on notification of a merger or consolidation by 2 or more hospitals, the Commission shall review the rates of those hospitals that are directly involved in the merger or consolidation in accordance with the rate review and approval procedures provided in § 19-220 of this subtitle and the regulations of the Commission.

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

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

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

(iii) Any other closure costs as defined in § 10-340 of the Economic Development Article; or

(iv) Agreements to allow retention of a portion of the savings that result for a designated period of time. (An. Code 1957, art. 43, § 568W; 1982, ch. 21, § 2; 1985, ch. 109, § 2; 1992, ch. 600; 1999, ch. 702, § 2; 2001, ch.29, § 5; 2008, ch. 307, § 1.)

§ 19-223. Fee for closed or delicensed hospitals.

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

(1) To the extent provided for in Title 10, Subtitle 3, Part IV of the Economic Development Article, the amounts required by § 10-350 of the Economic Development Article with respect to public obligations or closure costs of a closed or delicensed hospital; and

(2) Funding the Hospital Employees Retraining Fund. (1985, ch. 109, § 2; 1992, ch. 600; 1999, ch. 34, § 7; ch. 702, § 2; 2008, ch. 307, § 1; ch. 641.)

§ 19-224. Report of transactions with nonprofit facility by trustee, director, or officer.

(a) *Scope of section.* -- This section applies to each person that is concurrently:

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

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

(i) A partnership;

(ii) A firm;

(iii) A corporation; or

(iv) Any other business entity.

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

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

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

(c) *Filing requirements*. -- A report under this section shall be:

(1) Signed and verified; and

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

(d) *Willful failure to file*. -- A person that willfully fails to file any report required by this section is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500. (An. Code 1957, art. 43, § 568Y; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-225. Hearings and investigations.

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

(1) Hold a public hearing;

(2) Conduct an investigation;

(3) Require the filing of any information; or

(4) Subpoena any witness or evidence.

(b) *Oaths*. -- The Executive Director of the Commission may administer oaths in connection with any hearing or investigation under this section. (An. Code 1957, art. 43, § 568M; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-226. Further investigations.

(a) *Investigations authorized*. -- If the Commission considers a further investigation necessary or desirable to authenticate information in a report that a facility files under this subtitle, the Commission may make any necessary further examination of the records or accounts of the facility, in accordance with the rules or regulations of the Commission.

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

(1) Provided by the facility; or

(2) Performed by:

(i) The staff of the Commission;

(ii) A third party for the Commission; or

(iii) The Legislative Auditor. (An. Code 1957, art. 43, § 568Q; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)

§ 19-227. Appeals.

(a) *Right to appeal*. -- (1) Any person aggrieved by a final decision of the Commission under this subtitle may not appeal to the Board of Review but may take a direct judicial appeal.

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

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

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

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

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

(c) *Standing for hearings and appeals*. -- Any person, government agency, or nonprofit health service plan that contracts with or pays a facility for health care services has standing to participate in Commission hearings and shall be allowed to appeal final decisions of the Commission. (An. Code 1957, art. 43, § 568N; 1982, ch. 21, § 2; 1999, ch. 702, § 2.)