HB 403

Department of Legislative Services

Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 403 (Delegate Pendergrass)
Health and Government Operations Finance

Maryland Patient Referral Law - Compensation Arrangements Under Federally Approved Programs and Models

This bill exempts a health care practitioner who has a specified compensation arrangement with a health care entity from the prohibition against self-referral. At least 60 days before an exemption is implemented, the "participation agreement" and other relevant documents must be filed with the Insurance Commissioner. The filing is not required if the compensation arrangement is funded fully by the Medicare or Medicaid programs. Within 60 days after the participation agreement is filed, the Commissioner must determine if an exempt compensation arrangement is permissible. If not, the Commissioner must hold a hearing, with specified notice, and issue a specified order; an exemption is null and void if the Commissioner issues such an order.

The bill takes effect June 1, 2017.

Fiscal Summary

State Effect: No material impact in FY 2017. Minimal special fund revenue increase from the $125 filing fee established under the bill. Special fund expenditures for the Maryland Insurance Administration (MIA) increase by $80,900 beginning in FY 2018 to handle filings, review submitted participation agreements, determine if specified compensation agreements constitute the business of insurance, issue orders, and arrange hearings. Future years reflect elimination of one-time start-up costs.

(in dollars)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
SF Revenue	-	-	-	-	-
SF Expenditure	$80,900	$77,800	$81,200	$84,800	$88,700
Net Effect	($80,900)	($77,800)	($81,200)	($84,800)	($88,700)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Participation agreement" means a contract that is executed by a payor or program administrator and other participating entities and describes the requirements for participation in a payment model eligible for exemption from self-referral under the bill.

A health care practitioner who has a compensation arrangement with a health care entity is exempt from the prohibition against self-referral if the compensation arrangement is funded by or paid under (1) a Medicare Shared Savings Program accountable care organization (ACO); (2) an advance payment ACO model, a pioneer ACO model, or a next generation ACO model, as authorized under federal law; (3) an alternative payment model approved by the federal Centers for Medicare and Medicaid Services (CMS); or (4) another model approved by CMS that may be applied to health care services provided to both Medicare and non-Medicare beneficiaries.

These exemptions may not be construed to (1) permit an individual or entity to engage in the insurance business without obtaining a certificate of authority and satisfying all other applicable requirements; (2) impose additional obligations on a carrier providing incentive-based compensation to a health care practitioner or require the disclosure of information regarding the incentive-based compensation; (3) authorize a health care entity to knowingly make a direct or indirect payment to a health care practitioner as an inducement to reduce or limit medically necessary services to individuals who are under the direct care of the health care practitioner; (4) permit an arrangement that violates other specified provisions of law; (5) narrow, expand, or otherwise modify specified definitions; or (6) require another permitted compensation arrangement to comply with the bill's provisions.

For exempt payment models that apply to individuals covered under health insurance under which there is cash compensation, at least 60 days before an exemption is implemented, the participation agreement and other documents relevant to the payment model under which a compensation arrangement is funded or paid must be filed with the Commissioner. The filing is not required if the compensation arrangement is funded fully by or paid fully under the Medicare or Medicaid program. The filing is subject to a $125 filing fee.

Within 60 days after the participation agreement and other relevant documents are filed, the Commissioner must determine if any compensation arrangement is insurance business and violates the Insurance Article or a related regulation. If the Commissioner determines

that a compensation arrangement is insurance business and violates the Insurance Article or a regulation, the Commissioner must issue an order to the filer that specifies the ways in which the compensation arrangement is in violation. The Commissioner must hold a hearing before issuing an order and must give written notice of the hearing to the filer at least 10 days before the hearing. The notice must specify the matters to be considered at the hearing.

If the Commissioner issues an order that a compensation arrangement funded by or paid under such a payment model violates the Insurance Article or related regulations, the exemption is null and void.

If the compensation arrangement changes during its term, the filer must submit a revised filing to the Commissioner for review of the changes and the Commissioner must make a new determination as to whether the compensation arrangement is the business of insurance or violates the Insurance Article or a regulation.

Current Law: Under the Health Occupations Article, a health care practitioner may not refer a patient, or direct an employee or a person under contract with the health care practitioner to refer a patient, to a health care entity (1) in which the health care practitioner or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; (2) in which the practitioner's immediate family owns a beneficial interest of 3% or greater; or (3) with which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement.

However, this prohibition does not apply to a health care practitioner who refers in-office ancillary services or tests that are (1) personally furnished by the referring health care practitioner, a health care practitioner in the same group practice as the referring health care practitioner, or an individual who is employed and personally supervised by the qualified referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner; (2) provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner furnishes services; and (3) billed by the health care practitioner performing or supervising the services or a group practice of which the health care practitioner performing or supervising the services is a member.

"In-office ancillary services" is defined as those basic health care services and tests routinely performed in the office of one or more health care practitioners; except for a radiologist group practice or an office consisting solely of one or more radiologists, in-office ancillary services do not include magnetic resonance imaging services, radiation therapy services, or computer tomography scan services.

Under the Insurance Article, each individual or group health insurance policy issued in the State by an entity must include a provision that excludes payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. An entity may seek repayment from a health care practitioner for any money paid for a claim, bill, or other demand or request for payment for health care services that were provided as a result of a prohibited referral. Additionally, an entity may seek a refund of a payment made for a claim, bill, or other demand or request for payment that is subsequently determined to be for a health care service provided as a result of a prohibited referral.

Background: The Maryland Patient Referral Law (MPRL) was enacted in 1993 when fee-for-service (FFS) was the predominant method of payment. Federal Medicare reimbursement is shifting from FFS to value-based payment, and the State's all-payer model contract with the federal government needs to be amended to promote greater collaboration among providers. In recent years, new and innovative payment methods have begun to replace FFS. The federal Medicare Access and CHIP Reauthorization Act of 2015 seeks to move 80% of Medicare reimbursement away from FFS reimbursement to value-based payment by 2018. Value-based payment rewards health care providers for better care management and patient outcomes. The federal government will waive the Stark law prohibition on self-referral for provider arrangements that closely manage care and improve quality. These provider arrangements also require physicians and hospitals to coordinate and align their care delivery. Commercial payers are also developing their own value-based payments for physician services.

In 2015, the Maryland Health Care Commission convened a workgroup to examine possible changes to the MPRL. While the workgroup did not make specific recommendations, it did achieve consensus on the need to modernize the law to (1) allow for the development of additional bona fide value-based payment models, risk-sharing arrangements, and alignment models and (2) ensure emerging compensation arrangements are permissible.

During the 2016 interim, the chair of the House Health and Government Operations Committee requested that the Maryland Hospital Association and the Patient Care and Access Coalition convene a workgroup to attempt to achieve consensus on legislation to exempt collaborations to promote provider alignment from the prohibition on self-referral. The workgroup, comprising representatives of hospitals, physician groups, commercial payers, and government agencies, met six times. While the workgroup found some areas of agreement, it was unable to reach consensus on legislation.

According to the draft report of the workgroup, there was general consensus that the MPRL should not impede current or future Medicare payment models, but rather that Maryland law should protect and encourage these models. Despite this consensus, workgroup

members differed on the precise method by which referrals for health care services made within the context of financial relationships under any new federally created models should be protected. Areas of disagreement included the need for a separate State approval process for provider relationships under the federal payment models and the need to prohibit certain kinds of provider integration.

Extension of MPRL protection for referrals made by health care practitioners in commercial models that are structured consistent with the approved federal models was another area of controversy. Some workgroup members favored stronger consumer protections, such as notice to patients and protection from balance billing by health care practitioners participating in these commercial models.

Modifications to the MPRL have developed greater urgency due to the State's all-payer model contract with the federal Center for Medicare and Medicaid Innovation (CMMI). The Health Services Cost Review Commission advises that shared savings compensation arrangements between hospitals and physicians approved by CMMI could violate State law unless the MPRL is modified.

The Department of Health and Mental Hygiene (DHMH) is developing a new delivery system for individuals who are eligible for both Medicaid and Medicare ("dual eligibles"). The Dual Eligible Accountable Care Organizations (D-ACOs) will allow the State to meet the goal of including the Medicare and Medicaid total cost of care for dual eligibles in the next phase of the model contract. DHMH intends to pursue the authority to implement the program in part through CMMI. DHMH anticipates submitting waiver proposals for both Medicare and Medicaid authorities to CMS by the fall of 2017. As the D-ACO model is anticipated to be a CMS-approved alternative payment model, the D-ACO model should be lawfully permitted under the exemptions granted by this bill.

State Fiscal Effect: MIA special fund revenues increase beginning in fiscal 2018 from the $125 filing fee established under the bill and required for the submission of participation agreements and related documents for specified compensation arrangements. The amount of revenues depends on the number of filings but is anticipated to be minimal.

MIA special fund expenditures increase by $80,895 in fiscal 2018, which reflects a 30-day start-up delay. This estimate reflects the cost of hiring one full-time grade 16 form analyst. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses. The form analyst will review all initial and revised filings of participation agreements and related documents, including specific details about patient referrals, payment arrangements, and funding sources, and determine if the payment model is insurance business. For reviews that determine that an arrangement constitutes the business of insurance, the form analyst will assist the Commissioner in preparing an order and holding the required hearing.

Position	1
Salary and Fringe Benefits	$73,130
One-time Start-up Expenses	4,640
Ongoing Operating Expenses	3,125
Total FY 2018 State Expenditures	**$80,895**

Future year expenditures reflect a full salary with annual increases and employee turnover and ongoing operating expenses.

Small Business Effect: Specified health care entities and health care practitioners that participate in the compensation arrangements permitted under the bill may benefit from the exemption from current self-referral prohibitions and required beneficial interest disclosures. Participants in such compensation arrangements must file a participation agreement and related paperwork with the Commissioner and pay the associated filing fees.

Additional Comments: Related legislation, Senate Bill 886/House Bill 1272 of 2016 would have exempted "collaborations to promote provider alignment" from general prohibitions against self-referrals by health care practitioners and required disclosures of beneficial interests. Senate Hill 866 was heard by the Senate Finance Committee, but no further action was taken. House Bill 1272 was heard by the House Health and Government Operations Committee but was later withdrawn.

Additional Information

Prior Introductions: None.

Cross File: SB 369 (Senator Middleton) - Finance.

Information Source(s): Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - February 15, 2017
mm/ljm Third Reader - March 21, 2017
Revised - Amendment(s) - March 21, 2017

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510