HB 1053

Department of Legislative Services

Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 1053 (Delegate Pena-Melnyk, *et al.*)

Health and Government Operations Education, Health, and Environmental Affairs and Finance

Integrated Community Oncology Reporting Program

This bill establishes an integrated community oncology reporting program in the Department of Health and Mental Hygiene (DHMH). The bill exempts a health care practitioner who has a beneficial interest in and practices medicine at an integrated community oncology center in the program from general prohibitions against self-referrals by health care practitioners. The Maryland Health Care Commission (MHCC) must administer the program and (1) establish a specified clinical advisory workgroup to advise on the development of regulations and monitoring of participating centers; (2) adopt implementing regulations by November 1, 2017; (3) establish an application process, set application and participation fees, begin accepting applications on January 1, 2018, and monitor the performance of participating centers; (4) report on the performance of each center by December 1, 2019, and by December 1 annually through 2024; and (5) conduct a performance evaluation of each center and the impact of the program on Maryland's all-payer model contract by December 1, 2024. MHCC must select a consultant to serve as the program review manager to collect clinical, administrative, and patient satisfaction information and conduct required studies and reports.

The bill takes effect June 1, 2017, and terminates June 30, 2025.

Fiscal Summary

State Effect: No effect in FY 2017. MHCC special fund revenues and expenditures increase by as much as $250,000 beginning in FY 2018 from collection of application and participation fees that are set to cover the cost of contractual expenses, as discussed below.

(in dollars)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
SF Revenue	$250,000	$250,000	$250,000	$250,000	$250,000
SF Expenditure	$250,000	$250,000	$250,000	$250,000	$250,000
Net Effect	$0	$0	$0	$0	$0

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:

Definitions

"Health care practitioner" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession, and who has a beneficial interest in and practices medicine at an approved integrated community oncology center.

"Integrated community oncology center" means a health care entity that (1) offers medical oncology, radiation oncology, and nondiagnostic computer tomography scan services in the same group practice; (2) is owned wholly by an oncology group practice or jointly by an oncology group practice that has at least a 50% ownership interest and a hospital, hospital system, or academic medical center that has the remaining ownership; and (3) is approved by MHCC to participate in the program.

"Oncology group practice" means a group practice that, on January 1, 2018, and for the duration of the program, is composed solely of oncologists, at least 50% of whom are owners and practice medicine in the State under a Maryland license. (January 1, 2018, is the date that applications may be submitted; the program extends through May 31, 2025.)

Program Purpose

The purpose of the program is to determine if integrated community oncology centers that have health care practitioners who are exempt from the general prohibitions against self-referrals under the bill have the ability to (1) safely and appropriately deliver radiation therapy to patients; (2) reduce the per capita risk-adjusted total cost of care for cancer patients provided similar services in other settings; (3) reduce the average patient cost-sharing responsibility for cancer patients provided similar services in other settings; and (4) achieve the goals and milestones of Maryland's all-payer model contract.

Program Application and Participation

MHCC must establish an application process for the program, including an application fee that pays for the cost of the application process and is shared equally by all applicants, and

begin accepting applications on January 1, 2018. MHCC must also establish a selection process to approve up to four participating centers. Of these, up to two may be owned wholly by an oncology group practice and up to two may be owned jointly, as specified. MHCC must also set a participation fee that pays the cost of the collection and reporting of information, evaluations, studies, and required reports for the program, and that is shared equally by all program participants.

Applicants must show that they (1) have the ability to serve patients in specified areas with limited choices or underserved areas; (2) have participated in Medicare, Medicaid, and the Maryland Children's Health Program, if appropriate, for the previous three calendar years and are committed to continue to accept such patients for the duration of the program; (3) have sufficient expertise and ability to conduct specified studies, enroll patients in clinical trials, and collect and report any required information; (4) have the ability to meet a minimum number of patient encounters per year in the State, as established by MHCC; and (5) have plans to participate in evidence-based quality and standardized care programs, as specified.

At least two applicants must be approved to participate before the program may begin. At least one must be owned wholly by an oncology group practice, and at least one must be owned jointly, as specified. When approving centers to participate, MHCC must give preference to those that demonstrate the ability to serve patients in specified areas with limited choices in providers or underserved areas. An approved center may participate in the program from January 1, 2019, through May 31, 2025, as long as the center continues to meet program requirements.

Health Care Practitioner Prohibitions

A health care practitioner may not collect or attempt to collect any money from a patient for a service provided in a participating center if the payer issues an adverse decision that the care provided is or was not medically necessary, appropriate, or efficient and the health care practitioner, as authorized by the patient, has exhausted all available appeals. Further, a health care practitioner may not collect or attempt to collect any money from a patient for a covered service provided in a participating center that is greater than any deductible, copayment, or coinsurance amount for covered services, as calculated as if the service was in-network.

Additionally, a health care practitioner who provides services at a participating center may not reduce or withhold medically necessary care; order or deliver care that is not medically necessary; or increase the ordering of care beyond the volume and cost of services provided by other providers of similar services in similar settings.

A health care practitioner who makes a lawful referral must provide the patient with a written notice that includes specified information, including disclosures of beneficial interests.

A health care practitioner who violates the bill's prohibitions is guilty of a misdemeanor and is subject to a fine of up to $5,000.

Program Monitoring

MHCC must establish an ongoing monitoring process to ensure the program's purpose and to protect patients treated at each participating center from the reduction or withholding of medically necessary oncology; the ordering or delivery of care that is not medically necessary; or the increase in ordering of care beyond the volume and cost of services provided by other providers of similar services in similar settings.

MHCC, in consultation with the Health Services Cost Review Commission (HSCRC), the Health Education and Advocacy Unit of the Office of the Attorney General, and DHMH, must review reported participating center information and determine if the center may remain in the program, submit a corrective action plan, or be disqualified. MHCC must also establish an appeals process and specified requirements for corrective action plans and disqualified centers.

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, MHCC 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, and 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). HSCRC advises that shared savings compensation arrangements between hospitals and physicians approved by CMMI could violate State law unless the MPRL is modified.

State Fiscal Effect: The bill requires that the application process established by MHCC include an application fee that covers the cost of the application process. MHCC advises that it must contract with an outside entity at a cost of $250,000 in fiscal 2018 to establish an application process for the program. This analysis assumes that the application fee is set to cover these contractual expenses. MHCC must accept applications beginning January 1, 2018. Thus, special fund revenues and expenditures for MHCC increase by as much as $250,000 in fiscal 2018 due to receipt of application fee revenues and associated expenditures. Depending on how long the application process continues, some fee revenue may be collected in fiscal 2019. The application fee may vary depending on actual contractual costs and the number of applications. This analysis assumes that MHCC receives a sufficient number of applications, and, therefore, sufficient fee revenue, to cover the cost of the contractual expenses.

The bill also requires MHCC to set a participation fee that covers the cost of the collection and reporting of information, evaluations, studies, and required reports. Again, MHCC advises that it must contract with an outside entity at an annual cost of $250,000 in order to conduct these activities. This analysis assumes that the participation fee is set to cover these annual contractual expenses. Thus, as the program must have a minimum of two participants and a maximum of only four participants, the annual participation fee

could range from $62,500 to $125,000. The fee may vary depending on actual contractual costs each year and the number of approved participants. As the program must be in place by January 1, 2019, this analysis assumes that special fund revenues and expenditures for MHCC increase by as much as $250,000 annually beginning in fiscal 2019 due to participation fee revenue and associated expenditures. This analysis again assumes that MHCC is able to select the requisite number and type of program participants, and that it receives sufficient fee revenue to cover the cost of the contractual expenses.

The bill specifies that MHCC must select a *consultant* to serve as the program review manager to collect specified information and conduct required studies and reports. The Department of Legislative Services (DLS) assumes the cost of this consultant is included in the $250,000 annual contractual costs incurred by MHCC beginning in fiscal 2018, and that this consultant can assist MHCC in program coordination and development of any required regulations by November 1, 2017.

DLS additionally notes that, to the extent the bill results in increased utilization of services, Medicaid expenditures may increase (60% federal funds, 40% general funds); however, the bill may also result in cost savings to the extent the provision of oncology services is shifted to lower cost nonhospital settings.

Small Business Effect: Integrated community oncology centers may benefit from the exemption from current self-referral prohibitions under the bill. As an oncologist currently cannot refer patients to a radiation oncologist who is a business partner, the bill's exemption may result in increased revenue for these businesses. The insurance industry may also be affected, since the bill adds an additional exemption that would not be excluded under insurance policies.

Additional Information

Prior Introductions: HB 1422 of 2016, a bill with similar provisions, receiving a hearing in the House Health and Government Operations Committee but was subsequently withdrawn. Its cross file, SB 739, received a hearing in the Senate Education, Health, and Environmental Affairs Committee, but no further action was taken.

Cross File: None.

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

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