Department of Legislative Services
Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

House Bill 432 (Delegate Donoghue)
Health and Government Operations

Maryland Medical Assistance Program - Provider-Based Outpatient Oncology Centers - Reimbursement

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This emergency bill requires Medicaid to reimburse a "provider-based outpatient oncology center" for services rendered to a Medicaid recipient at a rate based on a percentage of the applicable Medicare rate. The Department of Health and Mental Hygiene (DHMH) must adopt regulations to implement this requirement. The bill also authorizes Medicaid to make payment for services provided by a freestanding outpatient oncology center if the invoice is received within two years after the date(s) of service.

Fiscal Summary

State Effect: Medicaid expenditures increase by an estimated $376,000 (50% general funds, 50% federal funds) beginning in FY 2013, contingent upon federal approval of a Medicaid State Plan Amendment (SPA). The Governor's proposed FY 2013 budget includes funding for the reimbursement required under this bill. Future years reflect inflation.

(in dollars)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
FF Revenue	$188,000	$197,400	$207,300	$217,700	$228,600
GF Expenditure	$188,000	$197,400	$207,300	$217,700	$228,600
FF Expenditure	$188,000	$197,400	$207,300	$217,700	$228,600
Net Effect	($188,000)	($197,400)	($207,300)	($217,700)	($228,600)

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: "Provider-based outpatient oncology center" means an outpatient oncology facility associated with a hospital that is located offsite and meets Medicare provider-based criteria (generally, that the facility in its entirety is a subordinate and integrated part of the main provider).

Current Law: DHMH must adopt rules and regulations for the reimbursement of Medicaid providers. Except for an invoice that must be submitted to a Medicare intermediary or carrier for an individual with dual eligibility, payment may not be made for an invoice that is received more than one year after the date(s) of the service(s) given.

DHMH must adopt regulations for the reimbursement of specialty outpatient treatment and diagnostic services rendered to a Medicaid recipient at a freestanding clinic owned and operated by a hospital that is under a capitation agreement approved by the Health Services Cost Review Commission (HSCRC). Generally, this reimbursement rate must be set according to the lesser of (1) Medicare standards and principles for retrospective cost reimbursement; or (2) charges.

HSCRC is an independent agency, established to contain hospital costs, maintain fairness in hospital payments, provide financial access to hospital care, and disclose information on the operation of hospitals in the State. In this role, HSCRC sets standard rates that hospitals may charge for the purchase of care.

Background: DHMH is aware of only one facility that currently meets the definition of provider-based outpatient oncology center under the bill, the John R. Marsh Cancer Center, part of Meritus Health (formerly Washington County Health System) in Hagerstown. The center is a provider-based entity under Medicare associated with Meritus Medical Center, but it is located offsite.

Historically, oncology services were provided at the hospital and reimbursed according to an HSCRC rate. In 2004, oncology services were moved offsite to the John R. Marsh Cancer Center. As HSCRC does not set rates for outpatient facilities that are not located *at the hospital*, the facility no longer has an HSCRC rate. Private insurance, Medicare, and Medicaid managed care organizations (MCOs) currently pay both provider charges and a facility fee associated with services provided at the center. However, Medicaid fee-for-service (FFS) pays only provider charges. DHMH indicates that this is because Medicaid FFS does not have a reimbursement methodology for nonhospital outpatient departments and therefore the center is not enrolled as a Medicaid FFS provider. According to the center, approximately half of the facility fee comprises pharmaceutical expenses related to oncology treatments. Prior to 2004, Medicaid FFS paid HSCRC

rates, including a facility fee, for oncology-related services when they were located at the hospital.

According to DHMH, in order to pay the center as specified under the bill, Medicaid will need an SPA to establish a new provider category and reimbursement mechanism. If approved by the federal Centers for Medicare and Medicaid Services (CMS), the center can become an approved Medicaid FFS provider and DHMH can adopt regulations establishing a rate. DHMH has already started the process of drafting an SPA and the regulations to begin paying the center at a rate of 80% of Medicare, irrespective of the bill, and anticipates that payment could begin as soon as July 1, 2012.

State Expenditures: Though the bill allows Medicaid to provide retrospective reimbursement to the center for up to two years, DHMH indicates that Medicaid reimbursement (with federal matching funds) cannot be provided on a retroactive basis and could begin only once the center obtained status as a Medicaid FFS provider. It is assumed that this will begin by July 1, 2012; thus, there is no impact in fiscal 2012. Based on this information, this estimate reflects *only prospective* payments under the bill.

Assuming that CMS grants approval for an SPA, Medicaid expenditures increase by an estimated $376,076 (50% general funds, 50% federal funds) beginning in fiscal 2013. This estimate is based on the following facts and assumptions:

- in calendar 2008, the John R. Marsh Cancer Center incurred approximately $580,485 in charges for FFS Medicaid enrollees;
- if Medicaid would have paid 52% of charges (similar to the Medicare payment), the center would have been reimbursed $301,852 in calendar 2008; and
- based on 5% annual medical inflation, Medicaid FFS will pay the center an estimated $183,451 for the second half of calendar 2012 and $385,248 in calendar 2013.

Future years reflect 5% medical inflation. Though DHMH is not aware of other provider-based outpatient oncology centers in the State, to the extent that there are other centers now or in the future, the cost to implement the bill will increase.

Additional Information

Prior Introductions: HB 1210 of 2011 was heard by the House Health and Government Operations Committee but was later withdrawn.

Cross File: None.

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

Fiscal Note History: First Reader - February 14, 2012
ncs/mwc

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