HB 1519

Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1519 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations

Self-Referrals - Oncology Group Practices - Exemption

This bill requires the Maryland Health Care Commission (MHCC) to develop a process to establish "integrated community oncology group practices" that are located in specified "target regions" of the State and are exempt from the general prohibitions against self-referrals by health care practitioners. MHCC must adopt implementing regulations by December 1, 2018, and must begin accepting applications by April 1, 2019. "Integrated community oncology group practices" must submit an annual performance report to MHCC for four years. After receipt of the fourth performance report, MHCC must submit a report to the General Assembly on whether the "integrated community oncology group practice" has achieved the goals and milestones of the State's all-payer model contract.

Fiscal Summary

State Effect: General fund expenditures increase by $43,900 in FY 2019. Future years reflect annualization and contractual services in FY 2023. Revenues are not affected.

(in dollars)	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Revenues	$0	$0	$0	$0	$0
GF Expenditure	43,900	52,600	54,100	56,100	258,200
Net Effect	($43,900)	($52,600)	($54,100)	($56,100)	($258,200)

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

"Integrated community oncology group practice" means an oncology group practice that is located in a "target region" and has received an exemption established by the bill.

"Oncology group practice" means a group practice that, on January 1, 2018, and for the duration of the time that the oncology group practice is practicing under an exemption established by the bill, is composed solely of oncologists who are owners of the practice and who practice medicine in the State under a Maryland license.

"Target region" means a county in the Western Maryland Region, the Southern Maryland Region, or the Eastern Shore Region, as specified.

The bill also alters the existing definition of "in-office ancillary services" to include an oncology group practice or an office consisting solely of one or more oncologists that provides radiation therapy services or nondiagnostic computer tomography scan services to plan and deliver radiation therapy.

Application Process and Exemption Requirements

MHCC's implementing regulations must authorize an oncology group practice with more than one practice location to obtain an exemption for more than one location but not more than one exemption for each target region.

Applicants seeking an exemption must show that the applicant (1) has participated in Medicare, Medicaid, and, if appropriate, the Maryland Children's Health Insurance Program, for the immediately preceding three calendar years and is committed to continue doing so for the duration of the exemption; (2) has sufficient expertise and capabilities to conduct specified studies, enroll patients in clinical trials, and collect and report information to MHCC; (3) has the ability to meet a minimum number of patient encounters per year in the State, as established by MHCC; (4) plans to participate in specified evidence-based quality and standardized care programs relating to the State's all-payer model contract; (5) is accredited to provide radiation therapy or nondiagnostic computer tomography scan services; and (6) is able to safely and appropriately deliver radiation therapy to patients and achieve the goals and milestones of the State's all-payer model contract.

MHCC must notify applicants of approval within 60 days of application receipt. Additionally, MHCC must review a submitted performance report within 60 days after receipt and determine whether the integrated community oncology group practice may retain its exemption or may retain its exemption subject to a corrective action plan.

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 an integrated community oncology group practice 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 practice 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 an integrated community oncology group practice may not reduce or withhold medically necessary care or order or deliver care that is not medically necessary.

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.

Current Law/Background:

Health Care Practitioner Self-referral

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.

In addition to other requirements and with specified exemptions, before referring a patient to a health care entity in which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family, owns a beneficial interest, the health care practitioner must provide the patient with a specified written statement (1) disclosing the beneficial interest; (2) stating that the patient may choose to obtain health care service from another entity; and (3) requiring the patient to acknowledge receipt of the statement in writing. A health care provider who fails to comply with these requirements is guilty of a misdemeanor and is subject to a fine of up to $5,000.

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.

Maryland All-Payer Model Contract

Effective January 1, 2014, Maryland entered into a five-year contract with the federal government to replace the State's 36-year-old Medicare waiver with the Maryland All-Payer Model Contract. The model contract will be deemed successful if Maryland can meet cost and quality targets without inappropriately shifting costs to nonhospital settings and if there is a measurable improvement in quality of care.

State Expenditures: MHCC advises that it must hire one full-time manager to establish an application and selection process in accordance with the bill's requirements. MHCC also advises that it must contract with an outside entity to produce the required reports to

the General Assembly in the fourth year of implementation, at a one-time cost of $200,000 in fiscal 2022.

However, the Department of Legislative Services (DLS) advises that, as the bill authorizes a maximum of three integrated community oncology group practices (one per target region), the bill's requirements can likely be handled with a part-time, rather than full-time, position. Further, assuming the first exemption is granted in fiscal 2019, the first performance report must be submitted by December 31, 2019 (fiscal 2020), and the corresponding fourth performance report must be submitted by December 31, 2022 (fiscal 2023).

Therefore, MHCC general fund expenditures increase by $43,927 in fiscal 2019, which accounts for the bill's October 1, 2018 effective date. This estimate reflects the cost of hiring one part-time (50%) grade 22 program manager to develop the required application process and regulations, approve exemptions, and review required reports. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses. This analysis also assumes that required regulations may be developed and adopted by December 1, 2018 (despite the bill's October 1, 2018 effective date).

Position	0.5
Salary and Fringe Benefits	$38,802
Ongoing Operating Expenses	5,125
Total FY 2019 State Expenditures	**$43,927**

Future year expenditures reflect a full salary with annual increases and employee turnover as well as annual increases in ongoing operating expenses. This analysis also includes $200,000 in contractual services in fiscal 2023 for MHCC to analyze performance reports and submit required information to the General Assembly. This analysis also assumes that such contractual services allow MHCC to develop a process by which to analyze future performance reports that are received after fiscal 2023, and thus are a one-time cost.

Further, DLS notes that the bill does not have a termination date. Thus, it is assumed that authorized exemptions under the bill do not expire. However, the bill only institutes reporting requirements for integrated community oncology group practices for four consecutive years, starting with the first year in which an exemption is granted. Although this analysis assumes MHCC must hire permanent staff to meet the bill's requirements, MHCC may no longer require additional staff in the out-years (depending on when the last report is received).

To the extent the bill results in increased utilization of services, Medicaid expenditures may increase (50% federal funds, 50% general funds); however, the bill may also result in

cost savings to the extent the provision of oncology services are shifted to lower cost nonhospital settings.

Small Business Effect: Integrated community oncology group practices 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 1053 of 2017, a bill with similar provisions, passed the House as amended and received a hearing in the Senate Education, Health, and Environmental Affairs Committee, but no further action was taken. SB 739 of 2016, another bill with similar provisions, received a hearing in the Senate Education, Health, and Environmental Affairs Committee, but no further action was taken. Its cross file, HB 1422, received a hearing in the House Health and Government Operations Committee and was subsequently withdrawn.

Cross File: SB 1024 (Senator Conway) - Education, Health, and Environmental Affairs and Finance.

Information Source(s): Office of the Attorney General; Maryland Department of Health; Department of Legislative Services

Fiscal Note History: First Reader - March 8, 2018
md/jc

Analysis by: Sasika Subramaniam

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