HOUSE BILL 1426

J3, C3 9lr0195

By: **Chair, Health and Government Operations Committee (By Request – Departmental – Health)**
Rules suspended
Introduced and read first time: March 7, 2019
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

AN ACT concerning

Health Services Cost Review Commission – Duties and Reports – Revisions

FOR the purpose of altering the information required to be included in a certain annual report required to be submitted to certain persons by the Health Services Cost Review Commission; altering a certain reporting date; repealing certain provisions of law rendered obsolete by certain provisions of this Act; authorizing the Commission, on request by the Secretary of Health, to assist in the implementation of certain model programs; making technical changes; defining a certain term; and generally relating to the Health Services Cost Review Commission.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–201, 19–207(b), and 19–219(c)
Annotated Code of Maryland
(2015 Replacement Volume and 2018 Supplement)

BY repealing
Article – Health – General
Section 19–214(e)
Annotated Code of Maryland
(2015 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–604
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

That the Laws of Maryland read as follows:

Article – Health – General

19–201.

(a) In this subtitle the following words have the meanings indicated.

(B) "ALL–PAYER MODEL CONTRACT" MEANS THE PAYMENT MODEL DEMONSTRATION AGREEMENT AUTHORIZED UNDER § 1115A OF THE SOCIAL SECURITY ACT, INCLUDING ANY AMENDMENTS TO THE AGREEMENT, BETWEEN THE STATE AND THE FEDERAL CENTER FOR MEDICARE AND MEDICAID INNOVATION.

[(b)**] (C)** "Commission" means the State Health Services Cost Review Commission.

[(c)**] (D)** "Facility" means, whether operated for a profit or not:

(1) Any hospital; or

(2) Any related institution.

[(d)**] (E)** (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 a freestanding medical facility licensed under Subtitle 3A of this title;

(iii) Outpatient services provided at a hospital;

(iv) Outpatient services, as specified by the Commission in regulation, provided at a freestanding medical facility licensed under Subtitle 3A of this title that has received:

1. A certificate of need under § 19–120(o)(1) of this title; or

2. An exemption from obtaining a certificate of need under § 19–120(o)(3) of this title; and

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

(2) "Hospital services" includes a hospital outpatient service:

(i) Of a hospital that, on or before June 1, 2015, is under a merged asset hospital system;

(ii) That is designated as a part of another hospital under the same merged asset hospital system to make it possible for the hospital outpatient service to participate in the 340B Program under the federal Public Health Service Act; and

(iii) That complies with all federal requirements for the 340B Program and applicable provisions of 42 C.F.R. § 413.65.

(3) "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)**] (F)** (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.

19–207.

(b) 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 purposes 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**]** **MAY** 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) 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;

(iii) 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**]**

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

(V) AN UPDATE ON THE STATUS OF THE STATE'S COMPLIANCE WITH THE PROVISIONS OF THE CURRENT ALL–PAYER MODEL CONTRACT, INCLUDING:

1. PERFORMANCE IN LIMITING INPATIENT AND OUTPATIENT HOSPITAL PER CAPITA COST GROWTH FOR ALL PAYERS TO A TREND BASED ON THE STATE'S 10–YEAR COMPOUND ANNUAL GROSS STATE PRODUCT;

2. ANNUAL PROGRESS TOWARD ACHIEVING THE STATE'S FINANCIAL TARGETS ESTABLISHED BY THE CURRENT ALL–PAYER MODEL CONTRACT;

3. A SUMMARY OF THE WORK CONDUCTED, RECOMMENDATIONS MADE, AND COMMISSION ACTION ON ACTIVITIES RELATED TO,

AND RECOMMENDATIONS MADE BY, WORKGROUPS CREATED TO PROVIDE TECHNICAL INPUT AND ADVICE ON THE ALL–PAYER MODEL CONTRACT;

4. ACTIONS APPROVED AND CONSIDERED BY THE COMMISSION TO PROMOTE ALTERNATIVE METHODS OF RATE DETERMINATION AND PAYMENT OF AN EXPERIMENTAL NATURE, AS AUTHORIZED UNDER § 19–219(C)(2) OF THIS SUBTITLE;

5. REPORTS SUBMITTED TO THE FEDERAL CENTER FOR MEDICARE AND MEDICAID INNOVATION RELATING TO THE ALL–PAYER MODEL CONTRACT; AND

6. ANY KNOWN ADVERSE CONSEQUENCES THAT IMPLEMENTING THE ALL–PAYER MODEL CONTRACT HAS HAD ON THE STATE, INCLUDING CHANGES OR INDICATIONS OF CHANGES TO QUALITY OF OR ACCESS TO CARE, AND THE ACTIONS THE COMMISSION HAS TAKEN TO ADDRESS AND MITIGATE THE CONSEQUENCES;

(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;

(9) Beginning October 1, 2014, and, subject to item (10)(ii) of this subsection, every 6 months thereafter, submit to the Governor, the Secretary, and, subject to § 2–1246 of the State Government Article, the General Assembly an update on the status of the State's compliance with the provisions of Maryland's all–payer model contract, including:

(i) The State's:

1. Performance in limiting inpatient and outpatient hospital per capita cost growth for all payers to a trend based on the State's 10–year compound annual gross State product;

2. Progress toward achieving aggregate savings in Medicare spending in the State equal to or greater than $330,000,000 over the 5 years of the contract, based on lower increases in the cost per Medicare beneficiary;

3. Performance in shifting from a per–case rate system to a population–based revenue system, with at least 80% of hospital revenue shifted to global budgeting;

4. Performance in reducing the hospital readmission rate among Medicare beneficiaries to the national average; and

5. Progress toward achieving a cumulative reduction in the State hospital–acquired conditions of 30% over the 5 years of the contract;

(ii) A summary of the work conducted, recommendations made, and Commission action on recommendations made by the following groups created to provide technical input and advice on implementation of Maryland's total cost of care model contract:

1. Payment Models Workgroup;

2. Physician Alignment and Engagement Workgroup;

3. Performance Measurement Workgroup;

4. Data and Infrastructure Workgroup;

5. HSCRC Advisory Council; and

6. Any other workgroups created for this purpose;

(iii) Actions approved and considered by the Commission to promote alternative methods of rate determination and payment of an experimental nature, as authorized under § 19–219(c)(2) of this subtitle;

(iv) Reports submitted to the federal Center for Medicare and Medicaid Innovation relating to the all–payer model contract; and

(v) Any known adverse consequences that implementing the all–payer model contract has had on the State, including changes or indications of changes to quality or access to care, and the actions the Commission has taken to address and mitigate the consequences; and**]**

[(10)**] (8)** If the Centers for Medicare and Medicaid Services issues a warning notice related to a "triggering event" as described in the all–payer model contract:

(i) Provide written notification to the Governor, the Secretary, and, subject to § 2–1246 of the State Government Article, the General Assembly within 15 days after the issuance of the notice; and

(ii) Submit the update required under item **[**(9)**] (6)(V)** of this subsection every 3 months.

19–214.

[(e) 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 Public Law No. 111–148 (The Patient Protection and Affordable Care Act); 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.**]**

19–219.

(c) Consistent with Maryland's all–payer model contract approved by the federal Center for Medicare and Medicaid Innovation, and notwithstanding any other provision of this subtitle, the Commission may:

(1) Establish hospital rate levels and rate increases in the aggregate or on a hospital–specific basis; **[**and**]**

(2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all–payer model contract**; AND**

(3) ON REQUEST BY THE SECRETARY, ASSIST IN THE IMPLEMENTATION OF FEDERALLY APPROVED MODEL PROGRAMS CONSISTENT WITH THE CURRENT ALL–PAYER MODEL CONTRACT.

Article – Insurance

15–604.

Each authorized insurer, nonprofit health service plan, and fraternal benefit society, and each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health – General Article, shall:

(1) pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission; and

(2) comply with the applicable terms and conditions of Maryland's all–payer model contract **[**approved by the federal Center for Medicare and Medicaid Innovation**], AS DEFINED IN § 19–201(B) OF THE HEALTH – GENERAL ARTICLE**.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2019.