Department of Legislative Services

Maryland General Assembly
2022 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 834 (Senators Beidle and Kelley)

Finance Health and Government Operations

Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

This bill authorizes a carrier to enter into a "two-sided incentive arrangement" with an "eligible provider" and specifies what is permitted, prohibited, and required under a bonus or other incentive-based compensation program or two-sided incentive arrangement. By December 31, 2023, and annually thereafter until 2032, the Maryland Health Care Commission (MHCC) must report to the Senate Finance Committee and the House Health and Government Operations Committee on the number and type of value-based arrangements entered into and related measures. The bill specifies that (1) a value-based arrangement that meets the requirements of specified federal regulations is not subject to Maryland's health care practitioner self-referral law; (2) a health care practitioner or set of health care practitioners that accepts capitated payments, but performs no other acts considered acts of an insurance business, is not considered to be doing an insurance business in the State; and (3) an adjustment to reimbursement made as part of a two-sided incentive arrangement is not subject to carrier requirements regarding a retroactive denial of reimbursement.

Fiscal Summary

State Effect: Any complaints regarding value-based arrangements are assumed to be minimal and absorbable within existing budgeted resources for the Maryland Insurance Administration (MIA). MHCC can likely compile and submit the required annual reports using existing budgeted resources. Revenues are not affected.

Local Effect: None.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Eligible provider" means a licensed physician or set of health care practitioners that voluntarily participate in a two-sided incentive arrangement. "Set of health care practitioners" means a group practice, clinically integrated organization, accountable care organization, or clinically integrated network, as specified. "Two-sided incentive arrangement" means an arrangement between an eligible provider and a carrier in which the eligible provider may earn an incentive and a carrier may recoup funds from the eligible provider in accordance with the terms of a contract that complies with the bill.

Bonus or Other Incentive-based Compensation or Two-sided Incentive Arrangements

A bonus or other incentive-based compensation program or two-sided incentive arrangement:

- must be voluntary;
- may not create a disincentive to the provision of medically appropriate or medically necessary health care services;
- must, if applicable, promote health equity, improvement of health care outcomes, and the provision of preventive health care services; and
- may reward a health care practitioner, set of health care practitioners, or eligible provider, based on satisfaction of performance measures, if all parties agree on (1) the performance measures; (2) the method and the time period for calculating whether the performance measures have been satisfied; (3) the method by which a reconsideration of the calculations by the carrier may be requested; and (4) if applicable, the risk-adjustment method used.

Participation in a two-sided incentive arrangement may not be the sole opportunity for a heath care practitioner or set of health care practitioners to be eligible to receive increases in reimbursement.

A carrier may not:

- reduce a fee schedule because a health care practitioner or a set of health care practitioners does not participate in the carrier's bonus or other incentive-based compensation or two-sided incentive arrangement program; or
- require as a condition of participation in the carrier's provider network that a health care practitioner or set of health care practitioners participate.

The bill authorizes an eligible provider (or designee), in addition to those authorized under current law, to file a complaint with MIA regarding a violation of these provisions.

A carrier must provide a health care practitioner, set of health care practitioners, or eligible provider with a copy of a schedule of all applicable fees or the 50 most common services billed by a health care practitioner in that specialty, whichever is less. The carrier must also provide the information about the practitioner and the methodology that the carrier uses to determine whether to recoup compensation from an eligible provider under a two-sided incentive arrangement and a summary of the terms of a two-sided incentive arrangement program.

A carrier that compensates health care practitioners or a set of health care practitioners wholly or partly on a capitated basis may not retain any capitated fee attributable to an enrollee or covered person during an enrollee's or covered person's contract year.

Under a two-sided incentive arrangement, a carrier may recoup funds paid to an eligible provider based on the terms of a written contract that, at a minimum:

- establish a target budget for the total cost of care of a population of patients adjusted for risk and population size or the cost of an episode of care;
- limit recoupment to not more than 50% of the excess above the mutually agreed on target;
- specify a mutually agreed on maximum liability for total recoupment that may not exceed 10% of the annual payments from the carrier to the eligible provider;
- provide an opportunity for gains by an eligible provider that is greater than the opportunity for recoupment by the carrier;
- following good faith negotiations, provide an opportunity for an audit by an independent third party and an independent third-party dispute resolution process;
- require the carrier and the eligible provider to negotiate in good faith adjustments to the target budget under specified conditions; and
- require the carrier to pay any incentive to or request any recoupment from the eligible provider within six months after the end of the contract year, except as specified.

Unless mutually agreed to, an arrangement may not provide an opportunity for recoupment by the carrier based on the eligible provider's performance during the first 12 months of the arrangement. A carrier that enters into a two-sided incentive arrangement in which the amount of any payment is determined, in whole or in part, on the total cost of care of a population of patients or an episode of care, must, at least quarterly, disclose specified information to the eligible provider. Unless mutually agreed to, a two-sided incentive arrangement may not be amended during the term of the contract.

Capitated Payments

The bill specifies that arrangements under a health benefit plan offered by a carrier or a self-funded group health insurance plan in which a capitated payment is made as specified and specified contracts between a health care practitioner or set of health care practitioners and a carrier that include capitated payments for services are not considered acts of an insurance business.

Current Law:

Value-based Arrangement

Under federal regulations, "value-based arrangement" means an arrangement for the provision of at least one value-based activity for a target patient population. Federal regulations (42 CFR § 411.357(aa)) specify the arrangements that facilitate value-based health care delivery and payment, including provisions regarding full financial risk, value-based arrangements with meaningful downside financial risk to the physician, and remuneration paid under a value-based arrangement.

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.

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.

Insurance Business in the State

Section 4-205 of the Insurance Article specifies what entities or actions are not considered to be doing an insurance business in the State, which includes (1) the lawful transaction of surplus lines insurance or reinsurance by insurers; (2) specified transactions that involve, and are subsequent to the issuance of, an insurance policy; (3) specified transactions that involve insurance contracts that are independently procured and on which the insurance premium tax is paid; (4) an attorney while acting in the ordinary relation of attorney and client in the adjustment of claims or losses; or (5) generally, transactions that involve group or blanket insurance or group annuities if the master policy of the group was lawfully issued and delivered in another state in which the person was authorized to engage in insurance business.

Reimbursement of Health Care Providers

An insurer, nonprofit health service plan, health maintenance organization (HMO), dental plan organization, and any other person that provides health benefit plans subject to State regulation (collectively known as carriers) may not reimburse a health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner.

A carrier may provide bonuses or other incentive-based compensation to a health care practitioner or a set of health care practitioners if the bonus or other incentive-based compensation (1) does not create a disincentive to the provision of medically appropriate or medically necessary health care services and (2) if the carrier is an HMO, complies with specified quality of care provisions.

A bonus or other incentive-based compensation (1) must, if applicable, promote the provision of preventive health care services or (2) may reward a health care practitioner or a set of health care practitioners, based on satisfaction of performance measures, if the performance measures, method for calculating whether the performance measures have been satisfied, and the method for reconsideration of the calculations by the carrier is agreed on in writing by all parties.

Acceptance of a bonus or other incentive-based compensation must be voluntary. A carrier may not require a health care practitioner or a set of health care practitioners to participate in the carrier's bonus or incentive-based compensation program as a condition of participation in the carrier's provider network. A health care practitioner, a set of health care practitioners, a health care practitioner's designee, or a designee of a set of health care practitioners may file a complaint with MIA regarding a violation of these provisions.

Retroactive Denial of Reimbursement

A carrier may retroactively deny reimbursement for services subject to coordination of benefits with another carrier, Medicaid, or Medicare during the 18-month period after the date that the carrier paid the health care provider or may retroactively deny reimbursement during the six-month period after the date that the carrier paid the health care provider. A carrier that retroactively denies reimbursement to a health care provider must provide the provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from coordination of benefits, the written statement must provide the name and address of the entity acknowledging responsibility for payment of the denied claim. These provisions do not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative services provider contract.

Small Business Effect: Small business health care practitioners may enter into voluntary value-based arrangements with carriers and may earn incentives (or have funds recouped) according to the terms of the contracts.

Additional Information

Prior Introductions: None.

Designated Cross File: HB 1148 (Delegate Pendergrass, *et al.*) - Health and Government Operations.

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

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