

Chapter 505

(Senate Bill 42)

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; repealing the requirement that the Commission annually publish certain acute care hospital charges; authorizing the Commission, on request of the Secretary of Health, to assist in the implementation of certain model programs; requiring that the Commission take certain actions consistent with a certain all-payer model contract; defining a certain term; making conforming and technical changes; 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)(6), (7), and (10), 19–214(b)(5), 19–219(b)(2)(ii) and (c),
19–220(d), 19–225(a), and 19–226(a)Annotated Code of Maryland
(2019 Replacement Volume)

BY repealing

Article – Health – General

Section 19–207(b)(8) and (9)

Annotated Code of Maryland
(2019 Replacement Volume)

BY repealing and reenacting, with amendments,

Article – Insurance

Section 15–604

Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

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

(6) On or before **[October] MAY** 1 of each year, submit to the Governor, to the Secretary, and, subject to § 2–1257 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;

(iv) An update on the status of the State's compliance with the provisions of [Maryland's] **THE** all-payer model contract that includes [the information specified in item (9) of this subsection]:

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, INCLUDING RECOMMENDATIONS MADE BY WORKGROUPS CREATED TO PROVIDE TECHNICAL INPUT AND ADVICE, AND COMMISSION ACTION ON ACTIVITIES RELATED TO 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 IN IMPLEMENTING THE ALL-PAYER MODEL CONTRACT HAS HAD ON THE STATE, INCLUDING CHANGES OR INDICATIONS OF CHANGES TO,~~ AS REPORTED TO THE FEDERAL CENTER FOR MEDICARE AND MEDICAID INNOVATION, THAT MAY NEGATIVELY IMPACT QUALITY OF OR ACCESS TO CARE, AND THE ACTIONS ~~THE COMMISSION HAS TAKEN TO ADDRESS AND~~ TAKEN BY THE COMMISSION TO MITIGATE THE CONSEQUENCES; and

7. ANNUAL PROGRESS MADE IN THE DEVELOPMENT OF PUBLIC AND PRIVATE PARTNERSHIPS BETWEEN HOSPITALS AND OTHER ENTITIES, INCLUDING COMMUNITY-BASED PHYSICIANS, COMMUNITY-BASED ORGANIZATIONS, AND OTHER POST-ACUTE CARE PROVIDERS, TO ACHIEVE THE POPULATION HEALTH GOALS ESTABLISHED WITH THE FEDERAL CENTER FOR MEDICARE AND MEDICAID INNOVATION; AND

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

(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) Subject to item (10)(ii) of this subsection, on or before May 1 each year, submit to the Governor, the Secretary, and, subject to § 2-1257 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 any workgroup created to provide technical input and advice on implementation of Maryland's all-payer model contract;

(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], **PROVIDE** written notification to the Governor, the Secretary, and, subject to § 2-1257 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) of this subsection every 3 months].

19-214.

(b) The Commission may adopt regulations establishing alternative methods for financing the reasonable total costs of hospital uncompensated care and the disproportionate share hospital payment provided that the alternative methods:

(5) Will not result in significantly increasing costs to Medicare or termination of [Maryland’s] **THE** all-payer model contract [approved by the federal Center for Medicare and Medicaid Innovation].

19-219.

(b) (2) A facility shall:

(ii) Comply with the applicable terms and conditions of [Maryland’s] **THE** all-payer model contract [approved by the federal Center for Medicare and Medicaid Innovation].

(c) Consistent with [Maryland’s] **THE** 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 OF THE SECRETARY, ASSIST IN THE IMPLEMENTATION OF FEDERALLY APPROVED MODEL PROGRAMS.

19-220.

(d) [The] CONSISTENT WITH THE ALL-PAYER MODEL CONTRACT APPROVED BY THE FEDERAL CENTER FOR MEDICARE AND MEDICAID INNOVATION, THE Commission shall:

(1) Permit a nonprofit facility to charge reasonable rates that will permit the facility to provide, on a solvent basis, effective and efficient service that is in the public interest; and

(2) Permit a proprietary profit-making facility to charge reasonable rates that:

(i) Will permit the facility to provide effective and efficient service that is in the public interest; and

(ii) Based on the fair value of the property and investments that are related directly to the facility, include enough allowance for and provide a fair return to the owner of the facility.

19-225.

(a) In any matter that relates to ~~the~~ A FACILITY'S cost of services ~~in facilities~~ **AND CONSISTENT WITH THE ALL-PAYER MODEL CONTRACT**, the Commission may:

- (1) Hold a public hearing;
- (2) Conduct an investigation;
- (3) Require the filing of any information; or
- (4) Subpoena any witness or evidence.

19-226.

(a) If the Commission considers a further investigation necessary or desirable to authenticate information in a report that a facility files under this subtitle, **CONSISTENT WITH THE ALL-PAYER MODEL CONTRACT**, the Commission may make any necessary further examination of the records or accounts of the facility, in accordance with the rules or regulations of the Commission.

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] **THE all-payer model contract [approved by the federal Center for Medicare and Medicaid Innovation], AS DEFINED IN § 19–201 OF THE HEALTH – GENERAL ARTICLE.**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2020.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 8, 2020.