MedChi

The Maryland State Medical Society

House Bill 1148/Senate Bill 834: Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization

Update:

As you know, MedChi has been working for over a year on a proposal that would authorize insurers to enter into arrangements with health care practitioners and health systems to allow for both bonus payments and the recoupment of funds. Maryland's current law does not allow these arrangements to be entered into outside of the federal waivers granted under Maryland's Total Cost of Care contract because any recoupment is categorized as "the practice of insurance" since it is managing risk. Under the auspice of the MedChi Physician Task Force, MedChi representatives held biweekly meetings with representatives from MHA and CareFirst to discuss the proposal. MedChi heard from both sides of the spectrum – those that wished to enter into such arrangements and those that did not want to enter into such arrangements (and did not want to feel pressure to do so). Therefore, throughout this process, MedChi has attempted to "thread the needle" to provide authorization and protections for both viewpoints.

This past week, both the House and the Senate committees voted favorable with amendments on the above-referenced legislation. MedChi is pleased to report that this legislation contains the strongest protections for the physician community for those physicians that chose to enter into these arrangements and for those that want to remain fee-for-service, including a provision that states that a carrier may not reduce the fee schedule of a physician who remains fee-for-service and does not participate in a two-sided incentive arrangement. Below is a chart illustrating the bill has initially put forth in December 2020 and the bill as passed by the committees. It is anticipated that the legislation will move through the full General Assembly and that the Governor will sign it.

Main Topic in Legislation	2020 Draft	2022 Draft
Capitation Authorization: Who is Covered	Allowed a health care provider to enter into a capitation agreement by exempting a health care provider who accepts capitated payments from the practice of insurance	Changes health care provider to health care practitioner (more appropriate term when referencing physicians) and a set of health care practitioner to allow the entering into capitation agreements in both the self-funded and fully insured marketplace. NOTE: Capitation is currently allowed in the fully insured marketplace.
Two-Sided Incentive Arrangement Authorization: Who is Covered	Extended the current bonus arrangement law to authorize a carrier to recoup funds paid under a two-sided incentive arrangement for any health care practitioner or set of health care practitioners	Uses the definition of "eligible provider," which means a licensed physician or a set of health care practitioners (group practice, CIO, CIN or ACO). A set of health care practitioners would include those non-physicians affiliated with a physician's group. Adds a definition for two-sided incentive arrangement that reflects both the receiving of a bonus and the recoupment of funds.
Protections for Non-Participation	Participation is voluntary and cannot be a condition of participation in a carrier's network.	Maintains voluntary and cannot be a condition of participation in a carrier's network and adds that a carrier may not reduce the fee schedule of a health care practitioner or set of health care practitioners based on non-participation in its bonus or other incentive-based compensation or two-sided arrangement program. NOTE: The statute allows a practitioner to file a complaint with the MIA for any violation of the above measures, including the reduction of the fee schedule.
Data Transparency	Makes no changes to current law	Expands current law to add requirements to increase the information that must be provided to the physician entering into a bonus or two-sided incentive arrangement (i.e., requires that at least all the applicable fees or at least fifty of the most common services billed in that specialty, whichever is less be provided rather than "up to" fifty; requires information to be provided by the carrier about the practitioner and the methodology that the carrier uses to determine whether to recoup compensation from the practitioner). ** The information must be also provided in writing prior to entering into a contract (not just at contract execution); 30 days prior to a change; and upon the request of the health care practitioner and prior to entering into the contract. In addition, at least quarterly carriers must provide:

		1. any amount paid to another health care provider that is included in the cost of care of a patient in the population or episode of care; and 2. any copayment, coinsurance or deductible that is included in the total cost of care of a patient in the population or episode of care.
Protections for Participation	Any recoupment is limited to: (1) no more than 50% of the excess above the mutually agreed upon annual target for cost of care; and (2) a mutually agreed upon maximum liability.	1. Requires that a contract, at a minimum, (i) establish a target budget for the total cost of care of a population of patients adjusted for risk and population size, or on episode of care (ii) limit recoupment to no more than 50% of the excess above the mutually agreed upon target budget (iii) specify a mutually agreed upon maximum liability for total recoupment that may not exceed 10 % of the annual payments (iv) provide an opportunity for gains by an eligible provider that is greater than the opportunity for recoupment by the carrier (v) provide an opportunity for an audit by an independent third party and an independent third-party dispute resolution process following good faith negotiation, which does not have to be exhausted prior to filing an appeal of a coverage decision under Maryland's appeals and grievance law (vi) require the carrier and the eligible provider to negotiate in good faith adjustments to the target budget: 1. When certain circumstances beyond the control of the carrier or the eligible provider arise, such as changes in hospital rates; and 2. When material changes occur in health care economics, health care delivery or regulation that impact the arrangement (vii) require the carrier to pay any incentive or request any recoupment from the eligible provider owed under the contract within 6 months after the end of the contract year, unless the carrier or the eligible provider initiates a dispute relating to the recoupment or incentive amount 2. In addition, an arrangement shall not provide an opportunity for recoupment

		based on the eligible provider's performance under the first twelve months of the arrangement, unless mutually agreed to by the eligible provider and the carrier; and on the date the eligible provider and the carrier enter the arrangement, the eligible provider has operated under an arrangement that includes an opportunity for incentive payments based on provider performance with any payer for at least 12 months. 3. Also, states that an arrangement may not be amended during the term of the contract unless mutually agreed to by the parties.
Capitation	Authorizes capitated rates in the self-insured market if the self-funded employer group leases a carrier's network; the self-funded employer group retains the obligation to provide access to covered health care benefits; and the contract does not include other reimbursement arrangements that are considered insurance. Note: Already permissible in fully insured.	At the request of MedChi, initially limited to primary care providers but then expanded again to all health care practitioners based upon member's requests. At the request of the MIA, language now includes fully and self-insured market (adding protections to the fully insured). Language added that capitation is voluntary.
Self-Referral	Did not address	Exempts a value-based arrangement established pursuant to an operated in accordance with the terms of the exceptions set forth at 42 C.F.R. 411.357 (AA)(1)-(3)
10-year Reporting Requirement	Silent	Beginning December 31, 2023, and annually thereafter for a period of ten years, the Maryland Health Care Commission must report to the Health and Government Operations Committee and Finance Committee on the progress of implementation of value-based care arrangements in Maryland, including the number and type of arrangements entered into, quality outcomes, impact of two-sided incentive arrangements on the fee schedules of health care practitioners included in the target budget that are not eligible providers, and disputes and resolutions thereof and cost-effectiveness of the programs.