HOUSE BILL 1148

J5 2lr1705
CF SB 834

By: **Delegates Pendergrass, Cullison, ~~and Kipke~~ Kipke, Bagnall, Belcastro, Bhandari, Carr, Chisholm, Hill, Johnson, Kaiser, Kelly, Kerr, Krebs, Landis, R. Lewis, Morgan, Reilly, Rosenberg, Saab, Szeliga, and K. Young**
Introduced and read first time: February 11, 2022
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 7, 2022

CHAPTER _____

AN ACT concerning

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

FOR the purpose of providing that value–based arrangements established under certain provisions of federal law are exempt from certain provisions of State law regulating health care practitioner referrals; providing that a health care practitioner or set of health care practitioners that accepts capitated payments in a certain manner but does not perform certain other acts is not considered to be performing acts of an insurance business; authorizing certain bonus or incentive–based compensation to include a two–sided incentive arrangement through which a carrier may recoup funds paid to an eligible provider in accordance with a written contract that includes certain requirements; prohibiting a carrier from requiring participation in a carrier's bonus or incentive–based compensation or two–sided incentive arrangement program or reducing a fee schedule based on nonparticipation; prohibiting participation in a two–sided incentive arrangement from being the sole opportunity for increases in reimbursement; and generally relating to health insurance, two–sided incentive arrangements, and capitated payments.

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 1–302(d)(12)
Annotated Code of Maryland
(2021 Replacement Volume)

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 4–205(a), 15–113, and 15–1008(b)
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 4–205(b) and (c) and 15–1008(c)
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

BY adding to
Article – Insurance
Section 15–2101 and 15–2102 to be under the new subtitle "Subtitle 21. Capitated Payments"
Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

Preamble

WHEREAS, Value–based care is a health care practitioner payment structure that ties practitioner revenue to improved health outcomes and the value of services delivered rather than the volume of services provided; and

WHEREAS, Value–based arrangements may help to reduce disparities, expand access to care, and improve outcomes, quality, and affordability; and

WHEREAS, Value–based care models promote the Triple Aim framework used by the Centers for Medicare and Medicaid Services to optimize health care systems through better care and experience for individuals, better health for populations, and lower per capita costs with demonstrated improvements in quality, cost–savings, and better management of chronic illnesses; and

WHEREAS, Value–based care models continue to show promising results and expand throughout the rest of the country and in Medicare and Medicaid, with broad support from both public and private stakeholders; and

WHEREAS, Hospitals, health care practitioners, and payers should be allowed to voluntarily participate in patient–focused, outcome–driven, value–based reimbursement arrangements in Maryland's commercial insurance markets that seek to align with value–based programs under Maryland's Total Cost of Care model and ensure that practitioners have adequate contract protections and that consumers continue to have access to high–quality care that promotes better health outcomes; and

WHEREAS, Maryland has unique statutory barriers precluding commercial payers from entering into certain value–based care arrangements outside of Maryland's Total Cost of Care model compared to other states in the nation; and

WHEREAS, In Maryland, changes are needed to the health care practitioner bonus and other compensation provisions applicable to the commercial market to allow practitioners to enter into both two–sided incentive and capitation arrangements with commercial plans as they do in other states and the Medicare and Medicaid segments; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health Occupations

1–302.

(d) The provisions of this section do not apply to:

(12) Subject to subsection (f) of this section, a health care practitioner who has a compensation arrangement with a health care entity, if the compensation arrangement is funded by or paid under:

(i) A Medicare shared savings program accountable care organization authorized under 42 U.S.C. § 1395jjj;

(ii) As authorized under 42 U.S.C. § 1315a:

1. An advance payment accountable care organization model;

2. A pioneer accountable care organization model; or

3. A next generation accountable care organization model;

(iii) An alternative payment model approved by the federal Centers for Medicare and Medicaid Services; **[**or**]**

(iv) Another model approved by the federal Centers for Medicare and Medicaid Services that may be applied to health care services provided to both Medicare beneficiaries and individuals who are not Medicare beneficiaries**; OR**

(V) A VALUE–BASED ARRANGEMENT THAT MEETS THE REQUIREMENTS OF 42 C.F.R. § 411.357(AA)(1) THROUGH (3).

Article – Insurance

4–205.

(a) This section does not apply to:

(1) the lawful transaction of surplus lines insurance;

(2) the lawful transaction of reinsurance by insurers;

(3) transactions in the State that involve, and are subsequent to the issuance of, a policy that was lawfully solicited, written, and delivered outside of the State covering only a subject of insurance not resident, located, or expressly to be performed in the State at the time of issuance of the policy;

(4) transactions that involve insurance contracts that are independently procured through negotiations occurring entirely outside of the State and that are reported and on which the premium tax is paid in accordance with §§ 4–210 and 4–211 of this subtitle;

(5) an attorney while acting in the ordinary relation of attorney and client in the adjustment of claims or losses; **[**or**]**

(6) unless otherwise determined by the Commissioner, transactions in the State 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**; OR**

(7) A HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS, AS DEFINED IN § 15–113 OF THIS ARTICLE, THAT ACCEPTS CAPITATED PAYMENTS IN ACCORDANCE WITH § 15–2102 OF THIS ARTICLE, BUT PERFORMS NO OTHER ACTS CONSIDERED ACTS OF AN INSURANCE BUSINESS.

(b) An insurer or other person may not, directly or indirectly, do any of the acts of an insurance business set forth in subsection (c) of this section, except as provided by and in accordance with the specific authorization of statute.

(c) Any of the following acts in the State, effected by mail or otherwise, is considered to be doing an insurance business in the State:

(1) making or proposing to make, as an insurer, an insurance contract;

(2) making or proposing to make, as guarantor or surety insurer, a contract of guaranty or suretyship as a vocation and not merely incidental to another legitimate business or activity of the guarantor or surety insurer;

(3) taking or receiving an application for insurance;

(4) receiving or collecting premiums, commissions, membership fees, assessments, dues, or other consideration for insurance;

(5) issuing or delivering an insurance contract to a resident of the State or a person authorized to do business in the State;

(6) except as provided in subsection (d) of this section, with respect to a subject of insurance resident, located, or to be performed in the State, directly or indirectly acting as an insurance producer for, or otherwise representing or helping on behalf of another, an insurer or other person to:

(i) solicit, negotiate, procure, or effect insurance or the renewal of insurance;

(ii) disseminate information about coverage or rates;

(iii) forward an application;

(iv) deliver a policy or insurance contract;

(v) inspect risks;

(vi) fix rates;

(vii) investigate or adjust claims or losses;

(viii) transact matters arising out of an insurance contract after the insurance contract becomes effective; or

(ix) in any other manner represent or help an insurer or other person to transact insurance business;

(7) doing any kind of insurance business specifically recognized as doing an insurance business under statutes relating to insurance;

(8) doing or proposing to do any insurance business that is substantially equivalent to any act listed in this subsection in a manner designed to evade the statutes relating to insurance; or

(9) as an insurer transacting any other business in the State.

15–113.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "ELIGIBLE PROVIDER" MEANS:

(I) A LICENSED PHYSICIAN, AS DEFINED IN § 14–101 OF THE HEALTH OCCUPATIONS ARTICLE, WHO VOLUNTARILY PARTICIPATES IN A TWO–SIDED INCENTIVE ARRANGEMENT; OR

(II) A SET OF HEALTH CARE PRACTITIONERS THAT VOLUNTARILY PARTICIPATE IN A TWO–SIDED INCENTIVE ARRANGEMENT.

[(3)**] (4)** "Health care practitioner" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "SET OF HEALTH CARE PRACTITIONERS" MEANS:

(I) A GROUP PRACTICE;

(II) A CLINICALLY INTEGRATED ORGANIZATION ESTABLISHED IN ACCORDANCE WITH SUBTITLE 19 OF THIS TITLE;

(III) AN ACCOUNTABLE CARE ORGANIZATION ESTABLISHED IN ACCORDANCE WITH 42 U.S.C. § 1395JJJ AND ANY APPLICABLE FEDERAL REGULATIONS; OR

(IV) A CLINICALLY INTEGRATED NETWORK THAT IS A PROVIDER ENTITY THAT MEETS THE CRITERIA ESTABLISHED IN GUIDANCE ISSUED BY THE FEDERAL TRADE COMMISSION, INCLUDING A NETWORK OF BEHAVIORAL HEALTH CARE PROGRAMS LICENSED UNDER § 7.5–401 OF THE HEALTH – GENERAL ARTICLE.

(6) "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

ENTERED INTO WITH THE ELIGIBLE PROVIDER THAT MEETS THE REQUIREMENTS OF THIS SECTION.

(b) A carrier 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.

(c) (1) **[**In this subsection, "set of health care practitioners" means:

(i) a group practice;

(ii) a clinically integrated organization established in accordance with Subtitle 19 of this title; or

(iii) an accountable care organization established in accordance with 42 U.S.C. § 1395jjj and any applicable federal regulations.

(2)**]** This section does not prohibit a carrier from**:**

(I) providing 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:**]; OR**

(II) ENTERING INTO A TWO–SIDED INCENTIVE ARRANGEMENT WITH AN ELIGIBLE PROVIDER.

(2) A BONUS OR OTHER INCENTIVE–BASED COMPENSATION PROGRAM OR TWO–SIDED INCENTIVE ARRANGEMENT AUTHORIZED UNDER THIS SECTION:

(i) **[**does**]** **MAY** not create a disincentive to the provision of medically appropriate or medically necessary health care services; and

(ii) if the carrier is a health maintenance organization, **[**complies**]** **SHALL COMPLY** with the provisions of § 19–705.1 of the Health – General Article.

(3) A bonus or other incentive–based compensation **OR TWO–SIDED INCENTIVE ARRANGEMENT AUTHORIZED** under this **[**subsection**]** **SECTION**:

(i) if applicable, shall promote **HEALTH EQUITY, IMPROVEMENT OF HEALTH CARE OUTCOMES, AND** the provision of preventive health care services; or

(ii) may reward a health care practitioner **[**or**],** a set of health care practitioners**, OR AN ELIGIBLE PROVIDER**, based on satisfaction of performance

measures, if the following is agreed on in writing by the carrier and the health care practitioner **[**or**],** set of health care practitioners**, OR ELIGIBLE PROVIDER**:

1. the performance measures**, INCLUDING THE SOURCE OF THE MEASURES**;

2. the method **AND THE TIME PERIOD** for calculating whether the performance measures have been satisfied; **[**and**]**

3. the method by which the health care practitioner **[**or**],** set of health care practitioners**, OR ELIGIBLE PROVIDER** may request reconsideration of the calculations by the carrier**; AND**

4. IF APPLICABLE, THE RISK–ADJUSTMENT METHOD USED.

(4) Acceptance of a bonus or other incentive–based compensation **OR TWO–SIDED INCENTIVE ARRANGEMENT** under this subsection shall be voluntary.

(5) A CARRIER MAY NOT REDUCE THE FEE SCHEDULE OF A HEALTH CARE PRACTITIONER~~,~~ OR A SET OF HEALTH CARE PRACTITIONERS~~, OR AN ELIGIBLE PROVIDER SOLELY~~ BECAUSE THE HEALTH CARE PRACTITIONER~~,~~ OR SET OF HEALTH CARE PRACTITIONERS~~, OR ELIGIBLE PROVIDER~~ DOES NOT PARTICIPATE IN THE CARRIER'S BONUS OR OTHER INCENTIVE–BASED COMPENSATION OR TWO–SIDED INCENTIVE ARRANGEMENT PROGRAM.

(6) PARTICIPATION IN A TWO–SIDED INCENTIVE ARRANGEMENT MAY NOT BE THE SOLE OPPORTUNITY FOR A HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS TO BE ELIGIBLE TO RECEIVE INCREASES IN REIMBURSEMENT.

[(5)**]** ~~**(6)**~~ **(7)** 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**:**

(I) A HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS TO PARTICIPATE IN THE CARRIER'S BONUS OR OTHER INCENTIVE–BASED COMPENSATION PROGRAM; OR

(II) AN ELIGIBLE PROVIDER TO PARTICIPATE IN THE CARRIER'S TWO–SIDED INCENTIVE ARRANGEMENT PROGRAM.

[(6)**]** ~~**(7)**~~ **(8)** A health care practitioner, a set of health care practitioners, **AN ELIGIBLE PROVIDER,** a health care practitioner's designee, **[**or**]** a designee of a set of

health care practitioners**, OR A DESIGNEE OF AN ELIGIBLE PROVIDER** may file a complaint with the Administration regarding a violation of this subsection.

(d) (1) A carrier shall provide a health care practitioner**, A SET OF HEALTH CARE PRACTITIONERS, OR AN ELIGIBLE PROVIDER** with a copy of:

(i) a schedule of **ALL** applicable fees **[**for up to**]** **OR** the **[**fifty**]** **50** most common services billed by a health care practitioner in that specialty**, WHICHEVER IS LESS**;

(ii) a description of the coding guidelines used by the carrier that are applicable to the services billed by a health care practitioner in that specialty; **[**and**]**

(iii) the information about the practitioner and the methodology that the carrier uses to determine whether to:

1. increase or reduce the practitioner's level of reimbursement; **[**and**]**

2. provide a bonus or other incentive–based compensation to the practitioner**; AND**

3. RECOUP COMPENSATION FROM AN ELIGIBLE PROVIDER UNDER A TWO–SIDED INCENTIVE ARRANGEMENT; AND

(IV) A SUMMARY OF THE TERMS OF A TWO–SIDED INCENTIVE ARRANGEMENT PROGRAM.

(2) Except as provided in paragraph (4) of this subsection, a carrier shall provide the information required under paragraph (1) of this subsection in the manner indicated in each of the following instances:

(i) in writing **[**at the time of**]** **BEFORE A** contract execution;

(ii) in writing or electronically 30 days **[**prior to**]** **BEFORE** a change; and

(iii) in writing or electronically **[**upon**]** **ON** request of the health care practitioner**, SET OF HEALTH CARE PRACTITIONERS, OR ELIGIBLE PROVIDER**.

(3) Except as provided in paragraph (4) of this subsection, a carrier shall make the pharmaceutical formulary that the carrier uses available to a health care practitioner**, A SET OF HEALTH CARE PRACTITIONERS, OR AN ELIGIBLE PROVIDER** electronically.

(4) On written request of a health care practitioner**, A SET OF HEALTH CARE PRACTITIONERS, OR AN ELIGIBLE PROVIDER**, a carrier shall provide the information required under paragraphs (1) and (3) of this subsection in writing.

(5) The Administration may adopt regulations to carry out the provisions of this subsection.

(e) (1) A carrier that compensates health care practitioners **OR A SET OF HEALTH CARE PRACTITIONERS** wholly or partly on a capitated basis **IN ACCORDANCE WITH § 15–2102 OF THIS ARTICLE** may not retain any capitated fee attributable to an enrollee or covered person during an enrollee's or covered person's contract year.

(2) A carrier is in compliance with paragraph (1) of this subsection if, within 45 days after an enrollee or covered person chooses or obtains health care from a health care practitioner **OR A SET OF HEALTH CARE PRACTITIONERS**, the carrier pays to the health care practitioner **OR SET OF HEALTH CARE PRACTITIONERS** all accrued but unpaid capitated fees attributable to that enrollee or person that the health care practitioner **OR SET OF HEALTH CARE PRACTITIONERS** would have received had the enrollee or person chosen the health care practitioner **OR SET OF HEALTH CARE PRACTITIONERS** at the beginning of the enrollee's or covered person's contract year.

(3) ACCEPTANCE OF A CAPITATED PAYMENT SHALL BE VOLUNTARY.

(F) (1) UNDER A TWO–SIDED INCENTIVE ARRANGEMENT THAT COMPLIES WITH THE REQUIREMENTS OF THIS SECTION, A CARRIER MAY RECOUP FUNDS PAID TO AN ELIGIBLE PROVIDER BASED ON THE TERMS OF A WRITTEN CONTRACT BETWEEN THE CARRIER AND THE ELIGIBLE PROVIDER THAT AT A MINIMUM:

(I) ESTABLISH A TARGET BUDGET FOR:

1. THE TOTAL COST OF CARE OF A POPULATION OF PATIENTS ADJUSTED FOR RISK AND POPULATION SIZE; OR

2. THE COST OF AN EPISODE OF CARE;

(II) LIMIT RECOUPMENT TO NOT MORE THAN 50% OF THE EXCESS ABOVE THE MUTUALLY AGREED ON TARGET ESTABLISHED IN ACCORDANCE WITH ITEM (I) OF THIS PARAGRAPH;

(III) 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;

(IV) PROVIDE AN OPPORTUNITY FOR GAINS BY AN ELIGIBLE PROVIDER THAT IS GREATER THAN THE OPPORTUNITY FOR RECOUPMENT BY THE CARRIER;

(V) FOLLOWING GOOD FAITH NEGOTIATIONS, PROVIDE AN OPPORTUNITY FOR AN AUDIT BY AN INDEPENDENT THIRD PARTY AND AN INDEPENDENT THIRD–PARTY DISPUTE RESOLUTION PROCESS;

(VI) REQUIRE THE CARRIER AND THE ELIGIBLE PROVIDER TO NEGOTIATE IN GOOD FAITH ADJUSTMENTS TO THE TARGET BUDGET WHEN:

1. CERTAIN CIRCUMSTANCES BEYOND THE CONTROL OF THE CARRIER OR THE ELIGIBLE PROVIDER ARISE, INCLUDING CHANGES IN HOSPITAL RATES; AND

2. MATERIAL CHANGES OCCUR IN HEALTH CARE ECONOMICS, HEALTH CARE DELIVERY, OR REGULATIONS THAT IMPACT THE ARRANGEMENT; AND

(VII) REQUIRE THE CARRIER TO PAY ANY INCENTIVE TO OR REQUEST ANY RECOUPMENT FROM THE ELIGIBLE PROVIDER WITHIN 6 MONTHS AFTER THE END OF THE CONTRACT YEAR, UNLESS THE CARRIER OR ELIGIBLE PROVIDER INITIATES A DISPUTE RELATING TO THE RECOUPMENT OR INCENTIVE AMOUNT.

(2) UNLESS MUTUALLY AGREED TO BY AN ELIGIBLE PROVIDER AND A CARRIER, AN ARRANGEMENT ENTERED INTO UNDER THIS SUBSECTION 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.

(3) A CARRIER THAT ENTERS INTO A TWO–SIDED INCENTIVE ARRANGEMENT WITH AN ELIGIBLE PROVIDER 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, SHALL, AT LEAST QUARTERLY, DISCLOSE TO THE ELIGIBLE PROVIDER THE FOLLOWING INFORMATION IN A MANNER THAT MEETS FEDERAL AND STATE DATA USE AND PRIVACY STANDARDS:

(I) ANY AMOUNT PAID TO ANOTHER HEALTH CARE PROVIDER THAT IS INCLUDED IN THE TOTAL COST OF CARE OF A PATIENT IN THE POPULATION OR EPISODE OF CARE; AND

(II) ANY COPAYMENT, COINSURANCE, OR DEDUCTIBLE THAT IS INCLUDED IN THE TOTAL COST OF CARE OF A PATIENT IN THE POPULATION OR EPISODE OF CARE.

(4) UNLESS MUTUALLY AGREED TO BY THE CARRIER AND ELIGIBLE PROVIDER, A TWO–SIDED INCENTIVE ARRANGEMENT MAY NOT BE AMENDED DURING THE TERM OF THE CONTRACT.

(5) THE OPPORTUNITY FOR INDEPENDENT THIRD–PARTY DISPUTE RESOLUTION PROVIDED FOR IN PARAGRAPH (1)(V) OF THIS SUBSECTION MAY NOT BE REQUIRED TO BE EXHAUSTED BEFORE A MEMBER OR MEMBER'S REPRESENTATIVE IS ALLOWED TO FILE AN APPEAL OF A COVERAGE DECISION UNDER § 15–10D–02 OF THIS TITLE.

(6) NOTHING IN THIS SUBSECTION MAY BE CONSTRUED TO:

(I) ALTER ANY REQUIREMENT FOR A CARRIER TO PAY A HOSPITAL OR RELATED INSTITUTION THE RATE APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION FOR HOSPITAL SERVICES; OR

(II) SUPERSEDE THE HEALTH SERVICES COST REVIEW COMMISSION'S JURISDICTION OR AUTHORITY OVER RATE REVIEW AND APPROVAL FOR HOSPITAL SERVICES.

15–1008.

(b) This section does not apply to an adjustment to reimbursement**:**

(1) made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract**; OR**

(2) MADE AS PART OF A TWO–SIDED INCENTIVE ARRANGEMENT THAT COMPLIES WITH § 15–113 OF THIS TITLE.

(c) (1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18–month period after the date that the carrier paid the health care provider; and

(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6–month period after the date that the carrier paid the health care provider.

(2) (i) A carrier that retroactively denies reimbursement to a health care provider under paragraph (1) of this subsection shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(ii) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

SUBTITLE 21. CAPITATED PAYMENTS.

15–2101.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "ADMINISTRATOR" MEANS A CARRIER ADMINISTERING A SELF–FUNDED GROUP HEALTH PLAN.

(C) "CARRIER" HAS THE MEANING STATED IN § 15–113 OF THIS TITLE.

(D) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 2–112.2 OF THIS ARTICLE.

~~(D)~~ (E) "HEALTH CARE PRACTITIONER" HAS THE MEANING STATED IN § 15–113 OF THIS TITLE.

~~(E)~~ (F) "MEMBER" HAS THE MEANING STATED IN § 15–10A–01 OF THIS TITLE.

~~(F)~~ (G) "NETWORK" HAS THE MEANING STATED IN § 15–112 OF THIS TITLE.

~~(G)~~ (H) "SET OF HEALTH CARE PRACTITIONERS" HAS THE MEANING STATED IN § 15–113 OF THIS TITLE.

~~(H)~~ (I) "PARTICIPANT" MEANS AN EMPLOYEE OR AN EMPLOYEE'S DEPENDENT WHO PARTICIPATES IN A SELF–FUNDED GROUP HEALTH INSURANCE PLAN.

15–2102.

(A) THIS SECTION APPLIES TO ARRANGEMENTS UNDER ~~AN INSURED~~ A HEALTH BENEFIT PLAN OFFERED BY A CARRIER OR A SELF–FUNDED GROUP HEALTH INSURANCE PLAN IN WHICH A CAPITATED PAYMENT IS:

(1) CALCULATED AS A FIXED AMOUNT PER MEMBER OR PARTICIPANT ASSIGNED OR ATTRIBUTED TO THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS;

(2) TO COVER THE PROVISION OF A SET OF SERVICES DEFINED IN THE HEALTH CARE PRACTITIONER'S OR SET OF HEALTH CARE PRACTITIONERS' CONTRACT AND RENDERED BY THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS; AND

(3) PAID PERIODICALLY REGARDLESS OF UTILIZATION OF THE SERVICES BY THE MEMBERS OR PARTICIPANTS.

(B) SUBJECT TO THE REQUIREMENTS OF SUBSECTION (C) OF THIS SECTION, A HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS IS NOT ENGAGED IN INSURANCE BUSINESS AS DESCRIBED IN § 4–205 OF THIS ARTICLE SOLELY BECAUSE THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS ENTERS INTO A CONTRACT WITH A CARRIER THAT INCLUDES CAPITATED PAYMENTS FOR SERVICES PROVIDED BY THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS.

(C) A HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS IS NOT ENGAGED IN INSURANCE BUSINESS AS DESCRIBED IN § 4–205(C) OF THIS ARTICLE SOLELY BECAUSE THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS ENTERS INTO A CONTRACT WITH AN ADMINISTRATOR THAT INCLUDES CAPITATED PAYMENTS FOR SERVICES PROVIDED BY THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS TO MEMBERS OF A SELF–FUNDED GROUP HEALTH PLAN IF:

(1) THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS PARTICIPATES IN THE ADMINISTRATOR'S NETWORK AND ACCEPTS CAPITATED PAYMENTS;

(2) THE SELF–FUNDED GROUP HEALTH PLAN RETAINS THE OBLIGATION TO PROVIDE ACCESS TO COVERED HEALTH CARE BENEFITS TO PARTICIPANTS; AND

(3) THE CONTRACT DOES NOT INCLUDE OTHER REIMBURSEMENT ARRANGEMENTS THAT ARE CONSIDERED ACTS OF AN INSURANCE BUSINESS UNDER § 4–205(C) OF THIS ARTICLE.

(D) NOTWITHSTANDING SUBSECTIONS (B) AND (C) OF THIS SECTION, NOTHING IN THIS SECTION MAY BE CONSTRUED TO:

(1) ALTER ANY REQUIREMENT FOR A CARRIER OR SELF–FUNDED GROUP HEALTH PLAN TO PAY A HOSPITAL OR RELATED INSTITUTION THE RATE APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION FOR HOSPITAL SERVICES; OR

(2) SUPERSEDE THE HEALTH SERVICES COST REVIEW COMMISSION'S JURISDICTION OR AUTHORITY OVER RATE REVIEW AND APPROVAL FOR HOSPITAL SERVICES.

SECTION 2. AND BE IT FURTHER ENACTED, That, on or before December 31, 2023, and annually thereafter until December 31, 2032, the Maryland Health Care Commission shall aggregate the following information and report it to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article:

(1) the number and type of value–based arrangements entered into in accordance with the authority established under Section 1 of this Act;

(2) quality outcomes of the value–based arrangements;

(3) the number of complaints made regarding value–based arrangements; ~~and~~

(4) the cost–effectiveness of the value–based arrangements; and

(5) the impact of two–sided incentive arrangements on the fee schedules of health care practitioners included in the target budget that are not eligible providers.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.