HOUSE BILL 432

J1, J3 EMERGENCY BILL 2lr2371
HB 1210/11 – HGO

By: **Delegate Donoghue**
Introduced and read first time: February 1, 2012
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Maryland Medical Assistance Program – Provider–Based Outpatient Oncology Centers – Reimbursement

FOR the purpose of requiring the Maryland Medical Assistance Program to reimburse provider–based outpatient oncology centers for certain services at a certain reimbursement rate; requiring the Department of Health and Mental Hygiene to adopt certain regulations; prohibiting the Department from making payments for certain invoices that are received after a certain date; defining a certain term; making this Act an emergency measure; and generally relating to reimbursement rates for services provided by provider–based outpatient oncology centers to Maryland Medical Assistance Program recipients.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–105
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

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

Article – Health – General

15–105.

(a) In this section, "dual eligibility" means simultaneous eligibility for health insurance coverage under both the Program and Medicare and for which the Department may obtain federal matching funds.

(b) The Department shall adopt rules and regulations for the reimbursement of providers under the Program. However, except for an invoice that must be

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

submitted to a Medicare intermediary or Medicare carrier for an individual with dual eligibility, payment may not be made for an invoice that is received more than 1 year after the dates of the services given.

(c) A provider who fails to submit an invoice within the required time may not recover the amount later from the Program recipient.

(d) (1) The Department shall adopt regulations for the reimbursement of specialty outpatient treatment and diagnostic services rendered to Program recipients at a freestanding clinic owned and operated by a hospital that is under a capitation agreement approved by the Health Services Cost Review Commission.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, the reimbursement rate under paragraph (1) of this subsection shall be set according to Medicare standards and principles for retrospective cost reimbursement as described in 42 C.F.R. Part 413 or on the basis of charges, whichever is less.

(ii) The reimbursement rate for a hospital that has transferred outpatient oncology, diagnostic, rehabilitative, and digestive disease services to an off–site facility prior to January 1, 1999 shall be set according to the rates approved by the Health Services Cost Review Commission if:

1. The transfer of services was due to zoning restrictions at the hospital campus;

2. The off–site facility is surveyed as part of the hospital for purposes of accreditation by the Joint Commission on Accreditation of Healthcare Organizations; and

3. The hospital notifies the Health Services Cost Review Commission in writing by July 1, 1999 that the hospital would like the services provided at the off–site facility subject to Title 19, Subtitle 2 of this article.

(e) (1) In this subsection, "provider" means a community–based program or an individual health care practitioner providing outpatient mental health treatment.

(2) For an individual with dual eligibility, the Program shall reimburse a provider the entire amount of the Program fee for outpatient mental health treatment, including any amount ordinarily withheld as a psychiatric exclusion and any copayment not covered under Medicare.

(f) This section has no effect if its operation would cause this State to lose any federal funds.

(g) The Program shall pay the rates set by the Health Services Cost Review Commission for hospital services, as defined in § 19–201 of this article, provided at:

(1) A freestanding medical facility pilot project authorized under § 19–3A–07 of this article prior to January 1, 2008; and

(2) A freestanding medical facility issued a certificate of need by the Maryland Health Care Commission after July 1, 2015.

(H) (1) IN THIS SUBSECTION, "PROVIDER–BASED OUTPATIENT ONCOLOGY CENTER" MEANS AN OUTPATIENT ONCOLOGY FACILITY ASSOCIATED WITH A HOSPITAL THAT:

(I) IS LOCATED OFFSITE; AND

(II) MEETS THE PROVIDER–BASED CRITERIA OF 42 C.F.R. § 413.65.

(2) (I) THE PROGRAM SHALL REIMBURSE A PROVIDER–BASED OUTPATIENT ONCOLOGY CENTER FOR SERVICES RENDERED TO A PROGRAM RECIPIENT AT A RATE BASED ON A PERCENTAGE OF THE APPLICABLE MEDICARE RATE.

(II) THE DEPARTMENT SHALL ADOPT REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS PARAGRAPH.

(3) NOTWITHSTANDING THE PROVISIONS OF SUBSECTIONS (B) AND (C) OF THIS SECTION, THE DEPARTMENT MAY NOT MAKE PAYMENT FOR AN INVOICE FOR THE REIMBURSEMENT OF SERVICES RENDERED TO A PROGRAM RECIPIENT BY A FREESTANDING OUTPATIENT ONCOLOGY CENTER THAT IS RECEIVED MORE THAN 2 YEARS AFTER THE DATES OF THE SERVICES GIVEN.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.