Ben Steffen of the Maryland Health Care Commission lead introductions and reviewed the aim of the workgroup, which is to modernize the Maryland self-referral law to align with new payment models.

Wynee Hawke and Noreen Rubin of the Board of Physicians presented background on the Stark law and Maryland's self-referral law

- Ms. Hawke acknowledged that Maryland's self-referral law applies to all health occupations, however the Board of Physicians is the only Board that has been asked to issue a decision on the Maryland statute.
- Dr. William Regine questioned why Chesapeake Urology was allowed to continue to own a radiation oncology group which it had a financial arrangement and Ms. Rubin explained a consent agreement was reached between the Board and the providers. The group will provide information to the Board as part of that agreement. Ms. Rubin will provide the public agreement to the workgroup.
- Dr. Arnold Levy commented that no other state has an exclusion for radiology or laws as stringent as Maryland.
- Dr. Ted Lee commented that 49 other states allow medical and radiation oncology to coexist.
- Dr. Regine responded that other states have Certificate of Need programs for linear accelerators.

Donna Kinzer presented the perspective from the Health Services Cost Review Commission on alignment of the state self-referral law with Maryland's All-Payer Model Agreement with the Centers for Medicare and Medicaid Innovation. She reviewed the triple aim of improving care, improving health and reducing cost. Ms. Kinzer stated that HSCRC is interested in any changes that may impact utilization and total cost of care. Ms. Kinzer focused on Alignment goals and the importance of aligning the interest of physicians and the interest of hospitals. HSCRC is focusing on aligning the systems both inside and outside of hospitals. She noted the importance of taking advantage of the Medicare Chronic care fee to bring medical homes to the Medicare population. A second based on Physician alignment workgroup recommendations was to move to gainsharing and pay for performance programs for inpatient hospital services and pay for performance programs to improve care for individuals with chronic conditions. Ms. Kinzer also stressed the importance of integrated care networks and ACO's of which one-third of all Medicare patients in Maryland are enrolled.

- Dr. Joel Suldan asked Ms. Kinzer if the HSCRC has thought about how the changes to the self-referral statue could help in aligning the waiver and if the current law gets in the way of alignment. Ms. Kinzer reiterated that the HSCRC is concerned about overutilization and total cost of care.

- Dr. Harry Ajrawat noted that there are three ACO's in MD and there is a need for more ACO's if CIN will move forward[1]. Ms. Kinzer agreed but suggested that any changes to care deliver needs to be evidence based and data driven.

Ben Steffen reviewed the structure of the existing statue and MHCC's role in the exemption process. He also noted that only two groups have filed for an exemption since the Court of Appeals upheld the Board of Physicians ruling. MHCC's role is to assess the need for the services. In the two instances MHCC found there was no need for the services for which the providers were requesting an exemption from the self-referral law. In both cases MHCC found there was no need in the area where the provider was located. The health secretary granted an exemption to one provider and denied an exemption to another. Mr. Steffen also reviewed the Commission's thinking on potential changes to the self-referral statute as outlined in the letter to the General Assembly dated January 8, 2015. The Commission suggested that office-based imaging could be permitted if three conditions were met:

1. The practice demonstrates that a very high proportion of care is reimbursed under risk-based financial arrangements;
2. The practice can demonstrate sufficient scale as to make ownership of imaging equipment viable and agrees to bundle imaging use under new risk-based arrangements; and
3. The practice commits to ongoing reporting of quality metrics linked to its patient outcomes.

Mr. Steffen outlined MHCC's thinking in these recommendations and then turned the floor over to the workgroup members to comment on these recommendations.

- Dr. Ted Lee commented that there is a CMS framework for payment reform that Maryland is not eligible to participate. He noted that radiation oncologists follow a decision making matric called *Pathways.* Opportunities for new reimbursement models are relatively limited in Maryland.
- Several physicians, including Dr. Levy, Dr. Grasso and Dr. Ajrawat noted that costs in hospitals are higher than costs for office based imaging. Dr. Grasso also pointed to several studies which illustrated lower utilization for office based services.
- Dr. Loralie Ma discussed the importance of maintaining high quality of imaging, as well as patient access to all imaging modalities.
- Hospital representatives including Ms. Towson and Nicole Stallings commented that integrated care is possible and the new waiver model requires integration but the goal is to reduce over-utilization system wide.
- Dr. Moody Warham commented that the conditions suggested by MHCC would lead to substantial costs as the plan is implemented.
- Dr. Tim Robinson noted that quality is not easy to measure particularly for specialists

[1] The Maryland Hospital Association later clarified that Maryland hospitals are participating in over 20 ACO's throughout the State.

- Insurance representatives including Deborah Rifkin and John Fleig stated that from their perspective they see both sides of the issue. Mr. Fleig suggested there are limitations in statue allowing for new payment models and this statute is not in line with the new waiver agreement.