Ben Steffen of the Maryland Health Care Commission led introductions and outlined the purpose of the meeting, which was to try to move the group toward consensus on some issues. Mr. Steffen broke the meeting into three parts;

- redefining the problem, as it existed when the self-referral statute was originally conceived, and what challenges existed in Maryland and nationally;
- several physicians in private practice to talk about how reimbursement is changing; and,
- open-ended discussion on potential solutions.

Guy D'Andrea of Discern Health began his presentation by providing context for the Maryland self-referral law. He discussed the Maryland law, which was passed in 1993 when fee-for-service was the predominant payment model, which at that time led to a perceived conflict of interest for providers to refer for services which they owned. At that time, the Federal Government enacted the Stark Law to restrict reimbursement and limit potential conflict. Maryland passed additional restrictions. The problem at that time was the perceived economic incentive built into the fee-for-service model where revenue could be generated by referring for more services.

Mr. D'Andrea then outlined the changing environment. New payment models are emerging which are focusing on total cost of care and pay-for-performance, etc. In an environment where providers take on risk, some concerns that precipitated the passage of the Maryland self-referral law, and Stark, may be mitigated. He posited that the self-referral statute, as currently constructed, might not align with shifting goals in the health care system where providers are being asked to become more integrated. CMS has identified alternative payment models as the long term solution to issues raised under Stark.

Mr. D'Andrea then created a new statement of the problem: "Maryland's self-referral restrictions may prevent providers from testing innovative care delivery models under value-based purchasing arrangements."

- Dr. Blumberg pressed Mr. D'Andrea, and other workgroup members to share specific cases where current law stops innovative care delivery and the movement towards new payment models. He believes that, perhaps, we need to add some guiderails for applying for an exemption which is already in current law
- Dr. Ajrawat questioned whether this law was still needed at all.

Dr. Lee presented the medical oncology perspective. He first outlined what medical oncology does, and the accountability standards that already exist in the oncology field, including the most commonly used "Pathways"- the national comprehensive cancer networks. He also outlined resources that a medical oncologist uses, including the SHINE program. Dr. Lee then discussed his practice, Maryland Oncology Hematology, P.A, that is managed in collaboration with U.S. Oncology, which is in 19 states and employs almost 1000 physicians. U.S Oncology has more than 100 value-based contracts. Fifteen practices outside of Maryland completed a letter of intent with CMS to participate in a new payment model. Physicians in Maryland are not able to participate in the CMS program. Dr. Lee went through various value-based contracts, including

models centered on pharmaceuticals, pay for performance, comprehensive care management, bundled payments, and exclusive capitated care.

- Mr. Steffen asked how revenue/compensation is shared. Dr. Lee said there were various ways to share revenue if practices are given the ability to offer radiation therapy. Within Maryland that is open to discussion, some practices share revenue equally, some in an RVU process.
- Dr. Regine then asked what in the law prevents Dr. Lee from integrating care, since the practice shares a building with two prominent hospital systems. Dr. Lee responded that while his practice model may not change with a change in the law, a change would allow physicians without the same arrangement to offer more services to patients.

Dr. Albert Blumberg and Dr. Loralie Ma presented on new payment models and the role of radiology. Dr. Ma first outlined the original problem that due to fee-for-service, which is still the predominant payment model, volume is still rewarded. With increased volume come increased costs and healthcare becomes less affordable for all. They presented on the role of the radiologist in accountable care organizations (ACOs), which are largely driven by primary care physicians. The radiologist's role in an ACO or other integrated care entity is to guide other members of the ACO in the appropriateness of imaging. Dr. Ma discussed how access does not equal ownership and a referring physician does not need to own the equipment to ensure access. In a survey conducted by the American College of Radiology, 27% have been approached to work in an alternative payment model by physicians of other specialties or by hospitals. Moving forward, it is likely that the fee-for-service model will continue to be the dominate payment model, especially in imaging. They concluded that there is no need for the change in the law.

- Dr. Ajrawat commented that as radiology centers are concentrated around the Baltimore and D.C. Metro areas, they are not serving the entire state of Maryland.
- Joel Suldan commented that if the payer does not care if the physician self-refers, then we should not care. However, most payments are still in the fee-for-service payment model where the payer would care.
- Dr. Levy argued that the law needs to be fluid and change with new payment models.

Mr. Steffen moved to a discussion of the various perspectives, and asked participants to move away from the positions they are dug into and think about new and different ideas. Mr. D'Andrea walked through possible solutions, including no change to the law; modifying CON or self-referral law to include imaging and other advanced technology; requiring practices to meet criteria on quality and payment; and fully aligning the Maryland self-referral law with the Federal Stark law. Mr. Steffen then walked through the regulatory and operational process for achieving each solution.

- Dr Levy, Dr. Grasso, and Dr. Ajrawat proposed fully aligning the statute with the Federal Stark law. They stated this would be less administratively burdensome than the current exemption process and the state law would then change with the federal law. The state law has not been amended since 1993 and the federal state law has been amended several times.

- Nicole Stallings from the Maryland Hospital Association asked for specific examples for when the law is a problem. She suggested we dig deeper into the specific issues that this law may be causing as a way to look into changing the law. She also suggested that the current exemption process would resolve access issues that may occur.