Provider/Carrier Workgroup-Study on Self-Referral

Introduction and MHCC Approach

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Criteria for an Exemption - Health Occupations §§1-301 – 305 and COMAR 10.01.15.05 and .06

Section 1-301 (b)(1) defines "Beneficial interest" means ownership, through equity, debt, or other means, of any financial interest.

Section 1-302(d)(5) of the statute provides that an applicant may be granted an exemption if the Secretary determines:

- …that the health care practitioner's beneficial interest is essential to finance and to provide the health care entity; and
- …in conjunction with the Maryland Health Care Commission, determines that the health care entity is needed to ensure appropriate access for the community to the services provided at the health care entity;

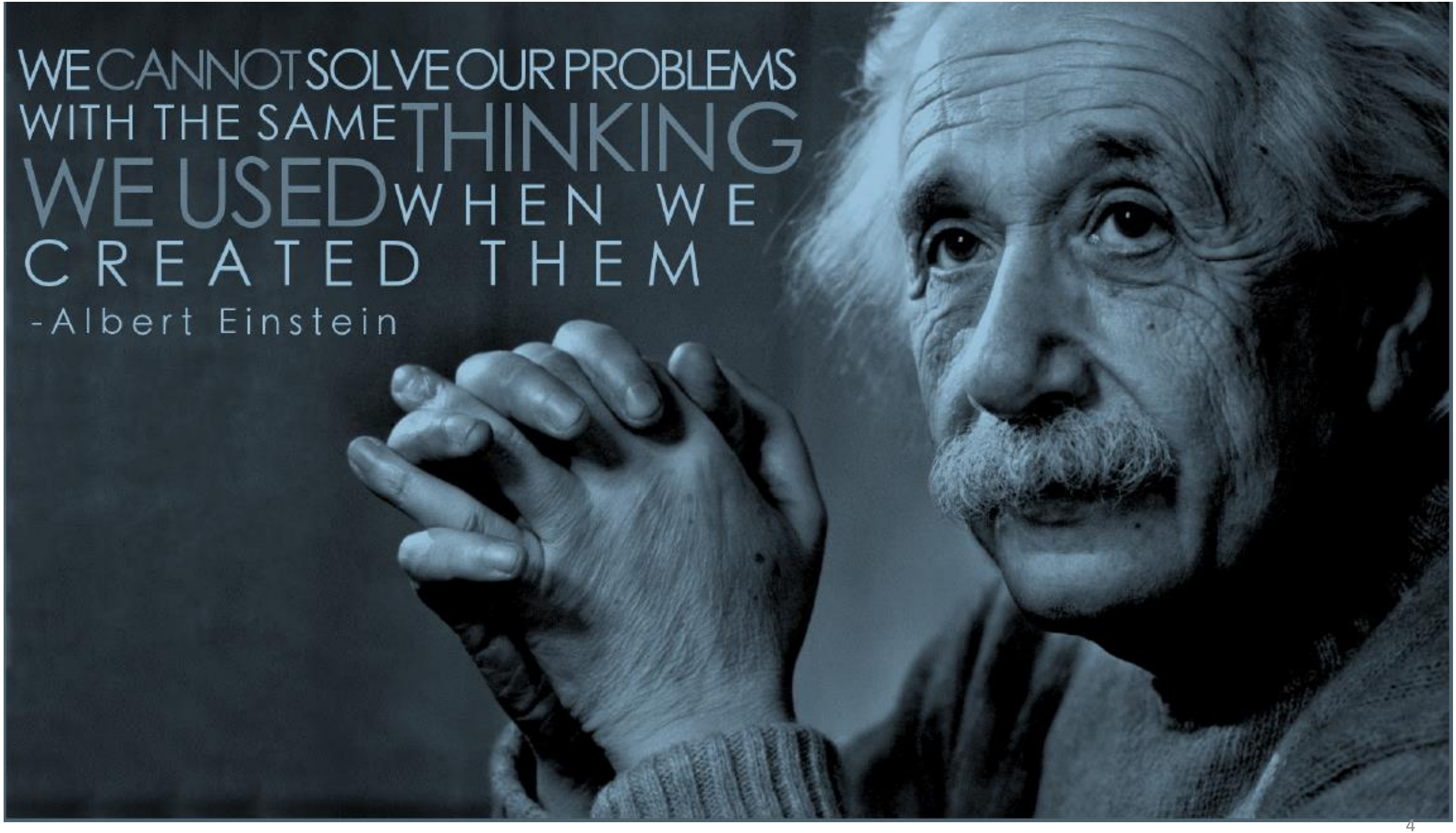
COMAR 10.01.15 - Exemption from Self-Referral Laws

- Defines format for exemption request
- Requires the Secretary to respond in 90 days
- Requires applicant to agree to relinquish the “beneficial interest”, if the Secretary denies the application
- Provides opportunity to renew the exemption

History of Exemption Process

The Secretary received two applications for exemptions since 2011

- Both applicants provided self-referral services prior to the Court of Appeals decision upholding BOP declaratory ruling
  - Orthopedic practice requested an exemption to provide advanced MRI services
  - Urgent care facility requested exemption to provide CT services in urgent care setting
- MHCC assessed whether the imaging services were needed to ensure appropriate access
  - Asked applicants to report volume of services provided, capabilities of imaging equipment
  - Inventoried other organizations providing advanced imaging services in the respective communities
  - Assessed capacity of other organizations to absorb additional volume
  - Concluded that advanced imaging services provided by the applicants were not essential to ensure appropriate access in their respective communities.
- Secretary agreed with MHCC's conclusion in one case and approved the exemption in the second.
- Applicant received a second exemption in 2013.


WE CANNOT SOLVE OUR PROBLEMS
WITH THE SAME THINKING
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-Albert Einstein

What MHCC said

… ownership of office-based imaging could be permitted if three conditions are met:

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

What MHCC was thinking

Practice demonstrates that a very high proportion of care is reimbursed under risk-based financial arrangements

- Practices participate with multiple payers in a meaningful way in value and risk based payments.
- Participation is broad and deep. Practices must be engaged for a significant share of patient care

CMS …. “30 percent of all fee-for-service payments to providers to quality initiatives through alternative payment models--particularly accountable care organizations (ACOs) and bundled payments--by 2016 and 50 percent by 2018, …. goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018.”

Caveats:

- Blended payment methods (e.g. capitation + pay for Performance +FFS)
- Payers have been slow to develop risk-based initiatives for specialists

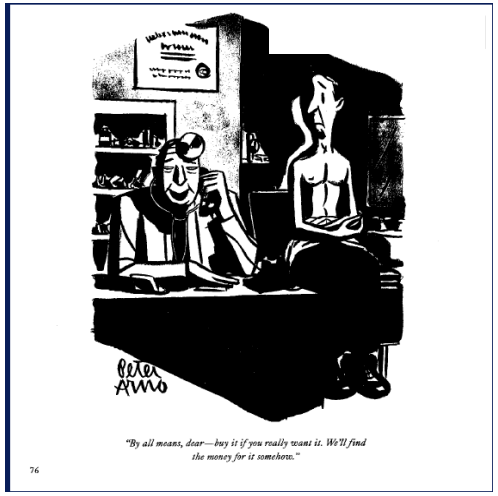
What MHCC was thinking

Sufficient scale

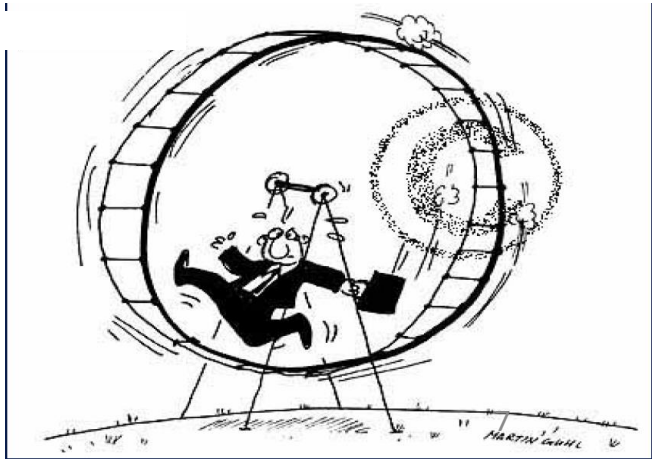
- Organization has sufficient size, ability to self-refer will not produce inefficiencies or lower quality of care

Caveat:

- Rapid proliferation of new capabilities will be very difficult to manage and compromise previous investments.
- Human scale, especially in clinical setting is important



Neither these works



What MHCC was thinking

Quality reporting focused on patient outcomes

- Start with meaningful performance measures at the level of the organization.
- Support culture changes focused on improving care, not on hitting narrow targets
- Incentivize intrinsic motivation = putting the patient first + continual striving to become a better physician

Caveats: Incentives based on measures that physicians don't view as highly important for patient care

- Align measures -- multiple overlapping but not quite identical quality measures are a significant drag on the performance improvement
- Meaningful quality and performance measures for specialties are limited, but can be developed, eg cardiology and anesthesiology