

DRAFT FOR CONVERSATION PURPOSES

To fulfill the charge of the Provider-Carrier Workgroup (PCW) (determining a path forward for modernization of current Maryland patient referral law to better align Maryland statute with emerging payment models and health care reform), we recommend that a well-defined pilot program for integrated community oncology (radiation therapy and medical oncology together in a group practice) be exempted from the patient referral law. The pilot program, including its application and selection process, should be administered by the MHCC under regulations established through DHMH rulemaking. Such a pilot program should allow for the following:

- Not more than five radiation therapy facilities to be established and operated within the following counties:
 - Baltimore County;
 - Calvert County;
 - Charles County;
 - Saint Mary's County;
 - Talbot County;
 - Caroline County;
 - Wicomico County;
 - Worcester County;
 - Somerset County;
 - Harford County;
 - Cecil County;
 - Frederick County
 - Garrett County;
 - Dorchester County;
 - Kent County
 - Prince George's County;
 - Washington County;
 - Montgomery County; and
 - Carroll County.
- Each facility should be at least 50% owned by a physician group practice;
- Each facility should be allowed to operate for a minimum of 10 years, provided it remains at least 50% owned by a physician group practice;
- Each group practice owning such facility(ies), and each commercial carrier contracting with such group practices, should report quarterly to MHCC information necessary to determine the following:
 - Referral rates for radiation oncology consultations and utilization rates for radiation therapy services by the practice's physicians,
 - Referrals for radiation therapy by practice's physicians in compliance with nationally accepted guidelines (pathways compliance),
 - Effects of integrated community oncology centers on average patient out-of-pocket costs, unplanned hospital utilization (ER visits, hospital admissions, and days in the hospital) by patients, overall radiation utilization rates, healthcare costs in the state, and the Maryland All-payer Waiver relative to the equivalent outpatient services provided across other care settings, and
 - Health outcomes of patients treated by integrated community oncology centers relative to statewide averages across other care settings.
- MHCC should report annually to the legislature the analysis performed and the data collected from the participating pilot program facilities over the prior year.

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- Following a pilot program facility's completion of 10 years of treating patients (and subsequent reporting as outlined above), MHCC will submit to the legislature a comprehensive report summarizing their findings for that facility compared to state averages for other care settings. The final report should include a recommendation on whether or not to grant the practice an exemption from the Maryland Patient Referral Law (MPRL) prohibition on radiation therapy ownership based on their performance within the pilot program. Recommendations should be based on the following:
 - Radiation utilization,
 - Pathways/guidelines compliance for radiation therapy,
 - Average cost per patient, per episode cost of care for integrated treatment,
 - Average patient out-of-pocket costs, and
 - Average unplanned hospital utilization rates per patient.
- Following the final report from MHCC, only an act of the legislature could authorize either granting practices owning pilot program facilities a broader exemption from the MPRL, or removing participating facilities from the pilot program.
- Each group practice with ownership in such facilities should meet the following criteria as of January 1, 2016, and at the time they apply, are accepted, and begin operating a facility under the pilot program:
 - Be composed entirely of physician owners who are oncologists or specialists who primarily treat oncology and hematology patients, and who are licensed and practice in Maryland;
 - Average more than 50,000 patient visits in Maryland per year throughout the practice for the past three years;
 - Demonstrate that the group practice has accepted Medicare and Maryland Medical Assistance Program patients for the preceding three consecutive years;
 - Demonstrate that the group practice has been treating patients in Maryland for at least ten years; and
 - Be affiliated with a national organization having expertise and technical capabilities sufficient to support:
 - Collection, analysis, and reporting required information to the state,
 - Practices' use of evidence-based clinical pathways through electronic medical records,
 - Conduct innovative oncology payment model studies with carriers in Maryland, and
 - Enroll cancer patients in clinical trials in at least one of the practice's locations in Maryland.

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We believe such a pilot program will allow the state to conduct overall cost of care comparisons between community- and hospital-based integrated oncology services, as well as fragmented cancer care between stand-alone medical oncology and radiation oncology practices, by collecting information on cost, cost savings, and utilization, while concurrently allowing providers and carriers to work together on improving emerging oncology payment models—to include more integrative, value-based oncology efforts in a way that mitigates risk and allows benefits to patients, providers, and carriers. We recommend this for the following reasons:

- Free-standing, community-based radiation oncology is lower both in terms of cost per treatment and for total cost of care (per episode) than hospital-based oncology, when measured by either costs to carriers or patient out-of-pocket costs. Currently most radiation patients in Maryland are treated in hospital-owned facilities.
- Risk is low due to the distinct differences between radiation oncology and diagnostic imaging. In oncology, a therapeutic service like radiation requires prior authorization, following evidence-based clinical pathways, and can only be administered after patient consultation with a radiation oncologist. A diagnostic service like imaging does not require the same. With these checks and balances, at most there would be a shift of patients to the low-cost setting for care, not an increase in the number of radiation patients treated. Moving outpatient services for expensive oncology services off hospital campuses will support the Maryland Waiver, and improve hospital profitability under their Global Budget Revenue caps.
- Clinical pathways are designed to reduce costly variation in care through recommended care processes for specific clinical situations. The ability to expand such work to radiation oncology—working between forward-thinking payers and oncology practices with national affiliations like The US Oncology Network—can provide both sides with the opportunity to test ways in which the integration of community cancer services can theoretically magnify cost savings in such models. This can increase the quality of care, patient experience, and efficiencies in care coordination while reducing duplication, medical errors, and hospital utilization.
- There are many innovative projects between payers and providers across the country underway, but none have yet determined how best to fit oncology services into major shifts away from fee for service. We need to be able to explore this, and allowing radiation gives us more “flexibility” in making it work.
- Oncology services in general are very expensive, with new drugs and new therapies adding to the increasing cost of providing “standard of care,” which itself is increasingly integrated in nature (dual- and multi-modality treatments). Much more testing of innovative payment models addressing cost and quality in oncology are needed.
- Already, due to unique features in Maryland, oncologists here are excluded from participating in CMS's Oncology Care Model pilot.
- A majority of cancer care (particularly chemo-therapy) nationally is provided in the independent, community based provider setting. Not being able to include these providers in new oncology models built around integrated care will hamper efforts to develop such models in Maryland.
- Regardless of what the PCW study ultimately recommends, the shift to performance based models will happen, and has been happening nationally. Maryland should modify the referral statute so that carriers and all oncology providers here can be a part driving positive change.