# Provider-Carrier Workgroup Study on Maryland's Self-Referral Statute

***Health and Government Operations Committee***

**January 19, 2016**

The MARYLAND
HEALTH CARE COMMISSION

# Maryland Patient Referral Law (MPRL) Overview

- Enacted in 1993 during a time of accelerating health care costs and fears that purchasers lacked tools to manage utilization
- Prohibits a health care practitioner (or directs an employee or person under contract) from referring a patient to a health care entity in which the health care practitioner has a beneficial interest or compensation arrangement.
- 11 specific exemptions in statute
- Broader than the federal self-referral law, known as the Stark Law
  - Applies to all health care practitioners licensed or certified under the Health Occupations Article, not just physicians
  - Applies to all payers, not just Medicare and Medicaid
  - Covers all services, not just designated health services

# MHCC MRI Study

- HB 536 (2013 Legislative Session) - Required DHMH to conduct a study on the ordering of MRI services by physicians in non-radiology group practices that owned an MRI prior to 2011 (No Vote)
- In a letter (dated July 10, 2013) Chairman Hammen requested MHCC to conduct a study using Medicare claims data, comparing utilization of MRI services by non-radiology group practices between CY 2010 and CY 2012
- Study completed and delivered to the Health and Government Operations committee in January 2015 found:
  - No evidence that financial interest influenced MRI rates in 2010 compared to 2012
  - Practices with a financial interest in MRI equipment had higher rates of MRI use in both 2010 and 2012

# Maryland Health Care Commission Advice

- Changes in the MPRL could be linked to broader payment reforms, with full participation in risk-based arrangements as a first condition.
- Ownership of 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 the risk-based arrangement; and
  3. The practice commits to ongoing reporting of quality metrics linked to its patient outcomes.

# Health Care Provider Carrier Workgroup & Chairman Hammen's Request

- Chapter 614 of 2014 established the Health Care Provider-Carrier Workgroup, with MHCC as the convener.
- Workgroup was formed in the fall of 2014 with a group of "standing" members that included payors, providers, and consumers.
- Delegate Hammen concluded that this group would be a forum for discussing MPRL and charged the MHCC to:
  - "…review and recommend changes to the State's prohibition on self-referral. The workgroup, with representation from affected stakeholder groups, is the appropriate vehicle for undertaking this charge."

# Workgroup was Broadly Representative

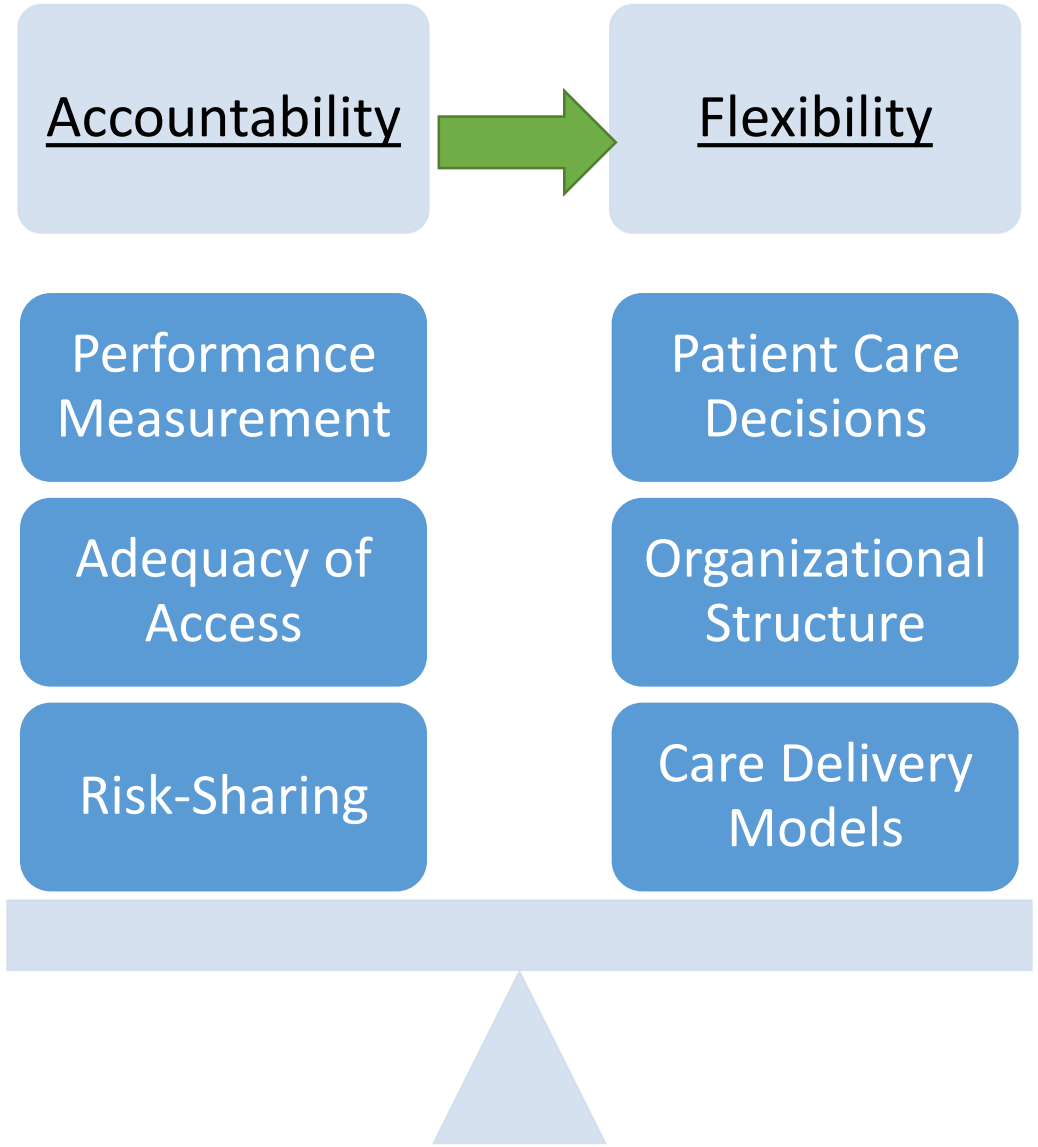
- Standing Members
  - Representatives from all major payors (7)
  - Provider representatives, including representatives from various specialties, hospitals, and community health centers (5)
  - Consumer representatives (4)
- Additional Issue-Specific Members
  - Hospital representatives (6)
  - Maryland Patient Care and Access Coalition (3)
  - Oncology (1)
  - Radiology (1)
  - Anesthesiology (1)
  - State Agencies, including; HSCRC, MBP, and Medicaid (3)
- 31 Total Members

# Meetings 1 and 2 – Slow Progress

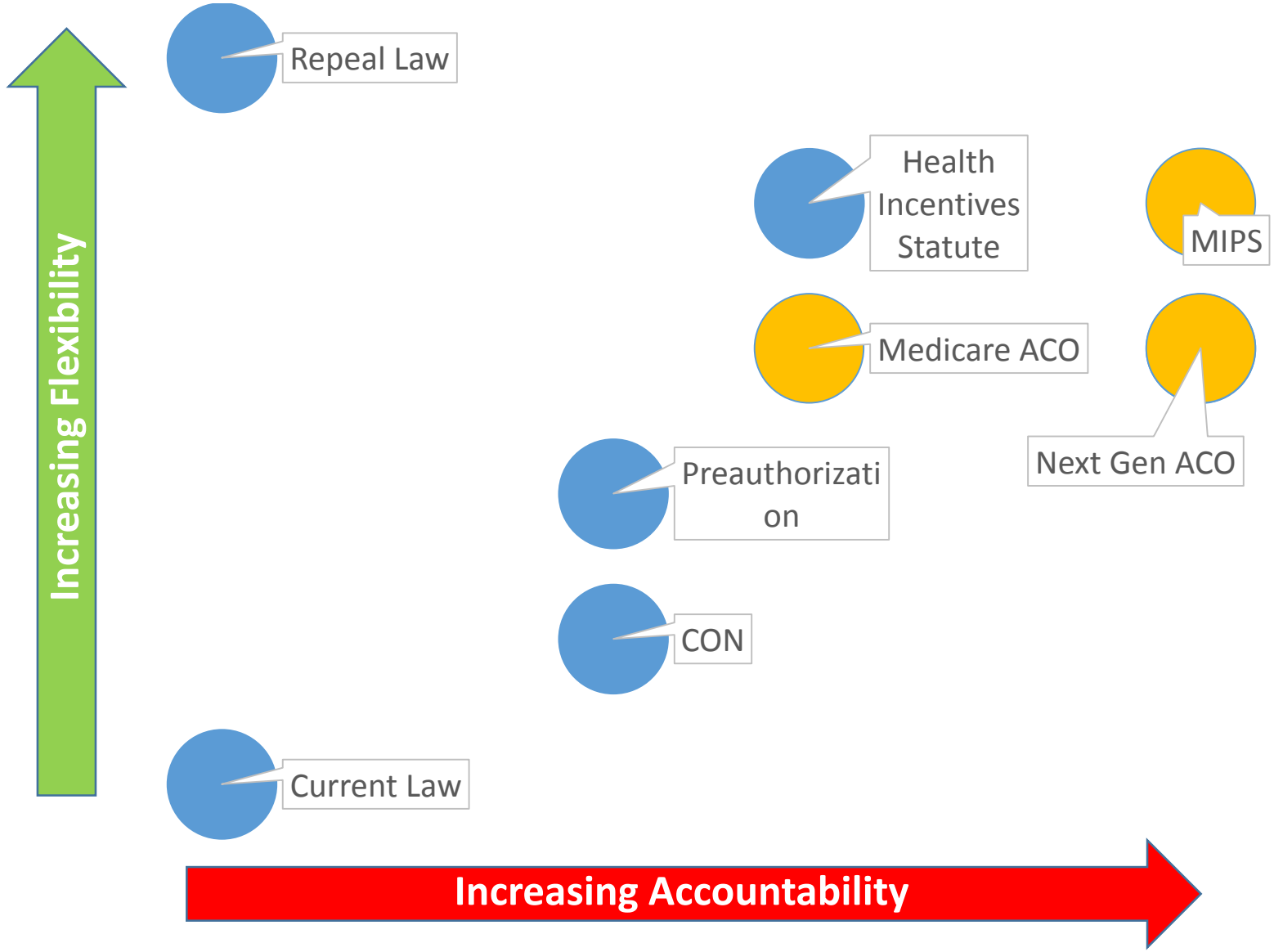
- Overview and History of MPRL
  - Background on MPRL
  - Alignment of self-referral with Maryland's All-Payer Model Agreement
  - MHCC approach to considering exceptions to MPRL
- Members offered their perspectives
- Shared Savings Programs and Opportunities Explored
  - Medicare and private payer programs
  - MHA gainsharing approach
  - Other models to consider
    - Clinically integrated organizations
    - Mandatory preauthorization
    - Certificate of Need

# MHCC Core Principle

Providers who take on greater accountability should have greater flexibility in managing their practices and patients.



# Continuum of Options: Making Trade-Offs



# Meetings 3 and 4 – Moving Beyond Historic Disagreements

- Staff concluded that focusing on imaging was too narrow and there was a need to refocus the workgroup to achieve broader consensus.
- Redefining the problem
  - Maryland's self-referral restrictions may prevent providers from testing innovative care delivery models under value-based purchasing arrangements.
- Providers developing innovative models beyond MRI, CT and radiation therapy may be inhibited by the MPRL.
- Stakeholders agreed to build broad consensus around a set of general principles.

# Consensus Principles

- The Affordable Care Act, innovative private payor arrangements, and Maryland's all-payor hospital model have created in Maryland a more rapid move toward value-based payment and provider integration.
- The opportunities presented by a value-based payment system are fundamentally different from those in the traditional fee-for-service system.
- The Maryland Patient Referral Law (MPRL) should be modernized to allow for the development of additional bona-fide value-based payment models, risk-sharing arrangements, and alignment models. The Workgroup effort has resulted in general consensus that greater clarity is needed to ensure that emerging compensation arrangements under these models are permissible.
- This aim can be achieved by working within the current MPRL framework, which covers referrals involving all payors (government, commercial, private), applies to all health care practitioners (not just physicians, as under the federal Stark law), and applies to all health care services (not just designated health services or entities providing designated health services, as under the federal Stark Law).

# Consensus Principles

- Maryland should consider incorporating the elements from the federal Stark law that can enhance the MPRL to provide payment clarity, predictability, and stability to health care practitioners as they consider partnerships and new models designed to achieve value-based payment goals.
- Changes should neither repeal the MPRL nor replace it with the federal Stark law.
- The well-being of patients must be paramount in the evaluation of any changes to the MPRL. Accordingly, any changes considered must not diminish important protections for patients against inappropriate utilization or costs of healthcare services.
- Any revisions to the MPRL cannot jeopardize Maryland's all-payor rate setting agreement with the federal government, which requires reduction in inappropriate utilization and strict limits on health care spending, both in and outside of the hospital.

# Takeaways from Workgroup


- MPRL is a broad statute and its impact on new delivery models is unclear.
- MPRL should not interfere with value-based payment and provider collaboration
- Agreement on general principles is a positive step in building consensus on changes to the MPRL.
- General principles can provide a template for assessing the credibility of specific reforms.