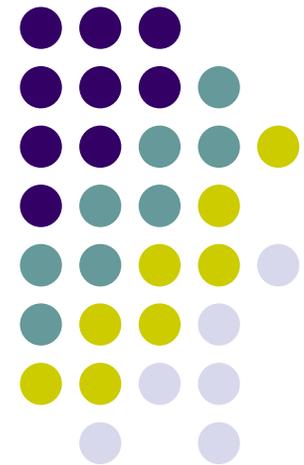


Advising Health Care Clients: Issues in Payment Reform

Maine Medical Association
August 7, 2013

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Agenda – Four Topics

- Background for health reform
- What's on the near-term agenda for health system reform?
- What might be in store for the long-term?
- What are implications for independent physician practices and hospitals?



Appendix

- How do antitrust laws and fraud and abuse laws impact collaboration among health care providers?
- Acknowledgment – limited time frame and strong desire for conversational interaction with reaction panel and attendees



Reaction Panel -- Modified

- John Wipfler, JD, MBA – CEO, OA Centers for Orthopaedics
- Christine Burke Worthen, Esq. – Assistant General Counsel, Eastern Maine Healthcare Systems
- Will look now to distinguished colleagues –
 - Attys Smith and Barnard -- MMA
 - Commissioners Head and Sheehan
 - Counsel to Major Systems – Attys Parsons, Bailinson
 - Counsel to multiple systems, practices and providers – Poulin, Belanger, Duddy, Coffin, Olivier, Sturtevant, Gleason, Riggle, Altholz, Stiles, Witham,

Topic 1: Background for Health Reform

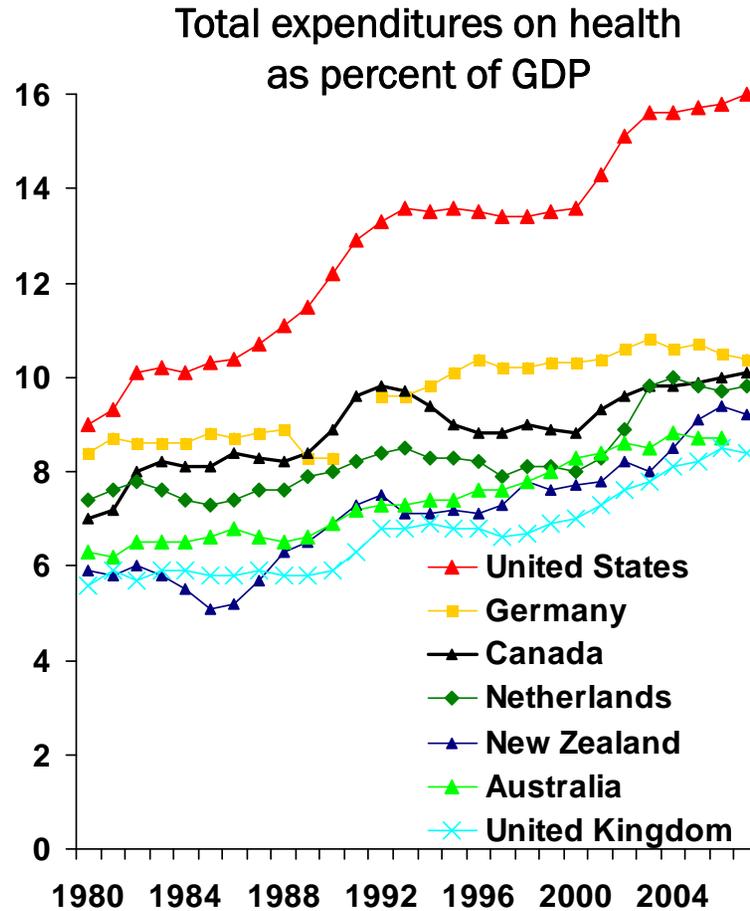
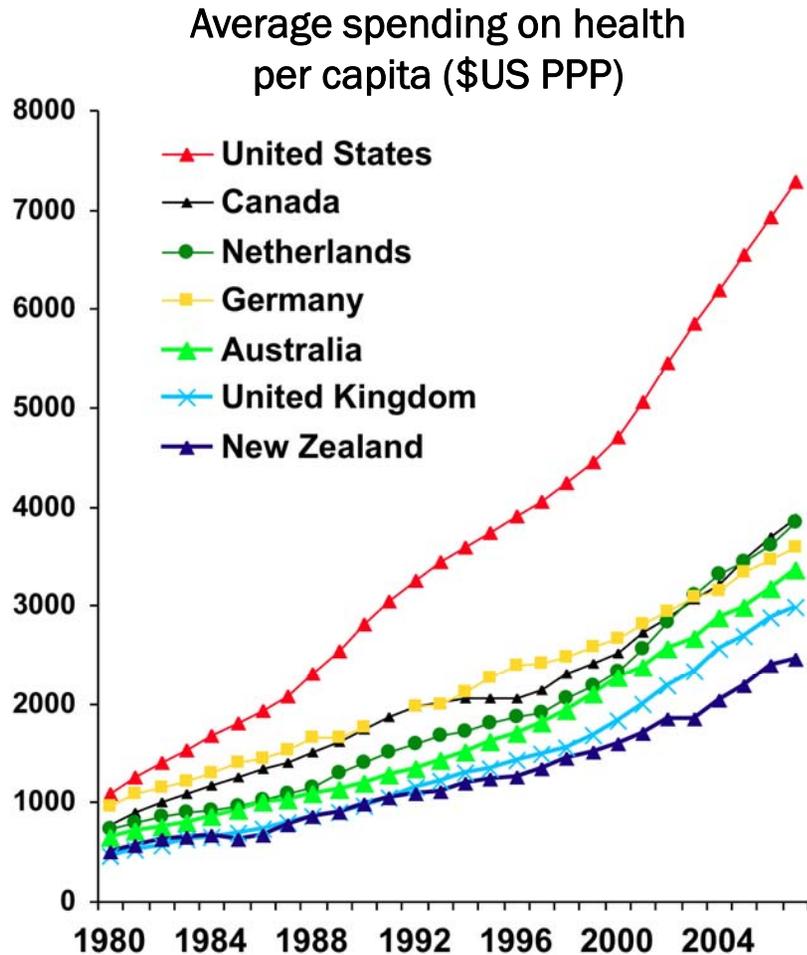




Overview...

- The economics of health care are requiring fundamental change to the health care delivery system.
 - Health care spending continuing to rise
 - and rise as % of GDP
- New Value Proposition: Transition away from volume-based, fee for service payment to a value-based, cost containing (reducing?) system is happening.
- Not “whether” but “when”

Health Care Spending



Note: \$US PPP = purchasing power parity.

Source: Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

Health Care Spending



- Is it getting better on its own?
- Maybe people will stop getting sick?
- Maybe people will voluntarily agree to seek less expensive care?
- Maybe people will voluntarily agree to curtail end of life care?
- Maybe the economy will come roaring back filling State and Federal tax coffers (and employers' bank accounts) so we don't care about the rising cost of care?
- Maybe personalized medicine or some other breakthrough transformation in care will eradicate disease?
- Maybe an advanced alien species will land on Earth and bring about a health utopia!

Health Care Spending



- Are we at least getting a great product for all we are spending?



Quality and Cost

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00



	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

So What Are We Doing About it?



- PPACA and recent efforts aren't revolutionary.
- The cost problem has been with us for years – and Medicare has been at the front line of trying to address it.

Warning: Oversimplification Approaching!



- We elected to move in this direction incrementally.
- 1980s/1990s:
 - Governmental payors moved from Cost/reasonable charge to PPS/RBRVS.
 - Commercial Payors experimented with (and failed at) "managed care". (Massachusetts stuck with it better than most).
- 1990s/2000s:
 - Rate reductions; no fundamental change; mandated benefits.
- Costs continued to rise.

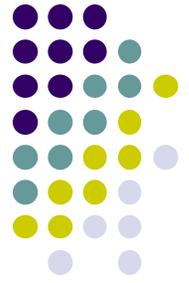


Today

- Governmental payors (CMS and States, e.g. Mass “RomneyCare”):
 - Health Reform.
 - Maine’s self-insured state employee plan*
 - Maine’s State Innovation Model Grant*
- Commercial payors:
 - tiered networks;
 - modest cost shifting;
 - rate pressure;
 - and a few bold initiatives*

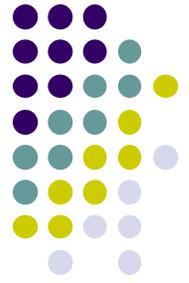
*More to follow

Maine SEHC Tiered Network experiment



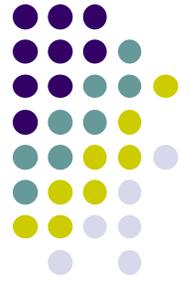
- Maine State Employee Health Commission forced to innovate on a fast track:
 - Maine's Biennial Budget enacted in 2011 for 2012-2013 **flat funded** the SEHC's health benefit plan
 - Limited to premium rate in effect in 2011
 - Legislature unable to repeal medical inflation
 - Rapid introduction of cost sharing, with 3-tiered network
 - Enormous learning curve; strong provider reaction

Maine SEHC Tiered Network experiment (cont'd)



- Evolution of Hospital Tiering –
 - Mercy Hospital initially able to announce it was the “only Tier 1 hospital in Greater Portland”
 - Significant negative reaction to perceived restrictions of choice – potentiated by sudden introduction of substantial cost sharing
 - By September 2012, most Maine hospitals had been added to Tier 1
 - As of 2013, ***all 36 general acute care hospitals*** are in Tier 1

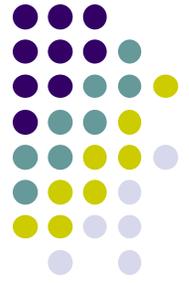
Maine SEHC Tiered Network experiment (cont'd)



- Legislative Response to Tiering experiment - 2012
 - Maine Senate President Kevin Raye, who lives in Washington County, said he and other members of the county's legislative delegation were "troubled" by what Raye described as "the seemingly arbitrary exclusion of certain hospitals, resulting in state employees in the same health care plan having widely varying deductibles."
 - Raye and other delegation members stepped in on behalf of the Calais and Machias hospitals. The commission agreed to reopen the application process and allow hospitals to submit new applications for the September meeting.

-- Bangor Daily News, September 19, 2012

Maine SEHC Tiered Network experiment (cont'd)



- Two bills introduced in 2013 Legislature to further regulate tiering (even though all 36 general acute care hospitals are now in the SEHC's Tier 1)
- Result: P.L. 2013, c.383: **“An Act To Clarify Transparency of Medical Provider Profiling Programs Used by Insurance Companies and Other Providers of Health Insurance”**
- Enhanced data disclosure
- Carriers (including self-insured public employee plans) must have appeal process for errors (but not methodology)



State Innovation Model Grant

- \$33 million awarded to Governor's Office/DHHS, February 2013
- 6 month ramp-up; 3 year implementation
- Wide-ranging payment reform, care coordination objectives
- State partnering with MHMC, MQC, HealthInfoNet
- Multi-payor ACO envisioned
- 137-page Operations Plan published August 2 –
 - <http://www.maine.gov/dhhs/oms/sim/operational-plans/MaineSIM-OPS-PLANAugust-13.pdf>

Elsewhere – a few bold initiatives:



- BCBSMA AQC; HPHC beneficiary incentives
- CareMore – “private ACOs” with health systems – substantial gainsharing
- Provider-sponsored health plans
- Direct contracting by employers
- Insurers acquiring providers (vertical integration)

Convergence

e.g., June 20, 2012 Wellpoint acquires 1-800-CONTACTS, Inc. (largest direct-to-consumer retailer of contact lenses in the U.S.)



Triple Aim

1. Patient Satisfaction;
2. Health of Populations;
3. Reduced Per Capita Cost.

Today's HealthCare Ecosystem



Triple Aim⁽¹⁾

Growing Importance of Outcomes Data to Demonstrate Value

Shift in Emphasis From Acute Care to Prevention

Related Value Based Purchasing (VBP) Between Payers and Integrated Delivery Systems Growing Apace

It Will Take More Than a Claim to Get Paid in the Future

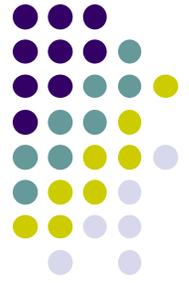
Shift in Emphasis From Volume-Based to Prepaid Population Management

IDN Competition for Physician and Consumer (ePatient) Mindshare

(1) Triple Aim = Patient Satisfaction, Health of Populations, Reduced Per Capita Cost.

Triple Aim: Care, Health and Cost

Health Affairs Article – Berwick, Nolan and Whittington, May 2008



- “Preconditions for this [Triple Aim] include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration.
- “The remaining barriers to integrated care are not technical; they are political.”

<http://content.healthaffairs.org/content/27/3/759.full.html>



Functions Of An Integrator

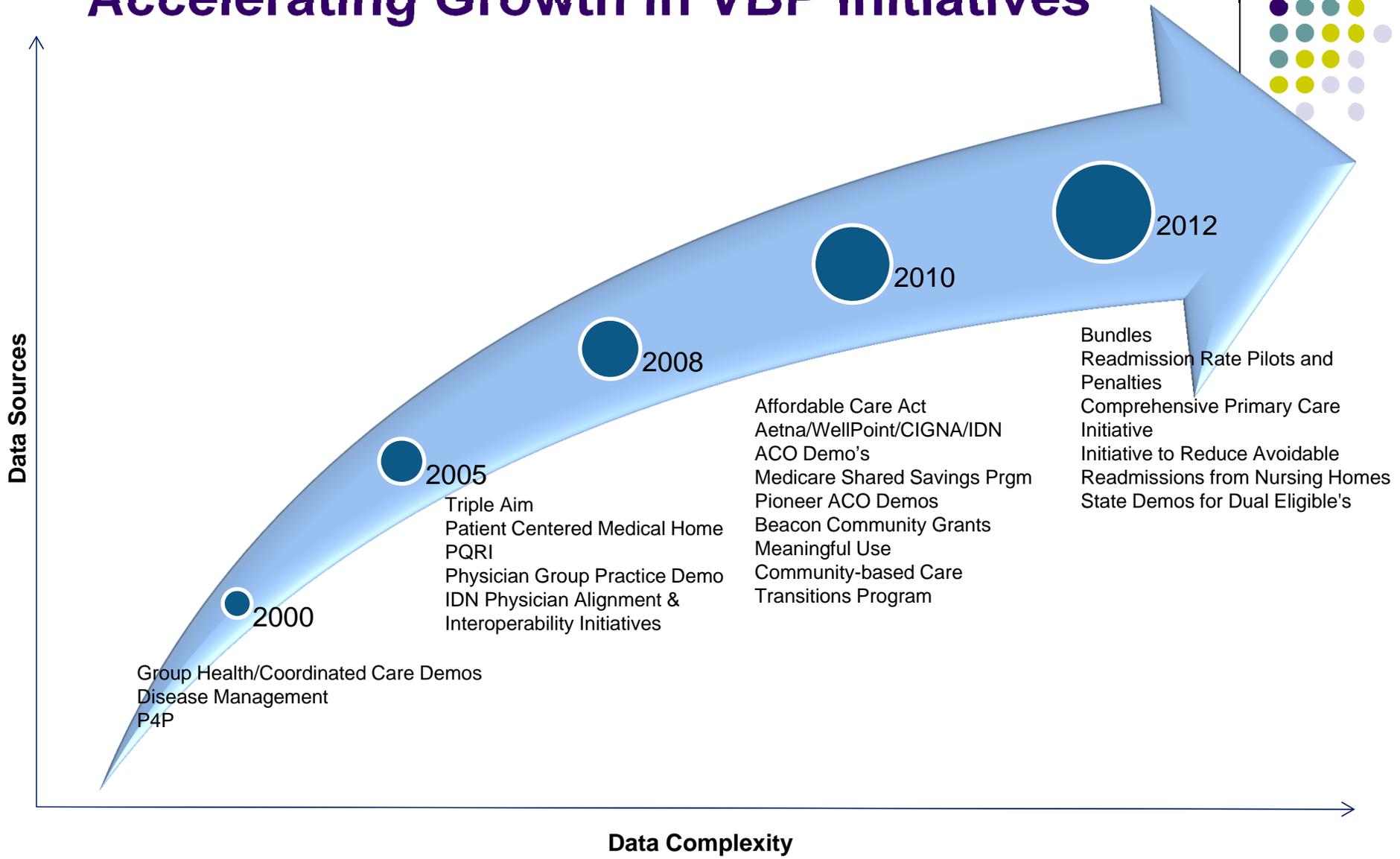
- Involving individuals and families
- Redesign of primary care services and structures
- Population health management
- Financial management system
- System integration at the macro level

Triple Aim – Conflict in Pursuing Three Aims at Once



- “Take hospitals as an example. Under current market dynamics and payment incentives, it is entirely rational for hospitals to try to fill beds and to expand services even though the work of Elliott Fisher and John Wennberg strongly predicts the net effect to be much higher cost and no higher quality.⁷ Most hospitals seem to believe that they can protect profits best by protecting and increasing revenues. Higher efficiency in local production can help, too, but systemic efficiencies that reduce revenues or admission rates are threats to profit. The same payment dynamics often lead hospitals to focus only on care within their walls, viewing CHF readmissions, for example, as indicating defects outside the hospital, not as their responsibility to avert.”

Accelerating Growth in VBP Initiatives



Topic 2: What's on the near-term agenda for health system reform?



Where is Federal “Health Reform” (Payment Reform) taking us?



- PPACA - not a fundamental change to Medicare/Medicaid
- Because no clear “winner,” a variety of demonstration projects
- Congress and CMS offered a shopping cart of experiments?

Where is Federal “Health Reform” (Payment Reform) taking us?



- Commonalities in Operations:
 - EHR & other technologies;
 - “accountability;”
 - change payment to incent better care not more care (though maybe/likely less care);
 - Evaluation of effectiveness;
 - Transparency;
 - “Patient-centeredness” (really???)

Where is Federal “Health Reform” (Payment Reform) taking us?



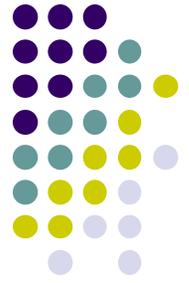
- Commonalities in Payment Modalities:
 - Shift risk to the Providers (many flavors)
 - Shift risk (or another type of accountability) to the patient/beneficiary/consumer (a couple of flavors)
 - Reward positive outcomes
 - Punish negative outcomes

Where is Federal “Health Reform” (Payment Reform) taking us?



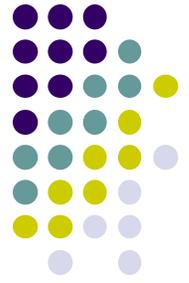
- What’s in the current shopping cart?
- Necessary to understand if you want to predict which product (or group of products) is ultimately the winner/winners

Where is “Health Reform” taking us?



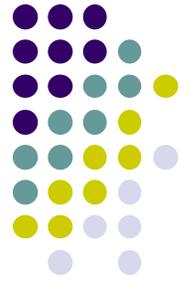
- PPACA Hospital Value-Based Purchasing Program
 - Incentive payments to hospitals that meet (or exceed) performance standards
 - Begin in FY 2013
 - Measures that cover at least the following five specific conditions or procedures:
 - (1) acute myocardial infarction (AMI);
 - (2) heart failure;
 - (3) pneumonia;
 - (4) surgeries; and
 - (5) health care-associated infections.

Where is “Health Reform” taking us?



- **Value-Based Payment Modifier Under the Physician-Fee Schedule**
 - Risk-adjusted measures of the quality of care furnished by a physician or group of physicians to individuals such as measures that reflect health outcomes.
 - Begin on January 1, 2015

Where is “Health Reform” taking us?



- Payment Adjustment for Conditions Acquired in Hospitals — Now Applicable to Both Medicare and Medicaid
 - Medicare will reduce payment for discharges by 1%
 - CMS will study expanding the HAC policy to other facilities:
 - inpatient rehabilitation facilities,
 - long-term care hospitals,
 - skilled nursing facilities (SNFs),
 - ambulatory surgical centers (ASCs), and
 - health clinics.
- Medicaid PPACA prohibits Medicaid payment for HACs
- Begin in 2015

Where is “Health Reform” taking us?



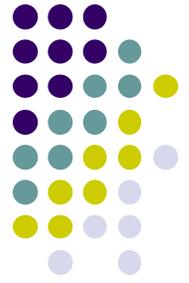
- Reporting Requirements
 - Improvements to the Physician Quality Reporting (PQR) Program
 - Quality Reporting for LTACH, IRF, Psych Hospitals and Hospice
 - Quality Reporting for Cancer Hospitals
 - Data Collection and Public Reporting
 - Improvements to the Physician Feedback Program
 - Adult Health Quality Measures
- Theory: (1) empower consumers; (2) shame providers into improvement

Where is “Health Reform” taking us?

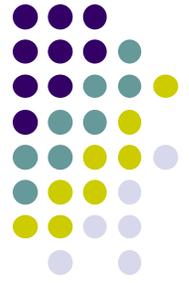


- **National Pilot Program on Payment Bundling**
 - Hospitals, physicians, and post-acute providers to provide integrated care.
 - Jointly accountable for an episode of care
 - beginning three days prior to, an inpatient admission and continuing for 30 days following discharge.
 - Bundled payment for eight conditions.
 - Payment is comprehensive, more than just medical services, also covers
 - care coordination,
 - medication reconciliation,
 - discharge planning,
 - transitional care services, and
 - other patient-centered activities.
 - Participants must report quality measures
 - Begins January 1, 2013
- **CMS/CMMI Bundled Payment Initiative**
- **States already looking at this.**
- **Commercial payors may be interested**

Where is “Health Reform” taking us?



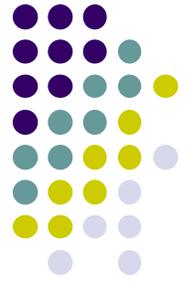
- **Center for Medicare and Medicaid Innovation (CMI)**
 - Testing innovative payment and service delivery. Initial models:
 - Patient-centered medical homes with comprehensive payment or salary-based payment
 - Direct contracting with provider groups to promote innovative care delivery models
 - Geriatric assessments and comprehensive care plans
 - Care coordination for chronically ill patients through Health IT and telehealth
 - Community-based health teams to support small-practice medical homes by assisting primary care practitioners in chronic care management
 - Assisting individuals in making informed health care choices by paying providers for using patient decision support tools
 - Allowing states to test and evaluate systems of all-payer payment reform for the medical care of residents
 - Aligning evidence-based guidelines of cancer care with payment incentives
 - Improving post-acute care through continuing care hospitals
 - Funding home health care providers for chronic care management in cooperation with interdisciplinary teams
 - The development of a collaborative of high-quality, low-cost health care institutions responsible for developing, documenting, and disseminating best practices and proven care methods and implementing and assisting other institutions in implementing such best practices and care methods
 - Innovations to be tested (including expanding pilot programs) do not require Congressional approval
 - Began January 1, 2011, allotted \$10 billion over the next 10 years



Where is “Health Reform” taking us?

- **ACO Models Broadly (per CMS)** “Accountable Care Organizations” (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve.”
- 278 Medicare ACO programs operating today
 - Medicare Shared Savings Program (220 awarded)
 - Pioneer ACO (Dec. 19, 2012 - 32 awarded; currently 23 participants. 7 in New England)
 - Advance Payment ACO (currently 35)
 - State ACOs (Medicaid in 16 states; very few (pediatric))
- Commercial ACOs (BCBS; Wellpoint; Anthem)

Where is “Health Reform” taking us?



- ACO Models in Maine
- Pioneer ACO – Beacon Health part of EMHS (Bangor)
- MSSP ACOs
 - Central Maine ACO (Lewiston)
 - ME Community ACO (Augusta)
 - MaineHealth ACO (Portland)
- Maine Quality Counts – ACO Series -
<http://www.mainequalitycounts.org/page/2-890/aco-series> ; <http://www.mainequalitycounts.org/articles/73-260/introduction-to-accountable-care/6>

Where is Health Reform Taking Us – HIXs for Maine



- Maine declined option for state sponsored exchange
- CMS proceeding with Federally Facilitated Exchange
- October 1, 2013 target date – on track
- 2 Insurers' rates and forms approved by Maine BOI July 31, 2013
 - Anthem
 - Maine Community Health Options
- Now subject to federal (CMS/CCIIO) approval

Premiums for Coverage Under HIX Plans



- Rates and Forms filed with Maine BOI
- Rate and benefit summaries published by BOI:
 - http://www.maine.gov/pfr/insurance/ACA_Index.html
 - E.g.,
http://www.maine.gov/pfr/insurance/ACA/PDF/Bronze_Plan_Comparison..pdf

Individual Health Plans - Bronze Monthly Premiums 2014



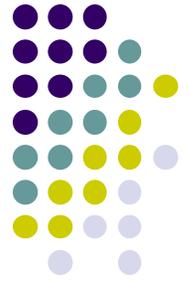
	Age	Anthem NonTobacco 710004/720004	Anthem Tobacco 710004/720004	MCHO 0030001
Area 1 HMO	30	\$208.39	\$270.91	\$216.15
Cumberland	40	\$234.64	\$305.03	\$243.38
Sagadahoc	50	\$327.91	\$426.28	\$340.13
York	60	\$498.29	\$647.78	\$516.86
Area 2 HMO	30	\$250.73	\$325.95	\$234.36
Knox, Oxford	40	\$282.32	\$367.02	\$263.89
Kennebec	50	\$394.55	\$512.92	\$368.79
Lincoln	60	\$599.55	\$779.42	\$560.41
Area 3* HMO	30	\$255.49	\$332.14	\$247.72
Androscoggin	40	\$287.68	\$373.98	\$278.93
Franklin	50	\$402.03	\$522.64	\$389.81
Waldo	60	\$610.92	\$794.20	\$592.35
Area 3* POS	30	\$286.97	\$373.06	\$247.72
Penobscot	40	\$323.13	\$420.07	\$278.93
Piscataquis	50	\$451.57	\$587.04	\$389.81
Somerset	60	\$686.21	\$892.07	\$592.35
Area 4 POS	30	\$312.08	\$405.70	\$286.58
Hancock	40	\$351.40	\$456.82	\$322.69
Aroostook	50	\$491.08	\$638.40	\$450.95
Washington	60	\$746.24	\$970.11	\$685.27

Bronze Plan Benefits	MCHO PPO- 0030001	Anthem HMO - 710004	Anthem POS - 720004
Deductible	\$5,000	\$5,750	\$6,000
OOP	\$6,350		
Coinsurance	50%	10%	0%
ER Co-pay	\$825	\$200 + Ded/Co	\$200 + Ded/Co
Office Visit	\$45	\$40 for the first 2 visits, then additional visits	\$40 for the first 2 visits, then ded applies to additional visits
Outpatient	\$45	Ded/Co	Deductible
Sp Office visit	\$140	Ded/Co	Deductible
Urgent Care	\$140	\$50+ Ded/Co	Deductible
Hearing/Physical	Ded/Co		Deductible
Rx Tier 1	\$30	Ded/Co	Deductible
Rx Tier 2	Ded/Co	Ded/Co	Deductible
Rx Tier 3	Ded/Co		Deductible
Rx Tier 4	Ded/Co		Deductible
Pediatric Dental	No	No	No

*Area 3 for Anthem only split for HMO and POS offering
Maine Bureau of Insurance

8/5/2013

Where is “Health Reform” taking us?



- **Pioneer ACO Model-** Designed for providers and organizations more experienced in offering coordinated care
- (July 16, 2013) Mixed results for first performance year for 32 organizations selected to begin Jan. 1, 2012:
 - 13 organizations shared savings (totaled \$87.6 million), with 25 organizations generating savings
 - 2 organizations returned funds (totaling \$4 million)
 - Pioneer ACOs performed better on all 15 clinical quality measures than FFS population
 - 9 organizations leaving Pioneer ACO Model: 7 intend to apply for the MSSP

Topic 3: What's the Future Going to Hold?



- A thought experiment
- Intended to be provocative

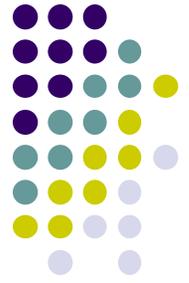
Which ones are the winners?



- Submitted for your consideration:
 1. Any model designed simply to squeeze costs out of existing system ultimately will;
 2. Once all easy costs are squeezed, maybe some last few drops can be squeezed;
 3. After the last few drops are squeezed, there can't be any more juice.

Therefore, “shared savings” and every other payment scheme designed merely to trim costs from existing system can't continue.

Which ones are the winners?



- Submitted for your consideration:
 1. Payment models designed to reward “inputs” will result in more inputs (in order to generate more rewards);
 2. Even if you only reward “good” or “smart” inputs, you are still rewarding *more* inputs (though they might be more worthy too).

Therefore, any payment plan based solely on addressing inefficiencies in current fee-for-service payment methodologies can only slow the growth of spending. It can't reverse the trend.



Which ones are the winners?

- Submitted for your consideration:
 1. Due to the complexity of health care and imbalance of information, regardless of transparency efforts, beneficiaries will never have sufficient information to evaluate provider quality effectively;
 2. If beneficiaries have freedom of choice of providers, they will always choose “brand” providers unless the economic “pain” tips the balance;
 3. For more serious health issues, the economic pain necessary to change beneficiary behavior that our society will not tolerate the perceptions of inequality and lack of distributive justice;

Therefore, either beneficiary choice must be eliminated or the benefits of being a “brand” provider must be eliminated.



Which ones are the winners?

- Submitted for your consideration:
 1. Jury may be out on whether care management for episodic acute needs is more cost effective than management of the whole person (preventative care), at least with small and mobile populations;
 2. It is hard to argue that some preventative care can't prevent some chronic disease (though, again, evidence is lacking due (perhaps) to lack of proper population studies);
 3. For an organization to manage a global budget effectively, it will need sufficient volume of covered lives in order to absorb outliers and capture benefits of statistically-significant trends of overall health improvement;
 4. For an organization to manage total cost of care, as opposed to episodic care it will need to control larger population and control that population over longer periods of time.

Therefore, assignment of beneficiaries will need to be in very large (likely larger than the 5,000 Medicare SSP numbers – perhaps 60,000-100,000) and beneficiaries will need to be locked in. AND

Therefore, provider networks will need to grow in size and scope.



Which ones are the winners?

- Submitted for your consideration:
 1. Current regulatory scheme is designed to prevent abuse of the fee-for-service systems (*i.e.*, excess charges and upcoding, charging for services not performed, charging for medically unnecessary services, etc.)
 2. If payment models shift from a “claims” basis to a “population” basis, the regulatory scheme changes too (*i.e.*, to a system designed to prevent stinting, cherry-picking, and dumping as well as testing base-lines, risk-adjustment, etc.);
 3. Current “insurance company” business model is not designed to address these (#2) new types of abuse, moreover, many of the abuses can be tracked mechanically and in an automated fashion.

Therefore, health care payors need to redesign their regulatory/enforcement apparatus.

Which ones are the winners?



- If you agree with those propositions, then:
 - “Shared savings” and every other payment scheme designed merely to trim costs from existing system won’t continue.
 - Either beneficiary choice must be eliminated or the benefits of being a “brand” provider must be eliminated.
 - Payment plans won’t simply address inefficiencies in current fee-for-service system.
 - Assignment of beneficiaries will be in very large numbers.
 - Provider networks will grow in size and scope.
 - Payors will retool regulatory/enforcement apparatus.

Which ones are the winners?

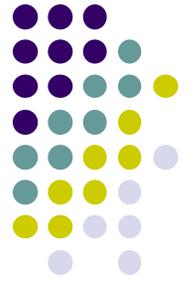


- If you agree with those propositions, then:
 - Final system will be a small number, of extremely large, regional provider networks taking full risk for large populations that are assigned and retained over time.
 - Payors will be regulating beneficiary assignment and minimum standards of quality.

Topic 4: What are implications for Independent Physician Practices and Hospitals?

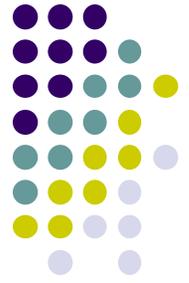


What's the role for independent physicians and hospitals in such a World?



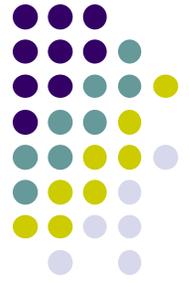
- The independent hospital or practice likely can't be such a large health system
- Will these hospitals be absorbed or acquired into the large regional systems?
- Or will they be a “vendor” to them (cost pressure and competitive bidding)?

What's the role for independent physician practices and hospitals in such a World?



- We are seeing high level of transactions
 - M&A, affiliations,
 - physician alignment transactions,
 - new payor contracting models
- What can independent physician practices or hospitals do together?

What's the role for independent practices and hospitals in such a World?



- Limited relationships:
 - Payor Contracting (risk vs. non-risk)
 - IT and clinical integration
 - Back-office management/MSO services
 - Jointly-arranged consulting, information services, other shared services
- More integrated relationships:
 - Joining larger systems (ACO participation, membership, acquisition)
 - Forming a new system (build it) – very hard to do, capital intensive

What's the role for independent practices and hospitals in such a World?

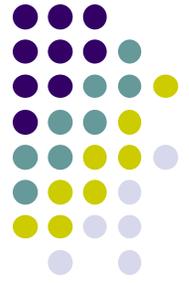


- Maine Hospital Affiliations
 - SMMC, Goodall & PenBay now part of MaineHealth – 2 involved COPA mechanism
 - Mercy joining EMHS -- pending CON
- Physician Practices
 - Spectrum Medical Group, PA merging with 2 Orthopedic groups
 - OA – Center for Orthopaedics, PA; and
 - Central Maine Orthopedics – April 2013 CON LOI

Appendix: How do Antitrust laws and fraud and abuse impact collaboration among health care providers?



Guard rails for independent practices and hospitals in such a World?



- From lawyers' perspective, some guard rails:
 - Anti-kickback/Stark Law
 - Antitrust
 - Tax Exemption considerations
- We'll focus mostly on the Antitrust and Fraud and Abuse considerations for today . . .

AHA recently addressed weakness in current FTC approach regarding hospital mergers



- At a time when hospital revenues are already strained, hospitals must respond to rapidly changing market forces, including
 - (1) reimbursement reductions and changes (volume to value),
 - (2) an increasing necessity to implement robust electronic health records systems, and
 - (3) limited access to capital.
- Mergers of smaller providers necessary to break the “downward spiral”
- Market forces driving urgent need for hospitals to make significant capital investments and achieve greater economies of scale.
- FTC must acknowledge both are critical to hospitals’ “future ability to compete.”
 - See, AHA’s brief in 6th Circuit ProMedica case (9/24/2012)



Antitrust 101

- Based on a few short statutes
 - Main federal law is Sherman Act
 - State statutes are often copycat laws
- Aim is to protect consumers by protecting competition
 - Competitors constrain, challenge each other on pricing, quality, innovation, variety of offerings
- Remedies can be sought by
 - DOJ Antitrust Division and Federal Trade Commission
 - State attorneys general
 - Private plaintiffs
- Damages, penalties can be significant
- Ok, so what can you do?

Target: Competitor collaborations



- Antitrust laws only prohibit agreements and collaborations among competitors that harm competition.
 - “naked” agreements to fix price, allocate customers/markets are presumed harmful, *per se* illegal
 - other arrangements evaluated by looking at effects in a relevant geographic/product market
- Lawsuits, enforcement can be based on just inference of agreement, evidence of parallel conduct.
- Key is to avoid even appearance of unlawful agreement
 - in documents
 - in tone and content of discussions
 - by avoiding core competitive information



“7 Dirty Words”

- Market
- Market Share
- Dominance
- Leverage
- Avoiding Wasteful Competition/Preserving Resources
- Cooperation
- Antitrust

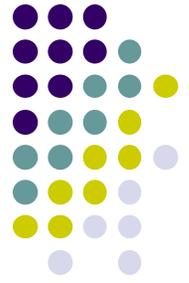
Steer Clear of Competitively Sensitive Information



- Reimbursement rates
- Terms, status of negotiation with payors
- Planned rate changes
- Strategic plans
- Employee compensation
- Other information kept confidential

Antitrust Enforcement in Maine

– Maine Health Alliance



- June 2003 Enforcement Actions by FTC and Maine Attorney General
- FTC Complaint and Order
- Maine Superior Court AG Complaint and Consent Order
- Injunctive Relief and Multi-conditioned order
- Alliance had 11 Hospital Members in Calais, Caribou, Machias, Houlton, Millinocket, Dover-Foxcroft, Mt. Desert, Ft. Kent, Lincoln and Bangor

Complaint Alleged the Following



- Alliance had 11 Hospital Members in Calais, Caribou, Machias, Houlton, Millinocket, Dover-Foxcroft, Mt. Desert, Ft. Kent, Lincoln and Bangor
- 325 participating physicians
- Alliance acted as exclusive agent for hospitals and physicians
- Hospitals set respective price lists independently
- Alliance determined maximum percentage discounts allowable and ranges



Alleged Adverse Impacts

- Aetna, Cigna, Anthem and Harvard-Pilgrim were impacted
- Competition was unreasonably restrained
- Prices for hospital and physician services were unreasonably restrained and were above levels that market would have generated otherwise
- Price of health care at Eastern Maine was above level that would have prevailed absent Alliance's alleged illegal conduct



Causes of Action Asserted

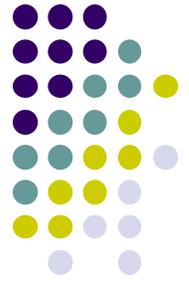
- Unlawful price fixing conspiracy
- Refusal to deal
- Competition was unreasonably restrained

Consent Order and FTC Order Relief – Injunctive Relief



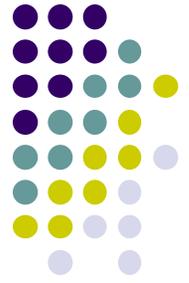
- Barred unlawful activity
- Multiple notice provisions regarding future contract negotiations
- Barred Diggins from negotiating contracts for three years

Simple Compliance Measures



- Have counsel attend meetings
- Distribute a guidelines document in advance
- Understand what the lawful, procompetitive options are and proceed from that point

Procompetitive Health Care Collaborations Encouraged



- Antitrust laws recognize that some competitor arrangements are, on balance, good for consumers.
 - Is the restraint “ancillary” or reasonably necessary to achieve procompetitive benefits?
- Health care is an area in which this idea is alive and well
 - Antitrust enforcement agencies recognize potential for provider collaboration to improve quality of care, innovation
 - Several avenues to lawful collaboration

Who Competes and Where?



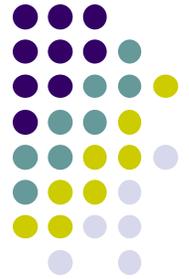
- Relevant Market
 - Determined by universe of products, services that are perceived as substitutes by consumers
 - Geographic component also determined by consumer preference, behavior
- Market definition determines whether certain market share confers market power.

Rural Health Care Markets



- Competition in rural health care markets is different
 - Often high market shares due to lack of competitors
 - Difficulty in attracting physicians and specialists
 - Guidance and agencies consider the difference, but enforcement actions still a reality

Avenue One: Messenger Model



- Simple model to avoid exchange of competitively sensitive information among competitors.
- Messenger is a communications agent between providers and payors but may not negotiate.
- FTC has brought enforcement actions and experience shows it can be difficult to
- Offers efficiencies in provider/payor information exchange, but little else

Avenue Two: Financial Integration



- FTC/DOJ Health Care Statements Definition:
 - Substantial financial risk shared among network providers where
 - providing services at a capitated rate
 - significant financial incentives to achieve cost containment goals
 - E.g., withholding compensation from all members with a return only if the cost containment goals met
 - providing course of care at fixed rate
- No antitrust safety zone for multiprovider networks including hospitals, but safety zone for physician collaborations

Avenue Three: Clinical Integration



- FTC/DOJ Health Care Statements Definition:
 - “[A]n active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”

Clinical Integration: Key Features



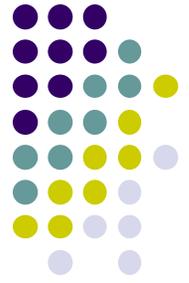
- Seamless integration of providers and facilities with a high level of interdependence
- Institution and enforcement of disease management protocols, quality and efficiency standards
- Common IT platform to share patient information, communicate updated protocols, and track utilization information to monitor performance
- Requires high-level of upfront time and financial buy-in from physicians and system to terminate non-compliant participants and reward performing participants
- Referrals within the organization

Avenue Four: Joint Operating Agreement, Actual Merger



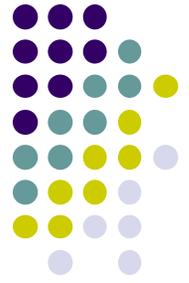
- In JOA, idea is that affiliated organizations will undergo virtual merger and function as a single entity
 - Under the antitrust laws, a single entity cannot “conspire” with itself.
 - Level of consolidation of administrative functions, governance, employment functions is very high.
- Actual mergers among hospitals on the rise, but also a focus of enforcement agencies
 - Must carefully consider what existing competition is in the market
 - FTC/DOJ have recognized that mergers more likely to produce efficiencies and savings in rural markets

Avenue Five: Technology, Specialty Care Joint Ventures



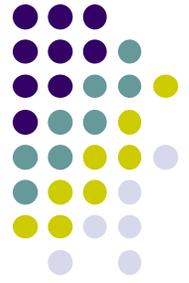
- FTC/DOJ Health Care Guidelines expressly provide for joint ventures among hospitals for acquisition of technology, specialty care
 - For equipment, safety zone exists where no participating hospital, acting alone, could recover costs of equipment and maintenance
 - Non-safety zone equipment JVs and specialty care JVs analyzed by looking at effects in the relevant market

Avenue Six: Maine Hospital and Healthcare Provider Cooperative Act



- 22 MRSA § 1841 et. seq.
- COPA provides State Action Immunity
- COPAs have had multiple conditions regarding Pricing, Charity Care, Monitoring
- Examples
 - MaineHealth and Pen Bay
 - MaineHealth and SMMC

Avenue Seven: ACOs and Antitrust



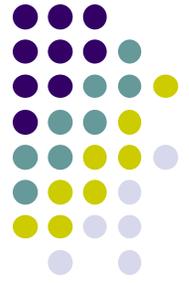
- FTC/DOJ issued final rule in November 2011 outlining treatment of ACOs under the antitrust laws.
- If an organization meets CMS guidelines for participation in MSSP, arrangement will not be treated as *per se* illegal and agencies will instead look at effects in the relevant market.
 - Must have same governance and practices in Medicare and commercial segments
- Antitrust “safety zone” for ACOs with share of <30% percent or less of each common service in each participant’s PSA



Antitrust Will be Waived

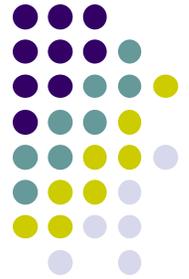
- FTC/DOJ Proposed Antitrust Policy:
 - Relates to joint contracting of independent participants in an ACO
 - Agencies will apply a “Rule of Reason” approach to ACOs that operate under Medicare SSP
 - Same analysis applies to commercial market ACOs, if ACO uses the same governance and leadership structure and clinical administrative processes

Antitrust Will be Waived (cont.)



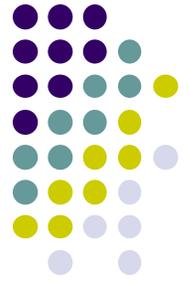
- Proposed Policy Establishes Safety Zones
 - If ACO Participants' combined share of 30% or less in all PSAs, then no review and no enforcement
 - If ACO Participants' combined share of more than 50% in any PSA, then mandatory review and need FTC or DOJ approval for ACO to be approved (90 day expedited review)
 - If ACO Participants' combined share is more than 30% and 50% or less, subject to investigation and potential challenge

Antitrust Will be Waived (cont.)



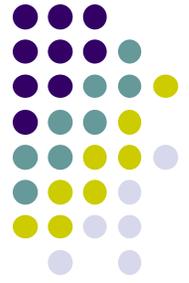
- Hospitals and ASCs participating in an ACO must be non-exclusive to fit in safety zone
- Exclusivity of physicians does not matter

Rural Exceptions to ACO FTC/DOJ Final Rule



- ACO may include on a non-exclusive basis one physician or one physician practice per specialty from each rural area and still otherwise qualify for the safety zone, so long as the physician or group practice's primary office is in a rural ZIP code.
- Recognizes reality of rural markets

Rural Exceptions to ACO FTC/DOJ Final Rule



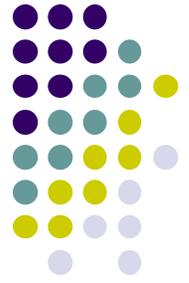
- ACO may include rural hospitals on a non-exclusive basis and qualify for safety zone, even if hospital causes ACO share is >30% in any participant's PSA.
- Hospitals in rural areas that have no more than 50 acute care inpatient beds, located at least 35 miles from any other inpatient acute care hospital, potentially eligible for exception.



Fraud, Abuse Enforcement

- Stark Law
- Anti-Kickback Statute
- False Claims Act
- Reverse False Claims Act
 - 60 day reporting under Section 6402 of ACA

Fraud, Abuse Enforcement Rules Will be Waived

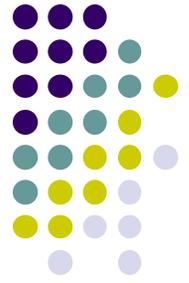


Stark and Anti-Kickback: proposed waiver for:

- The ACO's distribution of shared savings received from CMS under the SSP
 - To or among ACO participants during year shared savings earned; or
 - For activities necessary for and directly related to ACO'S participation in and operations under the SSP

can't distribute shared savings to referring physician outside the ACO unless activities necessary for and directly related to participation in the operation under SSP

Fraud, Abuse Enforcement Rules Will be Waived (cont.)

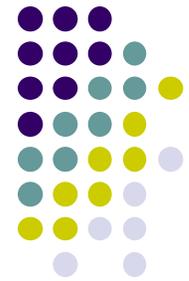
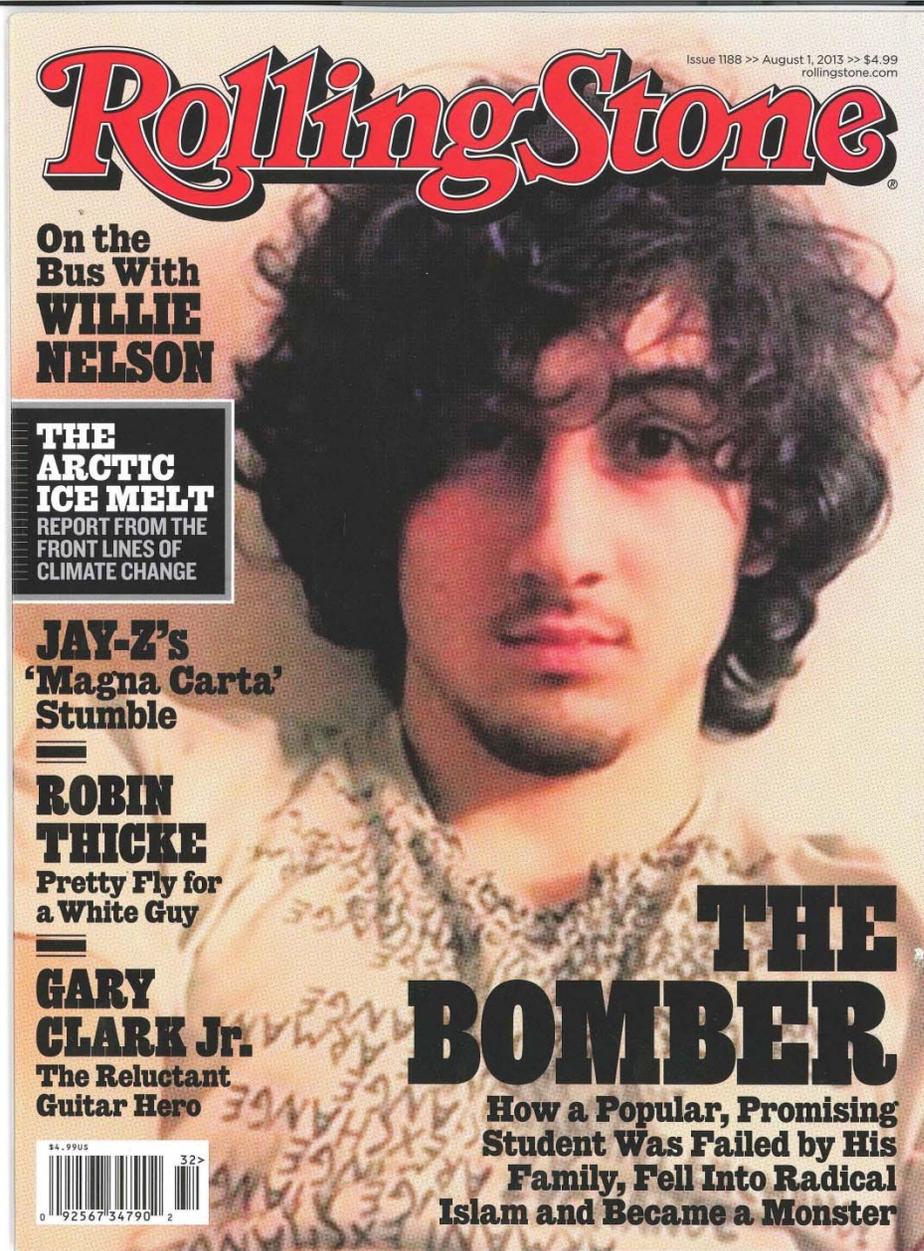


- For CMP (gainsharing/reduce or limit service) Law:
 - Distributions by ACO of shared savings received from CMS under the SSP where distributions
 - are not made **knowingly** to induce the physician to reduce or limit **medically necessary** item or services
 - the hospital and physician are ACO Participants or were when shared savings earned
 - Any financial relationship between or among the ACO and ACO participants necessary and directly related to the ACO's participation in and operations under the SSP that implicates Stark and complies with Stark exception

Fraud, Abuse Enforcement Rules Will be Waived (cont.)



- For OIG/CMS, Must Participate In SSP (But Waiver Authority Under CMMI and Demonstration Program)
- Only Payment of Shared Savings
 - No Part A or Part B Payments Allowed
- Waivers Apply During Term
- Not For:
 - Arrangements Setting Up The ACO
 - Building Infrastructure
 - Implicating Governance/Administration Requirements
 - Payments Received From Others
- Can't Use To Attract Physicians To Participate or Bring Other Business
- Can They Be Used To Keep Businesses Within ACO Participants
- **Take away: F&A waivers helpful, but has not opened the floodgates**





“I don't believe in looking back,” he says. “It'd be easy to look back and regret things that have happened. But you can't do anything.”

—Nelson on his tour bus, the Honeysuckle Rose

ENCOUNTER

Willie Nelson Rides High

Toking and chatting on the 80-year-old country great's tour bus By Patrick Doyle

THIS THING'S READY TO PUFF, JUST ABOUT," says Willie Nelson, staring at a small rocket-shaped marijuana vaporizer on the kitchen table of his tour bus. It's a scorching New Jersey summer afternoon, and Nelson is waiting patiently for a blinking light to signal that the device is ready to use. "It turned green, almost." But after he managed only a few hits, it loses power completely. Onboard Willie's bus, this is not a major problem. "We ought to have something else around here somewhere," he says. "Oh, I know where one is."

He digs around and emerges with a Volcano — a high-end vaporizer that works by pumping THC fumes into a big plastic bag with a mouthpiece. He bought it on the recommendation of his buddy Woody Harrelson ("\$600!" Nelson notes). He places it on the table next to a shiny, vintage Hopalong Cassidy lunchbox, which he opens to reveal a giant stash of bright-green, sparkling buds with several buried joints mixed in. "See how this works," he says, his eyes lighting up as the plastic bag inflates with vapor. He pushes the stop button at the last minute, just when it looks like it's about to explode. "He overfills everything," says his wife, Annie, rolling her eyes as she mixes an iced coffee. "That's what I do," Nelson says with a grin. "The things we have to live with..."

It's another day aboard the Honeysuckle Rose, Nelson's tour bus of the past 35 years. He's parked outside a four-star hotel, but, as usual, Nelson slept on the bus, ambling out of his bedroom just after 2 p.m., his hair tangled and unbraided, in a wrinkly black T-shirt and women's Ugg slippers (they're more comfortable, says his wife). His face is deeply lined, eyes bleary. No wonder: He's in the middle of a grueling East Coast run — 15 shows in 16 days. At 80, he still spends at least 200 nights a year on the road, playing with the same band since 1973, with sets drawing mostly from his 20 Number One country hits. In the past year, he's released two albums ranging from originals to covers of Pearl Jam and Coldplay, and his fourth book, *Roll Me Up and Smoke Me When I Die*.

"He makes it look real easy," says old friend Merle Haggard, who has known Nelson for 50 years. "He's on all the time. Any time you call on him, he can handle it and be Willie Nelson. And the older you get, the harder that gets to do." Off the road, Nelson unwinds in Maui, playing golf and staying up late with neighbors Harrelson and Owen Wilson. Or he'll go to his 700-acre ranch just outside Austin, which includes a replica of an Old West town (with a recording studio and a church) and a public golf course (rules include "No shoes, no shirt, no problem" and "Tell your spouse you're in a conference"). But even in Austin, [Cont. on 20]



THE CHOSEN ONE

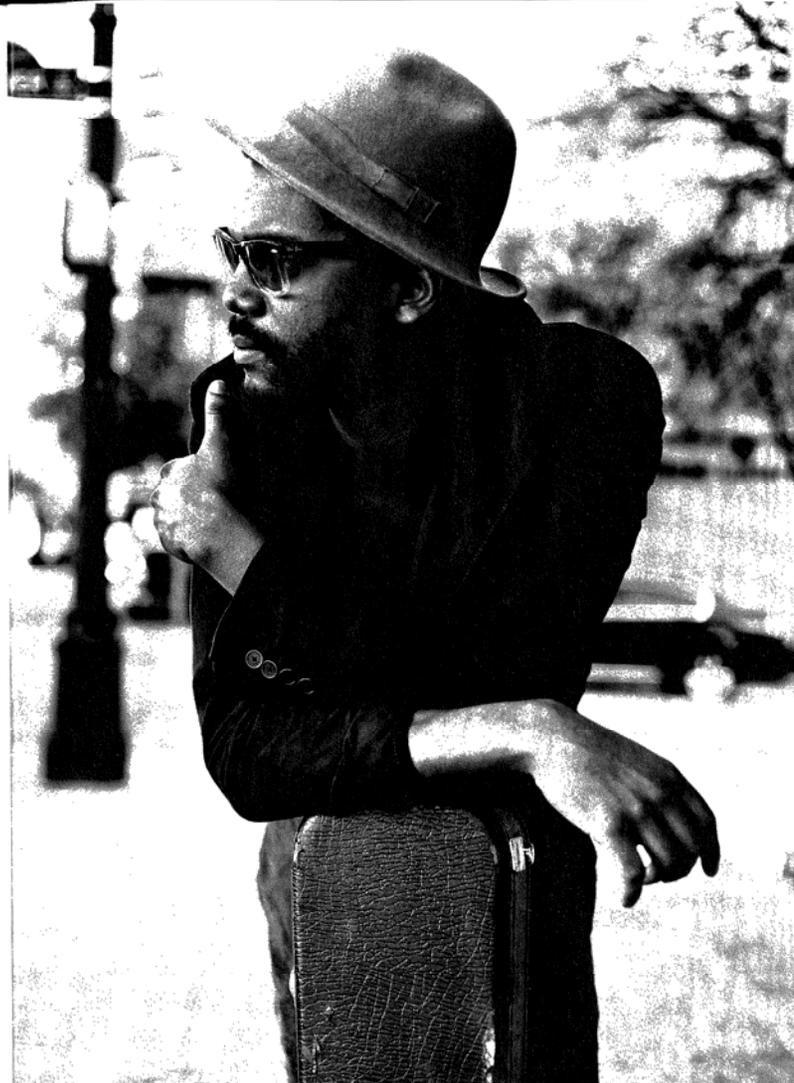
He made Eric Clapton want to play again, and Buddy Guy thinks he might save the blues. But Gary Clark Jr. isn't so sure he wants to be the next great guitar hero

BY PATRICK DOYLE *Photograph by LeAnn Mueller*

A BONE-RATTLING FUZZ ROARS OFF THE BACK WALLS of Madison Square Garden on a recent spring Saturday afternoon. Gary Clark Jr. stands onstage before 19,500 empty seats with his blue Epiphone hollow-body, playing the solo to "Numb" - a brooding blues song with ringing feedback, hazy harmonics and manic, octave-jumping squeals. He paces the stage, listening at all angles, before abruptly taking his guitar off to huddle with his manager. "See how Gary's twisting his hair?" Clark's road manager Blayne Tucker says from the side of the stage. "That means he's nervous." ¶ Clark is preparing for a late-night slot at Eric Clapton's Crossroads Guitar Festival, a gathering of three dozen of the world's biggest guitar heroes, including Keith Richards, Jeff Beck, the Allman Brothers Band, B.B. King, John Mayer and Buddy Guy. Clark, 29, is the only artist under 30 to score a full-band set. "There is pressure," he says quietly as the crew loads risers of amps onto the rotating stage. "Coming from Austin, there are so

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The Beach Boys

The reunited band celebrat



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