

## MAINE MEDICAL ASSOCIATION

PAYMENT REFORM UPDATE:  
CURRENT CONTEXT AND EMERGING ISSUES  
SEPTEMBER 2014

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## INTRODUCTION

Few periods in American history can match the present in terms of the rapid pace of change in the health care system. In October 2013, the Maine Medical Association published *Payment Reform Readiness: A Legal Toolkit for Physicians*. During the following few months, the following events (among many others) occurred on the national scene:

- Health insurance exchanges were established under the Affordable Care Act (“ACA”), either by individual states or by the federal government.
- Through the exchanges, individuals and small businesses were offered enrollment in Qualified Health Plans (“QHPs”). Numerous technical problems plagued the early part of the enrollment period, but the Commonwealth Fund and others have estimated that up to 9.5 million previously uninsured Americans have now obtained coverage under the ACA.
- Health care costs continued to rise, and expensive new drugs and treatments prompted debate over how best to keep health coverage affordable.
- Mergers and affiliations of health care providers prompted continued concern about their increased bargaining power and ability to demand higher reimbursement rates.
- The Federal Trade Commission hosted a two-day public workshop on “Examining Health Care Competition,” which included consideration of the effects on consumers of (among other things) price and cost transparency, quality measures, scope of practice limitations, and new health care delivery models such as retail clinics.
- The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (“CMS”) implemented Stage 2 meaningful use reporting requirements for health care providers seeking to justify continued incentive payments under the Electronic Health Record (“EHR”) Incentive Programs.

Meanwhile, a number of developments occurred in Maine, some of which are discussed in more detail below:

- After substantial efforts (including a Republican-led initiative that would have promoted a mandatory managed care initiative), the Maine Legislature narrowly rejected efforts to expand Maine’s Medicaid program (“MaineCare”) in accordance with the ACA.
- As part of Maine’s \$33 million State Innovation Model (“SIM”) grant, Maine’s Office of MaineCare Services initiated a “Value-Based Purchasing Strategy” that includes Health Homes, Behavioral Health Homes, and a MaineCare Accountable Communities Initiative.
- Maine’s State Employee Health Commission entered into risk-sharing arrangements with several of Maine’s major health systems.

- Almost 50,000 Maine residents enrolled in QHPs.
- Maine’s Consumer Oriented and Operated Plan (“CO-OP”), Maine Community Health Options (“MCHO”), obtained approximately 80% of Maine’s QHP enrollments, with the remainder going to a “narrow network” product offered by Anthem Health Plans of Maine, Inc.
  - Total first-year enrollment in MCHO was approximately double original projections.
  - A number of other carriers are reportedly interested in offering QHPs in Maine in the second or subsequent years.
- Consolidation of health care providers continued. Notably:
  - Mercy Hospital affiliated with Eastern Maine Healthcare Systems;
  - Memorial Hospital (in North Conway, New Hampshire) affiliated with MaineHealth;
  - Orthopaedic Associates, Maine’s largest orthopedic surgery practice, joined Spectrum Medical Group, Maine’s largest multi-specialty medical group; and
  - A number of specialty practices joined together in an Independent Practice Association (“IPA”) known as Specialty Solutions, for the purpose of pursuing risk-sharing reimbursement arrangements.

This publication provides additional information on current payment reform efforts and emerging issues. It also examines a few selected Maine case studies to see what lessons may be drawn from them.

## EXECUTIVE SUMMARY

- ACA implementation is still underway, and is proceeding in piecemeal fashion. The ACA may assure health coverage for up to half of the 50 million or so Americans who otherwise would be uninsured, but it does not address numerous other challenges, including the cost of health care.
- Notwithstanding Maine’s refusal to date to expand MaineCare eligibility under the ACA, MaineCare is pursuing a number of payment and care coordination innovations under its “Value-Based Purchasing Strategy.” Those innovations include both an “Accountable Communities Initiative” comparable to the Medicare Shared Savings Program, and two Health Home initiatives, one for MaineCare members with complex, chronic medical conditions, and one for MaineCare members with severe and persistent behavioral health issues.
- Vermont, another rural northeastern state that faces many of the same issues as Maine, is in the process of implementing a state single-payor system, and lessons learned from the Vermont experience may affect future Maine policy decisions.
- Some Maine primary care providers are exploring a “direct primary care” practice model, in which patients pay a monthly retainer fee to cover a defined set of services. Whether the direct primary care practice model will expand beyond a niche market remains unknown.
- Health care providers or practices owned by payors such as insurance companies or Health Maintenance Organizations have had little presence in Maine to date, but such arrangements are increasing nationally as providers seek support for technology investments and risk-sharing capabilities.
- Health care cost containment remains a major unsettled issue, and numerous approaches are being explored, ranging from moderate risk-sharing all the way to government rate regulation.
- Information technology remains critical in the health care system, but numerous challenges remain, including lack of EHR interoperability as well as difficulty in complying with multiple, overlapping confidentiality requirements.
- Proposals to increase the availability of health insurance coverage by supporting premium payments on behalf of individuals eligible for enrollment in QHPs have encountered resistance, especially where such payments would be made by providers who might then receive payment for covered services.
- A number of new strategies related to payment reform are underway in Maine, including the following:

- MaineHealth has implemented a “Primary Care Payment Reform Program,” in which certain primary care practices serve as laboratories for innovation.
  - Beacon Health, LLC, is using its participation in Medicare’s Pioneer ACO program to leverage an aggressive move toward population-based health care.
  - The State Employee Health Commission has entered into Accountable Care Agreements with major health systems, with risk-based payment incentives reflecting the quality and cost of care.
  - A number of Maine’s Federally Qualified Health Centers have formed Maine Community ACO, which participates in the Medicare Shared Savings Program.
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- Numerous legal challenges to the ACA remain pending, and in particular, two U.S. Circuit Courts of Appeals have issued contradictory opinions about whether the ACA permits premium subsidies for coverage obtained through federally sponsored exchanges.
  - Antitrust limitations, and privacy and confidentiality concerns, have emerged as key legal issues facing the health care system.

## AN OVERVIEW OF THE AFFORDABLE CARE ACT

So much attention has been given recently to individual pieces of the complex public-policy strategy embodied in the Affordable Care Act that it may be worth stepping back and looking at its overall architecture. In very general terms, the ACA seeks to make health insurance coverage more broadly available in the U.S. by combining the following elements:

- Medicare will remain in place, and will remain mostly unchanged in its basic operation (despite numerous demonstration projects and other initiatives).
- Medicaid eligibility may be expanded to cover many who would not have previously qualified. Under the decision of the U.S. Supreme Court upholding the ACA,<sup>1</sup> however, the decision whether to expand state Medicaid programs is left to each individual state.
- Large employers will be required to provide health insurance coverage for their employees.
- A “health insurance exchange” will be established for each state, through which individuals and small employers may purchase health insurance coverage. If a state does not establish its own exchange, then the federal government will operate an exchange on its behalf. Health insurance products eligible to be offered through an exchange are known as “Qualified Health Plans” or “QHPs.”
- Small employers will be eligible to purchase health insurance coverage for their employees through an exchange.
- Most individuals lacking other health insurance coverage not only will be eligible to purchase coverage from a QHP through an exchange, but will be required to do so or face tax penalties.
- Premium costs for individuals and for small employers purchasing health insurance coverage from a QHP through an exchange will be subsidized, on a sliding scale.<sup>2</sup>
- All forms of health insurance coverage will be subject to guaranteed issue, community rating, and a ban on pre-existing condition exclusions. The goal is to make moving from one form of coverage to another relatively seamless.

Despite its title, the ACA does little to address overall affordability of health care *services*. Instead, it seeks to make health *coverage* affordable, and more widely available. Inevitably, however, those who must budget for the cost of health care services – federal and state

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<sup>1</sup> *National Federation of Independent Business v. Sebelius*, No. 11-393, 567 U.S. \_\_\_, 132 S.Ct. 2566 (2012).

<sup>2</sup> As discussed below, premium subsidies are clearly authorized for individuals purchasing coverage through a state exchange, but federal courts have reached differing conclusions as to whether the ACA authorizes subsidies for coverage purchased through a federal exchange. *King v. Burwell*, No. 14-1158 (4<sup>th</sup> Cir. July 22, 2014) (subsidies authorized); *Halbig v. Burwell*, No. 14-5018 (D.C. Cir. July 22, 2014) (subsidies unauthorized).

government agencies, health insurance carriers, and large employers – are left seeking ways to control the financial impact of their coverage obligations.

While the ACA does include provisions for some payment reform demonstration projects,<sup>3</sup> most of the insurance products available through the exchanges are still using traditional FFS reimbursement. Some insurance carriers are offering “narrow network” plans as QHPs through the exchanges, on the theory that selective contracting with the most cost-effective providers will help minimize premium costs. Health insurance exchanges also feature a new kind of insurer created under the ACA: CO-OPs, which are nonprofit, member-run carriers. While the initial performance of CO-OPs has been variable elsewhere, the Maine CO-OP, Maine Community Health Options, has emerged so far as one of the most successful carriers of QHPs nationally.<sup>4</sup>

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<sup>3</sup> Some of the most significant Medicare demonstration projects (pay-for-performance, bundled payment, the Medicare Shared Savings Program, and gainsharing) are discussed in MMA’s *Payment Reform Readiness: A Legal Toolkit for Physicians* (October 2013).

<sup>4</sup> Historically, Blue Cross and Blue Shield (“BC/BS”) plans were created in the 1930s as nonprofit, member-run health plans; however, all but a very few BC/BS plans nationwide have since become for-profit insurance companies. MCHO, in collaboration with the Maine Bureau of Insurance, was able to use the statutory and licensing framework previously created for nonprofit BC/BS plans.

## NEW PAYMENT MODELS

### *Maine's Medicaid Initiatives*

To date, Maine has declined to expand MaineCare to cover the population that would newly be eligible under the ACA, despite the near-term availability of 100% federal funding. However, Maine's Department of Health and Human Services, Office of MaineCare Services ("OMS") is developing some payment reform initiatives of its own, collectively called the "Value-Based Purchasing Strategy."

#### MaineCare Accountable Communities

OMS has proposed a new MaineCare Accountable Communities Initiative, sometimes referred to as "ACI," which would essentially be a MaineCare counterpart of the Medicare Shared Savings Program ("MSSP").<sup>5</sup> The needed OMS rulemaking, and the approval of a State Medicaid Plan amendment by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS") are still in process, so the ultimate form of ACI remains unknown.

In its broad outlines, ACI would establish benchmark costs for the MaineCare population attributed to each Accountable Care Organization ("ACO")<sup>6</sup> that enters into a contract on behalf of its member providers to participate in ACI. Actual expenditures would be compared to the benchmark, and if the ACO achieves savings as compared to the benchmark, then Maine Care would pay a portion of the savings to the ACO; conversely, if actual expenditures exceed the benchmark, the ACO would pay a portion of the excess cost to MaineCare.

Because ACI is still in the planning stage, a detailed discussion is premature. However, ACI will need to address a number of issues, including:

- Member attribution may be problematic, in that MaineCare beneficiaries remain less likely than members of other covered populations to have an established relationship with a primary care provider.
- Because MaineCare providers generally cannot collect any cost-sharing payments (such as deductibles or co-payments) from MaineCare beneficiaries, it may be more difficult to change utilization patterns than would be the case for other covered populations. Additionally, OMS apparently will not seek any waiver of the Medicaid "freedom of provider choice" requirement.
- MaineCare beneficiaries, as a group, may have greater health care needs than other covered populations, although the same may not be true of specific subsets of the MaineCare population. Therefore, establishing appropriate benchmarks may be challenging, depending on the ability of OMS to segregate data from different portions of the MaineCare covered population.

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<sup>5</sup> MSSP, and shared savings programs generally, are discussed in *Payment Reform Readiness*.

<sup>6</sup> ACOs are briefly described in *Payment Reform Readiness*.

- Valid cost comparisons may be challenging, in that MaineCare reimbursement levels have historically been quite low, whereas the ACA mandated that state Medicaid programs raise their reimbursement rates for primary care services to match Medicare rates.
- OMS claims and payment data will need to be scrutinized with some care, given the well-publicized difficulties that OMS has experienced with its information systems.

### Health Homes

Building on the Patient Centered Medical Home (“PCMH”) model,<sup>7</sup> OMS is exploring the use of Health Homes to improve care coordination for MaineCare members with chronic conditions. Stage A of the Health Homes initiative, which focuses on members with complex medical chronic conditions, has been in operation since January 2013. Stage B, which will focus on members with severe and persistent mental health conditions and children with serious emotional disturbances, is currently being developed.

#### Stage A: Health Homes for Complex Medical Chronic Conditions

In the Stage A Health Home Initiative, MaineCare has sought to enroll eligible members both with a Health Home (“HH”) primary care practice, and with a Community Care Team (“CCT”). Participating HHs and CCTs shared data about enrolled members through a web portal.

Members eligible for enrollment in Stage A are either those who have two qualifying chronic medical conditions, or those who have one such condition and are at risk for another. Qualifying chronic medical conditions include cardiac and circulatory abnormalities, chronic obstructive pulmonary disease, developmental disorders, diabetes, heart disease, hyperlipidemia, hypertension, obesity, substance abuse, tobacco use, acquired brain injury, asthma, seizure disorder, and certain mental health conditions. Nearly 48,000 MaineCare members were enrolled with a HH in the first year of this initiative, but only 3% of those members were also enrolled with a CCT.

Results from the first year of this initiative appear mixed. HH practices reported frustration with increased administrative burdens, especially with respect to the enrollment process. Eligibility criteria related to mental health conditions were difficult to apply, especially in light of the separate eligibility criteria for the Stage B Behavioral Health Homes Initiative discussed below. The MaineCare reimbursement model for this initiative required HHs and CCTs to attest that enrolled members received HH services during the prior month, leading to ongoing uncertainty about funding and the ability to maintain staffing levels. While HHs and CCTs anecdotally reported some improved outcomes for individual members, conclusive data are not yet available.

Given these results, it appears likely that OMS will assess and refine the Stage A Health Home Initiative. Some possible improvements to this program may include:

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<sup>7</sup> The PCMH model is discussed in *Payment Reform Readiness*.

- Streamlined enrollment and referral processes;
- Uniform healthcare utilization reports, or “dashboard reports,” made available to HHs and CCTs;
- Improved EHR interoperability, or alternatively, shared access to other data about enrolled members’ health care services and needs;
- Increased training for both HHs and CCTs;
- Improvement of the web portal;
- Evaluation of “best practices,” and dissemination of information (or standardization of requirements) about service and staffing models; and
- Review of the MaineCare reimbursement model for this initiative, aimed at minimizing uncertainty about available funding.

#### Stage B: Behavioral Health Homes

MaineCare has also proposed a new Stage B Behavioral Health Homes (“BHH”) initiative, designed to link mental health and substance abuse treatment services with primary care services. As with ACI, the actual rulemaking and State Medicaid Plan amendment approval remain in process, so the details are unknown. However, in its broad outlines, the BHH program would adapt the principles of the PCMH model to serve MaineCare beneficiaries with long-term mental health or substance abuse treatment needs. (As a group, such individuals have unmet health needs that far exceed those of other covered populations, and coordination of their behavioral health and primary care needs has proven challenging.)

Under BHH, certain licensed mental health or substance abuse treatment agencies would be designated as a Behavioral Health Home Organization (“BHHO”), and would receive a set Per Member Per Month (“PMPM”) reimbursement for providing care management services for designated MaineCare beneficiaries, which would include:

- Administrative and liaison services with OMS;
- Assignment of each BHH beneficiary to a multi-disciplinary care team;
- Assuring that each BHH beneficiary has an appropriate plan of care;
- Arranging peer supports for each BHH beneficiary;
- Coordinating individual and family support services for each BHH beneficiary; and

- Coordinating community and social support service referrals for each BHH beneficiary.

Meanwhile, each BHH beneficiary would also be assigned a Health Home (“HH”), a primary care practice that would provide (or coordinate the provision of) needed medical services in collaboration with the BHHO, and in accordance with the BHH beneficiary’s plan of care. In addition to receiving FFS reimbursement for any other MaineCare-reimbursable services that it might provide to the BHH beneficiary, the HH would receive PMPM reimbursement for its care management services.

The financial impact of the BHH program is likely to be modest; certainly, the PMPM reimbursement levels that have been proposed to date, both for BHHs and for HHs, are relatively small. However, the BHH initiative has the potential to deliver an outsized benefit in terms of the Triple Aim. The need for better care management and coordination for this particular population has long been identified as essential to improving this population’s quality of care and overall health, and also to reducing this population’s disproportionately high cost of care.

Challenges for the BHH initiative include the historic lack of connection between providers of mental health and substance abuse treatment services, on the one hand, and providers of medical and other traditional physical health care services, on the other. This gap manifests in many ways, including distinct confidentiality laws and rules governing the different providers.

#### *Vermont Single Payor Initiative*

The State of Vermont is in the process of attempting to develop a statewide single-payor model, to be known as Green Mountain Care, that will include Medicare, Medicaid, all private insurance, and any state employee self-insurance plans. However, plans that are subject to other federal law, such as federal employee benefit plans, ERISA self-insured plans, or TriCare (which covers members of the armed services and their families), will not be included; these exclusions may have a significant impact in Vermont, a small state in which some of the largest employers maintain ERISA self-insured plans.

In general, Green Mountain Care would create a state-managed insurance pool, essentially a state-run health insurance exchange, that would be funded both by federal Medicare and Medicaid funds (which will require a CMS waiver), and by state funds raised through a new payroll tax. In theory at least, by replacing employer contributions to health insurance premiums with the payroll tax, this funding mechanism should alleviate the current burden on employers.

Green Mountain Care still faces substantial obstacles to implementation, however. It remains unknown whether CMS will issue the required federal waiver. The benefits that would be covered have yet to be defined, and therefore it remains difficult to estimate the likely cost of the program. The statute authorizing Green Mountain Care requires a three-year budget that costs less than current health care expenditures, and that target is proving elusive. Notwithstanding the lower burden on employers in terms of benefit plan contributions, it appears possible that the new payroll tax could prove prohibitively high, and Vermont is actively studying alternatives for funding Green Mountain Care.

Given the projected cost of Green Mountain Care, calls for health care cost containment are inevitable, and Vermont is seriously examining whether implementing Green Mountain Care may require systematic statewide regulation of provider reimbursement. Whether Vermont will have the appetite to implement a rate regulation system remains to be seen. Alternatively, Green Mountain Care could become a *de facto* rate setter, simply by establishing statewide fee schedules and other reimbursement mechanisms.

### *Direct Primary Care Practice Model*

Some primary care practices have recently expressed interest in a “direct primary care” practice model, sometimes referred to as a “retainer” model, in which patients would pay a regular monthly fee for basic primary care services provided by the practice. This model blends certain aspects of the cash-only model and the “concierge” model of primary care.<sup>8</sup>

In common with the “concierge” model, the direct primary care practice model involves a prepaid monthly fee for all included services, which are generally limited to a defined set of those primary care services offered by the practice (and which may include some limits on the amount of those services per month). The services covered by the retainer payment are typically outside those covered by any other health insurance that the patient may have (otherwise, difficult coordination-of-benefits issues may arise).

The most significant challenge with the direct primary care practice model is its financial feasibility. While this model may eliminate the need for significant coding and claims submission to third-party payors, it requires the practice to develop and maintain its own billing and collection capabilities, which may include the need to develop a fee schedule for services that are not covered by the retainer payment. A primary care practice that is seriously considering the direct primary care practice model should start by developing a business plan. Numerous business planning tools are available from various sources.<sup>9</sup> The demographics of the patient population may ultimately determine whether this model is affordable and marketable within the practice’s service area.

The direct primary care practice model poses a few key legal issues:

- The practice will need to develop a clear subscriber agreement that defines the scope of covered services.
- The practice will need to assure that the direct primary care practice model does not conflict with any contractual relationships with third-party payors, either on the part of the practice or on the part of patients.
- If the only covered services are those delivered by the practice, then the direct primary care practice model should create only business risk, and is unlikely to cause the practice

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<sup>8</sup> The cash-only and “concierge” practice models are discussed in *Payment Reform Readiness*.

<sup>9</sup> A particularly good (and free) resource is *How to Write a Business Plan*, published by the U.S. Small Business Administration, and available online at: <http://www.sba.gov/writing-business-plan>.

to be deemed to be engaging in the business of insurance; however, legal advice, or direct discussions with the state insurance authorities, may be in order.

### *Payor-Owned Practices*

In the past, health care providers have expressed interest in entering the health insurance market by developing provider-sponsored health care delivery networks that would ultimately be able to assume risk and/or offer insurance products, either directly or through an affiliated Health Maintenance Organization (“HMO”). In Maine, the most prominent example has been Martin’s Point Health Care, Inc., a nonprofit organization originally sponsored by a group of physicians. In addition to offering TriCare and Medicare Advantage plans, and marketing its HMO to ERISA self-insured plans, Martin’s Point also operates nine different health centers with various configurations of physicians and other providers, mostly offering primary care services.

More recently, however, the gap between providers and payors has increasingly been bridged from the other direction, with health insurance carriers purchasing and operating health care providers. This phenomenon is not exactly new, as Kaiser Permanente has used this model for decades, but the pace seems to have increased in recent years. In Maine, the most prominent example would be Concentra, a provider of urgent care and workplace health clinics that is owned by Humana, a large national for-profit health insurance company.

Payor ownership would obviously represent a significant change for most Maine physicians. A health insurance company would likely be able to furnish easy access to capital, and a robust administrative infrastructure. Depending on the company, it might also be able to provide EHR and other information technology solutions that a private practice would be hard-pressed to afford on its own. On the other hand, the potential for differences in management culture and philosophy should not be underestimated.

## EMERGING ISSUES

### *Cost Containment*

Expanded access to health insurance coverage has only exacerbated the issue of health care cost, posing significant budgetary pressures on governmental payors, private insurers, and employers. Unsurprisingly, ways to control costs are now a prominent topic of discussion.

Notwithstanding the discussion of various payment reform models contained in this publication and in *Payment Reform Readiness*, it is important to remember that to date, these initiatives represent a very small fraction of health care expenditures. Moreover, none of these mechanisms has yet demonstrated significant results.

### Rate Regulation

A few states, including Maine, have experimented in the past with various forms of health care provider rate regulation, with varying results.<sup>10</sup> As cost containment pressures increase, proposals for renewed governmental oversight of health care payments may emerge. Whether such proposals will be politically viable remains to be seen. Any comprehensive rate regulation mechanism is likely to require creating a substantial new governmental body to administer it, with accompanying administrative burdens and transaction costs for providers; additionally, given the many different factors driving health care costs (including prescription drug costs), it is unclear whether a state, by itself, can make a measurable difference on total health care expenditures. Overall, it seems likely that much more experimentation with risk-sharing and similar mechanisms will need to occur before any shift to direct governmental regulation becomes palatable.

### Reference Pricing

Under “reference pricing,” a health care payor establishes a schedule of the amounts it will pay for particular items or services. (The Medicare physician fee schedule, though more complicated in actual practice, would be an example.) Some providers may accept the reference price as payment in full. If the patient chooses to obtain the item or service from a provider that charges a higher price, however, the patient is financially responsible for the balance. In theory at least, reference pricing could be a useful cost containment tool.<sup>11</sup>

Reference pricing does raise technical legal issues that remain, as yet, unresolved. In particular, the U.S. Department of Health and Human Services (“DHHS”) and the U.S. Department of

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<sup>10</sup> Maryland has regulated hospital rates through its Health Services Cost Review Commission since 1971, and West Virginia has regulated hospital rates since 1985. Mandatory hospital rate review was tried and abandoned in Connecticut, Massachusetts, New Jersey, New York, Washington, and Wisconsin; Illinois repealed its rate regulation legislation before it actually took effect. The Maine Health Care Finance Commission, which actually regulated hospitals’ “gross patient service revenues” rather than rates, ceased operations in 1995.

<sup>11</sup> Any agreement between competitors on a reference pricing schedule could, of course, raise antitrust concerns. Additionally, use of reference pricing by a purchaser with significant market power might be viewed as a “monopsony” violation. Monopsony is a buyer’s use of its market power over demand to control the prices it pays – the inverse of monopoly, where a seller uses its market power over supply to control the prices it charges.

Labor, Employee Benefits Security Administration (“EBSA”) have expressed concern that “such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers.”<sup>12</sup> If so, then reference pricing could run afoul of the ACA limitations on cost-sharing, and the ACA prohibition on annual limits on the dollar amount of benefits for individuals. For the time being, however, DHHS and EBSA have taken a wait-and-see approach to reference pricing.

### Defined Contribution Plans

Some consultants and vendors have advised employers to shift from “defined benefit” employer sponsored health plans to “defined contribution” plans, comparable to a shift in retirement plans from pension to 401(k) plans, in order to save health care benefit costs. In essence, employees would purchase their own health insurance coverage, and the employer would reimburse their costs in accordance with the “defined contribution” amount. The argument in favor of such arrangements has been that they are comparable to medical reimbursement plans, employer payment plans, flexible spending arrangements, or health reimbursement arrangements, all of which have been permissible in the past as tax-favored employee benefit plans under various sections of the Internal Revenue Code.

However, current federal guidance strongly suggests that such “defined contribution” arrangements generally will not pass muster under the ACA, because they might violate the ACA prohibition on annual limits on the dollar amount of benefits for individuals, or the ACA limitations on cost-sharing for certain prevention and wellness services. No rules have yet been promulgated, and it appears likely this issue may remain unsettled for some time.

### Restrictions on Facility Charges for Outpatient Services

An express reason for making physician services into hospital outpatient services has been the ability of a hospital to charge a facility fee for such services, reflecting the hospital’s administrative overhead, as well as the professional fee. When physician services are classified as “hospital-based” or “provider-based,” the physician practice or other outpatient setting is deemed a department of the hospital. This additional reimbursement provides a strong financial incentive for hospitals to obtain provider-based status for their affiliated physician practices. Because provider-based practices must meet hospital licensure requirements, the result may arguably be an improvement in the facilities and the quality of services.

However, when patients and their payors encounter facility charges for physician services, in addition to the professional charges that they were previously paying, their reaction is typically negative. Numerous proposals have recently emerged that would prohibit providers from charging a facility fee for outpatient services.<sup>13</sup> Because facility charges are deeply embedded in the Medicare payment system, however, limiting such charges, or assuring an “equal playing field” with the amounts that can be charged in non-provider-based settings, may prove

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<sup>12</sup> “FAQs about Affordable Care Act Implementation (Part XIX),” published May 2, 2014, available via the EBSA website at: <http://www.dol.gov/ebsa/faqs/faq-aca19.html>.

<sup>13</sup> See, for example a recent paper from the National Institute for Health Care Reform regarding price disparities between provider-based and non-provider based services: <http://www.nihcr.org/Hospital-Outpatient-Prices>.

challenging. In announcing the proposed 2015 policy and payment changes to the Medicare Physician Fee Schedule, CMS noted that it intends to begin collecting data on services furnished in off-campus provider-based departments of hospitals, by requiring a modifier on both physician and hospital claims related to these services.

### *EHR Interoperability*

Different EHR and other health information systems have proliferated over the past few decades, and few if any of them support easy portability of data to other systems. The difficulty of making patient information available across systems is increasingly being viewed as a significant barrier to efficiency in the health care system.

The Health Insurance Portability and Accountability Act (“HIPAA”), enacted in 1996, attempted to address this issue through “Administrative Simplification” – that is, defining a standard set of health care payment transactions, and requiring such transactions to be in a common format. While the HIPAA transaction standards have been reasonably successful, they apply only to a very small subset of all electronic health information communication needs. In particular, exchange of information among different providers’ EHR systems has been largely unaffected.<sup>14</sup>

Health Information Exchanges (“HIEs”) represent an attempt to ease the interoperability problem among different EHR technology, by creating a simplified clearinghouse for health information. In essence, HIEs gather patient health information from providers and make it available in a common database that can be queried by other providers treating the same patient. This approach avoids barriers due to lack of EHR interoperability, although it tends to sacrifice some EHR functionality due to the need for common formatting. Maine’s HIE is Maine Health Information Network, known as “HealthInfoNet” or “HIN.”

A particular issue that complicates the use of HIEs is the existence of multiple, overlapping laws and rules regarding the privacy and confidentiality of different categories of health care information. Especially in an environment where behavioral health care providers and primary care providers are trying to coordinate their services, differing confidentiality standards for different categories of information can pose significant issues. From a legal standpoint, the safest approach is to obtain specific written authorization from the patient for such information to be shared; however, that approach obviously creates an additional barrier to easy and efficient sharing of information.

### *Premium Support*

All other considerations being equal, health care providers would generally prefer their patients to be insured instead of uninsured. Relatively few uninsured patients can easily pay providers’ charges out of pocket; rather, they tend to add to providers’ burdens of bad debt and charity care. To what extent may providers help patients obtain third-party coverage? In particular, may a health care provider pay a patient’s health insurance premium in order to obtain third-party coverage for that patient?

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<sup>14</sup> Such communications are heavily affected by the HIPAA privacy, security, and data breach notification requirements, however.

Providing non-financial enrollment assistance for patients who are eligible to enroll in Medicare or Medicaid, but who have not yet done so, has not been deemed to violate the Medicare and Medicaid prohibitions on beneficiary inducement. The beneficiary inducement provisions, however, limit providers' possible financial assistance to patients for the purpose of paying any applicable coverage premiums for federally funded healthcare programs.

For patients eligible for private insurance, however, the legal limits on premium assistance are not nearly so clear. The out-of-pocket cost to a provider of paying a patient's premium for third-party coverage may be significantly less than the uncollectible bill that would otherwise accrue. The availability of individual coverage through the exchanges has highlighted this issue; in the past, even if such coverage were available, the premium cost might well have been prohibitive.

Securing coverage for uninsured patients might seem, at first glance, to be a clear benefit from a public policy perspective. The problem, however, is adverse selection. Insurance carriers set their premiums on the basis of actuarial assumptions about the population at large. The patients for whom a health care provider would be most motivated to help secure coverage, on the other hand, are likely to be those who are facing the highest charges. Selectively adding those patients can distort the carrier's actuarial assumptions about premium structure, utilization, and benefit plan design. Further, providers might well choose to enroll high-cost patients, pay premiums only for a short time, and then let coverage lapse once they obtain reimbursement for their own services.

To balance these differing objectives, CMS has recently expressed the view that premium support payments for QHPs should pose little concern if they are made (i) by Indian tribes, tribal organizations, urban Indian organizations, or federal or state programs or grantees (such as the Ryan White HIV/AIDS Program), or (ii) by private nonprofits, based on financial need and not health status, and the payments are for the entire policy year. It is not clear that CMS currently has the legal authority to prohibit premium support payments that do not meet these criteria (such as direct payments by health care providers for the highest-cost patients), but such practices appear risky in view of the uncertain regulatory environment.

In view of this uncertainty, the emerging best practices for QHP premium support payments include the following:

- If providers fund QHP premium support payments, it is more prudent for them to do so indirectly, by funding a third-party nonprofit, rather than supporting QHP premiums directly for their own patients.
- Eligibility for QHP premium support should be based on established criteria relating to the patient's financial need, and not on the likely financial impact on a provider of providing uncompensated care to the patient.
- The QHP coverage secured through premium support payments should be *bona fide* coverage for the entire enrollment period (typically a year), and not merely a short-term subterfuge to assure payment of a specific provider.

## CASE STUDIES

### *MaineHealth Primary Care Payment Reform Program*

MaineHealth, Maine’s largest health care system, is a multi-hospital, multi-provider system that includes a tertiary care hospital, several community hospitals, a specialty psychiatric hospital, and numerous affiliate and subsidiary corporations that provide medical services, behavioral health care, home health care, clinical laboratory services, and other health care services. MaineHealth affiliates hold a significant share of the provider market in southern and western Maine, serving a large proportion of Maine’s population.

MaineHealth is undertaking extensive economic modeling for its primary care practices, in an effort to forecast their financial performance under both FFS and capitation scenarios.<sup>15</sup> The first stage of this effort involves basic financial analysis of existing and reasonably foreseeable revenues and expenses. The next step will be to develop “lab practices” – that is, specific primary care practices within the MaineHealth system that will volunteer to be demonstration sites for advanced Primary Care Medical Home (“PCMH”)<sup>16</sup> efforts. The concept is simple, but the execution is not. In undertaking this effort, MaineHealth benefits from its substantial existing investment in clinical integration, including a sophisticated shared EHR platform. Key elements of the MaineHealth effort include:

- Use of all-payor claims data from the Maine Health Data Organization to estimate annual per capita benchmark costs of care for the projected patient populations involved.
- Using practice improvement specialists to assist each participating practice in implementing PCMH best practices:
  - Training providers to operate “at the top of their license”;
  - Improving delegation to nurses and medical assistants;
  - Updating work flows and streamlining processes; and
  - Exploring how to redesign physician compensation to reward participation in a team approach.
- Using the MaineHealth EHR and claims data to track the effect of PCMH activities on utilization of other health care services, such as avoidable Emergency Department visits.
- Improving care management:
  - Proactive outreach to patients to identify unmet clinical needs;
  - Reviewing charts before each patient visit to identify appropriate preventive screenings; and
  - Increasing provider availability to address acute needs.

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<sup>15</sup> Specific issues regarding FFS and capitation models are discussed in *Payment Reform Readiness*.

<sup>16</sup> The Primary Care Medical Home model is also discussed in *Payment Reform Readiness*.

- Tracking available quality measures, plus wait times, patient satisfaction surveys, and focus groups.

Ultimately, MaineHealth should be able to use information from the “lab practices” to develop not only a care delivery model for capitation-based services, but also a financial model of how a “lab practice” may perform under capitation – that is, so-called “shadow capitation.” Preliminary “shadow capitation” results of the MaineHealth effort to date suggest that the advanced PCMH model can be sustainable under capitation; however, these predictions are sensitive to a significant number of variables. Further work on this project may include such activities as ongoing re-design of the lab practices; development of more sophisticated measures of population health impacts; and identifying optimum patient panel sizes under a capitated reimbursement system.

### *Beacon Health, LLC*

Beacon Health, LLC (“Beacon Health”) is an affiliate of Eastern Maine Healthcare Systems (“EMHS”) that was formed specifically to pursue accountable care activities. In addition to the eight EMHS hospitals, Beacon Health has entered into contractual participation arrangements with numerous other Maine providers.

Beginning January 1, 2012, Beacon Health was one of only 32 participants nationwide in Medicare’s Pioneer ACO program, which is entirely separate and distinct from the MSSP. Described as “designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings,” the Pioneer ACO model aggressively moves participating ACOs from an initial shared savings payment model to “population-based payment” – *i.e.*, full risk-sharing. Pioneer ACO participants are required to enter into similar payment arrangements with private payors by their third year of operation.

Beacon Health currently has about 22,000 Medicare patients enrolled in Pioneer ACO, and a roughly similar number enrolled in similar arrangements through other payors, including 15,000 EMHS employees and their dependents. By 2015, Beacon Health anticipates that it may have shared-savings or population-based payment arrangements covering as many as 100,000 patients, or roughly one-third of the total patient population served by EMHS, its affiliates, and other Beacon Health participating providers.

Key elements of Beacon’s approach to implementing a population health approach, which Beacon Health views as a significant culture change, include:

- Multidisciplinary teams including representation of patients, physicians, care coordinators, quality nurses, home health providers, community care teams, skilled nursing facilities, pharmacies, administration, IT, project management, and wellness programs;
- Focused work groups addressing items such as pharmacy, clinical standards, post-acute care, care management and coordination, utilization review, and quality review;

- An emphasis on transparency, including extensive use of performance “dashboards,” sharing best practices, and near-constant communication (much of which is Internet-based);
- Redesign of primary care practices using a team-based approach, and emphasizing appropriate standardization across practices;
- Robust cost and revenue accounting;
- Extensive use of EHR and claims data, both for risk modeling and to guide population-based health efforts; and
- An intensive and extensive care coordination program – the only such program in the nation associated with a health system to have received accreditation from the National Committee for Quality Insurance (“NCQA”), the leading accreditation body for managed care organization.

Beacon Health has documented significant achievements, including decreased hospital readmissions, increased patient satisfaction, and increased performance on quality measures. In May 2014, Beacon Health received accreditation from NCQA – the only NCQA-accredited program not affiliated with an insurance company.

On the other hand, Beacon Health’s achievements have come at a cost. Its projections have it reaching the break-even point sometime around the beginning of 2016. EMHS views Beacon Health as a long-term investment in successfully learning how to assume risk for the total cost of care for the population it serves, and continues to support the Beacon Health transformation because it is convinced the new healthcare delivery model that Beacon Health represents is the right way to go. Accordingly, the ultimate success of Beacon Health will be measured by the extent to which it enables that transition and the improved health and well-being of the people served by EMHS and the other Beacon Health participating providers.

#### *Maine State Employee Health Commission*

The Maine State Employee Health Commission (“SEHC”) oversees a self-insured health benefit plan that covers State of Maine and University of Maine System employees and non-Medicare retirees, and their families. Over the past several years, SEHC has imposed a tiering system on Maine hospitals, which it ranks according to their performance on certain quality and cost measures. Covered individuals who receive care at those hospitals ranked as “preferred” or “Tier 1” hospitals have the lowest cost-sharing obligations, whereas those receiving care from other hospitals incur higher co-payment obligations. The financial impact on non-preferred hospitals can be significant. SEHC has developed innovative risk-sharing arrangements with several of Maine’s largest health systems, including MaineHealth, Beacon Health, and Kennebec Region Health Alliance (“KRHA”).

KRHA is a physician-hospital organization composed of MaineGeneral Medical Center (“MGMC”), a hospital with campuses in Augusta and Waterville, Maine, and local providers and

practitioners that are affiliated with MGMC through Medical Staff membership. These providers include physician practices owned by MGMC, private practices, and community health centers. Because Augusta is the state capital, state employees and retirees form a relatively high proportion of KRHA patients.

SEHC and KRHA have entered into a multi-year Accountable Care Agreement in an effort to control costs and improve quality, and also to assure predictability for future years. In return for assurance that MGMC will be deemed a Tier 1 hospital, KRHA and its participating providers share in SEHC's financial risk for the cost of health services provided to SEHC members who receive their primary care services from KRHA practices. In broad outline:

- The parties establish a target PMPM amount in advance;
- KRHA providers bill and collect on a FFS basis;
- After the risk-measurement period, the parties compare the actual total amount billed to the total target amount;
- If actual payments exceed the target, then KRHA pays a portion of the difference to SEHC as a risk-sharing payment;
- If actual payments are below the target, SEHC makes a risk-sharing payment to KRHA; and
- Risk-sharing payments from SEHC to KRHA may be further adjusted to reward KRHA for achieving certain pre-established quality targets.

The risk-sharing mechanism includes thresholds and caps on the parties' risk-sharing obligations, and many of the details (including member attribution, quality measures, and the mechanism for establishing the target payment amounts) are complicated; nevertheless, this Accountable Care Agreement appears to be a significant step toward aligning the interests of SEHC, KRHA's providers, and the covered beneficiaries.

### *Maine Community ACO*

Universal American, a national insurance company, has established a subsidiary, Collaborative Health Solutions ("CHS"), to act as a vehicle for providing "turnkey" ACO services for physician group practices or other providers who might not otherwise have sufficient infrastructure to participate in the Medicare Shared Savings Program ("MSSP").<sup>17</sup> CHS provides ACO infrastructure through a management and administrative services agreement, relieving the ACO's providers of the need to do so.

Nine of Maine's community health centers have entered into a joint venture with CHS, under the name Maine Community ACO, which is now in its second year of MSSP participation.

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<sup>17</sup> MSSP, and shared savings programs generally, are discussed in *Payment Reform Readiness*.

Community health centers are one variety of Federally Qualified Health Center (“FQHC”). FQHCs are nonprofit health care providers that operate in accordance with section 330 of the Public Health Service Act. They must meet a number of program requirements, including use of mid-level providers and a sliding fee scale for needy patients; in return, they receive favorable Medicare and Medicaid reimbursement, and may be eligible for Public Health Service grant funding. FQHCs are the quintessential “safety net” providers for medically underserved communities.

Because FQHCs in general, and Maine’s community health centers in particular, have historically operated on fairly low margins, the benchmark costs for their attributed populations in a shared-savings model seem unlikely to yield as many opportunities for Medicare savings as might occur with, for example, a large physician group in a relatively affluent area. Consistent with this prediction, while Maine Community ACO has achieved some modest savings compared to its Medicare benchmark, the level of savings to date has not yet been high enough to qualify for a distribution of shared savings from Medicare.

MSSP is a self-limiting initiative; if a particular ACO is successful in achieving shared savings, then diminishing returns will set in quickly as the benchmark levels are adjusted downward over time. Accordingly, an important question with a “turnkey” ACO model is whether the participating providers, having contracted with CHS for the ACO infrastructure, will actually gain enough experience in managing outcomes and expenses to ease their transition into other payment models involving risk assumption. The community health centers that participate in Maine Community ACO are continuing to review the ACO’s performance with that question in mind.

## KEY LEGAL ISSUES

Summarized below are some of the important legal developments related to health care payment reform that have occurred since the publication of *Payment Reform Readiness*.

### *Antitrust*

Mergers and affiliations of healthcare providers have proceeded rapidly. The providers involved generally assert that achieving efficiencies and economies of scale is critical to preparing for a transition away from FFS payment, but critics, including some in the antitrust enforcement agencies, have expressed concern about the potential for increased health care costs through concentrations of market power.

The most recent case addressing the role of the antitrust laws with respect to provider integration arose after St. Luke's Health System acquired Saltzer Medical Group in Nampa, Idaho. The acquisition was challenged both by competing health care providers, and by the Federal Trade Commission ("FTC"), on grounds that the acquisition would give St. Luke's dominant market power, including the ability to raise prices, in the market for "adult primary care services sold to commercial insurers" in Nampa. The U.S. District Court for the District of Idaho agreed, and ordered the affiliation unwound.<sup>18</sup> St. Luke's and Saltzer have appealed, and the 9<sup>th</sup> Circuit Court of Appeals has stayed the District Court's order pending a decision on the appeal.

The District Court's "Findings of Fact and Conclusions of Law" explicitly address the relationship between the antitrust laws and health care payment reform. The court noted that while the motivation for the transaction was to position St. Luke's and Saltzer better for value-based reimbursement in place of FFS, the affiliation would also significantly diminish competition and give them the ability to raise prices charged to health insurance plans and consumers, in violation of section 7 of the Clayton Act. The efficiencies and integration needed to prepare for value-based reimbursement, according to the court, could be achieved through other (unspecified) organizational structures that would not yield the same increase in market power.

While the District Court's decision expresses sympathy for the goals of provider integration to prepare for payment reform, it does not discuss the many legal issues (including Stark and anti-kickback concerns) that may act as barriers to integration when providers are less than fully merged. Thus, the result in the St. Luke's case, at least to date, demonstrates the extent to which antitrust concerns based on the current FFS system may pose a barrier to providers seeking to position themselves for a value-based payment system.

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<sup>18</sup> The Court's "Findings of Fact and Conclusions of Law" are available via the FTC's website, at: <http://www.ftc.gov/system/files/documents/cases/140124stlukesfindings.pdf>. The Court's Final Order is available at: <http://www.ftc.gov/sites/default/files/documents/cases/140124stlukesmemodo.pdf>.

Separately, in March 2014 the Federal Trade Commission hosted a public workshop on various other elements of competition in the health care industry.<sup>19</sup> Topics considered at the workshop included professional regulation of health care providers; innovations in health care delivery; advancements in health care technology; measuring and assessing health care quality; and price transparency of health care services. The FTC invited public comments following the workshop, but has not yet announced any reports or policy changes resulting from it.

Health care payment reform and the ongoing transformation of the health care system with respect to both payors and providers pose numerous important antitrust issues. At the most basic level, the St. Luke's case raises a serious question as to when, if ever, improvements in quality and efficiency may overcome concerns about increased market power. More broadly, it remains unclear how the existing public policy favoring vigorous competition can be reconciled with an increasingly integrated and interdependent health care marketplace.

### *Privacy and Confidentiality*

In the wake of numerous reported breaches of consumers' data security through hacking and other unauthorized disclosures, substantial concern has been expressed about the risk of such incidents in the healthcare system. New technology may exacerbate those concerns:

- Many EHR systems now include “patient portals” where individuals can view their own information, because payors and providers believe that patient engagement is an important tool in providing efficient care.
- Health care providers, especially primary care providers, are increasingly communicating with patients via e-mail, text messages, or social media.
- Internet-enabled devices permit remote monitoring of patients, even in the home.

In response to these concerns, in May 2014 the FTC hosted a seminar on the privacy ramifications of consumer generated and controlled health data.<sup>20</sup> While the FTC solicited public comments in connection with the seminar, it has not yet announced any reports or policy changes resulting from it.

### *ACA Litigation*

Notwithstanding the U.S. Supreme Court's 2012 ruling broadly upholding the constitutionality of the Affordable Care Act,<sup>21</sup> litigation over certain aspects of the ACA has continued:

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<sup>19</sup> The FTC's announcement of the public workshop, and links to comments submitted following the workshop, are available online at: <http://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition>.

<sup>20</sup> The FTC's announcement of the seminar, and links to public comments, are available online at: <http://www.ftc.gov/news-events/events-calendar/2014/05/spring-privacy-series-consumer-generated-controlled-health-data>.

<sup>21</sup> *National Federation of Independent Business v. Sebelius*, No. 11-393, 567 U.S. \_\_\_, 132 S.Ct. 2566 (2012).

- In the widely-reported *Hobby Lobby* case,<sup>22</sup> the U.S. Supreme Court held that certain closely-held for-profit corporations whose owners have sincere religious beliefs are entitled to the same exceptions to coverage mandates that are afforded to nonprofit religious organizations under the federal Religious Freedom Restoration Act.
- Federal courts of appeals have reached differing conclusions as to whether the ACA authorizes federal subsidies for QHPs purchased through federal exchanges, as well as for QHPs purchased through state exchanges.<sup>23</sup> The issue remains unsettled, and appears likely to reach the U.S. Supreme Court unless Congress revises the text of the statute.
- Technical challenges to the ACA based on separation of powers arguments, on its alleged violation of the Origination Clause, or on its alleged violation of state sovereignty, have largely been rejected in the courts, though a few appeals remain pending.
- John Boehner, the Speaker of the U.S. House of Representatives, has proposed a lawsuit challenging President Obama's executive action delaying implementation (for one to two years) of the employer mandate of the ACA. Whether the House will approve such a lawsuit remains uncertain; most legal scholars appear to agree that if brought, it would have a very remote likelihood of success. (Paradoxically, the House has previously passed legislation that would have delayed the employer mandate, but it failed in the Senate.)

It remains unclear to what extent the issues raised in these pending or proposed cases may affect healthcare providers in their efforts to prepare for changes in the payment system.

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<sup>22</sup> *Burwell v. Hobby Lobby Stores, Inc.*, No. 13-354, 573 U.S. \_\_\_\_ (June 30, 2014).

<sup>23</sup> *King v. Burwell*, No. 14-1158 (4<sup>th</sup> Cir. July 22, 2014) (subsidies authorized); *Halbig v. Burwell*, No. 14-5018 (D.C. Cir. July 22, 2014) (subsidies unauthorized).

## SUMMARY

Expanded health care coverage under the ACA has accelerated trends, and exacerbated tensions, that were already present in the health care system, even as the ACA has posed new challenges. With millions of Americans newly covered, the cost of health care services is emerging as a key issue. Making the transition from FFS reimbursement to risk-based or population-based reimbursement arrangements appears to be a major element of the solution, but we remain in the middle of that transition. The risk-sharing arrangements now underway in Maine appear to be, at best, stepping stones to an outcome-based reimbursement system.

Meanwhile, however, some tangible lessons have emerged. Focusing on primary care, especially prevention and wellness, benefits patients. Care coordination and care management increase quality and reduce overall costs. Objective measures and benchmarks should inform clinical practices and protocols. Now that the quality and cost-effectiveness improvements attributable to these seemingly simple elements have proven themselves, it appears unlikely that they will disappear entirely, regardless what may happen with other aspects of payment reform and the ACA.

## ADDITIONAL RESOURCES

For an overview of payment reform efforts and practice readiness issues, see the Maine Medical Association's *Payment Reform Readiness: A Legal Toolkit for Physicians* (October 2013), available online at:

<http://www.mainemed.com/sites/default/files/content/MMA%20Legal%20Toolkit%20for%20Payment%20Reform%20FINAL%20Oct%201%202013.pdf>.

MMA also provides other helpful payment reform resources on its website:

<http://www.mainemed.com/cme-education-info/payment-reform-resources>.

An overview of the EHR meaningful use requirements is available online at:

[http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful\\_Use.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html).

CMS has published information about the Stage 2 meaningful use requirements in the publication *Eligible Professional's Guide to Stage 2 of the EHR Incentive Programs*, available online at:

[http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2\\_Guide\\_EPs\\_9\\_23\\_13.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Guide_EPs_9_23_13.pdf).

For antitrust issues in health care, see the Federal Trade Commission's "Competition in the Health Care Marketplace" website:

<http://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care>

For additional information on fraud and abuse implications in payment reform, see the Office of Inspector General's website on advisory opinions:

<https://oig.hhs.gov/compliance/advisory-opinions/>

For more information about the MaineHealth Primary Care Payment Reform Program, contact MaineHealth's Director of System Development, Stephanie Peters, at (207) 661-7584 or [PETERS6@mainehealth.org](mailto:PETERS6@mainehealth.org).

The free business planning tools published by the U.S. Small Business Association are available online at: <http://www.sba.gov/category/navigation-structure/starting-managing-business/starting-business/how-write-business-plan>.

Health care rate regulation is discussed in A. Sommers, C. White, and P. Ginsburg, "Addressing Hospital Pricing Leverage through Regulation: State Rate Setting," NIHCR Policy Analysis No. 9, published by the National Institute for Health Care Reform ("NIHCR") in May 2012, available online at: [http://www.nihcr.org/State\\_Rate\\_Setting.pdf](http://www.nihcr.org/State_Rate_Setting.pdf). NIHCR has also published numerous other articles on health care cost containment and improving the health care delivery system.

The American Academy of Family Physicians has published a helpful overview of the direct primary care practice model, entitled *Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework*, available online at:

[http://www.aafp.org/dam/AAFP/documents/practice\\_management/payment/DirectPrimaryCare.pdf](http://www.aafp.org/dam/AAFP/documents/practice_management/payment/DirectPrimaryCare.pdf).

The National Conference of State Legislatures maintains numerous issue briefs and other reference materials on health care cost containment strategies, available on line at:

<http://www.ncsl.org/research/health/health-cost-containment-issue-briefs.aspx>.

CMS provides information on the Pioneer ACO model through its Innovation Center website, at:

<http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>.

The CMS interim final rule on QHP premium support payments by third parties is 45 C.F.R. § 156.1250, available online at:

<http://www.gpo.gov/fdsys/pkg/FR-2014-03-19/pdf/2014-06031.pdf>.

Subsequent advisory guidance on this topic is contained in a letter from Secretary Sebelius to Richard Umbdenstock, president of the American Hospital Association, dated May 21, 2014.

OMS maintains a website with materials on the MaineCare Value-Based Purchasing Strategy at:

<http://www.maine.gov/dhhs/oms/vbp/>.

Background information about CO-OPs generally, and Maine Community Health Options in particular, is available on MCHO's website at: <https://www.maineoptions.org/>.

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