The Times They Are A-Changing: ACOs and Payment Reform

March 9, 2011

Deborah K. Gardner
Ropes & Gray
Deborah.Gardner@ropesgray.com
617.951.7207

Michael F. Sexton
Ropes & Gray
Michael.Sexton@ropesgray.com
617.951.7807

Housekeeping

How to Participate

- Submit your text question using the email address ropesgrayllp@ropesgray.com
- Your line will be muted.
- A recording of today's presentation will be made available

Overview

- Federal Payment and Delivery System Reform Initiatives
- Private Payor Payment Models
- State Payment and Delivery System Reform Initiatives

Payment and Delivery System Reforms

- New Federal Initiatives in Patient Protection and Affordable Care Act (ACA)
  - Medicare and Medicaid Programs
    - ACOs and Shared Savings Programs
    - Bundled Payment Initiatives
    - Capitated Payment Demonstrations
  - Center for Medicare & Medicaid Innovation

Medicare Shared Savings

- Medicare Shared Savings Program
  - Option to form accountable care organizations (ACOs) to share in achieved cost savings if certain cost, care and quality benchmarks are met
  - Accountable for the quality, cost and overall care for assigned Medicare FFS beneficiaries
  - Implemented no later than January 2012
  - Proposed regulations sent to OMB mid-January

Medicare Shared Savings

- Shared Savings Program:
  - Payments continue to be made to providers and suppliers participating in ACO under FFS under Parts A and B
  - Bonus payment of a percent of the difference between
    - The estimated avg. per capita Medicare expenditure in a year (adjusted for beneficiary characteristics) of ACO Medicare patients
    - The benchmark for the ACO

Medicare Shared Savings

- Requirements
  - Eligible providers include groups of providers with mechanism for shared governance:
    - Groups of physicians
    - Networks of individual practices
    - Partnerships or joint ventures between hospitals and physicians
    - Hospitals employing physicians and
    - Any other provider groups that the Secretary determines are appropriate

Medicare Shared Savings

- Formal legal structure
- Willing to become accountable for quality, cost and overall care of Medicare FFS beneficiaries assigned to it
  - Patient Assignment
    - Based on primary care service utilization
    - At least 5,000 Medicare patients
  - Assignment may not be visible to Medicare patients
  - If Secretary determines that ACO is avoiding patients, Secretary may impose sanctions
- 3 yr. participation agreement

Medicare Shared Savings

- Must submit quality and other data
- Must meet quality performance standards
  - Set by Secretary
    - Clinical processes and outcomes
    - Patient and caregiver experiences of care
    - Utilization of services
  - Higher standards and new measures will be added over time

Medicare Shared Savings

- Reporting requirements
  - Quality and cost measures
  - Other data including hospital discharge planning and post-discharge follow-up
  - May include other reporting requirements such as PQRI
- Minimum savings requirement
  - Estimated avg. per capita Medicare expenditures under ACO for Medicare FFS beneficiaries for Parts A and B services, adjusted for beneficiary characteristics. . .
  - Must be at least the percent specified by the Secretary below the applicable benchmark

Medicare Shared Savings

- Cost Savings Benchmark
  - Estimated by Secretary for each agreement period for each ACO
  - Based on the most recent available 3 years of per-beneficiary Parts A and B expenditures for ACO's assigned beneficiaries
  - Adjusted for beneficiary characteristics and other factors Secretary deems appropriate
  - Updated by the projected national growth in per capita expenditures for Parts A and B services

Medicare Shared Savings

- Cost Savings Benchmark
  - For each 12-month period, estimated expenditures per beneficiary must be at least the percent specified by Secretary below applicable benchmark
  - Benchmark reset at start of each agreement period
  - Bonus payment program – no penalties for failing to meet minimum savings requirement

Medicare Shared Savings

- Shared Savings
  - Secretary will determine percentage of shared savings ACOs may receive
  - ACOs to distribute savings among provider participants
  - Secretary will establish limits on total amount of shared savings that may be paid to ACO

Medicare Shared Savings

- Other payment models possible
  - Partial capitation:
    - ACO at financial risk for some, but not all, of items or services covered under Parts A and B
    - Secretary may limit model to ACOs that are highly integrated and capable of bearing risk
    - Payments may not result in spending more for beneficiaries of ACO than would otherwise be expended for such ACO for such beneficiaries
    - Involves upside and downside risk
    - Discretionary model

Medicare Shared Savings

- Potential issues
  - Cooperation within the ACO
  - No administrative or judicial review
    - Assignment of Medicare patients to ACO
    - Quality measures and ACO's performance
    - Eligibility for shared savings and amount of shared savings
  - Patient cooperation
  - IT infrastructure, programs to manage certain patient populations, data sharing

Medicare Shared Savings

- Prior Related Medicare Initiative: Medicare Physician Group Practice (PGP) Demonstration
  - Started in April 2005, 5-year demonstration
  - Similar goals as the Medicare Shared Savings program
    - Incentive to coordinate overall care, reduce costs, improve quality
  - Bonus payments to 10 provider organizations and physician networks for improving quality and cost-efficiency of health services

Medicare Shared Savings

- Medicare PGP Demonstration (cont.)
  - Beneficiaries who received at least one evaluation and management (E&M) service from a participating PGP during a given year were eligible for assignment to the demonstration
  - 2% minimum saving benchmark
  - 32 quality measures
  - PGPs eligible to receive up to 80% of savings beyond 2% threshold while 20% retained by Medicare

Medicare Shared Savings

- Medicare PGP Demonstration (cont.)
  - Received FFS payments and bonus if improved care and reduced costs
    - PGPs were also partially responsible for spending above cost thresholds through reductions in future bonus payments
  - Improved efficiency and quality of care through clinical management of patients
  - Through year 3, $32M in Medicare cost reductions
    - all 10 achieved success on most quality measures
      - Only 6 met cost savings target
    - 5 collectively received over $25M in shared savings

Medicare Shared Savings

- Existing Related Medicare Initiative: Medicare Health Care Quality (MHCQ) Demonstration
  - Launched in 2010 to improve quality of care and increase efficiency
  - Open to groups of physicians, integrated health care delivery systems and regional coalitions of groups
  - Two organizations participating:
    - Indiana Health Information Exchange
    - North Carolina Community Care Networks, Inc.
  - Shared savings tied to cost savings, improvements in quality and outcome measures, and reductions in costs of targeted population

Medicaid Shared Savings

- Pediatric ACO Demonstration Project
  - 5-year demonstration (Jan. 2012 – Dec. 2016)
  - Implemented through CMMI in conjunction with participating State Medicaid Directors
  - States apply to participate
  - Pediatric medical providers that meet specified requirements may be recognized as ACOs and receive incentive payments under Medicaid

Medicaid Shared Savings

- Pediatric ACO Demonstration Project
  - Program will be similar to Medicare ACO requirements
    - ACOs eligible for cost savings if meet:
      - performance guidelines set by Secretary; and
      - annual minimum savings level set by State in consultation with Secretary
    - Secretary determines percentage of savings to be shared
    - Payment amounts may be subject to caps
  - ACOs must agree to participate for at least 3 years

Bundling for Episodes of Care

- Medicare Payment Bundling Pilot
  - 5-year program to be implemented by January 1, 2013
  - Secretary must submit plan before Jan. 1, 2016 to Congress to expand pilot if pilot looks successful
  - Bundled payment - a/k/a "episode-based payment":
    - single payments for all services related to a treatment or condition
    - may span multiple providers in multiple settings

Bundling for Episodes of Care

- Medicare Payment Bundling Pilot (cont.)
  - Focuses on single medical episode rather than overall care
  - Episode of care, a period of time that includes:
    - 3 days prior to admission to the hospital,
    - The length of stay at the hospital, and
    - 30 days following discharge from the hospital
    - Secretary may establish a different period for an “episode of care” under the pilot
  - Forces hospitals and physicians to take responsibility for coordination of care after discharge

Bundling for Episodes of Care

- Medicare Payment Bundling Pilot (cont.)
  - Bundled payment for applicable services:
    - Acute care inpatient services,
    - Physician services delivered in and outside of an acute care hospital setting,
    - Outpatient hospital services, including emergency department services,
    - Post-acute care services
  - And “other appropriate services”
    - Care coordination, medication reconciliation, discharge planning, transitional care services, other patient-centered activities as Secretary determines

Bundling for Episodes of Care

- Medicare Payment Bundling Pilot (cont.)
  - Secretary required to select 10 “conditions” to which bundled payments will apply
    - Conditions selected must include mix of chronic and acute conditions as well as medical and surgical conditions
  - Unclear whether participants required to accept bundled payment for all covered conditions
  - Secretary will determine bundled payment methodology
    - Providers likely will bid
  - Requires reporting on quality measures

Bundling for Episodes of Care

- Medicare Payment Bundling Pilot (cont.)
  - Legislation does not specify shared savings incentive but likely feature
  - Legislation requires application for participation to include certain providers:
    - Hospital, physician group, SNF, HHA
  - Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications
  - Providers do not assume the insurance risk that a patient will acquire a condition, as is the case under capitation

Bundling for Episodes of Care

- Medicare Payment Bundling Pilot (cont.)
  - Secretary to test bundling pilot in continuing care hospital model
  - "Continuing care hospital"
    - Entity that provides under common management the medical and rehab. services provided in inpatient rehab. hospitals and units, long term care hospitals, and SNFs
  - "Episode of care":
    - Full period that a patient stays in the continuing care hospital plus the first 30 days following discharge
  - Applicable conditions not limited to 10

Bundling for Episodes of Care

- Prior Related Medicare Project: Medicare Acute Care Episode (ACE) Demonstration
  - A 3-year hospital-based demonstration launched in 2009
  - Ongoing in four states: Texas, Oklahoma, New Mexico and Colorado
  - Tests bundled payments for both hospital and physician services for a select set of inpatient episodes of care to improve the quality of care delivered through Medicare FFS
  - Acute-care episodes related to cardiac and orthopedic surgical services

Bundling for Episodes of Care

- Medicare ACE Demonstration
  - Participating sites known as Value-Based Care Centers and must meet particular procedure volume thresholds
  - Eligible organizations: entities that include affiliation of at least one physician group and at least one hospital
  - Hospitals at financial risk for costs related to hospitalization and physician services furnished in that episode

Bundling for Episodes of Care

- Medicare ACE Demonstration
  - Hospitals that applied for demonstration had to submit bids to Medicare with discounts for each relevant DRG
    - Payments made to hospital for distribution
  - Participants report on quality measures quarterly
  - CMS shared up to 50% of Medicare savings with beneficiaries
  - Hospitals may share any savings with physicians over those offered in the bid as long as gainsharing amounts do not exceed 25% of their fee schedule
    - Bonus in some demonstrations tied to meeting quality and savings thresholds

Bundling for Episodes of Care

- Prior Related Medicare Project: Medicare Participating Heart Bypass Center Demonstration
  - Conducted in early 1990s
  - The largest evaluation of bundled payment
    - Included all inpatient and physician services during hospitalization, readmissions within 72 hours, and related physician services during 90-day global period
    - Excluded other pre- and post-discharge physician services
  - Payment rate determined through competitive bidding process

Bundling for Episodes of Care

- Prior Related Medicare Project: Medicare Participating Heart Bypass Center Demonstration
  - Payment made to hospital
    - Hospital and physicians free to divide payment as they chose
  - Results and Issues:
    - Improved quality of care
      - Fewer re-operations, lower readmissions, shorter lengths of stay, lower mortality rates
    - Some reduction in hospital costs
    - Difficulty aligning physician and hospital incentives
    - Difficulty adapting to novel billing system

Bundling for Episodes of Care

- Prior Related Medicare Project: Medicare Cataract Alternative Payment Demonstration
  - Medicare tested bundled payment in the outpatient setting
  - Episode included physician and facility fees for cataract removal surgery, intraocular lens costs, and selected pre- and post-operative tests
    - Episode payment rates negotiated with participating providers
    - Rates modestly discounted from non-demonstration rates for same services
  - Provider interest low - only 3.7 percent of eligible providers indicated a willingness to participate

Bundling for Episodes of Care

- Medicaid Bundled Payment Demonstration
  - Demonstration to run from January 2012 through December 2016
    - Conducted under Medicaid in 8 states
  - Designed to evaluate integrated care around a hospitalization
  - Intended to support states' efforts to shift from the current FFS payment system to an integrated payment system

Bundling for Episodes of Care

- Medicaid Bundled Payment Demonstration (cont.)
  - State may target project to particular categories of beneficiaries or particular geographic regions of state
  - Bundled payment to apply to an episode of care which includes a hospital stay, and concurrent physician services provided during hospitalization
    - State specifies the episode of care that the project will address
    - State specifies services to be included in bundled payment

Bundling for Episodes of Care

- Payments under the project to be adjusted for severity of illness and other beneficiary characteristics

– States must report to Secretary data necessary to monitor outcomes, costs and quality and evaluate reasonableness of selection of episodes of care

– Hospitals must have robust discharge planning systems

– Secretary and participating states must ensure that beneficiaries do not receive fewer services than otherwise

– Law allows Secretary to waive any Social Security Act provisions necessary to accomplish goals of demonstration

Capitated Payments

- Medicaid Global Payment System Demonstration
  - Seeks to support states' efforts to shift from the current Medicaid FFS payment structure for safety net hospitals to a capitated payment model
  - Up to 5 states can participate
  - Fiscal years 2010 through 2012
  - Capitated payments would cover services and procedures provided by facility and its physicians to a targeted population
    - Fixed price per member based on age, gender and health status, and adjusting for inflation

Capitated Payments

- Medicaid Global Payment System Demonstration (cont.)
  - Conducted in coordination with CMMI
  - Participating facilities would include large safety net hospital systems or networks
  - CMMI is to test and evaluate the project with respect to health outcomes and spending, and the Secretary may modify or terminate a project during the testing
  - Selection process, requirements placed on eligible participants, and state incentives unclear

PPACA Option to Use Other Payment Models

- Partial capitation model
- Or “any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.”

PPACA Option to Use Other Payment Models

- Oct. 2010 BCBSA: Move away from fee-for-service, toward quality and value-based payment
- Nov. 2010 MedPAC letter: Providers should share financial risk with Medicare
- Dec. 2010 CMMI Director: Build off of existing payment models; experiment with multiple payors

Other Payment Models

- ***What are private payors doing?***
- What are the states doing?

Private Payor Payment Models

- Episode-based payment
- Global payment
- Pay-for-performance
- Medical home models
- Also: benefit design (e.g., tiered networks, evidence-based purchasing)

Private Payor Payment Models

- Recent examples:
  - 2009: CIGNA “medical home” pilot program with Texas multispecialty physician group. Others in Colorado, Pennsylvania, Vermont, New Hampshire
  - 2010: Independence Blue Cross PCP incentive programs in Pennsylvania
  - 2010: UnitedHealthcare bundled payment model for cancer treatments in Minnesota
  - 2011: North Dakota BCBS moves to outcome-based compensation with multiple health systems

Private Payor Payment Models

- Focus on: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract
  - Source: Chernew et al., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract'", *Health Affairs* 30, No. 1 (2011)
  - Source: Robert Mandel, BCBSMA, "An Alternative Quality Contract" Presentation, 2008 (http://www.bcbs.com/issues/uninsured/final-hill-briefing-4-15-08.ppt#309)

BCBSMA Alternative Quality Contract

- Began in 2009
- Now at least 12 provider groups
- Provider organization accountable for managing care within an annual budget. Opportunity to earn financial rewards for meeting clinical performance targets.
- Eligibility
- Five-year term

BCBSMA Alternative Quality Contract

- Global budgets with negotiated annual spending limits
  - For all services to BC HMO and POS patients, whether or not provided by the contracted group
  - Base year budget
  - Negotiated annual growth rates
  - Risk and other adjustments
  - Group bears financial risk (50 – 100%)

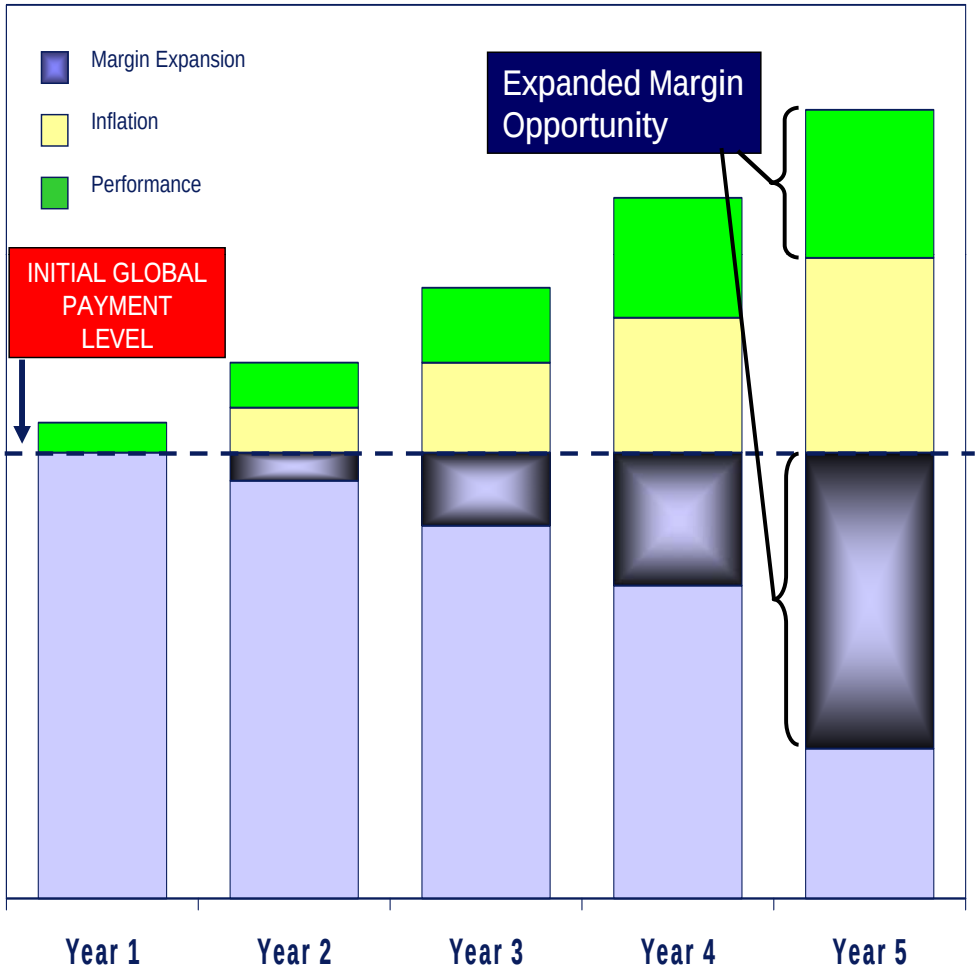
BCBSMA Alternative Quality Contract

- Quality incentive payments
  - Up to 10% of total PMPM payments
    - Up to 5% for ambulatory and office based services (mostly primary care)
    - Up to 5% for hospital care
  - Based on nationally accepted quality measures
  - Based on absolute, not relative, performance

Financial Structure of the Alternative QUALITY Contract

Financial Structure based on four components:

- Global payment
  - Based on total medical expenses
  - Health status adjusted
- Margin Retention
  - Initial Global Payment includes inefficiencies
- Performance Incentive
  - Up to 10% of Total Medical Expense
- Inflation
  - Set at general inflation



Source: Robert Mandel, BCBSMA, "An Alternative Quality Contract" Presentation, 2008

Performance Measure Set

Hospital Quality and Safety

- Clinical process measures
  - Acute MI
  - Heart Failure care
  - Pneumonia care
  - Surgical care
- Clinical outcomes measures
  - Hospital-acquired infections
  - Complications after major surgery (AMI, PE/DVT, Pneumonia)
  - Obstetric trauma
- Patient Care Experiences
  - Communication (MD, nursing staff)
  - Responsiveness
  - Discharge support/planning

Source: Robert Mandel, BCBSMA, "An Alternative Quality Contract" Presentation, 2008

Ambulatory Care Quality

Clinical process measures

- Depression
- Diabetes
- Cardiovascular Disease
- Cancer Screening
- Pediatric: Appropriate Testing / Treatment
- Pediatric: Well Child Visits

Clinical outcomes measures

- Diabetes (HbA1c in poor control, LDL-C control, blood pressure control)
- Hypertension (blood pressure control)
- Cardiovascular Disease (blood pressure control, LDL-C control)

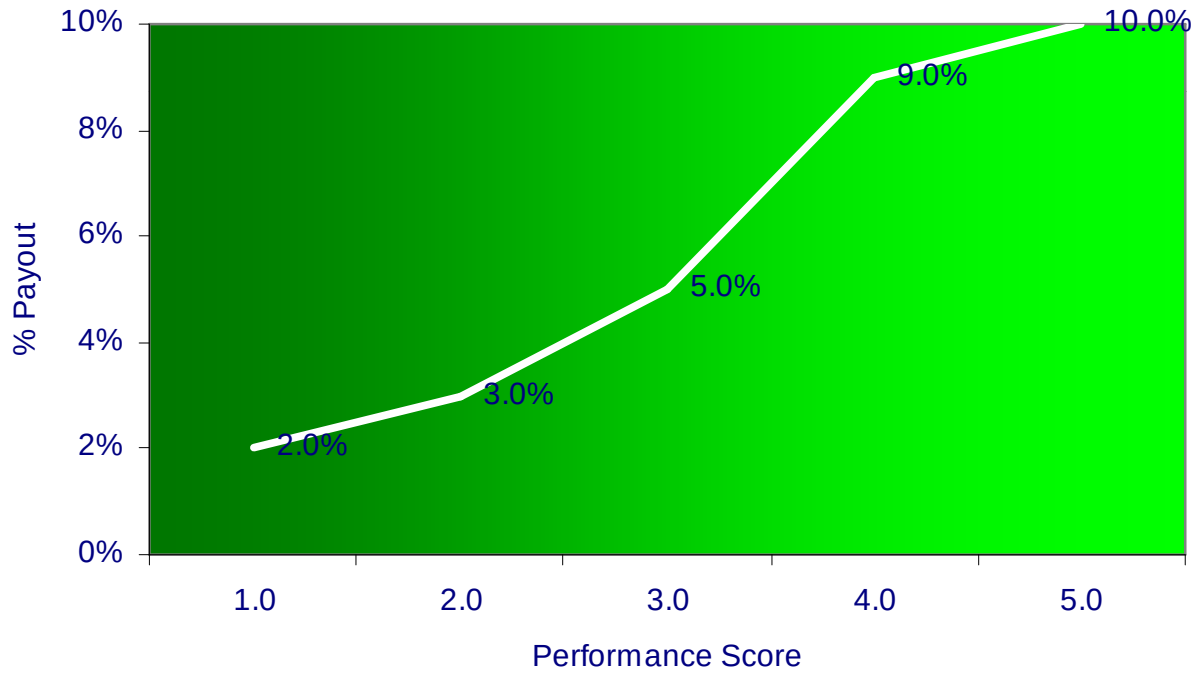
Patient Care Experiences

- Quality of clinical interactions
- Integration of care
- Access to care

Performance Achievement Model

- An aggregate performance score is calculated based on the provider's hospital and ambulatory quality to determine a percentage payout

Performance Payment Model



Example:	An aggregate score of 3.0 would yield a 5% payout, which if applied to a global payment of $200 PMPM would yield an additional $10 PMPM for the provider

Source: Robert Mandel, BCBSMA, "An Alternative Quality Contract" Presentation, 2008

BCBSMA Alternative Quality Contract

EXHIBIT 3

Groups Enrolled In The Blue Cross Blue Shield Of Massachusetts Alternative Quality Contract Through 2009

Group name	Description	No. of primary care physicians	No. of specialists	Typical physician group size[a]	No. of hospitals	Prior BCBSMA risk contract
Atrius Health	Multispecialty group	400	444	Large	0	Yes
Caritas Christi Network Services	PHO	276	843	Small	6	No
Hamden County IPA	IPA	72	0	Small	0	No
Lowell General PHO	PHO	80	200	Small	1	No
Mt. Auburn Cambridge IPA	IPA with aligned hospital	112	399	Small	1	Yes
New England Quality Care Alliance[b]	Hospital-owned IPA	369	982	Mixed	0	For some providers
Signature Healthcare	Integrated system	50	109	Large	1	No
South Shore PHO[c]	PHO	98	281	Small	1	No

SOURCE Data from Blue Cross Blue Shield of Massachusetts (BCBSMA). **NOTES** PHO is physician-hospital organization. IPA is independent practice association. [a]"Small" means that the majority of physicians practice in groups of five or fewer. "Large" means that the majority of physicians practice in groups of twenty-one or more. [b]Organization works with Tufts Medical Center. [c]The number of physicians was estimated by Blue Cross. Other groups reported numbers of physicians.

Source: Chernew et al, "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract'", *Health Affairs* 30, No. 1 (2011)

BCBSMA Alternative Quality Contract

- Technical support for providers
- Operation
  - Provider perspective
  - Enrollee perspective
- Experience to date
- Challenges

BCBSMA Alternative Quality Contract

- Differences from Medicare Shared Savings Program
  - Financial risk on providers
  - Assignment of members/beneficiaries
  - Negotiated payment rates and budgets

Other Payment Models

- What are private payors doing?
- ***What are the states doing?***

State Payment Reform Proposals

- Utah: Feb. 2011 Senate bill to replace Medicaid FFS with capitated risk-based system
- Vermont: Feb. 2011 legislation to phase in single-payor health care system
- Massachusetts: Feb. 2011 legislation to move away from FFS to alternative payment methods by 2015

Massachusetts Payment Reform – Context

- 2006: Passed health reform legislation with the goal of providing health insurance coverage to all Massachusetts residents
- 2008: Special Commission on HC Payment System
- 2010: Per capita spending on health care in Massachusetts is 15% higher than the rest of the nation and is projected to grow at 6% per year
- Why?
  - "Cost and quality problems in health care are either caused or exacerbated by the current FFS payment system."

Massachusetts Payment Reform – Proposed Legislation

- Legislation filed by Governor Patrick on February 17, 2011
  - Attempt to move the market from FFS to alternative payment methodologies, such as global payments
  - Encourage formation of ACOs, other integrated care organizations
- Timeline
  - Expand use of alternative payment methodologies, and reduce use of FFS, by the end of 2015
  - Establish minimum requirements for ACOs by June 1, 2012
  - All payors must develop alternative payment methodologies consistent with new regulations for the provision of integrated health care services to ACO patients and must offer these methodologies to compensate ACOs
  - Massachusetts Medicaid (MassHealth), other state-funded health programs must implement “alternative payment methodologies” and use integrated care organizations and ACOs “to the maximum extent feasible” by January 1, 2014

Massachusetts Payment Reform – Proposed Legislation

- "Alternative payment methodologies" defined to include:
  - Shared savings arrangements
  - Bundled payments
  - Episode-based payments
  - Global payments
- Definition of "alternative payment methodology" specifically excludes any payment based on a fee-for-service methodology

Massachusetts Payment Reform – Proposed Legislation

- Bill defines an "accountable care organization" as:
  - An entity comprised of provider groups
  - Operates as a single integrated organization
  - Accepts at least shared responsibility for the cost of care and
  - Accepts primary responsibility for the quality of care
  - For a specific population of patients cared for by the groups' clinicians
  - Operates consistent with principles of a patient centered medical home
  - Has a formal legal structure to receive and distribute savings
  - Complies with federal requirements for an ACO
- Providers may participate by contract or corporate structure
- Primary care providers may be network providers in only one ACO (unless regulations permit otherwise)

Massachusetts Payment Reform – Proposed Legislation

- ACOs must accept responsibility for the delivery, management, quality and cost of all "integrated health care services" for ACO members
  - Includes physician, inpatient acute care, day surgery, diagnostic services
- ACOs must have (directly or through contracts) certain functional capacities, including:
  - Clinical service coordination, management, and delivery functions, including ability to provide services in accordance with principles of a patient centered medical home. Primary care coordination and referral services must be provided internally and not through contracts.
  - Population management functions, including health information technology and data analysis tools to provide patient-specific provider data and management reports
  - Financial management capabilities, including management of claims processing and payment functions for ACO network providers

Massachusetts Payment Reform – Proposed Legislation

- ACOs' functional capacities (cont.):
  - Contract management capabilities, including network provider creation and management functions
  - Quality management functions
  - Patient and provider communications functions
  - Ability to provide behavioral health services
- ACO organizational structures must include consumer representatives
- ACO decision-making must reflect views of physicians, nurses, and other providers
- ACOs must accept as ACO patients all individuals, regardless of payor source or clinical profile

Massachusetts Payment Reform – Proposed Legislation

- Provider-payor risk sharing
  - Regulations will include parameters for clinical outcomes that are not within the clinician's control and for which ACOs and ACO network providers should not be responsible
  - Division of Insurance to develop methodologies for risk adjustments, risk corridors, outliers, and reinsurance to protect ACOs from assuming excess risk
  - All ACOs to be members of a new Massachusetts ACO Reinsurance Plan
  - If, by January 1, 2014, risk and other adjustments "are not adequately standardized and consistent" across all payors and such standardization is necessary to contain costs, improve quality, and maintain access to care, the Division of Insurance shall establish standard risk adjusters to be used by all payors.

Massachusetts Payment Reform – Proposed Legislation

- Provider-payor risk sharing (cont.)
  - Risk adjusters to accommodate the following factors (among others):
    - Cost experience and efficiencies
    - Acuity of patient case mix
    - Clinical health status and probability of illness
    - Socioeconomic case mix
    - Geographic location
    - Cultural and linguistic diversity in patient mix
    - Volume of underserved low-income patients
  - Division of Insurance may adopt financial oversight regulations which require reserves or include other requirements related to financial solvency for ACOs

Massachusetts Payment Reform – Proposed Legislation

- Other controls on prices and costs:
  - "No carrier shall enter, renew or extend a contract or agreement with any health care provider unless the rate of reimbursement in the new, renewed or extended contract increases by an amount less than or equal to an amount established by the commissioner" of the Division of Insurance.
  - "Any savings realized by the carrier from any reduction or mitigation in the growth of provider prices shall be incorporated in the premiums charged to insured health plan members."
  - "No carrier shall enter or renew a contract or agreement on or after January 1, 2012 with any hospital or inpatient facility with contract provisions that require the carrier to contract with other health care facilities that may be affiliated with that hospital or inpatient facility."
  - Development of "mechanisms to narrow the gap between payments to different providers for the same services."

Massachusetts Payment Reform – Proposed Legislation

- Compared to PPACA
- Compared to private payor models
  - Government regulation of
    - ACO composition, structure, operations
    - Quality measures
    - Payment methodologies
    - Provider payment rates, use of “savings” by payors
    - Reinsurance through government plan
  - Return of rate setting?
  - Pricing and contracting “transparency and information dissemination”

CLE Information

For CLE credit, complete and return Attorney Affirmation form within 48 hours.

CLE Code:

Email: professionaldevelopment@ropesgray.com

Fax: +1 617 235 9606

Note: A recording of today's presentation will be made available in a follow-up email.

Thank You For Participating

Time for Questions

- Please submit your questions now to ropesgrayllp@ropesgray.com
- **Note:** A recording of today's presentation will be made available.