Massachusetts Senate Health Reform Bill Imposes Fewer Requirements on Payors and Providers than House Bill

Following on the heels of the Health Care Quality Improvement and Cost Reduction Act of 2012 introduced by the Massachusetts House of Representatives on May 4, 2012 ("House Bill"), the Massachusetts Senate released its own version of health care reform on May 9, 2012, An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation ("Senate Bill").

Although the House Bill and the Senate Bill share features in common, the Senate Bill adopts a more voluntary approach to health care payment and delivery reform. Unlike the relatively prescriptive House Bill, the Senate Bill provides incentives for payors and providers to adopt alternative payment methodologies and other reforms, but generally does not expressly require payors and providers to do so.

This alert highlights some of the key provisions in the Senate Bill.

Health Care Quality and Finance Authority

The Senate Bill creates a new independent public entity, the Health Care Quality and Finance Authority ("Authority"), to oversee and implement many of the health care payment and delivery reforms in the Senate Bill. The Authority's role under the Senate Bill is similar to the role of the Division of Health Care Cost and Quality under the House Bill.

- The Authority will be led by a board of eleven members that includes government officials, health care finance and policy experts, and provider, consumer, business, and labor representatives.
- The Senate Bill requires the Authority to establish cost containment goals and promote payment and delivery reforms that reduce growth in health care costs and improve quality. To further this purpose, the Authority will produce best practices and standards for alternative payment methodologies to be used in programs funded by the Commonwealth. Private payors are permitted, but not required, to adopt these best practices and standards. The Authority will also support the evaluation and implementation of promising models for health care payment and delivery reform. Models that are successful in improving quality or reducing costs will be shared with providers and payors for their voluntary adoption.
- Each year, the Authority will establish a health care cost growth benchmark that is tied to the Commonwealth's general economic growth benchmark. This health care cost growth benchmark will serve as the Commonwealth's target for average growth in total health care expenditures for the coming year.
- Providers will be put on notice if their increases in health status adjusted total medical expense threaten the ability of the Commonwealth to meet the health care cost growth benchmark. Beginning in 2015, the Authority will help these providers establish performance improvement plans that outline how the providers will lower costs and improve efficiency. Although the Authority will review and approve the performance improvement plans, the Authority is not authorized to require a provider to include specific elements in its performance improvement plan. Providers who are subject to a performance improvement plan will be listed on the Authority's website.

Institute of Health Care Finance and Policy

Under the Senate Bill, the Division of Health Care Finance and Policy would be restructured to become an independent state agency called the Institute of Health Care Finance and Policy ("Institute"). Through the collection, examination, and publication of data, the Institute will monitor and report on the extent to which the Commonwealth's health care reforms are affecting the cost of health care and the landscape of the health care delivery system.

- The Institute will issue regulations that require providers and payors to uniformly report data. This data will allow the Institute to analyze the financial condition of acute care hospitals, health care premiums, plan benefits and cost-sharing levels, plan cost and utilization, types of provider payment methods used, and the adoption of alternative payment methodologies.
- The Institute will publish reports on an annual basis. Annual reports will identify and analyze various trends in the Commonwealth's health care system, including factors contributing to financial distress of acute care hospitals and cost trends among providers and public and private payors. These annual reports will publicly identify acute care hospitals in financial distress, including acute care hospitals the Institute deems to be in danger of closing or of discontinuing essential health services. The costs and cost trends published in the annual report will be compared with the health care cost growth benchmark established by the Authority.
- Providers will be required to notify the Institute before making any changes to their operations or governance structure. Notice of material changes (*e.g.*, affiliations between providers and carriers, hospital mergers and acquisitions, certain provider group mergers and acquisitions) must be filed at least sixty days in advance of the change.
- The Institute's other responsibilities include working with the Division of Insurance to develop a certification process for providers entering into alternative payment contracts and maintaining a publicly accessible website for health care consumers in order to improve patient choice and information transparency.

Accountable Care Organizations

The Senate Bill includes a number of provisions that encourage providers to form and to become certified as "Beacon ACOs" under the supervision of the Authority. In general, rather than prescribing requirements and standards for Beacon ACOs, the Senate Bill sets forth a list of requirements and standards that the Authority should "consider" implementing for Beacon ACOs.

- The Authority may certify a "provider organization" as a Beacon ACO if the provider organization can meet certain standards of quality, cost management, and patient protection. These standards are based in part on requirements developed by the Centers for Medicare & Medicaid Services for accountable care organizations participating in the Pioneer ACO Model. "Provider organization" is defined broadly to include any organization that contracts with payors for reimbursement for the provision of health care services, such as physician organizations, physician hospital organizations, independent practice associations, accountable care organizations, and provider networks.
- The Senate Bill suggests that, in order to achieve certification as a Beacon ACO, the provider organization should satisfy the following requirements, among others: (i) exist as an independent legal entity with a tax identification number, organized under the laws of Massachusetts; (ii) receive a majority of its revenues under alternative payment methodology arrangements; (iii) include patient and consumer representation on its governing body; and (iv) pledge that at least 50% of the provider

organization's primary care providers are certified as meaningful users of electronic health record technology. The Authority will develop additional standards and requirements for Beacon ACOs in consideration of the standards and requirements suggested by the Senate Bill.

- If MassHealth, the Group Insurance Commission, the Commonwealth Health Insurance Connector Authority, and other state funded insurance programs in the Commonwealth determine that accountable care organizations "offer opportunities for cost-effective and high quality care," these programs must prioritize Beacon ACOs as providers of publicly funded health care.

Other Key Provisions of the Senate Bill

- *Use of Alternative Payment Methodologies by State Funded Programs*: On or before July 1, 2014, the Group Insurance Commission, MassHealth, and other state funded programs must adopt alternative payment methodologies "to the maximum extent feasible."
- *Use of Alternative Payment Methodologies by Private Health Plans*: Unlike the House Bill, the Senate Bill does not require private health plans to institute alternative payment methodologies.
- *Medicare Waiver*: There is no provision in the Senate Bill, as there is in the House Bill, directing the Authority or any other individual or entity to seek a waiver from Medicare to allow the use of alternative payment methodologies or accountable care organizations for Medicare beneficiaries.
- *Attorney General Oversight*: The Attorney General is directed to monitor the health care market and take action to prevent excess provider consolidation, provider collusion, and other related anti-competitive actions by providers.
- *Special Commission to Review Provider Prices*: The Senate Bill creates a special commission to analyze variation among the prices paid to different providers and to recommend actions to reduce this variation.
- *Establishment of Funds*: The Senate Bill establishes a number of funds to support its initiatives, including (i) the Health Care Workforce Transformation Fund, which will provide funding for loan repayment programs, career ladder programs, and other similar initiatives supporting health care industry employees; (ii) the Prevention and Wellness Trust Fund, which will provide funding for efforts to maintain health care expenses below the health care cost growth benchmark set by the Authority, to reduce preventable illness, and to support wellness, among other efforts; (iii) the Health Safety Net Trust Fund, which replaces the current uncompensated care pool; (iv) the Healthcare Payment Reform Fund, which will support the Authority's initiatives and support health care payment and service innovation; and (v) the e-Health Institute Fund, which will support the activities of the Massachusetts e-Health Institute (described below) and the Health Information Technology Council.
- *Surcharge on Provider Payments*: A principal means by which the Senate Bill proposes to raise funds for its various initiatives is by assessing a surcharge on payments made to acute hospitals and ambulatory surgical centers by certain payors. The surcharge will not apply to payments from Medicare, MassHealth, or other governmental assistance programs. The revenue raised by the surcharge payments will be split equally between the Prevention and Wellness Trust Fund and the e-Health Institute Fund.

- *Health Information Technology*: The Massachusetts e-Health Institute will be established and charged with furthering the adoption of health information technology in the Commonwealth, including the use of a statewide health information exchange.
- *Determination of Need*: The Senate Bill strengthens determination of need requirements for substantial capital expenditures and substantial changes in services by allowing fines to be assessed for violation of applicable determination of need requirements. Fines may be as high as three times the expenditure amount or three times the value of the service. The Senate Bill also authorizes the Department of Public Health to require applicants to provide an independent cost-analysis to ensure that the application does not conflict with the Authority's cost-cutting efforts.
- *Patient Choice of Physician Assistants*: The Senate Bill will require payors to allow patients to choose physician assistants as their primary care providers.
- *Medical Malpractice*: The Senate Bill establishes a 182 day cooling-off period before a medical malpractice action can be commenced and deems provider apologies and similar statements of regret inadmissible as evidence of liability in a judicial or administrative proceeding. The Senate Bill also caps liability for medical malpractice claims against non-profit charities providing health care at $100,000.

A copy of the Senate Bill can be found here. The Massachusetts Senate will begin debate on the Senate Bill on May 15, 2012.

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If you have any questions regarding the Senate Bill or implementation of other areas of health reform, please see our Health Reform Resource Center or contact your regular Ropes & Gray lawyer.