Health Care Reform Advisory: Massachusetts Takes the Next Step: An Interim Step Toward Payment Reform?

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Massachusetts continues to be in the vanguard of reform in the American health care system. In 2006, it enacted legislation to extend coverage to the uninsured, establishing a model many of the features of which found their way into the federal health care reform legislation enacted in March 2010. Recognizing the importance of constraining cost and enhancing quality in the context of increased access, in 2008 Massachusetts adopted wide-ranging legislation that, among other elements, sought to examine provider and insurer costs and payments in order to set the groundwork for potentially comprehensive reform of the payment system ("Chapter 305" of the Acts of 2008). The third step of this development has now occurred, in August 2010, with the enactment of Chapter 288 of the Acts of 2010 ("Chapter 288"). This legislation has been explicitly presented as an interim measure—some of its provisions have a statutorily prescribed short shelf life—to provide premium relief for small business through regulation of small group and individual policies (a combined market in Massachusetts), preparatory to more comprehensive reforms anticipated to be considered in the 2011 legislative session.

Chapter 288, along with Chapter 305 and what may emerge in 2011, represent efforts to address cost and quality concerns arising in conjunction with, and as a result of, the extension of insurance coverage to previously uninsured individuals. They may, therefore, provide some guidance to what may happen at the federal level and in many of the individual states in response to the increase in access to care afforded by federal health care reform.

While the principal focus of Chapter 288 is not on health care providers, it contains a number of features that are explicitly and implicitly relevant to providers. This advisory focuses only on those elements.

The key provider-related components of the legislation include an effort to build on the work of the Special Commission on Payment Reform established under Chapter 305 and further work, in the form of expanded reporting requirements, aimed at gathering information on payer payments to providers (including relative prices) and on provider costs. It additionally calls for the development of a uniform reporting mechanism for quality measures. Chapter 288 also displays particular solicitude for community hospitals, considering their need for improved access to capital and the competitive threats they face in their local markets. Finally, because of its principal focus on insurance regulation and the formation of limited or tiered provider networks by carriers (a return in some respects to the managed care contracting strategies of the early 1990s), the legislation is likely to put more pressure on provider payments.

Each of these elements is described below.

Bundled Payments

The legislation directs the Division of Health Care Finance and Policy (DHFCP) to initiate activities to foster adoption by payers and providers of bundled payment arrangements in lieu of fee-for-service. DHFCP is to provide support services for this purpose, including technical assistance, research on bundled payment models in use elsewhere, and an examination of federal programs promoting such a payment methodology. The legislation sets as an objective for DHCFP—but not as requirement—the implementation of pilot bundled payment programs, for at least two acute conditions or procedures by January 1, 2011, and for at least two chronic conditions by July 1, 2011. While a pale reflection of the robust mandate that Chapter 305 gave to the Payment Reform Commission and a very modest element of that Commission's recommendations issued in July 2009, this direction does evidence the Legislature's continuing interest in promoting alternative payment mechanisms.

Special Commission on Provider Price Reform

Chapter 288 provides for a special commission on provider price reform that is tasked with investigating "the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers."

The commission is directed to examine a number of issues, including:

- the variation in costs of providers for services of comparable acuity, quality and complexity;
- the correlation between price paid to providers and (i) the quality of care, (ii) the acuity of the patient population, (iii) the provider's payer mix, (iv) the provision of unique services, including specialty teaching services and community services, and (v) operational costs, including labor costs;
- the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and
- policies to promote the use of providers with low health status adjusted total medical expenses.

The Secretary for Administration and Finance and the Commissioner of DHCFP are to co-chair the special commission, with the remaining members consisting of: the executive director of the Group Insurance Commission, one appointee by the Senate President and one by the Speaker of the House, and five appointees of the Governor, one each representing the Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, the Massachusetts Hospital Association and the Massachusetts Medical Society, and one health economist or expert in the area of payment methodologies.

The commission is to consult widely with interested stakeholders. Its recommendations must consider the July 2009 recommendations of the Special Commission on the Payment System established by Chapter 305, and must be consistent with those recommendations. This special commission's report and recommendations are to be filed by February 1, 2011.

Reporting and Metrics Associated with Cost, Payment and Quality

Chapter 288 extends DHFCP's existing right to receive data relating to provider costs and payments by expanding its authority to require submission of information by payers. Under the new legislation, DHCFP is to require both private and public payers to report "health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology" and relative prices paid to every institutional provider type in the payer's network, "by type of provider and calculated according to a uniform methodology," and, in addition, private payers to report hospital inpatient and outpatient costs, including direct and indirect costs, again according to a uniform methodology.

Health Status Adjusted Total Medical Expenses

"Health status adjusted total medical expenses" is defined as "the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status, and expressed on a per member per month basis…" By October 1, 2010, DHCFP, in consultation with the Insurance Division, is to issue regulations establishing a uniform methodology for calculating and reporting health status adjusted total medical expenses. The uniform methodology is to apply to a uniform list of provider groups and their constituent local practice groups for each zip code in the Commonwealth. The legislation established the minimum requirements associated with the uniform methodology, which include but are by no means limited to a uniform method for calculating all medical expenses based on allowed claims and all non-claims related payments, including supplemental payments and payments for pay-for-performance, care management, infrastructure, grants, surplus payments, government shortfall payments, etc.

Relative Prices

"Relative prices" is defined as "the contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claim related payments and expressed in the aggregate relative to the payer's network-wide average amount paid to providers…" By October 1, 2010, DHCFP, in consultation with the Insurance Division, is to issue regulations establishing a uniform methodology for calculating and reporting relative prices. The uniform methodology must, at a minimum, specify a method for basing the calculation on a uniform mix of products and services by payer that is case mix neutral, and is to include in the calculation all non-claims related payments; permit relative price in the aggregate for all physician groups whose price equals the payer's standard fee schedule rates; and designate and annually update the physician group for which the payers are to report relative prices.

Hospital Costs

DHCFP is to promulgate regulations by October 1, 2010, containing a uniform methodology for calculating and reporting inpatient and outpatient hospital costs, with the intent of having hospitals report cost and cost trend information on a uniform basis. Before DHCFP issues these regulations, it is to consult with the Insurance Division, the Group Insurance Commission, CMS, the Attorney General and representatives of the Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, the Massachusetts Health Information Management Association and the Massachusetts Health Data Consortium.

Standard Set of Health Care Quality Measures

In addition to the work that DHFCP is to do on cost and pricing information, the Department of Public Health is to pursue the development of a uniform reporting mechanism for a standard set of health care quality measures for each health care facility, medical group or provider group in Massachusetts. Chapter 288 establishes an advisory committee for this purpose, consisting of State agencies, providers and payers; and sets out the minimum quality measures to be included in this standard set.

Note that, in Chapter 288's provisions relating to payer regulation, it states that carriers are to "prominently promote providers based on quality performance, as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices."

Community Hospitals

Chapter 288 sets in motion various studies of community hospitals and a new funding source through the Massachusetts Health and Educational Facilities Authority (HEFA).[1]

The legislation authorizes HEFA, effective October 1, 2010, to establish special funds, to be known as Community Hospital and Community Health Center Capital Reserve Funds, for the benefit of non-profit community hospitals and non-profit community health centers. For purposes of this authorization, a community hospital is defined as one that has a ratio of residents to inpatient beds of no more than 0.25. Amounts in a Fund are to be used for debt service payments on loans secured by payment of principal on HEFA bonds issued for the benefit of one of the hospitals or community health centers. Loans to be made with proceeds of bonds secured by the Funds require the approval of the Secretary of Health and Human Services, with regard to the project to be financed, and of the Secretary of Administration and Finance, with respect to the terms of the issuance of the bonds.

A term of approval is the borrower's agreement to reimburse the Commonwealth in the event it is obliged to advance amounts to the Fund to assure that the Fund has sufficient resources to pay the principal and interest maturing and coming due in a succeeding calendar year in the event of a default by borrower. If it appears that the borrower will be in default, HEFA may notify other agencies of State government with regulatory or other control over the borrower's operations.

The agencies may then undertake reviews to determine what they can do to assist the borrower and assure its continued prudent operation and provision of services. But default or potential default under the terms of these borrowings can be quite severe since the legislation allows the Commonwealth to tap into all funds otherwise owed the borrower by or through agencies of the Commonwealth, including third-party payments under contracts entered into by the Group Insurance Commission, the Connector and MassHealth.

The legislation also establishes a special commission to examine the capital needs of community hospitals with regard to technology, the adequacy of their facilities and their ability to meet the "health care needs of the general population" in the next decade. The commission is tasked to evaluate the role of public programs, payments and regulations in supporting capital accumulation. It has an unusually large membership for a special commission, perhaps indicating the broad impact of community hospitals and the broad concern about their well-being. The commission is to include the Secretaries of Health and Human Services and Administration and Finance; the Commissioner of Public Health; representatives of the Massachusetts Council of Community Hospitals, Massachusetts Hospital Association, Associated Industries of Massachusetts and Massachusetts Business Roundtable; the CEOs of HEFA and the Massachusetts Development Finance Agency; the chairs of the House and Senate Committees on Ways and Means and of the Joint Committee on Health Care Financing; a member of each of the House and Senate to be appointed by the minority leader of each; a "chief elected local official" with a community hospital located in that community to be appointed by the Governor; and individuals to be appointed by the Governor who are knowledgeable about demographic trends and hospital utilization and about hospital finance and construction. The commission's report is due by December 31, 2011.

DPH is also directed to conduct a study of community hospitals, with its focus being on the outmigration of patients and related trends, "including but not limited to an examination of observed effects and their potential causes with respect to":

- the impact on individual community hospitals caused by opening new services by other providers within the community hospital's primary service area;
- recruitment and retention of personnel; and
- changes in payer mix.

DPH's report is due by December 31, 2010.

Insurance Premium Regulation

Building on emergency regulations initially adopted by the Insurance Division in February 2011, Chapter 288 empowers the Commissioner of Insurance (the "Commissioner") to require that, effective October 1, 2010, carriers offering small group insurance plans are to file for any changes in small group product base rates or small group rating factors at least 90 days in advance of the proposed effective date of the change. The Commissioner is directed to disapprove any such change if, with respect to a base rate, the change is "excessive, inadequate or unreasonable in relation to the benefits charged," and if with respect to rating factors, the change is "discriminatory or not actuarially sound."

Further, for the period from October 1, 2010, through September 30, 2012, a filing regarding a base rate change is deemed to be "presumptively" disapproved as "excessive" if (a) the administrative expense loading factor of the base rate, not including taxes and assessments, is to increase by more than the most recent calendar year's percentage increase in the New England Medical CPI; or (b) if the carrier's reported contribution to surplus exceeds 1.9% (2.5% if the carrier's risk-based capital ratio falls below 300% for the most recently reported four quarters); or (c) if the aggregate medical loss ratio (MLR) for all products the carrier offers to small groups is less than 88% (that percentage rises to 90% effective October 1, 2011). Note that if a filing would otherwise be presumptively disapproved based on not meeting the 88%/90% MLR standard, it would not be presumptively disapproved if the carrier's aggregate MLR for all of its small group plans is not less than 1% greater than what the carrier's equivalent MLR had been 12 months prior to the filing under review. That is, the filing is not presumptively disapproved if the only basis would have been failure to meet the 88%/90% MLR test but the carrier seems to be making progress toward increasing its overall MLR up to the required minimum. However, as was noted above, the "presumptive disapproval" provisions are in the statute only for a two-year period. This "savings clause" suggests, then, an expectation that the control on MLR—a matter also addressed in the federal legislation—will be continued if more comprehensive legislation is adopted in 2011 or 2012.

Where there is presumptive disapproval based on the MLR tests, the carrier is required to refund the excess premium to bring its MLR into line with the required minimum. Further, the Commissioner is to conduct a public hearing on the presumptive disapproval (not merely at the request of the carrier—although presumably the carrier could refile an approvable rate to avoid the hearing), and the Attorney General may intervene and seek more information that she considers necessary to assure compliance. Following final disapproval, the carrier has a right of appeal within the Insurance Division.

Limited or Tiered Networks

While not undertaking any direct regulation of providers, Chapter 288 does address the ability of carriers to promote limited or tiered networks. It in fact goes beyond encouraging to mandating that, as of January 1, 2011, any carrier offering a provider network and having 5,000 or more enrollees in plans sold to small businesses or individuals must offer all small businesses and individuals in at least one geographic area at least one plan that contains either a limited network or a tiered network.

To seek to achieve the savings from such a benefit design, the legislation requires, in addition, that the base premium for a limited or tiered network product must be at least 12% lower than the base premium for the carrier's "most actuarially similar" plan that does not include such a network. Note that, while there is some ambiguity in the statutory language, it appears that this requirement, and the requirements listed below, apply to all limited or tiered network plans offered by a carrier to a small business or individual, not just the one that is required to satisfy the statutory mandate.

There are additional requirements applicable to limited or tiered network plans, as follows:

- Variations among member cost-share obligations in a tiered plan must be "reasonable in relation to the premium charged," as long as the carrier provides "adequate access" to covered services at lower patient cost share levels.
- The Commissioner is to determine "network adequacy" for each type of network based on the availability of sufficient network providers in the overall network.
- In determining network adequacy, the Commissioner is to consider factors that include location of participating providers, the employers or members that enroll in the plan, the range of services provided by network providers in the plan, and any plan benefits that "recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network."
- Carriers may determine only once a year which providers are to be in their limited or tiered network, but may at any time reclassify providers among tiers for a tiered network or add new providers to a limited network.

Chapter 288 contains provisions that are intended to take effect subsequent to January 1, 2011, that address how the 12% differential referenced above may be achieved.[2]

The differential can be achieved by means that include, as examples:

- Excluding providers with "similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices"; or
- Increasing member cost share for members who utilize providers for non-emergency services with "similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices."

Chapter 288 also prohibits carriers from entering into contracts with providers that:

- provide a guaranteed right of participation in a limited or tiered network;
- require the carrier to place all members of a provider group in the same tier of a tiered network plan;
- require a carrier to include all members of a provider group in a limited network on an all-or-nothing basis;
- require a provider to participate in a new limited or tiered network product without allowing the provider to have an opt-out right with respect to such product; or
- require or permit the carrier or provider to alter or terminate a contract in order to achieve parity with an agreement with other carriers or providers or based on a decision to introduce or modify a limited or tiered network product.

"Special Sessions" to be Conducted by the Insurance Division

The Insurance Division recently announced that it would hold a series of "special sessions" to discuss the implementation of certain sections of Chapter 288. The Division apparently intends not to structure these as traditional public hearings but more as open discussions at which members of the public will be able not only to submit written comments but also to participate in

a general discussion regarding implementation, including with respect to the provisions relating to limited or tiered networks. These hearings are scheduled for various dates in September and October 2010.See information on these schedules posted on the Division's website at www.mass.gov/Eoca/docs/doi/Legal_Hearings/special_sessions.pdf.

Conclusion

While not as comprehensive as Chapter 305, Chapter 288 does build upon some of the concepts in the earlier act. It expands reporting requirements to allow for what presumably will be a better understanding of payer payment policies and underlying provider costs, particularly hospital costs; promotes more standardization in measuring quality; moves toward more rigorous regulation of small group premiums to address the most economically and politically evident source of heath care cost concern, the premiums payable by small business; and encourages the use of limited or tiered networks as an important component of offering less costly insurance products. Chapter 288 also builds on the work of the Special Commission on the Payment System established under Chapter 305, without yet mandating changes in basic fee-for-service payment methodologies. Finally, it addresses concerns that have arisen since enactment of Chapter 305, including those raised by the Attorney General relating to relative pricing by payers under provider contracts and those relating to the status of community hospitals. Key regulatory provisions of Chapter 288 have defined sunsets, reflecting their interim nature. Other provisions continue Chapter 305's approach of putting together the building blocks of what may be expected to be efforts at much more comprehensive and permanent reform aimed at attacking underlying costs of care and reforming the provider payment system. For providers, it is time to buckle up the seat belts and see what comes next in this evolving world of health care reform.

Endnotes

[1] Note that in an enactment occurring almost simultaneously with passage of Chapter 288, HEFA and the Massachusetts Development Finance Agency are to be consolidated.

[2] Through what appears to be a drafting error, while the basic limited or tiered network requirements described in the text are slated to go into effect on January 1, 2011, the description of how the 12% may be achieved, as contained in this paragraph of the text, has an effective date of August 10, 2010, the date of Chapter 288's enactment, or a date in advance of the imposition of the 12% differential requirement. Presumably this will be corrected by a technical amendment.

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