Massachusetts House Lawmakers Propose Overhaul to Health Care Payment and Delivery System

On May 4, 2012, lawmakers in the Massachusetts House of Representatives introduced a bill entitled *Health Care Quality Improvement and Cost Reduction Act of 2012* ("the Act") that would overhaul the health care payment and delivery system in Massachusetts.

The Act offers an alternative to the health reform legislation announced by Governor Deval Patrick on February 17, 2011. Similar to the Governor's legislation, the Act seeks to control rising health care costs in part by transitioning the Commonwealth to a health care payment and delivery system in which providers organized as accountable care organizations ("ACOs") receive global payments, bundled payments, and other "alternative payment methodologies." A new Division of Health Care Cost and Quality ("Division") will oversee the transition and manage the new health care payment and delivery system. This alert highlights some of the key provisions in the Act.

Division of Health Care Cost and Quality

The Act creates the Division as an independent public entity that is charged with overseeing the health care quality and cost reforms.

- A board of nine members, including government officials, health care professionals, health care administrators, and other experts in the field, will lead the Division.
- The Division's primary functions will include promoting the formation and overseeing the certification of ACOs and adopting appropriate regulations for ACOs; overseeing the development of patient center medical homes; requiring providers to adopt alternative payment methodologies and delivery systems; and overseeing providers' use of standard quality measures. Alternative payment methodologies are defined to include global payments, bundled payments for acute care episodes and chronic diseases, and shared savings arrangements and to exclude fee-for-service payments.
- The Act requires the Division to assess a surcharge on providers whose "contracted average price" exceeds 120% of the "median contracted price" in the Commonwealth. The surcharge will equal 10% of the difference between the provider's contracted average price and the Commonwealth's median contracted price multiplied by the units of services provided. The funds collected from the surcharge will be paid into a trust fund for distressed hospitals.
- The Division will also assess a one-time surcharge on most acute hospitals, ambulatory surgery centers, and payors. This surcharge will also be paid into the distressed hospital trust fund.
- The Division will collect and publish data concerning the cost of health insurance within the Commonwealth, hold annual hearings, and provide recommendations to reduce costs, improve patient care, and improve access to health care services.
- The Division's health care cost oversight responsibilities will include setting a target per capita medical expense for each calendar year. If the actual per capita medical expense of providers in the Commonwealth exceeds the target per capita medical expense, the Division can take actions to limit the actual per capita medical expense, including making changes to alternative payment methodologies, requiring providers and payers to implement a corrective action plan or reopen contracts that contribute to excessive spending, or propose additional legislation to combat spending.

ACOs

The Act includes a number of requirements regarding the formation and structure of ACOs in the Commonwealth. The Act's requirements for ACOs are generally consistent with the requirements for ACOs participating in the Medicare Shared Savings Program (implemented under the Patient Protection and Affordable Care Act of 2010).

- The Act defines ACO broadly as an entity comprised of health care providers that accept shared risk for the cost and quality of patient well-being. Providers that integrate or contract with an ACO are considered "ACO participants."
- The principle requirements for the formation of an ACO include the submission of a collaborative care plan; the establishment of a governance body, executive officer, and a medical director; the acceptance of compensation by an alternative payment methodology; the adoption of interoperable electronic health information technology; coverage for between 15,000 and 400,000 covered lives; and holding adequate reserves to enter into risk arrangements.
- There are several patient protection mechanisms in place for ACOs, including a requirement to report pricing information to consumers. Patients will generally have the right to appeal decisions made by their ACO providers and the right to a second opinion. ACOs will be liable for up to $500,000 for medical malpractice claims made against any of their constituent participants based on actions taken on behalf of the ACO.

Other Key Provisions of the Act

The Act would implement a number of other changes that seek to reduce the cost and improve the quality of health care in the Commonwealth.

- *Private Health Plan Use of Alternative Payment Methodologies*: Private health plans will generally be required to implement alternative payment methodologies "to the maximum extent feasible" by January 1, 2015.
- *Medicare Waiver*: The Executive Office of Health and Human Services is directed to seek a waiver from Medicare to allow alternative payment methodologies, integrated care organizations, and ACOs for Medicare beneficiaries.
- *Medicaid Use of ACOs and Patient-Centered Medical Homes*: The Act encourages the use of ACOs within the state Medicaid program, setting a goal that by January 1, 2015, 80% of Medicaid payments are under the ACO or patient-centered medical home health care delivery model. Medicaid fee-for-service reimbursement will be permitted only if part of a shared savings payment program.
- *Medicaid Payment Increase*: Medicaid payments to acute care hospitals and primary care providers will increase by 2% starting July 1, 2013, but only if the hospital or provider demonstrates a "significant transition to the use" of alternative payment methodologies. The Division will establish regulations to govern what constitutes a significant use.
- *Fraud and Abuse Waivers*: By August 15, 2012, the Division will seek waivers of the requirements under the federal Stark law and anti-kickback statute to allow for the transition to alternative payment methodologies, risk sharing among providers, and the formation of ACOs.
- *Prohibition on Joint Contracting*: Public and private payers will generally be required to negotiate separate contracts with hospitals and clinics that are part of the same system. Each hospital and clinic within

the system must maintain a separate negotiating team. A firewall mechanism must be in place to prevent information sharing between negotiation teams.

- *Determination of Need*: A determination of need will be required before the acquisition of a hospital. The determination may include considerations such as financial capacity of the prospective owner, the affect of the acquisition on the availability or accessibility of health care services, and the prospective owner's plan for provision of community benefits and essential health services.
- *Attorney General Oversight*: During the transition of the health care payment and delivery system, the Attorney General will monitor the size and composition of ACOs, consolidation by providers, payer contracts, and patients' choice of providers and ACOs. The Attorney General will have the power, in consultation with the Division, to take action to prevent excess consolidation or collusion of providers, ACOs or payers and to prevent other anti-competitive behavior.
- *Health Information Technology*: A Health Information Technology Council will advise the Division on health information technology in the Commonwealth, including the creation of a statewide electronic health information exchange by January 1, 2017.
- *Physician Assistants*: The Act provides for patient choice of and insurance coverage for physician assistant services.
- *Nurse Overtime*: The Act prohibits hospitals from requiring nurses to work mandatory overtime except in emergency situations where the safety of the patient requires such overtime and there is no reasonable alternative.
- *Patient Disclosure*: A health care provider must, upon request by a patient or prospective patient, disclose the actual or estimated charges for a proposed admission, procedure, or service.
- *Loan Repayment*: The Act establishes a loan repayment program for health professionals that serve in medically underserved areas for at least two years. The loan repayment program will be administered by a Health Care Workforce Center established within the Division.
- *Medical Malpractice*: An apology or similar statement made by a health care provider will be inadmissible as evidence in a judicial or administrate proceeding. Also, a 180 day cooling-off period will be established to allow for settlement negotiations.

A copy of the Act can be found here. The Act has been referred to the House Committee on Ways and Means where it will be further refined during the coming weeks before debate by the full House of Representatives. The Massachusetts Senate released its own proposal for health care payment and delivery reform on May 9, 2012. A Ropes & Gray alert on the Senate proposal is forthcoming.

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