Proposed Massachusetts Legislation Aims to Contain Health Care Costs: Highlights for Providers

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Massachusetts senators recently proposed a health care reform bill intended to reform the Commonwealth's health care system by controlling costs while improving outcomes. A corresponding report [1] issued by the Senate Working Group on Health Care Cost Containment and Reform (the Working Group) summarizes the recommended legislation, emphasizing the need to ensure a health care system "that provides the right care at the right place for a fair price," with a focus on increasing access to preventative care, reducing unnecessary hospital visits, protecting consumers from excessive costs, and continuing Massachusetts' commitment to supporting innovative care delivery and payment models. The proposed bill is particularly notable for its focus on health care costs and the health care delivery system rather than the regulation of health insurance markets.

History of Health Reform in Massachusetts

Massachusetts has long been a leader in health care reform. In 2006, Massachusetts passed a comprehensive health reform law designed to provide near-universal health insurance coverage, which later served as a model for the Patient Protection and Affordable Care Act (ACA).[2] Among other things, that legislation created an exchange, which served as a health insurance marketplace allowing individuals to compare policies and purchase coverage, and established subsidies to make coverage more affordable for low-income individuals. Within a year the non-elderly uninsured rate in Massachusetts dropped 5.4 percentage points from 10.9 percent in 2006 to 5.5 percent.[3]

In 2012, Massachusetts passed health reform legislation[4] designed to keep health care spending growth in line with the overall growth of the economy. The legislation did this by establishing a health care cost growth benchmark and also established the Massachusetts Health Policy Commission (HPC), an independent state agency which develops policies to reduce health care cost growth and improve patient care.

Despite these efforts, Massachusetts health care spending exceeded the established health care cost benchmark of 3.6 percent between 2013 and 2015, and growth in health care costs continues to outpace the Commonwealth's overall economy.[5] In addition, a comparison of the MassHealth budget between FY 2013 and FY 2018 shows an increase of 42 percent, and the HPC estimated that in 2015 there was $12.1 billion to $22.4 billion in wasteful health

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care spending, due to overtreatment, failure of care coordination, administrative complexity, and other causes.[6]

The Working Group formed in the fall of 2016 to explore strategies used in other states to control health care costs while improving outcomes. The group also identified potential approaches to implement in Massachusetts, resulting in the proposed legislation. States of emphasis included Minnesota, Oregon, Washington, Texas, Maryland and Vermont. A wide-ranging group of Massachusetts health care stakeholders also participated in a series of roundtable meetings to inform this effort in August 2017.

Key Components of the Proposed Legislation

In its report, the Working Group set forth the following goals: 1) Reduce hospital readmissions and hospital emergency department use; 2) Reduce the use of institutional post-acute settings; 3) Reduce growth in prescription drug spending; 4) Reform the commercial market to increase accountability for excessive spending, reduce unexpected costs, mitigate provider price variation, and increase adoption of alternative payment models; 5) Reform MassHealth to include promotion of employer-sponsored insurance; and 6) Implement other best practices and transparency reforms, including stakeholder access to health care price information.

The proposed legislation attempts to meet these goals by including wide-ranging, system-wide reform. A selection of key components of the proposed legislation are identified below.

Target hospital rate distribution: The legislation would establish a minimum reimbursement rate for hospital services at 90% of the statewide commercial relative price in the prior calendar year; this would be known as the "target hospital rate distribution." Payors would be required to annually certify that their reimbursement rates comply with the target hospital rate distribution, and if any hospital receives a rate increase, all contracting hospitals must receive an increase (although the proposed legislation does not require increases to be proportionate). The goal of these provisions is to address pricing variation issues between hospitals. A hospital alignment and review council (the **Council**)[7] would have the authority to assess penalties against payors for failing to meet the certification requirements.

Growth in hospital spending: At the same time, the legislation would instruct the Council to establish a "target growth in hospital spending," defined as a percentage growth in total commercial spending on hospital inpatient and outpatient services equal to the "market basket percentage increase" pursuant to 42 U.S.C. Section 1395ww. The Council would also have the authority to assess penalties against the three hospitals whose spending most outpaced the established target growth in hospital spending, if hospital spending exceeds the target growth in any given year. Further, if the Council determines that the target hospital rate distribution or target growth in hospital spending is not met in any given year, it may amend the definitions of those terms.

Readmissions reduction benchmark: The HPC would establish a readmissions reduction benchmark, and have the authority to require providers with excessive readmissions to develop and implement a performance improvement plan. The HPC could also impose a civil penalty against providers with excessive readmissions under certain circumstances.

Out-of-network rates established: The legislation establishes out-of-network rates for emergency and non-emergency services and such payments would constitute payment in full to out-of-network providers. For the sake of clarity, the legislation provides that these provisions would not require payment for non-emergency health care services if the insured beneficiary had a reasonable opportunity to have the services performed by an in-network provider.

Facility fees: Hospitals, health systems, and hospital-based facilities would not be permitted to bill or collect a facility fee for services using certain CPT codes. Notably, further restrictions could be imposed to prohibit a hospital, health system, or hospital-based facility from charging, billing or collecting a facility fee, including limitations on physical locations; these restrictions could also be based on whether the facility is on a "campus" (defined to align with the definition under the CMS provider-based rules). Other provider-based facility requirements similar to those required by CMS are included in the legislation (*e.g.*, notification of the separate facility fee and signage to make clear that the facility is hospital-based).

Use of alternative payment methodologies: The proposed legislation builds upon Chapter 224 of the Acts of 2012, which encouraged payers in Massachusetts to adopt "alternative payment methodologies" or APMs, meaning methods of payment not based solely on fee-for-service reimbursement that incorporate quality metrics into the reimbursement determination process. This concept also appears in recent Medicare regulations, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under this proposed legislation, all commercial insurers, hospital service corporations, medical service corporations, and health maintenance organizations would be required to increasingly reimburse for health care services based on alternative payment methodologies, as follows: 1) By July 1, 2019, reimbursement with alternative payment methodologies would be required for at least 50% of enrollees; for 25% of enrollees, providers must bear downside risk at a level no less than the amount required for a MassHealth ACO; 2) By July 1, 2022, the respective percentages would increase to 65% and 45%; and 3) By July 1, 2025, the respective percentages would increase to 85% and 65%. This transition from the fee-for-service payment methodology toward value-based payment is consistent with national trends.

Expanding access to telemedicine: Under the proposed legislation, MassHealth and its contracted plans may provide coverage for telemedicine services, meaning the use of "interactive or other electronic media for a diagnosis, consultation or treatment of a patient's physical or mental health." The legislation would also provide parameters for private payor coverage for telemedicine (*e.g.*, a provider could not be required to document a barrier to an in-person visit). Physicians could obtain proxy credentialing and privileging for telemedicine services with other health care providers. The Massachusetts Medical Board would promulgate regulations to address topics such as medication prescription, establishment of a patient-provider relationship, consumer protections, and compliance with appropriate standards of care. Such a move would bring Massachusetts more in line with other states, such as Texas, where the state medical board's rules govern the provision of services via telemedicine.

Creation of post-acute care referral program: The Executive Office of Health and Human Services (EOHHS), in collaboration with the Executive Office of Elder Affairs, the Office of Medicaid, and the Department of Public Health, would develop a post-acute care referral program to assist providers and consumers in determining appropriate post-acute care setting and coordinating patient care.

Passive enrollment into MassHealth's Senior Care Options program: The EOHHS would seek a federal waiver to enroll eligible individuals into MassHealth's Senior Care Options program, a comprehensive health plan that combines health services with social support services through its provider network, unless an individual opts out. A number of other provisions focus on Medicaid reform, including the option to seek federal approval to permit MassHealth beneficiaries to access urgent care facilities for emergency services without referral or prior authorization, and required reporting on the role of long term services and supports within MassHealth and the MassHealth ACO program.

Aligned quality measures: The legislation aligns measures of provider quality and performance to ensure consistency in the use of quality measures in payor contracts. Private payors would be required to use these quality measures and disclose the methodology used for an in-network provider's tier placement.

Encouragement of employer-sponsored insurance by small businesses: A small group incentive program would provide subsidies and technical assistance to encourage small businesses to offer health insurance to employees. In addition, individuals or employers may have the option to purchase an expanded MassHealth plan.

Oversight of pharmaceutical companies: Pharmaceutical manufacturers would be required to submit to oversight and required to submit pricing information. A task force would be formed to investigate joining a multi-state prescription drug bulk purchase consortium.

Expansion of digital health innovation: The legislation would encourage the creation and adoption of digital health in the health care and technology community to drive economic growth and improve health care outcomes and efficiencies.

Other provisions include, without limitation, the establishment of a licensure process for behavioral health urgent care facilities; collection and publication of prices for health care services; establishment of the Mobile Integrated Health Care

Trust Fund, the Hospital Alignment and Review Trust Fund, and the Prevention and Wellness Trust Fund; expansion of the role of certain mid-level providers and creation of a registration category for dental therapists; requirement for certain payors to offer plans with a reduced network of providers or certain other variations to plan design intended to reduce cost; and a requirement that a carrier certify that its coverage includes certain mental health home-based and community-based services for children.

A number of task forces and commissions would also be formed to study certain topics, including, without limitation: (i) how to license foreign-trained medical professionals and expand access to services in underserved areas; (ii) how to encourage housing security as a social determinant of health (including prioritizing designation of shelter beds for individuals post-discharge); and (iii) feasibility of a regulatory waiver process to implement innovative initiatives resulting in increased access to care and cost savings.

STEPS TO ENACTMENT

On Monday, October 23, the Special Senate Committee on Health Care Cost Containment and Reform held a public hearing to discuss the proposed legislation. A prevailing theme of the hearing was the importance of controlling health care costs, with many panelists and committee members noting that Massachusetts had successfully combatted access-related issues through its 2006 health care reform efforts. A range of provider entities expressed support for the proposed 90% reimbursement floor, and many participants supported the expansion of telemedicine services and for digital health initiatives more broadly. There was, however, disagreement over how these reimbursement modifications should be funded, and whether it is appropriate for certain hospitals to shoulder a larger portion of that burden. While these issues garnered considerable attention, it remains to be seen whether there will be further revisions to this proposed legislation before the bill is considered in the Senate.

Before being presented to the Governor for possible enactment, the final version of this bill would need to pass both the Senate and the House. Governor Baker's position on the legislation is not yet clear. His press secretary stated that the "administration will carefully review legislation that reaches the governor's desk, and believes final legislation must include serious reforms that are needed to stabilize the health care safety net and protect taxpayers from picking up the tab for more worker's health coverage."[8]

Hooper, Lundy & Bookman will continue to monitor legislative developments in the Statehouse and may provide updates as this legislative effort evolves. For more information, please contact: in Boston, Amy Joseph or Jeremy Sherer or Mark Reagan at 617.532.2700; in Washington, D.C., Alex Brill or Bob Roth at 202.580.7700; or in San Francisco, Katrina Pagonis at 415.875.8500.

**(Ms. Joseph and Mr. Sherer have also authored an article on Massachusetts Health Law Basics, available here.*

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[1] Massachusetts Senate Working Group on Health Care Cost Containment and Reform Report, "Working Together to Improve Our Health: Right Care, Right Place, Fair Price" (2017) (hereinafter the "Working Group Report").

[2] Massachusetts Health Reform Law of 2006, ch. 58, 2006 Mass. Acts.

[3] United States Census Bureau, the Current Population Survey (CPS), 2006 & 2007 Massachusetts state data.

[4] Act of August 6, 2012, ch. 224, 2012 Mass. Acts.

[5] *See* Working Group Report, p. 4.

[6] *Id.*

[7] The three-member Council would consist of the following individuals or a designee of their choosing: the Commissioner of Insurance, who would serve as the Council's Chair; the Executive Director of the Center for Health Information and Analysis; and the Executive Director of the HPC.

[8] Katie Lannan, "State Senators Unveil Far-Reaching Mass. Health Care Legislation," wbur.org, available at http://www.wbur.org/commonhealth/2017/10/17/state-senators-unveil-far-reaching-mass-health-care-legislation (Oct. 17, 2017).

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