HEALTH CARE PAYMENT REFORM CONFERENCE COMMITTEE REPORT

Health Policy Commission (HPC)
Governed by an 11 member board within but not subject to the control of A&F (similar to GIC).
Administers the Health Care Payment Reform Fund; conducts annual cost trend hearings; develops best practices and standards for development of alternative payment methodologies (APMs); certifies provider organizations, ACOs, and patient-centered medical homes; establishes and reviews health care cost growth benchmarks; oversees performance improvement plans; conducts market impact reviews; includes the Office of Patient Protection (moved from DPH).

Center for Health Information and Analysis (CHIA)
Governed by an executive director appointed by majority vote of Governor, Attorney General, and State Auditor (similar to IG).
Collects provider cost data and information from private and public health care payers; develops uniform reporting of a standard set of quality measures; conducts annual report on quality and provider and payer cost trends; participates in and supports the Commission's cost trend hearings; analyzes data to identify payers and providers whose increases in health status adjusted total medical expense is excessive; maintains consumer health information website; includes the Betsy Lehman Center for Patient Safety and Medical Error Reduction (moved from HHS).

Health Care Cost Growth Benchmark
The Commission shall establish the statewide health care cost growth goal for the health care industry, pegged at an amount no greater than the potential growth of the state economy, as follows:

- Years 2013 through 2017: Potential GSP
- Years 2018 through 2022: -0.5% below potential GSP
- Years 2023 and beyond: Potential GSP

Estimated Savings: $200 billion over 15 years

One-Time Provider/Insurer Assessment of $225 million
The Commission shall assess a surcharge on providers ($60 million) and insurers ($165 million), to be paid in a single payment or in four annual, equal installments.

Distribution of assessment funds:

1) $135 million to the Distressed Hospital Trust Fund to enhance the ability of community hospitals to serve patients more effectively. Provides for a competitive grant process, to be developed by the Commission, for awards to distressed hospitals.
2) $60 million to the Prevention and Wellness Trust Fund to fund grants for preventative health activities at the community level. DPH to administer fund.
3) $30 million to the e-Health Institute Fund to fund the Massachusetts eHealth Institute (MeHI). MeHI will conduct the regional extension center program, run the electronic health records incentive program, and develop a plan to complete the implementation of electronic health records with all providers in Massachusetts.

Health Care Payment Reform Fund
Previously established to collect one-time gaming revenue from gaming facilities; funded by 5% administrative surcharge on assessments. The Commission shall create a competitive bid process to provide incentives, grants, or technical assistance to health care entities trying to develop payment or delivery system changes.

Medicaid Reform

- Provides an increase of 2% to Medicaid rates, not to exceed $20 million, paid to providers that transition to new payment methodologies. Creates a special commission to review rates paid by public payers.
- Directs HHS, in collaboration with the Dept. of Veterans' Services and MassHealth, to investigate methods to improve access to Department of Veterans' Affairs benefits for qualified veterans, survivors, and dependents currently enrolled in the MassHealth program.
- Requires Medicaid, the GIC, and all other state funded health care programs to pay for health care based on alternative payment methodologies for 25%, 50%, and 80% of its enrollees by July of 2013, 2014 and 2015, respectively.

Provider Organizations and Accountable Care Organizations (ACOs)

- Provider organizations are health care providers that cover 15,000 lives or more and contract with insurance carriers for payment for health care services; can choose to organize as an ACO.
- Creates a certification process for provider organizations and ACOs and directs DOI to review reserves to ensure their ability to handle risk arrangements.
- Certified ACOs are responsible for care coordination, and the delivery, management, quality, and cost of all services provided under the ACO; they must integrate physical and behavioral health care services and accept alternative payment methodologies.
- Establishes a new "Cost and Market Impact Review" to examine provider organizations to determine whether any provider's market concentration exceeds certain federally-established parameters. If the Commission determines, based on its review, that actions of a provider constitute unfair practices or unfair methods of competition or other violations of law, the Commission must refer the matter to the Attorney General for further action.
- Requires ACOs, patient-centered medical homes, and provider organizations that receive a risk-based payment to set up a system of internal appeals. The appeals process may last no longer than 14 days.
- Requires certified ACOs to guarantee access to all medically necessary services for patients, either internally or through providers outside of the ACO.
- Model ACOs, as designated by the Commission, will receive preference in state contracting.

Medical Malpractice Reform

- Creates a new 182-day cooling off period for medical malpractice claims while both sides try to negotiate a settlement. Requires the exchange of information between the plaintiff and defendant to promote early settlement.
- Allows a health care provider or facility to admit a mistake or error. The admission cannot be used in a court as an admission of liability. However, if a provider lies under oath about the error or mistake, then the statement can be used as an admission of liability.
- Reduces the interest rate for medical malpractice from +4% to +2%.
- Raises the non-profit damage cap from $20k to $100k.
- Creates a task force to study defensive medicine and medical overutilization.

Workforce Development and Innovate Incentives

- Establishes the Health Care Workforce Transformation Fund to fund programs such as medical and nursing school loan forgiveness grants, health care job training and placement services, primary care residencies, and rural health rotation programs at medical and nursing schools.
- Establishes a new wellness tax credit for businesses that implement recognized workplace wellness programs, up to $10,000 per employer (up to 25% of the cost of implementation).
- Requires that DPH develop a "model guide" for wellness programs for businesses and to provide stipends to help businesses establish programs.

- Requires health insurance companies to provide a premium adjustment for small businesses that adopt approved workplace wellness programs.
- Establishes the Health Information Technology (HIT) Revolving Loan Fund for making grants to providers for the costs associated with implementation of health care IT required under state and federal law. Provides for zero interest loans to providers and agreements with outside lending institutions to process applications and loans.
- Bans the use of mandatory overtime for nurses in a hospital setting unless patient safety requires it in an emergency situation. The Commission is directed to determine what constitutes an "emergency situation." Nurses are not allowed to exceed 16 hours of worked time in a 24 hour period and must be given 8 hours off immediately after working a consecutive 16 hours.
- Directs state agencies responsible for the purchase of prescription drugs to form a uniform procurement unit to negotiate for bulk purchases.
- Raises the full-time equivalent (FTE) threshold for fair share contributions from 11 to 21 employees.
- Expands an existing workforce loan forgiveness program to include providers of behavioral, substance abuse, and mental health services.

Consumer Protections and Patient Access

- Develops a process to track price variation among different health care providers over time and establishes a Special Commission to determine and quantify the acceptable and unacceptable factors contributing to price variation among providers.
- Expands upon the existing consumer health information website to include more detailed comparative information on the cost and quality of health care services, including the individual prices of health care services. Adds new resources to the website such as the factors to consider when choosing an insurance product and shared decision-making tools.
- Increases the minimum premium savings for "tiered" or "selective" network health products from 12% to 14% and establishes a new "smart-tiering" option.
- Incentivizes the accelerated adoption of connected health technology, such as telemedicine.
- Requires the Commission to review methods and make recommendations relative to increasing the use of health savings accounts and similar tax-advantaged health plans.
- Allows nursing homes to move residents to a different room if the resident's clinical needs have changed.
- Allows "limited services clinics" to provide the scope of services offered by a nurse practitioner.
- Allows nurse practitioners and physician assistants to be recognized as primary care providers.
- Allows primary care providers, behavioral health providers, and specialty care providers to be certified as patient-centered medical homes, providing patients with a single point of coordination.
- Establishes a new primary care residency program supported by DPH to increase the pipeline of primary care providers.

Transparency, Disclosure, and Administration Simplification

- Requires DOI to develop a summary of payments form to be used by all health care payers. The form would be provided to health care consumers and written in an easily readable and understandable format showing the consumer's responsibility, if any, for payment of any portion of a health care provider claim.
- Requires the development of standard prior authorization forms, which would be available electronically, so that providers would use only one form for all payers.
- Authorizes penalties for non-compliance with standardized coding and billing requirements.
- Directs insurers to disclose in real-time the out-of-pocket costs for a proposed health care service and protects patients from paying more than the disclosed amount.
- Streamlines data reporting requirement by designating a single agency as the secure data repository for all health care information reported to and collected by the state.