SUMMARY

An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments

SECTION 1. Findings and Purposes

Powers of the Attorney General (AG)

SECTION 2. Adds a new Section 11M after section 11L to chapter 12:

Section 11M: The AG is directed to monitor, assist, and intervene in the market consistent with the following:

(a) Monitor trends in the health care market during the reorganization of the health care system including trends in ACO size and composition, consolidation in the ACO and provider markets, payer contracting trends, impact on patient selection of provider and ACO and other market effects.

(b) In consultation with the Coordinating Council, intervene to prevent excess consolidation of providers or ACOs, collusion, anti-trust, or other anti competitive dynamics in the health care market.

(c) Provide assistance for the Commonwealth to obtain any needed exemptions or waivers from federal laws, including anti-kickback and "Stark" laws to permit physician referrals to other providers as needed to implement alternative payment methods and ACO formation.

SECTION 3. Amends Chapter 93A by adding a new section:

Section 115. Health care providers are prohibited from attempting to recoup amounts in excess of the amounts charged to carriers by increasing charges to other health benefit plans or payers. The AG is given regulatory authority to enforce and penalize providers for violations of this subsection.

SECTION 4.

Requires the AG to analyze all state and federal laws and regulations that impact the implementation of the act, including antitrust, and make recommendations to the legislature for any statutory and regulatory changes needed to create sufficient tools and authority to protect consumer and purchaser interests.

Health Information Technology (HIT) Council

SECTION 5 . Amends Section 6D of chapter 40J; deletes existing subsection (b) and inserts a new subsection (b).

Adds the following additional members: 1 from an academic medical center; 1 from a community hospital; 1 from a community health center; 1 from a long term care facility; 1 from large physician group practice; 1 from a small physician group practice; 1 who represents health insurance carriers; and 3 additional members who have experience or expertise in health information technology.

Powers of the Department of Public Health (DPH)

Expansion of Medical Peer Review

SECTION 6. Amends section 204 of chapter 111 by adding new subsection (f):

Existing peer review provisions are extended to any committee formed by an individual or group to perform the duties or functions of medical peer review.

Division of Health Care Resource Planning

SECTIONS 7. through 10. Adds a new section 25E1/2 after 25E; amends sections 25B and 25C of the general laws (conforming changes).

(a) A new division of health planning is established within DPH. The division of health planning is required to develop a state health plan every 2 years.

(b) A health planning council is established within DPH, consisting of the commissioners/secretary or designee of: DPH, Medicaid, Division of Health Care Finance and Policy (DHCFP), the Executive Office of Health and Human Services (EOHHS), the director of the division of health planning at DPH and 3 experts appointed by the Governor (experts in health economist, health policy and planning, health care market planning and service line analysis).

(c) The state health plan must include an inventory of current health care facilities and all services or supplies that are subject to a determination of need, and an assessment of the need for every such service or supply on a statewide or regional basis with projections for such need for at least 5 years**.**

(d) DPH is authorized to issue guidelines and regulations consistent with the state health plan for making determinations of need.

Powers of Office of Patient Protection (OPP)

SECTION 11. Adds a new clause 8 to paragraph (a) of section 217 of chapter 111 of the General Laws, as amended by section 8 of chapter 288 of the acts of 2010.

OPP is required to establish procedures and rules relating to appeals by consumers from accountable care organizations (ACOs), and conduct hearings and issue rulings on appeals brought by ACO consumers that are not otherwise properly heard through the consumer's payer or provider.

Powers of the Division of Health Care Finance and Policy

SECTION 12. Amends chapter 118G of the General Laws by adding a new section:

Section 42: (a) In consultation with the Coordinating Council, DCHFP is directed to monitor and report on costs and payments for health care services, and is required to:

1) Establish benchmarks for expanding the use of alternative payment methods and reducing the use of fee for service methods for the purposes of adopting alternative payment methods across the industry by the end of year 2015 and lowering annual increases in total medical expenditures.

2) Establish standards for alternative payment methodologies. Require payers to develop alternative payment methodologies and offer them to compensate ACOs.

3) Establish requirements for disclosure of ACO costs and payments made by payers to ACOs;

4) Require payers to submit documentation demonstrating that rates of payment in contracts with ACOs and providers is within certain cost and growth rate benchmarks.

5) Monitor compliance by ACOs, providers and payers with cost and growth, and payment methodology transition benchmarks.

6) Hold hearings to determine appropriate cost growth and other benchmarks.

7) Waive any requirements to support demonstrations and pilots.

8) Encourage voluntary adoption by providers of alternative payment methodologies.

(b) To promote transparency and information dissemination in the health care system, DHCFP is directed to:

1) Collect from payers, providers and ACOs data pertaining to health care costs, payments, and competition among payers, providers and ACOs.

2) Analyze the data to assess health care cost trends and the impact of the transition from fee for service to alternative payment methods; and

3) Include its analysis in the annual report..

(c) To support the transition to alternative payment methodologies, DHCFP is directed, in consultation with the Coordinating Council, to:

1) By March 31, 2012, document, categorize and publish all payment arrangements in the commonwealth.

2) Establish, facilitate and support transitional payment methodologies through pilots and other interim programs which have as their objective the modification of fee for service payment methods in a manner which promotes higher quality and more efficient care.

3) Evaluate cost growth trends in interim payment methods used during the transition to alternative payment methodologies, and report and publish its findings.

(d) With the input of expert advice, and in consultation with the Coordinating Council, DHCFP is directed to evaluate and take measures to address ERISA restrictions.

(e) DHCFP must evaluate best practices for the provision of high quality, efficient care in other states and nations for potential adoption into alternative payment methodologies under the act.

(f) DHCFP must submit a written report annually to the Coordinating Council on all of its findings, evaluations, and regulations, and a plan for achieving all milestones set forth in this section.

(g) The Commissioner of DHCFP or designee must participate in all meetings of the Coordinating Council and to adopt all recommendations made by the Coordinating Council to DHCFP.

Health Services System and Payment Reform, Including Coordinating Council

SECTION 13. Repeals Sections 16J through 16L of chapter 6A of the General Laws.

SECTION 14. Amends the General Laws by adding after chapter 118H a new chapter 118I,

HEALTH SERVICES SYSTEM AND PAYMENT REFORM.

Section 1. Definitions. Define new terms relevant to ACOs and alternative payment methods, and include:

"Accountable care organization" or "ACO", an entity comprised of provider groups which operates as a single integrated organization that accepts at least shared responsibility for the cost and primary responsibility for the quality of care delivered to a specific population of patients cared for by the groups' clinicians; which operates consistent with principles of a patient centered medical home and satisfies the other requirements of this chapter; which has a formal legal structure to receive and distribute savings; and which complies with any federal requirements applicable to ACOs, however named, which have been or may be enacted or adopted in law or regulation.

"Alternative payment contract", an agreement between a payer and an ACO or other provider in which reimbursement available under the agreement is pursuant to an alternative payment methodology, as defined in this chapter, for services provided by an ACO or other provider. The contract shall include at least some performance based quality measures with associated financial rewards or penalties, or both.

"Alternative payment methodologies or methods", methods of payment that are not fee-for-service based and compensate ACOs and other providers for the provision of health care services, including but not limited to shared savings arrangements, bundled payments, episode-based payments, and global payments, as defined in regulations adopted by the division of health care finance and policy. No payment based on the fee-for-service methodology shall be considered an alternative payment.

"Integrated health care services", health care services relating to the treatment of certain conditions, including but not limited to all conditions required to be covered under regulations of the commonwealth health insurance connector authority defining the core services and a broad range of medical benefits required for minimum creditable coverage and as adopted through regulation by the division in accordance with this chapter.

Section 2. (a) A new health services system and payment reform Coordinating Council (Coordinating Council or Council) is established within but not subject to control of EOHHS. The Council is directed to establish a plan, timeline, benchmarks and standards to facilitate the establishment of ACOs and transition to utilization of global and alternative payment methods by all payers by June 2015, and protect quality, access and choice. The Council is authorized to coordinate and make recommendations to agencies and entities represented on the Council relating to pricing, reimbursement methods, ACOs and quality measures. The Council is designated as a public body.

(b) The Coordinating Council consists of: the secretary of EOHHS, the commissioner of the Department of Mental Health (DMH), the director of Medicaid, the commissioner of DPH,

commissioner of DHCFP, the commissioner of DOI, the director of the Health Insurance Connector Authority (Connector), the secretary of Administration & Finance or designee, the secretary of housing and economic development or designee, and the director of the Massachusetts eHealth Institute. The secretary of EOHHS is the chair of the Council.

(c) The Coordinating Council is directed to consult with an advisory committee of 18 members: the AG or designee, the Inspector General (IG) or designee, 2 representatives of acute care hospitals appointed by the Massachusetts Hospital Association, 1 representative of the Mass. Association of health Plans, 1 representative of Blue Cross Blue Shield of Mass.; and 10 other members appointed by the governor with expertise in health care systems and payments: 2 specialty physicians, 2 primary care physicians, 1 advanced practice nurse with expertise in the patient centered medical home model of health care delivery, 1 behavioral health provider, 1 consumer health advocacy organization representative, 1 large self insured employer representative, 1 small employer representative, 1 representative of organized labor representing health workers, 1 representative of organized labor representing other workers, and 1 expert in health policy.

(d) No member of the Coordinating Council may have any conflicts of interest while serving on the Council.

Section 3. (a) DHCFP will staff and support the Council. DHCFP is directed to facilitate the establishment of ACOs throughout the Commonwealth by June 2015, and ensure consistency and efficacy in the establishment and use of quality measures. DHCFP is directed to establish a plan of action, timeline, benchmarks and standards consistent with its purpose of promoting ACO development and protection of quality and access.

(b) No staff member or other agent of DHCFP may have any conflicts of interest while employed or otherwise providing services to DHCFP.

Section 4. The Coordinating Council is directed to:

(a) Monitor and assure inter-agency consistency and appropriate consumer protections with the implementation of health care payment and delivery reform by coordinating actions among and recommending actions to state agencies.

(b) Monitor health care expenditures and recommend actions to agencies and entities represented on the Council to contain health care costs.

(c) Review and publish reports from the agencies represented on the Council.

(d) Ensure that data submission and other requirements are implemented in a manner that promotes administrative simplification, avoids duplication, and does not impose an undue burden on any entity or individual.

(e) Make recommendations to the agencies and entities represented on the Council regarding all aspects of the transition to alternative payment methodologies, ACO models of care, and controlling the cost of health care in the commonwealth.

(f) Prepare and submit reports to executive and legislative bodies relating to the achievement of benchmarks and other developments in the transition to alternative payments, the use of the ACO model of care, and cost containment.

Section 5. DHCFP is directed to:

(a) Monitor, assist, and promulgate regulations pertaining to the establishment of ACOs and the establishment of standardized quality measures.

(b) Adopt regulations and issue guidance concerning the establishment of ACOs, and standardized quality measures.

(c) Allow independent physician associations, physician-hospital organizations, and other integrated health care organizations to qualify as an ACO if they meet the criteria of this act and established by DHCFP.

(d) Facilitate establishment of ACOs, provide by regulation for the certification or licensing of ACOs, and by June 1, 2012, establish minimum requirements for the formation of ACOs consistent with certain parameters including:

1) ACOs must share responsibility with their network providers for the delivery, management, quality and cost of the provision of at least all integrated health care services;

2) ACOs must possess internally or through contractual arrangement the following functional capacities:

a) Clinical service coordination, management and delivery functions. ACOs must provide primary care coordination and referral services and not solely through contracts.

b) Population management functions.

c) Financial management capabilities.

d) Contract management capabilities.

e) Quality measurement competence.

f) Patient and provider communications functions, and

g) The ability to provide behavioral health services either internally within the ACO or by contractual arrangement.

3) ACOs organizational structures must include consumer representation and ensure that ACO decision making reflects the views of health care clincians.

(e) Monitor ACO formation and in consultation with the Council, establish benchmarks for the transition of providers into integrated care delivery systems.

(f) Establish safeguards against underutilization of services and protections against inappropriate denials of services or treatment in connection with utilization of any alternative payment method or transition to a global payment system.

(g) Establish safeguards against and penalties for inappropriate selection of low cost patients and avoidance of high cost patients by ACOs and their network providers, including requiring that ACOs accept all individuals regardless of payer source or clinical profile.

(h) Establish standards under which physicians and other providers may participate in more than one ACO. Primary care clinicians are required to participate in only one ACO except as otherwise permitted by DHCFP.

(i) Establish parameters to ensure access by disabled and other individuals with chronic or complex medical conditions to appropriate specialty care.

(j) Establish reporting and disclosure requirements for ACOs and their network providers.

(k) Identify by regulation appropriate quality measures and parameters for quality measures, in consultation with DHCFP and DPH.

(l) In consultation with DPH and DOI, establish parameters for clinical outcomes beyond the control of the clinician for which ACOs and providers shall not be financially responsible.

(m) Monitor ACO delivery systems to ensure they possess the competencies necessary to operate as an effective ACO.

(n) Provide guidance relative to consumer protections and any deficiencies of patient choice.

(o) Establish requirements for ACOs to address consumer grievances. Any individual aggrieved by restrictions on patient choice or quality of care resulting

from final ACO action may request an external review by filing a request with the OPP within 45 days of the notice of adverse determination or receipt of care that raises quality of care issues.

(p) Monitor and evaluate provider complaints and may establish requirements for ACOs to address provider grievances;

(q) Monitor compliance by ACOs, providers, and payers, barriers to entry by providers, excess consolidation of ACOs, and trends in patient choice among providers and ACOs.

(r) Promote transparency and information dissemination and:

a. Collect from payers, providers and ACOs data pertaining to quality and other matters relevant to its authority under this section;

b. Analyze the data to assess trends in performance, the impact of the transition to ACO delivery systems, and progress toward shared responsibility for the needed infrastructure, legal, and technical support for providers;

c. Include its analysis in the annual report;

d. Monitor provider and ACO acquisition and implementation of health information technology;

e. Establish parameters and rules to require obtaining patient consent for sharing information regarding patient care across all providers within a patient centered medical home and ACO.

(s) Advance the study of quality measures, by evaluating current standards of best clinical practices, and establishing new quality measures that advance the level of clinical practice.

(t) Evaluate best practices for the provision of high quality, efficient care in other states and nations for potential adoption.

(u) Provide guidance to ACOs and providers seeking to form an ACO on the potential implications of anti-kickback and “Stark” laws.

(v) Submit an annual written report to the Coordinating Council on all findings, evaluations, and regulations.

This section is to be construed in a manner consistent with any applicable federal laws or regulations governing ACOs, except as otherwise explicitly provided in this chapter or implementing regulations.

Section 6. (a) Self funded plans may implement alternative payment methods in their discretion and as permitted by law.

(b) By January 1, 2014, publicly funded programs (including Medicaid, the Group Insurance Commission, and the Connector) must implement alternative payment methods and use ACOs for the delivery of publicly funded health services, to the extent feasible.

Section 7: (a) The Coordinating Council is required to submit an annual report setting forth all findings, evaluations, and regulations issued by each agency represented on the Coordinating Council. The report must be filed with the governor, president of the senate, speaker of the house, the chairs of the joint committee on health care financing, the chairs of the house and senate committees on ways and means, and the health care quality and cost council starting one year from the date of enactment. The report must be posted on the EOHHS website.

(b) The Council's report must set forth specific benchmarks for the reduction of health care costs and the improvement of quality, and include detailed information regarding the proportion of health care expenditures paid using alternative payment methods, the proportion of patients receiving care outside of an ACO, and a wide variety of information relating to the transition to the ACO model of care and use of alternative payment methodologies.

(c) The Council must also submit bi-annual reports to the anti-trust and public protection divisions of the AG, to provide information and data needed for the AG to perform its oversight, monitoring, compliance and enforcement duties under section 11M of chapter 12.

Section 8. Interest on legal judgments against an ACO will be assessed at the federal funds rate in effect at the time the judgment is entered.

Powers of the Division of Insurance

SECTION 15. Amends chapter 176J of the General Laws, subsection (b) of section 6, by adding a new paragraph:

Carriers must file information to demonstrate that reimbursement to health care providers is consistent with section 5A of chapter 176O.

SECTION 16. Amends chapter 176J, subsection (d) of section 6, by adding a new paragraph:

If a carrier files a base rate change that is not consistent with the requirements of section 5A of chapter 176O, that carrier's rate will be presumptively disapproved as excessive.

SECTION 17. Amends chapter 176O of the General Laws by inserting after section 5 four new sections:

Section 5A.

(a) No carrier can enter into, renew or extend any contract with any health care provider unless the rate of reimbursement in the new, renewed or extended contract increases by an amount less than or equal to an amount established annually by the Commissioner, in consultation with the Commissioner of DHCFP. The Commissioner may establish different amounts for differing categories of contracts or providers, based on the factors in subsection (b).

(b) In establishing the amount provided in subsection (a), the Commissioner must consider the following factors:

(1) the rate of increase in the gross domestic product or consumer price index for the commonwealth;

(2) the rate of increase in total medical expenses;

(3) a provider's rate of reimbursement with a carrier; especially in relation to the carrier's statewide average relative price, including variability in rates where providers are above, at or below the statewide average;

(4) whether the carrier and a contracting provider or accountable care organization are transitioning from a fee-for-service contract to an alternative payment contract; and

(5) other factors that the commissioner may prescribe by regulation.

(c) Any savings realized by the carrier from any reduction or mitigation in the growth of provider prices must be incorporated in the premiums charged to insured health plan members.

Section 5B. No carrier can enter or renew a contract on or after January 1, 2012 with any hospital or inpatient facility with contract provisions that require the carrier to contract with other health care facilities that may be affiliated with that hospital or inpatient facility.

Section 5C. Beginning on January 1, 2014, carriers will be required to reduce claims payments to providers who do not file claims electronically. Carriers are required to report annually to the commissioner on calculation of the reduction and the number of providers affected by the reduction.

Section 5D. To facilitate the transition to the assumption of risk by ACOs, the Division is directed to:

(a) Monitor risk arrangements between payers and ACOs and, in consultation with the Coordinating Council and DHCFP, establish any benchmarks necessary to facilitate the transition of health care providers into integrated care delivery systems that accept risk.

(b) Solicit expert advice to develop methodologies for risk adjustments, risk corridors, outliers and reinsurance and such methodology must consider the factors set forth in subsection (j).

(c) Require that all payers maintain for all members a current roster of providers and ACOs available under the member's health benefit plan and submit such roster to the DOI.

(d) Establish a nonprofit entity called the Massachusetts ACO Reinsurance Plan.

1. All ACOs must be members of the plan, which shall be prepared and administered by a governing committee consisting of 7 members representing ACOs participating in the plan.

2. The governing committee must submit to the commissioner a plan of operation.

3. The plan will not reimburse an ACO with respect to claims of a reinsured patient until the ACO has paid benefits in a calendar year for services otherwise covered by its contract.

4. Meetings of the governing committee are subject to open meeting law requirements.

5. The governing committee will determine at the close of each fiscal year the premiums to be charged for reinsurance coverage for the next fiscal year.

6. Any net loss for the year must be recouped by assessment of members, which may not exceed 5% of the total reimbursement form ACO contracts in the prior year.

7. The governing committee must report annually to the commissioner and the joint committee on financial services.

8. If other funding sources are not made available, the committee may negotiate with plan members to resolve any deficit through reductions in future payment levels; the Plan is required to conduct an actuarial study within the first 3 years to evaluate relative risks being assumed by ACOs.

(e) Commencing January 1, 2014, in consultation with the Coordinating Council and DHCFP, if DOI determines that risk and other adjustments are not adequately standardized and consistent across all payers, it will establish by regulation appropriate standard risk adjusters to be used by all payers that shall include accommodation for factors including, but not limited to:

1. Cost experience and efficiencies;
2. Acuity of patient case mix;
3. Clinical health status and probability of illness;
4. Socioeconomic case mix;
5. Geographic location;
6. Cultural and linguistic diversity in patient mix; and
7. Volume of underserved low income patients.

(f) Adopt measures to ensure that its activities with respect to regulation of risk do not undermine the ability of consumers to have access to an appropriate forum for the resolution of any grievances relating to care received through an ACO.

(g) Have authority to adopt regulations to establish financial oversight provisions that apply to ACOs and other health care providers that take on risk pursuant to an alternative payment contract; the Medicaid program is required to implement DOI's regulatory standards to the extent consistent with federal law.

(h) Submit a written report annually to the Coordinating Council on all risk and methodological evaluations performed, and regulations promulgated, which will include a plan for achieving and implementing standardized risk adjustments.

(i) Participate in all meetings of the Coordinating Council.

(j) Adopt all recommendations made by the Coordinating Council to DOI.

SECTION 18.

DOI is directed to conduct a study of the impact of section 5A of chapter 176O on carrier provider networks, network adequacy, rates paid to non-participating providers, and the overall impact on carrier member premiums. DOI is required to file a report no later than January 1,

2014 to the Coordinating Council and the clerks of the Senate and House of Representatives and may make recommendations for legislation.

Clinician-Patient Communication and Grievance Resolution

SECTION 19. Amends chapter 231 of the general laws and adds a new section 60L:

(a) A person cannot bring suit against a health care provider unless the person has given the health care provider written notice of not less than 180 days.

(b) The notice must be mailed to the health care provider's last known business or residential address.

(c) The notice period is shortened to 90 days under certain specified conditions.

(d) The notice must contain a detailed statement regarding facts and causation.

(e) Within 30 days after giving notice, the claimant must allow the health care provider access to all of the medical records related to the claim.

(f) Within 90 days after receipt of notice, the health care provider must furnish to the claimant a detailed written response regarding facts and causation.

(g) Within 90 days after receipt of notice, the health care provider must furnish the claimant all medical records related to the claim that are in the provider's control.

(h) If the claimant does not receive the written response required in subsection (f), the claimant may commence a medical malpractice action upon the expiration of the 90 day period.

(i) If the health care provider notifies the claimant that it does not intend to settle the claims, the claimant may commence a medical malpractice action.

(j) If the claimant does not have and could not reasonably have had knowledge or notice of his injury, then the statute of limitations will be tolled for a sufficient time to allow for compliance with this section before commencing an action against a health care provider.

Treatment of Provider Apology in Litigation

SECTION 20. Amends the general laws by inserting after section 79K of chapter 233 a new section 79L).

(a) Defines terms used in subsection (b).

(b) Provider apologies are made inadmissible as evidence in any claim or proceeding relating to an unanticipated outcome..

SECTION 21. Duties of the Executive Office of Health and Human Services

To promote the adoption of alternative payment methodologies and contracting with ACOs, EOHHS is directed to:

(a) Seek to obtain a federal waiver to permit Medicare to participate in the commonwealth's alternative payment methods.

(b) By August 15, 2011, request from the federal Office of the Inspector General waivers from the federal anti-kickback and "Stark" laws and implementing regulations.

(c) Facilitate the use of alternative payment methods and contracting with ACOs across all state entities. EOHHS is to take the lead in negotiations with CMS in contracts for services for reimbursement for Medicare services.

(d) Develop a pilot program with one or more health systems that are early adopters of the ACO model, provided that doing so will not conflict with other EOHHS pilot programs.

(e) Submit a written report annually to the Coordinating Council on all of its obligations.

(f) Participate in all meetings of the Coordinating Council, and must adopt and implement all recommendations made by the Coordinating Council to it.

Behavioral Health Care Task Force

SECTION 22.

(a) A new behavioral health care task force is established comprised of nine representatives with expertise in behavioral health treatment, service delivery, integration of behavioral health with primary care, and behavioral health reimbursement systems, to be designated by the Coordinating Council.

(b) The task force must report to the Coordinating Council its findings and recommendations relative to the most effective approach to including behavioral health services in the services provided by ACOs, how reimbursement methods and covered benefits may need to be modified to achieve better behavioral health outcomes, and the extent to which and how payment for behavioral health services should be included under alternative payment

methods. The task force members must be appointed and hold the first meeting within sixty days of enactment of the act, and report its findings and recommendations no later than April 1, 2013.