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SUMMARY AND ANALYSIS OF CHAPTER 244 OF THE ACTS OF 2012
(MA HEALTH CARE PAYMENT REFORM LEGISLATION)

ISSUE	SECTION	SUMMARY
Health Planning Council & Determination of Need (DON)	14 & 16(19) & 71	Council, in conjunction with an advisory committee, will develop the state health plan. The plan will identify the commonwealth's needs with respect to health care services, providers, programs, and facilities; the available resources; and the priorities for addressing those needs. The plan will include an inventory of the location, distribution and nature of all state health care resources, regardless of ownership. The plan also will identify certain categories of health care resources, and make recommendations for the appropriate supply and distribution of such resources. All information compiled by the Health Planning Council will be publicly available. The Health Planning Council will issue regulations or other guidance regarding the DON process.
Health Policy Commission	15	**Structure** The Health Policy Commission will be an independent public entity with the executive office for administration and finance. The Commission will not be required to obtain the approval of any other executive agency in connection with developing or administering its budget. **Duties** The Commission will be tasked with: • Monitoring the reform of the health care delivery and payment system; • Administering the Healthcare Payment Reform Fund (HPRF); • Establishing a competitive process for health care entities to develop or implement promising models in health care payment and health care service development; o Ideas will be solicited from providers, provider organizations, carriers, and other stakeholders, but the Commission will consider only those proposals that meet certain criteria. o

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Health Policy Commission Continued	15	• Coordinating expenditures from the Healthcare Payment Reform Fund with other public expenditures; and • Reporting to set cost containment goals and develop transparency for provider organizations **Funding/Assessment** Effective 2016, acute hospitals to provide 33% of DHCFP funding based on percent of GPSR to total MA GPSR. Current funding is $21M annually, likely to increase under the bill given the many additional responsibilities of the agency. **Healthcare Payment Reform Fund** Funds will be awarded through competitive process for delivery system innovation; coordinated with other funds including DSTI. **Cost Growth Benchmark; Performance Improvement Plans** Benchmark: Equal to the state economy overall through 2017; for the following five year reduce to half a percentage point below the growth of the state's economy. GSP for 2013 3.6%. Entities exceeding the benchmark shall be subject to actions from Commission including filing performance improvement plan. Providers that fail to file a plan, implement a plan "in good faith," or knowingly fail to file information with the Commission can be fined. **Registration of Providers** Registration for provider organizations with additional admin burdens on reporting. Risk certificate required from DOI to bear risk. "Material changes," e.g., mergers, must be reviewed. Market impact review to follow with many factors listed, then three required factors: dominant market share, materially higher prices (all providers in same market), and materially higher TME. Also, market impact review can be initiated for high cost providers identified by the Center for Health Information and Analysis (see below). **ACO Registration** Provider orgs to be voluntarily certified as ACOs. Second reporting and certification burden on top of new provider org burden. For example: the commission may require an ACO to "establish mechanisms to protect patient provider choice including parameters for accessing care outside the ACO" and the Commission may establish a review process for providers who are excluded from an ACO. ACO must have written criteria for including or excluding providers.

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Center for Health Information and Analysis Continued	19	**Structure** The administrative head of the Center (Executive Director) will be appointed by a majority vote of the Attorney General, state auditor, and the Governor, on the basis of expertise in health care policy, health care finance, and other educational requirements. **Center Requirements for Registered Providers** Registered providers will be required to annually submit the following information: • organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations and community advisory boards; • the number of affiliated health care professional full-time equivalents by license type, specialty, name and address of principal practice location and whether the professional is employed by the organization; • the name and address of licensed facilities by license number, license type and capacity in each major service category; • a comprehensive financial statement, including information on parent entities and corporate affiliates as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves; • information on stop-loss insurance and any non-fee-for-service payment arrangements; • information on clinical quality, care coordination and patient referral practices; • information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; • information regarding charitable care and community benefit programs; and • for any risk-bearing provider organization, certificate from the Division of Insurance. The Center may add to this list. Certain reporting requirements may be waived based on the operational size of the provider, the provider organization's annual net patient service revenue, the degree of risk assumed by the provider organization, and other criteria determined by the Center. **Other Provider Reporting Requirements** Providers also will be required to report any agreements through which one provider agrees to furnish another provider with a discount, rebate or any other type of refund or remuneration in exchange for, or in any way related to, the provision of heath care services.

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Center for Health Information and Analysis Continued	19	**Fines for Failing to Meet Reporting Deadlines** Provider organizations that fail to meet the reporting deadlines and fail to meet a reporting deadline and fail to respond notice from the Center within two weeks will be fined up to $1,000/week for each week of delay up to a maximum of $50,000. **Access to Data** • Providers, provider organizations, payers and govt. agencies will be permitted to access de-identified data for research, benchmarking, and/or analytical purposes. • The Attorney General will be permitted to review and analyze ANY information submitted to the Center, including by way of example: revenues, charges, costs and prices of health care services; relative prices; provider performance on alternative revenue contracts; and hospital inpatient and outpatient costs. **Identification of Excessive Growth** The Center will confidentially provide to the Health Policy Commission a list of providers who increase in health status threatens the ability of the state to meet the health care growth benchmark.
Distressed Hospital Trust Fund	29	Distressed Hospital Fund will consist of funds from public and private sources, including gifts, grants, and donations, interest earned on such revenues and any funds provided from other sources. Expenditures from the Fund must have at least one of the following purposes: • to improve and enhance the ability of community hospitals to serve populations efficiently and effectively; • to advance the adoption of health information technology, including interoperable electronic health records systems; • to accelerate the ability to electronically exchange information with other providers in the community to ensure continuity of care; • to support infrastructure investments necessary for the transition to alternative payment methodologies, including technology investments in data analysis functions and performance management programs, including systems to promote provider price transparency, necessary to aggregate and analyze clinical data on a population level; • to aid in the development of care practices and other operational standards necessary for certification as an ACO; and

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Distressed Hospital Trust Fund Continued	29	• to improve the affordability and quality of care. Funds will be awarded through competitive grant process to non-academic, community providers with RP below median. Factors to consider include EBITDA and others.
Interoperable HIT	38 & 134(7) & 243	Mass eHealth Institute to facilitate the implementation of interoperable HIT system between providers. All providers have interoperable systems that connect to statewide HIT exchange by Dec. 31, 2016. Notably, the Institute's electronic health records plan must give patients the option of allowing only designated health care providers to disseminate their PHI.
Medicaid Rates	123	Secretary of the Executive Office of Health and Human Services (EOHHS) will be responsible for developing rates for Medicaid.
Telemedicine	158	Allows insurers to limit telemedicine coverage to those health care providers in a telemedicine network approved by the insurer. Insurers may apply co-pay or deductible to such services.
Alternative Payment Referrals	169 & 173	Payers shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer's network for the purpose of referrals.
Select Network Products	177	Min 14% discount on select/tiered network product – increase of 2% from current standard. Carriers with 5,000 or more lives may use "smart tiering" for restricted networks, but not required.
Risk Certificates	198	Carriers may enter into or continue alternate payments involving downside risk with only those provider organizations that have received a risk certificate.
Risk-Bearing Entities	216	Risk bearing orgs may be subject to provisions of DOI statutes, if accepting downside risk must have risk certificate with DOI. DOI may examine "the affairs" of risk-bearing org. Annual filings will be required, including detailed descriptions of the mechanisms to monitor financial solvency.
One Time Assessment	241	$60M to be paid by acute hospitals or acute hospital systems with more than $1,000,000,000 in total net assets and less than 50% of revenues from public payers.

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Telemedicine Study	249	DOI and BORM to study the potential for out-of-state physicians to practice telemedicine in Massachusetts; report due by July 1, 2013.
Medicaid Payments	261 & 262	Medicaid to develop alt payments with alignment with CMS demos. Models to preserve use of MATF funds in use as of 2012. Required rate increase of 2% to hospitals and other providers in FY14 that accept alt payments from Medicaid or Medicaid MCO.
Special Commissions	270 & 277 &279	Commissions on Public Payer Rates, on impact of Graduate Medical Education, and on Variation in provider prices.
Government Program Alternative Payments	280	GIC, Medicaid, Connector to implement alt payment method to extend possible.