

CHAPTER 224 OF THE ACTS OF 2012: IMPLICATIONS FOR MASSHEALTH

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INTRODUCTION

Chapter 224 of the Acts of 2012 is Massachusetts' ambitious effort to tame the rate of growth in health care spending. This new legislation comes six years after Massachusetts enacted Chapter 58, the historic law that brought health care coverage to 98 percent of the state's residents.¹ The continued success of Chapter 58 depends to a great extent on the new cost containment legislation attaining its goals.

Chapter 224's official title² suggests that cost containment (and improved health care quality) will come as the result of increased transparency, efficiency, and innovation. The law gives the state's health care providers, payers, and state agencies new requirements and responsibilities in these areas. MassHealth, which covers more than one in six state residents and accounts for nearly one dollar in three of the state's budget, shares in these responsibilities. As a major payer, MassHealth will be subject to the same scrutiny of its spending growth as private sector insurers. And as a state-run program, the law directly addresses the rates MassHealth pays providers in a number of ways, and it seeks to push MassHealth (and other state-sponsored coverage) to the forefront of payment innovations intended to control costs and enhance quality. Chapter 224 also contains provisions that may improve MassHealth members' access to certain services.

This brief summarizes the provisions of Chapter 224 that directly involve or otherwise affect the MassHealth program.

I. MASSHEALTH COST GROWTH OVERSIGHT

Chapter 224 places the responsibility to rein in health care costs on "health care entities," including MassHealth.³ The newly formed Health Policy Commission (the HPC) and Center for Health Information and Analysis (CHIA) will subject health care entities to hearings, performance improvement obligations if appropriate, reporting requirements, and reviews of costs.

Health Policy Commission Hearings on Health Care Cost Trends

Chapter 224 creates the HPC to establish and enforce caps on health care cost growth, among other functions. To that end, the HPC will hold hearings on the growth of health care costs over the previous year.⁴ Because MassHealth is a payer that contributes to health care cost growth, the HPC may call on its representatives to testify alongside its private insurer counterparts. Testimony may include factors underlying cost growth, benefit design, and payment policies.

Consequences if MassHealth (or Other Health Care Entities) Exceed Cost Growth Benchmark

In addition to holding hearings, the HPC establishes the health care cost growth benchmark for health care entities.⁵ Starting in 2015, if a health care entity, including MassHealth, is found by CHIA to have exceeded the health care cost benchmark, the HPC may require that entity to file

¹ Chapter 58 of the Acts of 2006

² "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation"

³ The law defines a "health care entity" as a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization, or payer. Section 15 (MGL c. 6D § 10)

⁴ Section 15 (MGL c. 6D § 8)

⁵ Section 15 (MGL c. 6D § 9)

and implement a Performance Improvement Plan.⁶ The Plan is subject to the approval of the HPC's board.

If a health care entity does not cooperate in filing or implementing the Performance Improvement Plan, the HPC could, "as a last resort," fine the entity up to \$500,000.⁷ Because MassHealth is a public agency, it is unlikely that it would ever face this penalty; still, the fine signals seriousness of intent.

Reporting Requirements from the Attorney General's Office

Chapter 224 directs the Attorney General's Office to oversee the health care market in the areas of consolidation and anti-competitive behavior.⁸ MassHealth, along with other payers and providers, must cooperate with the Attorney General's Office in its oversight of the health care industry by providing documents, answering interrogatories, and providing testimony under oath. Required documents include certain filings with CHIA, the HPC, the Department of Public Health, and federal agencies.

Reporting Requirements from the Center for Health Information and Analysis

Prior to Chapter 224, public and private payers, including MassHealth, were required to provide certain information to the Division of Health Care Finance and Policy (DHCFP), including data regarding provider payments and plan designs. Chapter 224 directs payers to provide this information to CHIA instead and adds to the requirements information on the performance of providers in alternative payment contracts, growth rate of provider prices, and a comparison of provider prices.⁹

II. MASSHEALTH PAYMENT RATES

The Executive Office of Health and Human Services (EOHHS), through DHCFP, historically has set Medicaid and other public payer rates for physicians and other health care providers and for social services. With the dissolution of the DHCFP in Chapter 224, EOHHS retains the authority to set rates and gains the ability to delegate that authority to an entity outside EOHHS, such as the newly formed CHIA.¹⁰ Chapter 224 also creates a Public Payer Commission to study public payer rates and specifies rate increases for certain providers.

Special Commission on Public Payer Reimbursement Rates (Public Payer Commission)

This Commission will study the impact of public payer rates on providers and report to the legislature by April 2013.¹¹ Specifically, the Public Payer Commission will "examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care." The report will include an analysis of "Medicaid rate and rate methodologies . . . ; cost-shifting and the interplay between public payer reimbursement rates and health insurance premiums; possible funding sources for increased MassHealth rates including, but not limited to, utilizing

⁶ Section 15 (MGL c. 6D § 10)

⁷ Id.

⁸ Section 18 (MGL c. 12 § 11N)

⁹ Section 19 (Line 1826) (MGL c 12C § 10)

¹⁰ Section 123 (MGL c 118E § 13C); Section 151 (MGL c 118E §76); Section 132

¹¹ Section 270

increased federal Medicaid assistance percentage funds received under the [federal Affordable Care Act].” Members of the Public Payer Commission will include the EOHHS Secretary and Medicaid Director.

Increased Rate for Providers Who Adopt Alternative Payment Methodologies (APMs)

Chapter 224 offers an incentive to providers to accept payment from MassHealth using APMs. See Section III of this report.

Increased Rate for Franciscan Children’s Hospital

Chapter 224 also directs MassHealth to increase its inpatient reimbursement rate for Franciscan Children’s Hospital by 50 percent in state fiscal year (FY) 2014, and to keep it at least at that level in FYs 2015 and 2016.¹²

III. ADOPTION OF APMs BY MASSHEALTH

Chapter 224 seeks to encourage the growth of APMs, in both the public and private sectors, in furtherance of its goals to contain health care costs and improve quality. Chapter 224 directs MassHealth, along with other public payers, to increase the use of APMs via program design changes, increased provider rates, and prioritization of “model ACOs” (Accountable Care Organizations).

Requirements for MassHealth Adoption of APMs

Chapter 224 defines APMs as methodologies that do not rely solely on fee-for-service arrangements, which are thought to promote overspending. Examples of APMs cited in the law are shared savings arrangements, bundled payments, and global payments. The intent is for APMs to encourage efficiency and quality.¹³

Chapter 224 directs MassHealth, along with the Group Insurance Commission and the Connector, to adopt APMs to the “maximum extent feasible” by **July 1, 2014**.¹⁴ APMs are to be “developed in consultation with all affected publically funded health plans, including, but not limited to, the Medicaid managed care organizations.”¹⁵

Specifically, Chapter 224 directs MassHealth to pay for health care utilizing APMs for no fewer than

- 25% of its members by **July 1, 2013**;
- 50% of its members by **July 1, 2014**; and
- 80% of its members by **July 1, 2015**.¹⁶

These benchmarks will apply to MassHealth members enrolled in managed care organizations (MCOs) and the Primary Care Clinician Plan (PCCP). Requiring MCOs to use APMs with their providers will likely require modification of MassHealth’s MCO contracts. Because providers often

¹² Section 271. The rate increase applies to “chronic disease rehabilitation hospitals located in the commonwealth that serve solely children and adolescents.”

¹³ Section 261

¹⁴ Sections 278 and 280

¹⁵ Section 280

¹⁶ Section 261

contract with more than one MCO and/or the PCCP, MassHealth has an interest in there being some consistency across plans in the APMs they adopt, which should affect how prescriptive MassHealth will be about APMs in its contract amendments.

The law excludes from the APM benchmarks members who are covered by other health insurance (typically Medicare) in addition to MassHealth.¹⁷ This group includes most of the 140,000 seniors in MassHealth, about 110,000 non-elderly MassHealth members who are also enrolled in Medicare, and about 60,000 other members with coverage from other sources. This is important because the so-called dual eligibles (those enrolled in MassHealth and Medicare) account for a disproportionate amount of total MassHealth spending – more than 40 percent, for less than 20 percent of members¹⁸ – and these dollars will not be affected by the APM targets in the law. However, in its Request for Proposal for Integrated Care Organizations to provide the full spectrum of services to dual eligible members ages 21-64, MassHealth required those organizations to describe how they would use alternative payment methodologies in their provider contracts.

Increased Rate for Providers Who Adopt APMs

The Affordable Care Act (ACA) increases Medicaid rates for primary care physicians up to the rate of Medicare provider rates from **January 2013 through December 2014**.¹⁹

Chapter 224 directs MassHealth, from **July 2013 through June 2014**, to increase by 2 percent the rates it pays to providers of primary care, to acute hospitals, and to non-acute hospitals that demonstrate a “significant transition to the use of alternative payment methodologies.”²⁰ MassHealth may establish by regulation what constitutes a “significant transition.” Chapter 224 directs MassHealth to “seek federal financial participation” to offset the cost of this provision. The rate increase occurs in state fiscal year 2014 only, and is capped at \$20 million.²¹

MassHealth may not “offset the rate increase by reducing Medicaid base rates to acute hospitals or providers of primary care.” Thus it appears that Chapter 224 intends for primary care physicians to receive both the ACA and Chapter 224 increases in rates.

Prioritization of ACOs for MassHealth Contracting

Chapter 224 describes an Accountable Care Organization (ACO) as an arrangement of providers that accepts the risks and potential rewards of efficiently maintaining the health of a defined population. Chapter 224 requires that ACOs meet certain certification criteria, including that they receive payments using APMs. Chapter 224 directs MassHealth to prioritize provider organizations that have been designated as “model ACOs” by the HPC, but only to the extent that MassHealth “determines that provider organizations organized as ACOs offer opportunities for cost-effective and high quality care.”²² ACOs are likely to play a significant part in MassHealth’s efforts to reach the goals Chapter 224 sets for using APMs, described above in Section III.

¹⁷ *Id.*

¹⁸ Kaiser Family Foundation, *Statehealthfacts.org*, accessed September 10, 2012 (2009 data)

¹⁹ Affordable Care Act § 1202 (42 U.S.C. 1396a(a)(13))

²⁰ Section 262

²¹ The \$20 million “shall be in addition to any annual rate calculations, including updates for inflation, case-mix adjustments, base year updates and any other improvements to the rate methodology.” Section 262

²² Section 268

EOHHS to Seek Waiver for Medicare APMs

Chapter 224 directs EOHHS to seek waivers from MassHealth's federal oversight agency, the Centers for Medicare and Medicaid Services (CMS), to "permit Medicare to participate in [APMs]."²³ Upon federal approval, "such participation shall be commenced and continued." MassHealth will soon launch a demonstration project involving APMs for non-elderly adult members dually eligible for Medicaid and Medicare. Attaining CMS permission for Medicare to participate in APMs could broaden MassHealth's authority to implement payment and delivery reform for the entire dually eligible population, beyond the current demonstration project's scope.

IV. HEALTH CARE ACCESS

Several provisions of Chapter 224 affecting MassHealth fall broadly into the category of promoting better access to health care. One section is intended to keep eligible people enrolled in the program; others seek to improve MassHealth members' access to particular types of services.

Eligibility Retention

Chapter 224 authorizes MassHealth to institute new procedures to help members, particularly children, maintain their eligibility. Many states, including Massachusetts, have worked to reduce the incidence of Medicaid and Children's Health Insurance Program (CHIP) members being disenrolled for administrative reasons, such as the failure to return a required form on time, when they otherwise remain financially eligible.²⁴ Such "churn" causes confusion and disruptions in members' health care, and is administratively costly to MassHealth.

Section 267 instructs MassHealth to pursue adoption of the "express-lane" option for eligibility renewals created in the federal reauthorization of CHIP in 2009. Express lane will allow MassHealth to renew eligibility for children and their eligible parents based on other state or federal programs' eligibility requirements that are within those of MassHealth. MassHealth already has authority from CMS, in its Section 1115 Waiver, to use express-lane eligibility (ELE) for parents of MassHealth-eligible children. This procedure will go into effect when CMS approves a companion request to use ELE for children. In both cases, the MassHealth eligibility determination could be made by relying on the determination of eligibility by the Department of Transitional Assistance for the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), rather than requiring members eligible for SNAP to submit the same or similar documentation to MassHealth.

A second provision in Section 267 requires MassHealth, by January 1, 2014, to provide families with renewal forms already filled in with whatever current information it has available. The member would then just need to correct or update the information and return the form, rather than having to complete it in its entirety. A final provision in Section 267 mandates a study of the feasibility of continuous eligibility for children in MassHealth. Continuous eligibility usually means a set period of time (often 12 months) during which a child would remain eligible for MassHealth regardless of changes in family income. Section 267 focuses specifically on enabling

²³ Section 280(b)

²⁴ See, for example, Robert Seifert, Garrett Kirk, and Margaret Oakes, *Enrollment and Disenrollment in MassHealth and Commonwealth Care*, Massachusetts Medicaid Policy Institute, April 2010. In addition to these provisions in Chapter 224, MassHealth is pursuing other retention strategies as part of its "MaxEnroll" project, and in its Section 1115 Waiver.

children to remain in the same health plan when they transition between programs, and it names MassHealth and Commonwealth Care. This muddies the intent of this section because children do not participate in Commonwealth Care; a clarifying technical amendment may be needed. The study is due June 30, 2014.

Access to Specific Services

Certain sections of Chapter 224 focus on improving MassHealth members' access to specific types of health care services. Section 265 requires MassHealth to issue regulations for the health plans with which it contracts to comply with federal and state mental health parity laws, beginning in July 2013. MassHealth must report annually to the legislature on how MassHealth and its contractors are complying.

Medicare law specifies that a three-day inpatient hospital stay is required before Medicare will authorize admission to a skilled nursing facility.²⁵ Under current rules, Medicare will not pay a nursing facility for services delivered to someone admitted directly from his or her home, a doctor's office, a hospital emergency room, or even a hospital stay of less than three days or one designated as "observation status" rather than "inpatient."²⁶ This particularly burdens MassHealth, which in many cases absorbs the cost of the nursing facility care when Medicare requirements are not met. Section 245 instructs EOHSS to seek a federal waiver from Medicare's three-day hospitalization requirement.

MassHealth members who are veterans or the survivors and dependents of veterans might qualify for federal veterans' health care benefits. Section 250 requires MassHealth, EOHSS, and the state Department of Veterans' Affairs to study methods for improving access to federal veterans' benefits for those who qualify. The study would include identification of existing barriers to benefits and an examination of the feasibility, costs, and benefits of using the federal public assistance reporting information system (PARIS) to identify veterans, dependents, and survivors who are enrolled in MassHealth. Findings of the study are due to the legislature by April 1, 2013.

V. NEW RESPONSIBILITIES

Health Safety Net Office

Effective November 1, 2012, Chapter 224 transfers responsibility for administering the Health Safety Net (HSN) Office from the then-defunct DHCFP to the Office of Medicaid.²⁷ The legislation also adds behavioral health and substance abuse to the list of conditions considered to be emergency medical conditions, which could change how the HSN is distributed.

Nursing Home Assessment

Prior to Chapter 224's effective date, DHCFP collects an assessment from nursing homes. Effective November 1, 2012, Chapter 224 transfers responsibility for the nursing home assessment to the Office of Medicaid.²⁸

²⁵ This requirement does not apply to non-traditional Medicare plans such as Senior Care Organizations (SCO), Programs of All-Inclusive Care for the Elderly (PACE), and Medicare Advantage plans.

²⁶ Zhanlian Feng, Brad Wright, and Vincent Mor, *Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns About Causes and Consequences*, 31 Health Affairs 6, pp 1251-1259 (June 2012).

²⁷ Section 131 (MGL c 118E §§ 64-69)

²⁸ Section 131 (MGL c 118E § 63)

Personal Care Attendant Workforce Council

Chapter 224 also moves responsibility for the Personal Care Attendant Workforce Council from DHCFP to the Office of Medicaid effective November 1, 2012.²⁹ The Council remains within, but not subject to the control of, EOHHS.

VI. OTHER PROVISIONS

Certification for Patient-Centered Medical Homes (PCMHs)

Chapter 224 directs the HPC, in consultation with MassHealth, to “develop and implement standards of certification for patient-centered medical homes.”³⁰ The law directs the agencies to take into account a number of factors, including dedicated-care coordinators, shared decision making, and after-hours care. PCMHs should be able to assess members for mental health and substance abuse needs, and provide or arrange for appropriate behavioral health care. Certification is voluntary for PCMHs.

The HPC is also directed to consult with MassHealth in establishing patient-centered medical home training for PCMHs “to learn the core competencies of the patient-centered medical home model.”

Independent Care Coordinator for Members in the Duals Demonstration Project

As noted in Section III, MassHealth is planning a demonstration project for dual eligible ages 21 to 64. Members in the demonstration will enroll in an Integrated Care Organization (ICO), a managed care entity that provides for medical care, behavioral health care, and long-term services and supports (LTSS). In order to help enrollees manage their LTSS needs, Chapter 224 requires ICOs to provide an “independent community care coordinator” for members in the Duals Demonstration project.³¹ ICOs may not have a financial ownership connection with the community care coordinator. This was already a feature of the planned demonstration.

Social Security Numbers Required on Medical Benefit Request Forms

MassHealth must ensure, within six months of enactment of Chapter 224, that all applicants who have Social Security numbers provide them on their application for benefits. Chapter 224 further requires that EOHHS verify the identity, age, residence, and eligibility of anyone applying for payment from the Health Safety Net (HSN), except for emergency bad-debt payments.³² Application for MassHealth and the HSN are made using the same form.

²⁹ Section 131 (MGL c 118E §§ 70-75)

³⁰ Section 15 (MGL c 6D § 14)

³¹ Section 117 (MGL c 118E § 9F)

³² Section 266

VII. CONCLUSION

Chapter 224 envisions a restructuring of how health care is delivered and paid for, with the goals of permanently slowing the rate of growth of spending while improving health and health care. The law uses incentives, targets, and increased public scrutiny to achieve the goals. In the case of MassHealth and other public programs, Chapter 224 adds specific requirements for how and how much to pay providers. Many in Massachusetts and across the country will be studying the effectiveness of this new law as it unfolds, judging whether it can stand alongside the 2006 coverage law as a second pillar of health care reform. MassHealth will play no small role in meeting the challenges of Chapter 224.