CHAPTER 224: WHAT DOES IT MEAN FOR HOSPITALS AND HOSPITAL SYSTEMS?

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SIGNIFICANT NEW OVERSIGHT AND REVIEW OF INDIVIDUAL HOSPITALS, HOSPITAL SYSTEMS, AND AFFILIATED PROVIDERS

Hospitals will be subject to a wide range of new state oversight. They will be required to register with the newly created Health Policy Commission (HPC) every two years and to report regularly, in more detail than they do now, on their financial, market, cost, and quality performance, and organizational structure. These new reporting requirements will make it much easier for policymakers and the public to understand and analyze the composition and performance of individual institutions and hospital and health systems.

INTENSE PUBLIC SCRUTINY OF INDIVIDUAL HOSPITAL EXPENSES AND EXPENSE GROWTH

The cost performance of individual hospitals will receive more intense public scrutiny, with the goal of increasing pressure to control costs. Any hospital whose cost growth rate (measured in terms of the change in per capita health-status-adjusted total medical expenses) exceeds the annual health care cost growth benchmark may be required to file a performance improvement plan with the HPC and will be listed on a public website. Hospitals that fail to engage in the reporting or performance improvement process will be subject to fines of up to $500,000.

NEW STANDARDS FOR ASSESSING HOSPITAL MARKET POWER AND MARKET DOMINANCE

The law allows the state to undertake cost and market impact studies in certain situations, such as when a provider proposes to make significant changes in its operations or governance. The law also permits such studies of any provider that exceeds the state's cost growth benchmark. Providers whose market conduct raises concerns can be referred to the Attorney General's (AG's) office for investigation of unfair business practices or anticompetitive behavior. The statute also requires the AG to monitor market trends, including provider consolidation, payer contracting trends, and access and quality issues for patients. These provisions provide an opportunity for the state to articulate and apply new standards for defining the existence of potentially problematic market power.

ENCOURAGEMENT OF ALTERNATIVE PAYMENT ARRANGEMENTS

The law seeks to encourage the growth of alternatives to fee-for-service payment by public and private payers. Private payers are directed to reduce the use of fee-for-service payment methods to the maximum extent possible. Public payers, including Medicaid, the Group Insurance Commission, and the Connector, are required to develop and adopt alternative payment methods, and the state will seek a federal waiver to allow Medicare to participate in such arrangements. Medicaid will increase rates slightly for hospitals that accept alternative payment arrangements. Hospitals and other providers that enter into alternative payment arrangements under which they bear significant downside financial risk will be required to obtain a certificate from the Division of Insurance that attests to their financial solvency and the adequacy of their reserves. These provisions will likely accelerate the growth of alternatives to fee-for-service that is already well under way in the state.

FINANCIAL INCENTIVES TO PARTICIPATE IN ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

HPC is directed to develop a process for ACO certification, including standards for conferring "model ACO" status on organizations that adopt best practices for quality improvement, cost control, and patient protection. While no provider organization is required to become an ACO, the law encourages ACOs to receive state certification by giving preferential treatment to certified ACOs in state-funded health programs.

NEW FINANCIAL SUPPORT FOR HOSPITALS TO ADAPT TO THE CHANGING ENVIRONMENT

The law establishes several new funds to help hospitals and other providers adapt to the changes under way in the health care system. Certain hospitals, including those that receive relatively low rates of payment, will be eligible to compete for funding from a new Distressed Hospital Trust Fund and the e-Health Institute Fund, both financed by an assessment on payers and certain hospitals. Funds will be available to help hospitals invest in health information technology, including electronic medical records, and develop the infrastructure needed to succeed under global payment and other alternative payment arrangements. A new Healthcare Payment Reform Fund will support hospital efforts to comply with the health care cost growth benchmarks.

ATTEMPTS TO SIMPLIFY ADMINISTRATIVE PROCESSES BETWEEN PROVIDERS AND PAYERS

Several provisions of the law address provider concerns about the administrative complexity and costs of dealing with multiple private payers. The Division of Insurance is required to develop standardized forms for prior authorization and summary of payment, and also a standardized process for determining a patient's eligibility for services.