MASSACHUSETTS CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
REPORT OF COUNSEL
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I. HEALTH CARE PAYMENT REFORM

On August 6, 2012, Governor Patrick signed into law comprehensive health care payment reform legislation, Chapter 224 of the Acts of 2012, which is intended to contain health care costs in Massachusetts over the next 15 years. This will have a dramatic impact on the health care system in the Commonwealth. Much of the details of the law are left to new state agencies charged with implementing the reform. MCAAP will carefully monitor the process of implementation and will strongly advocate on behalf of children to ensure that quality and appropriate care are accessible to all children in the Commonwealth.

Highlights of Chapter 224:

- Limiting Health Care Spending Growth. The law sets a statewide annual health care spending growth benchmark (cap) pegged at an amount no greater than the growth of the state's overall economy: Gross State Product or GSP.
    1. For years 2013-2017 the cap is set at GSP. The law sets GSP for 2013 at 3.6%.
    2. For years 2018-2022 the cap is set at GSP minus 0.5%.
    3. For years 2023 and beyond the cap is set at GSP.

    Massachusetts becomes the first state to impose a system wide cap on spending. The cap will apply to hospitals, physician groups and other providers. There are provisions to make adjustments in the annual cap.

    Provider groups that exceed the spending cap may be required to file a performance improvement plan.

    Physician contracting units with a patient panel of 15,000 or fewer, or represents providers who collectively receive less than $25 million net patient revenue are exempt.

- Transition to Global Payments. The law encourages, but does not require, a transition from the traditional fee-for-service to alternative payment methodologies; such as, global payments, shared savings arrangements, bundled payments and episode payments. The insurance market in Massachusetts is moving in that direction anyway. The new law requires the state's Medicaid program, state employee health insurance plans and all other state-funded programs to transition to alternative payment methodologies. No such transition is required for the private or commercial health insurance market.

- ACOs. The law would create a certification process for ACOs and medical homes that meet certain minimum standards. There is no requirement that ACOs or networks be certified, but certified ACOs would receive preference in state health programs, such as MassHealth.

Of particular note for pediatrics, are the following standards an ACO must meet to be certified:

- Promote the health and well being of children, including but not limited to, improving access to pediatric care, providing access to mental and behavioral health services for children, developing and improving pediatric quality measures, developing and improving on pediatric risk adjustments.
- Establish mechanisms to protect provider choice, including parameters for out-of-ACO arrangements.
- Include access to health care services and quality care for vulnerable populations, including children.

- Medical Home. By June of 2014, the state will implement a certification process for medical homes that meet standards established by the Health Policy Commission. There is no requirement that medical homes be certified. It is voluntary. However, certified medical homes will get preference in contracting with state health programs. In developing standards for certification the Commission is required to consider existing standards of the National Committee for Quality Assurance (NCQA) or other independent accrediting organizations.

- New Regulatory Agencies. Several new agencies are created.
  i. Health Policy Commission: would oversee implementation of the overall legislation; set the health care cost growth benchmark (GSP); monitor and review the impact of changes in the health care system.
  ii. Center for Health Information and Analysis: collect cost and quality data from providers, and publish cost and quality data so that consumers and referring physicians can make informed referral and care decisions.
  iii. Health Information Technology Council: encourage the development of interoperative health information exchanges.

- Provider Cost Reports: The state will collect and publish cost and quality data provided by health care providers to the Center for Health Information and Analysis. Requirement as to who will report (physician group size) will be determined by regulation. Health insurers are required to provide a toll-free number and website that enables consumers to request and obtain price information.

- Health information Technology. Requires implementation of a fully interoperative health information exchange that will allow for the secure electronic exchange of health records among all providers in the state by 2017. Electronic order entry is also a goal, and physicians will be required to demonstrate competency in the meaningful use of electronic medical records.

- State Health Plan. A Health Planning Council will develop a state health plan determining the future medical capital needs of the Commonwealth every 5 years. Also, the Determination of Need program is expanded.

- Administrative Simplification for Health Care Providers. The law requires the development of standardize prior authorization forms for use by all providers. It also requires uniform quality measures.

- Nurse Practitioners and Physician Assistants. To address the perceived shortage of primary care physicians, the law enhances the role of nurse practitioners and physician assistants, and allows them to be primary care providers. While the statutory scope of practice of NPs does not specifically change, the law allows NPs to sign, certify, stamp and verify documents previously requiring a physician's signature. The law limiting the number of physician assistants a physician can supervise at any one time (4) is repealed.

- Limited Services Clinics. The Department of Public Health is directed to rewrite Limited Services Clinic regulations to promote the availability of such clinics as a point of access for health care services within the full scope of practice of a nurse practitioner. Limited Services Clinics can not be a patient's primary care provider, but they can be an after hours contractor for a medical home. These clinics can not refer patients to a non-primary care physician, unless the limited services clinic is a satellite of, or affiliated with, a hospital.

- Addressing Primary Care Shortage. The law establishes various loan repayment, loan forgiveness and primary care training programs to address health care workforce shortages. Pediatricians would be included in the definition of primary care provider.

- Prevention and Wellness Programs. Chapter 224 encourages community based prevention and wellness programs aimed at reducing the most costly and most prevalent avoidable health conditions. It is funded through grants, and tax credits are available to businesses that establish wellness programs.

- Medical Malpractice Reform. The law implements the Michigan Model of "Disclosure, Apology and Offer" and establishes a 180 day cooling off period before a party initiates suit; creates a process for providers and aggrieved patients to communicate and exchange documents prior to litigation in the hope of resolving disputes; and makes a provider's apology inadmissible as evidence.

II. PRESCRIPTION DRUG MONITORING PROGRAM

Just as the Legislature closed it formal session for the year on July 31, it passed a law, Chapter 244, that expands the state's Prescription Monitoring Program (PMP). Physicians will be automatically enrolled in the Prescription Drug Monitoring Program, when they renew their state drug license.

Chapter 244 requires the Department of Public Health, in consultation with all relevant licensing authorities, to promulgate regulations that require all prescribers to utilize the PMP prior to seeing a new patient. Authorized support staff may use the prescription monitoring program on behalf of a registered prescriber.

Other significant provisions of Chapter 244 include:

- Restricts the issuance and filling of Schedule II narcotics to only those issued by physicians in a contiguous state or Maine, making Schedule II narcotics tougher to fill in Massachusetts.

- Allows naloxone or other opioid antagonists to be prescribed and dispensed to someone at risk or experiencing a drug overdose or to a family member or other person assisting that person.
- Provides immunity from drug possession charges and prosecution when a drug related overdose victim or witness to an overdose seeks medical attention, and for possession of maloxone.
- Criminalizes “Bath Salts.”
- Requires MassHealth to establish a controlled substance management program for enrollees who use excessive quantities of prescription drugs, and restricts places where enrollees can fill prescriptions.
- Requires DPH to establish a Working Group to investigate, study and promulgate regulations relative to best practices to promote safe and responsible opioid prescribing practices for all prescribers.

III. INSURANCE COVERAGE FOR HEARING AIDS FOR CHILDREN, AND CLEFT PALATE

During the final hours of the legislative session, the following bills were passed:

- Chapter 233, Acts of 212,"An Act to Provide Access to Hearing Aids for Children," requires health insurers to provide coverage for hearing aids for children 21 years or younger. Coverage is the full cost of a hearing aid per hearing impaired ear up to $2,000 for each hearing aid every 36 months. To receive such insurance benefits, the child's treating physician must provide a written statement that the hearing aids are medically necessary. Coverage includes all related services prescribed by an audiologist or hearing instrument specialist including initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds.
- Chapter 234, Acts of 2012, "An Act Relative to the Treatment of Cleft Palate and Cleft Lip," requires health insurers to provide coverage for children under the age of 18 for treatment of cleft lip and cleft palate. Coverage includes benefits for "medical, dental, oral and facial surgery, surgical management and follow up care by oral and plastic surgeons, orthodontic treatment and management, preventative and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services," only if prescribed by the treating physician or surgeon as medically necessary.

IV. CHILDHOOD VACCINE PROGRAM.

The Chapter sponsored Childhood Vaccine Program bill, which creates a vaccine trust fund, passed the Senate as S.2362 in late July, and was referred to the House Ways & Means Committee during the last week of the formal legislative session. Despite strong efforts by the bill’s supporters, the bill did not make it through the final frenzy of the formal legislative session. The Legislature continues to meet in informal sessions where non-controversial matters can be taken up. The Chapter is working with Rep. Alice Wolf to try to pass the bill in the remaining months of the 2012 session.

The Childhood Vaccine Program will create a stable financing framework enabling Massachusetts to guarantee that all children 0-18 years of age receive all the vaccines recommended by the Advisory Committee on Immunization Practices, which sets national standards for immunizations. Not only will S.2362 allow access to all recommended vaccines for children, it also will fund the Massachusetts Immunization Registry which assists providers in keeping immunizations up-to-date by identifying those who are not vaccinated

V. STATE RELAXES PHYSICIAN GIFT BAN

Restrictions imposed in 2008 banning drug and medical device makers from treating Massachusetts physicians to meals and drinks in restaurants have been lifted. The new proposed regulations, which were legislatively mandated by an outside section of the state budget that passed in late June, were released by the Public Health Council at its September meeting. The rules now allow pharmaceutical and medical device companies to pay for "modest" meals and refreshments for doctors as part of informational sessions about their products. No specific dollar limit was set, though the regulations define modest as "similar to what a provider may pay" for a meal when eating out. The Council is expected to issue final regulations in November, following a public hearing on Oct. 19th.

The Massachusetts state legislature is now in recess, meeting informally twice weekly. Informal sessions are intended to address non-controversial matters only, as any one member of the House or Senate can object and halt further action on any bill. However, matters can, and do, move through the legislature, and MCAAP will continue to closely monitor activities for the rest of the session.

Respectfully submitted,
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