Government Affairs Update - *June 29, 2016*

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State Issues

Fiscal Outlook for FY2017 – Temporary Budget

Earlier this week Governor Charlie Baker signed a budget bill to keep state government functioning when the new fiscal year starts later this week. The new fiscal year begins on July 1 and legislative leaders and the Baker administration are trying to come up with plans to address the potential for tax collections next fiscal year to run $450 million to $750 million below the estimates used to build the $39.5 billion spending bills currently in conference. State officials are believed to be considering spending cuts to address their overly optimistic revenue estimate, and conferees can shave spending by agreeing to lower fiscal 2017-line item levels in the dueling House and Senate spending plans. Sluggish tax revenue growth may also be insufficient to trigger a January 1st reduction in the income tax rate from 5.1 to 5.05%, which would preserve about $80 million in revenues for next fiscal year's budget, according to the Massachusetts Taxpayers Foundation. As of this writing, it has been reported that the conferees have reached agreement on the budget and that the legislature may enact it in time for the start of the new fiscal year, July 1.

Governor Charlie Baker's administration has filed a financial statement disclosing that FY2017 tax revenues could be $750 million or more below projections that state budget makers use when crafting their FY2017 proposals. The filing shows tax collections for the current budget year $320-$370 million below benchmarks, and expected tax revenues for FY2017 are now likely to be between $450-$750 million below expectations that Baker and the House and Senate Ways and Means Committees relied upon. The reduction in estimated revenues further complicates what many had already anticipated to be a difficult conference committee negotiation as a result of differences in the policy riders "outside sections" that were included in both the House and Senate budgets.

The $5.3 billion temporary budget will extend capital accounts that would otherwise expire and enable cities, towns and school districts to receive advance local aid payments if they demonstrate "an emergency cash shortfall." This will allow more work time for the six-member legislative conference committee responsible for agreeing to a final spending plan.

We will continue to monitor this process as it continues. For the hospital community, this means that certain items, such as the $15 million state contribution to the Health Safety Net, could receive further scrutiny. While the state has customarily contributed $30 million to the Health Safety Net annually, Governor Baker included no state funding for the program in his FY2017 proposal. The House and Senate proposals, currently under review by the conference committee, both committed $15 million to the Health Safety Net.

Legislative Homestretch

Formal legislative sessions are scheduled to close on July 31. As the session enters its final month and a half, legislator participation in the respective national political conventions will further compress the available timeframe for legislative activity. The complicated revenue picture adds additional complexity. House and Senate leadership have notified their members to be prepared for full formal sessions almost every day in the first few weeks of July (save July 4) and also to be prepared for rarely seen weekend sessions on July 23-24 and July 30-31. Among the major bills that may be addressed in the final weeks include: the state budget (HB4201/SB2305); Governor Baker's Economic Development bill; a House-passed energy bill and the transgender anti-discrimination bill, to name a few.

State Seeks Massive Overhaul of MassHealth

EOHHS has released the state's Medicaid waiver proposal – the document that lays out the state's plans for operating the state's Medicaid program (MassHealth) and related healthcare initiatives. EOHHS is seeking public comment on the proposal through July 15 before submitting it formally to CMS.

Section 1115 of the Social Security Act allows the federal government to waive certain aspects of the Medicaid program to allow states the flexibility to devise programs for certain populations or to permit a state to use federal Medicaid funds in ways that are not otherwise authorized under federal rules.

The main thrust of the state's waiver proposal is to shift the basic structure of MassHealth from a fee-for-service program (where providers are paid for each individual service) to an accountable care model (where services and payments throughout the full spectrum of care are bundled). To do this, EOHHS' Office of Medicaid proposes offering providers three Accountable Care Organization models that are each tied in some form to MassHealth's managed care organizations.

Another key component of the state's waiver involves restructuring the state's Safety Net Care Pool. Massachusetts needs CMS to sign off on the proposed waiver because the federal authorization for the current Safety Net Care Pool – as well as other healthcare programs – expires on June 30, 2017. "If Massachusetts does not reach an agreement to restructure the Safety Net Care Pool prior to the end of June 2017, it will lose federal authorization for over a billion dollars in expenditures each year," EOHHS notes in the waiver proposal.

Behavioral healthcare – generally recognized as the portion of the Massachusetts system most in need of repair – is a major focus of the waiver. EOHHS writes that "an explicit goal of this waiver demonstration is the integration of physical health and behavioral health for individuals with a range of behavioral health needs." To do so, the state offers a variety of approaches, including "the role of certified Behavioral Health Community Partners; contractual expectations for managed care plans, the Massachusetts Behavioral Health Partnership, and ACOs; and other payment model adjustments." Massachusetts also will encourage ACOs to integrate behavioral health and long-term services and supports community partners into care teams.

The state's 92-page Section 1115 Demonstration Project Amendment and Extension Request is attached.

Hospitals Seeking Legal Clarifications
Related to the recent Massachusetts Executive Office of Health and Human Services (EOHHS) reductions in retroactive coverage and changes in eligibility for the Health Safety Net is the creation of a new Health Safety Net "presumptive determination" policy. Under the new policy, representatives at hospitals and community health centers determine if an applicant qualifies for the Health Safety Net based on the applicant's self-attested information. EOHHS will not verify the application information and no verification requests will be sent from the Health Safety Net to the individual patient based on the application. As such, the policy appears to be in violation of a Chapter 224 requirement that EOHHS "ensure that the identity, age, residence and eligibility of all applicants are verified before payments, other than emergency bad debt payments, are made by the Health Safety Net Trust Fund." Because of the ambiguity, the Massachusetts Hospital Association (MHA) has sent the attached letter to EOHHS General Counsel Jesse Caplan seeking written confirmation that the presumptive eligibility determination does indeed comply with all aspects of state law.

Federal Issues

House Energy and Commerce Committee Unanimously Approves Mental Health Bill
The House Energy and Commerce Committee voted 53-0 to approve the "Helping Families in Mental Health Crisis Act," H.R. 2646, after several modifications were made to the bill as a result of bipartisan negotiations. While Committee Democrats voted in favor of the legislation, many called the bill a good first step, but also maintained more work needs to be done on issues like parity between mental health

and physical health, as well as access to treatment for behavioral health. During the markup, Chairman Fred Upton (R-MI) said the bill will likely be considered on the House floor in the fall.

The bill includes provisions that would reauthorize suicide prevention programs and authorize a minority fellowship program for mental health professionals; codify a Medicaid managed care regulation allowing optional state coverage of Institutions for Mental Disease services for adults; and require the Department of Health and Human Services (HHS) to clarify the circumstances in which covered entities may disclose protected health information of a patient with mental illness.

The bill does not include provisions to revise 42 CFR Part 2 regulations to permit sharing a patient's alcohol- and drug-abuse treatment records within health information exchanges, health homes and other integrated care networks. A section-by-section summary is attached.

House Approves Hospital Bill

On June 6, the House passed H.R. 5237 by voice vote. The "Helping Hospitals Improve Act of 2016" would revise Section 603 of the Bipartisan Budget Act to move the grandfather date for off-campus hospital outpatient departments under development from November 2, 2015 to December 31, 2016 or 60 days after enactment, whichever is later. Current law reimburses grandfathered facilities at the HOPD rate, while new facilities are capped at the lower Physician Fee Schedule rate.

The bill would adjust the Hospital Readmissions Reduction Program to account for socioeconomic status, and extend the Rural Community Hospital Demonstration Program for five years. It would bar the termination of certain Medicare Advantage contracts. According to the Congressional Budget Office (CBO), the bill would reduce mandatory spending by a net $14 million from fiscal 2017 through 2026. The prospects for Senate approval are still unclear, but if Senate consideration does occur, it will likely be during the lame duck session.

Speaker Ryan Unveils Policy Plan

Speaker Paul Ryan released a policy plan that will serve as a legislative blueprint for the House Republicans moving forward. It touches on a wide array of issues includes taxes, regulation and healthcare. Though a lot of the proposals are general, the healthcare section did include the repeal of the "Bay State Boondoggle," otherwise known as a repeal of the rural floor, a major benefit to hospitals in Massachusetts. There was no inclusion of actual legislative language, a score from the Congressional Budget office or pay-fors plan in this plan. Though it was largely seen as a campaign document, we will continue to monitor this issue closely.

House Bill to Improve Health Care Price Transparency Introduced

Representatives Michael Burgess (R-TX) and Gene Green (D-TX) have introduced the "Health Care Price Transparency Promotion Act" (H.R. 5547), which would require states to establish and maintain laws requiring disclosure of information on hospital charges, to make such information available to the public, and to provide individuals with information about estimated out-of-pocket costs for health care services. Additionally, the bill calls for research on: (1) the types of cost information that individuals find useful in making decisions regarding healthcare; (2) how this useful information varies according to an individual's health insurance coverage, and if so, by what type of coverage they have; and (3) ways that this information may be distributed in a timely and simple manner.

Medicare Trustees Report Shows Health Care Costs Continue Slow Growth

According to the Medicare Board of Trustees report released on June 22, Medicare spending has continued to grow, but not quickly enough to trigger the Independent Payment Advisory Board. The report said the Medicare Hospital Insurance Trust Fund will have sufficient funds to cover its obligations until 2028, two years earlier than projected last year. The report notes that the revised solvency date is still 11 years later than projected before passage of the ACA.

The 75-year actuarial deficit in the Hospital Insurance Trust Fund is projected at 0.73% of taxable payroll, up from 0.68% projected in last year's report, primarily due to lower taxable payroll and higher projected use of inpatient hospital services. According to the Centers for Medicare and Medicaid Services (CMS), per- enrollee Medicare spending growth has averaged 1.4% over the past five years and is expected to

remain lower than overall health spending growth over the next decade. However, Medicare costs for prescription drugs continue to exceed other cost growth, with average Part D spending per enrollee expected to grow 5.8% annually through 2025. The 2016 annual report is posted here.

Senators urge DOJ to challenge Aetna-Humana, Anthem-Cigna mergers
Sens. Richard Blumenthal (D-CT), Al Franken (D-MN), Elizabeth Warren (D-MA), Sherrod Brown (D-OH), Edward Markey (D-MA), Dianne Feinstein (D-CA) and Mazie Hirono (D-HI) have urged the Department of Justice to challenge the proposed mergers of health insurance companies Aetna and Humana and Anthem and Cigna. "Highly concentrated markets rarely benefit consumers," the senators said in a letter to Assistant Attorney General Renata Hesse. The senators highlight the anticompetitive harm posed in the Medicare Advantage market from the Aetna-Humana merger, and the drastically reduced competition across Blue Cross Blue Shield and non-Blue markets that would result from the Anthem-Cigna merger. They also call into question the effectiveness of divestitures as a remedy for restoring competition, noting that "they have so clearly failed in the recent past."

CMS Issues Final Rule Revising Medicare Payment System for Laboratory Tests
The Centers for Medicare & Medicaid Services (CMS) has issued a final rule (found here) revising the Medicare payment system for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule and implementing other changes required by section 216 of the Protecting Access to Medicare Act of 2014. CMS will implement the new approach to setting CLFS payment rates on Jan. 1, 2018, a one-year delay from the date the agency originally proposed. CMS, in the final rule, decided to use the national provider identifier to apply the statutory requirements to determine whether a laboratory is considered an applicable laboratory. CMS had proposed using taxpayer identification numbers as a mechanism for defining an applicable laboratory, which would have meant virtually no hospital-based laboratories and only 4% of physician office laboratories would qualify as applicable laboratories. For more on the final rule, see the CMS factsheet

CMS to Host Call Reviewing Final Rule on Clinical Laboratory Test Payment System
CMS will host a July 6 call on its final rule revising the Medicare payment system for clinical diagnostic laboratory tests. CMS experts will provide a high-level overview of the final policies. To register for the call, visit here. The final rule is posted here.

MedPAC Issues June Report to Congress
The Medicare Payment Advisory Commission has released its June report to Congress, which annually looks at issues affecting the Medicare program and health care delivery and services. The report also recommends a prototype design for a unified prospective payment system for skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and long-term care hospitals, as required by the Improving Medicare Post-Acute Care Transformation Act of 2014. The Centers for Medicare & Medicaid Services is expected to use the prototype to develop a PAC PPS by 2023. As previously proposed by MedPAC, the prototype would pay for post-acute care services based on a patient's clinical characteristics rather than the site of service. Also as previously proposed, the report recommends reducing dispensing and supplying fees for Medicare Part B drugs to rates similar to other payers, and giving isolated rural hospitals the option to convert to an outpatient-only model that would be sustainable in a community with declining inpatient volumes. The commission also recommends changes to the Part D program to lower program costs and protect beneficiaries with high costs. In addition, the report presents an analysis of Medicare telehealth services, including use of telehealth in Medicare Advantage, and recommends expanding the use of waivers in Center for Medicare & Medicaid Innovation programs to include a broader range of telehealth services.

SAMHSA Issues Mental Health Parity Resource; Task Force Accepting Comments
The Substance Abuse and Mental Health Services Administration has released a resource to help consumers understand their rights under the Mental Health Parity and Addictions Equity Act. The brochure reviews the law's parity protections, how consumers can find out more about their health plan's benefits and coverage, and their right to appeal a claim if denied. The Department of Health and Human Services also has launched a webpage for the Mental Health and Substance Use Disorder Parity Task Force, established by the president in March to identify and promote best practices to better ensure

compliance with parity requirements. Comments and recommendations for the task force may be submitted online.