CHAPTER 224 TRACKING TOOL

A FOCUS ON 2016–2017 ACTIVITY

LAST UPDATED NOVEMBER 2017

FOUNDATION
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BACKGROUND: CHAPTER 224 OF THE ACTS OF 2012

In August of 2012, the Commonwealth of Massachusetts enacted Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation." Chapter 224 has the ambitious goal of bringing health care spending growth in line with growth in the state's overall economy. It aims to do so through a number of mechanisms, including the creation of commissions and funds, the adoption of alternative payment methodologies, increased transparency on the structure and functioning of the health care system, increased transparency for consumers, a focus on wellness and prevention, an expansion of the primary care workforce, health information technology improvements, and health resource planning, among other initiatives. (Read the Blue Cross Blue Shield of Massachusetts Foundation's summary of the law here.) Many of these tasks will take time to implement and will require legislators and state agencies to make additional decisions.

CHAPTER 224 TRACKING TOOL

This abbreviated Tracking Tool highlights progress the state has made in implementing key components of Chapter 224 since the last release of this Tool in September 2016. A more comprehensive Tracking Tool, which documents progress the state has made in implementing the law since its passage in 2012 is available here. These tools are designed for policymakers, advocates, and other stakeholders who wish to track when and how state leaders have addressed policy issues that pertain to Chapter 224. The goal is to provide a basic overview and timeline of Chapter 224-related requirements being implemented by state leaders. *This Tracking Tool is a living document and is updated regularly. If you have any suggested additions or corrections, please email the Blue Cross Blue Shield of Massachusetts Foundation policy team at policy@bluecrossmafoundation.org.*

IMPLEMENTING CHAPTER 224: KEY AGENCIES

The Health Policy Commission (HPC) is the entity charged with implementing many of the major provisions of Chapter 224. (Information on state progress can be found on the HPC's website.) In addition to creating the HPC, Chapter 224 created another state agency, the Center for Health Information and Analysis (CHIA), and assigned new responsibilities to existing state agencies. Below is a description of some of the key state agencies and their respective responsibilities associated with implementation of Chapter 224.

Health Policy Commission

The Health Policy Commission (HPC) was created by the law as an independent agency residing in but not under the control of the Executive Office for Administration and Finance (ANF). It is governed by a diverse 11-member board with input from an advisory council. In December 2012, David Seltz was named executive director of the HPC. The HPC was funded by the Healthcare Payment Reform Trust Fund until June 30, 2016, and has been subsequently funded by an annual assessment on hospitals, ambulatory surgical centers, health plans, and surcharge payers.

The HPC has several key responsibilities, including:

- Establishing the annual cost growth benchmark (by April 15), monitoring progress through annual cost trends hearings (by October 1), and publishing an annual cost trends report (by December 31);
- Registration of provider organizations (RPOs), as well as the certification of accountable care organizations (ACOs) and patient-centered medical homes (PCMHs);
- Analyzing material changes to a provider organization's operations, including mergers and affiliations, and conducting cost and market impact reviews (CMIRs) of changes anticipated to have a significant impact on costs or market functioning;
- Requiring certain payers or providers identified as having excessive cost growth to implement performance improvement plans (PIPs);
- Investing in and directly supporting care delivery and provider transformation;

- Evaluating and testing innovative approaches to delivering cost-effective, high-quality, integrated care, with a focus on behavioral health and care for populations with complex, high-cost needs;
- Administering the Healthcare Payment Reform Trust Fund and the Distressed Hospital Trust Fund; and
- Overseeing the Office of Patient Protection.

To govern execution of its statutorily required responsibilities, the HPC created the following committees. Click on the links to see the committees' members, responsibilities, and meeting information:

1. Care Delivery and Payment System Transformation (CDPST) Committee
2. Community Health Care Investment and Consumer Involvement (CHICI) Committee
3. Cost Trends and Market Performance (CTMP) Committee
4. Quality Improvement and Patient Protection (QIPP) Committee
5. Administration and Finance Committee

Center for Health Information and Analysis

The Center for Health Information and Analysis (CHIA) was created by the law as an independent state agency led by an executive director who is appointed by the attorney general, the state auditor, and the governor for a term of five years. Ray Campbell is the executive director of CHIA as of August 2016.

In July 2015, as part of the state's fiscal year (FY) 2016 budget, a new 11-member oversight council was established to oversee the activities of CHIA. This agency is funded by an assessment on hospitals, ambulatory surgical centers, and certain purchasers (such as commercial health plans) of services from hospitals and such centers.

CHIA has the following responsibilities associated with Chapter 224:

- Measuring the annual change in total health care expenditures (THCE), which is the basis for measuring the state's performance against the HPC's annual cost growth benchmark;
- Compiling an annual report on the performance of the health care system, including analysis of THCE, premiums, total medical expenses (TME), and payment methods;
- Collecting and disseminating data from an All Payer Claims Database (APCD) to further the work of other state agencies and health care improvement efforts broadly; and
- Supporting the Betsy Lehman Center for Patient Safety and Medical Error Reduction (BLC), previously supported by the Department of Public Health (DPH).

CHIA also assumed many of the responsibilities previously under the purview of the Division of Health Care Finance and Policy (DHCFP), including:

- Collecting and analyzing payer and provider data, including monitoring the performance and financial stability of hospitals;
- Managing a consumer health information website;
- Developing a standard quality measure set; and
- Studying the uninsured and underinsured.

Betsy Lehman Center for Patient Safety and Medical Error Reduction

Chapter 224 reestablished the Betsy Lehman Center for Patient Safety and Medical Error Reduction (BLC) as a separate entity that is administratively supported by CHIA. The BLC's board consists of the attorney general, the secretary of health and human services, the undersecretary of consumer affairs, and the executive director of CHIA. Chapter 224 assigns the BLC a broad mandate to enhance patient safety in Massachusetts through:

- Coordination of state agency efforts on patient safety;
- Research and dissemination activities;
- Provider engagement; and
- Patient engagement.

Although the BLC does not perform a regulatory function, it receives reports of Serious Reportable Events and other mandated provider submissions related to patient safety.

Health and Human Services Secretariat

The Executive Office of Health and Human Services (EOHHS), the Office of Medicaid (MassHealth), the Department of Public Health (DPH), and the Department of Mental Health (DMH), among other agencies, gained many important new responsibilities under Chapter 224. These responsibilities include:

- Adopting alternative payment methodologies (APMs) within MassHealth;
- Convening a number of boards and commissions, including the Health Information Technology (HIT) Council, the Public Payer Commission, and the Special Commission on Graduate Medical Education (GME);
- Developing a state health plan;
- Administering the Prevention and Wellness Trust Fund (PWTF); and
- Implementing changes to the regulation of the delivery system, including limited service clinics and determination of need (DoN). In January 2017, DPH issued a revised DoN regulation (105 CMR 100.000) that more closely aligns with the Commonwealth's cost containment and delivery system reform goals.

EOHHS also manages the Commonwealth's State Innovation Model (SIM) grant, a federal grant from the Center for Medicare and Medicaid Innovation that helps to support the state's payment and delivery system reform initiatives.

Office of the Attorney General

The Office of the Attorney General (AG) may require that any provider, provider organization, or payer produce documents, answer interrogatories, and provide testimony under oath related to health care costs and cost trends, factors that contribute to cost growth within the Commonwealth's health care system, and the relationship between provider costs and payer premium rates. The AG may disclose such confidential information through the HPC's cost trends hearings (see M.G.L. Chapter 12, Section 11N), as amended by Section 18 of Chapter 224. In addition, Chapter 224 provides the AG with new responsibilities, including:

- Appointing three members to the HPC board: a health care consumer advocate, a health economist, and an expert in behavioral health, substance use disorder, mental health services, and mental health reimbursement systems;
- Investigating any provider organization referred by the HPC through the CMIR process described above. Specifically, if the HPC identifies through a CMIR process that an entity 1) has a dominant market share for the services it provides, 2) charges prices for services that are materially higher than the median prices charged by other providers, and 3) has health-status-adjusted TME materially higher than the median for other providers, the HPC must refer the entity to the AG, who may conduct an investigation to see if the provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of Chapter 93A or any other law, issue a report to the HPC on the findings of the investigation, and, as appropriate, take action under Chapter 93A or any other law to protect consumers in the health care market;
- Intervening to obtain exemptions or waivers from certain federal laws pertaining to provider market conduct, including a waiver or expansion of the "safe harbors" provision from the federal Office of the Inspector General; and
- Intervening at DoN hearings (see M.G.L. Chapter 111, Section 25C), as amended by Section 71 of Chapter 224.

CHAPTER 224 TRACKING TOOL NAVIGATION

COLUMNS IN THE CHAPTER 224 TRACKING TOOL

Ch. 224 Topic: Chapter 224 topics that require action or implementation.
Ch. 224 Requirements: A description of what the state law requires.
Additional Information: Background information to provide context and/or additional issues that state leaders must consider when making policy decisions.
State Players: State entities, agencies, legislators, and other bodies that may be involved with implementing a particular aspect of Chapter 224.
Timing: Key dates associated with the implementation process as specified by Chapter 224.
Status Update: Actions taken or progress that has been made.

Please note: All provisions of Chapter 224 took effect on November 5, 2012, unless otherwise noted in the "Timing" column below.

INDEX OF TRACKING TOOL ACRONYMS

ACO	accountable care organization
AG	Office of the Attorney General
ANF	Executive Office for Administration and Finance
APCD	All Payer Claims Database
APM	alternative payment methodology
BLC	Betsy Lehman Center for Patient Safety and Medical Error Reduction
BORIM	Board of Registration in Medicine
CDPST	Care Delivery and Payment System Transformation
CHART	Community Hospital Acceleration, Revitalization, and Transformation
CHIA	Center for Health Information and Analysis
CHICI	Community Health Care Investment and Consumer Involvement
CMIR	cost and market impact review
CMS	Centers for Medicare and Medicaid Services
CTMP	Cost Trends and Market Performance
CY	calendar year
DHCFP	Division of Health Care Finance and Policy
DMH	Department of Mental Health
DOI	Division of Insurance
DOR	Department of Revenue
DPH	Department of Public Health
DSM	data submission manual
DSRIP	Delivery System Reform Incentive Payment
EHR	electronic health record
EOHHS	Executive Office of Health and Human Services
EOLWD	Executive Office of Labor and Workforce Development
FSA	flexible spending account
FTE	full-time equivalent
FY	fiscal year
GIC	Group Insurance Commission
GME	graduate medical education
HIE	health information exchange
HIT	health information technology
HPC	Health Policy Commission
HRA	health reimbursement account
HSA	health savings account
ICU	intensive care unit
MeHI	Massachusetts eHealth Institute
M.G.L.	Massachusetts General Laws
MCN	Notice of Material Change
MCO	managed care organization
NCQA	National Committee for Quality Assurance
NP	nurse practitioner
PA	physician assistant
PCMH	patient-centered medical home
PCP	primary care provider
PCPR	Primary Care Payment Reform
PGSP	potential gross state product
PIP	performance improvement plan
PWTF	Prevention and Wellness Trust Fund
QIPP	Quality Improvement and Patient Protection
RBPO	risk-bearing provider organization
RPO	registered provider organization or registration of provider organizations
SIM	State Innovation Model
SQAC	Statewide Quality Advisory Committee
SQMS	standard quality measures set
THCE	total health care expenditures
TME	total medical expenses

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
COST-CONTAINMENT REQUIREMENTS					
Cost Growth Benchmark	• Chapter 224 requires HPC to set the target growth rate for total per person medical spending in the state (see THCE, below). • The cost growth benchmark is pegged to the growth in the state's economy, or the growth rate of potential gross state product (PGSP). • Each year, HPC will notify all health care entities (providers and payers) identified by CHIA as having excessive cost growth and as threatening the benchmark, and beginning in 2016, HPC may require any such entities to file and implement a PIP. A PIP must identify the factors that led to cost growth and include specific cost-saving measures for the entity to undertake within 18 months.	• Chapter 224 set PGSP for 2013 at 3.6%. • For calendar years (CY) 2013–2017, the benchmark is equal to PGSP. • For CY2018–2022, the benchmark is equal to PGSP minus 0.5%, but may be modified up to PGSP. • For CY2023 and beyond, the benchmark is set to PGSP, but can be modified to any figure. • HPC will post on its website the names of entities implementing PIPs. • Entities can be fined up to $500,000 for failure to submit, implement, or report on their PIPs.	• HPC • ANF • House and Senate committees on Ways and Means	• By January 15 annually: The Secretary of ANF and the House and Senate committees on Ways and Means must jointly agree on the PGSP for the coming calendar year. • By April 15 annually: HPC must set the state's health care cost growth benchmark. • 2016 and beyond: HPC can require any entity identified by CHIA as having excessive cost growth and threatening the cost growth benchmark to file a PIP.	• Fall 2016: HPC conducted an initial review of all entities (25 providers and 8 payers) identified by CHIA based on final 2014 data (2012-2013) and preliminary 2015 data (2013-2014) to determine whether a PIP or CMIR is required. • November 2016: HPC board declined to require a PIP for the 2016 CHIA-identified entities. • February 2017: HPC issued proposed PIP regulation and draft instructions and forms (that would be used by entities to submit a PIP) for public comment. • March 8, 2017: HPC held a public hearing on the potential modification of the 2018 cost growth benchmark, which is set to PGSP minus 0.5% (e.g., 3.1%) unless HPC determines that an adjustment to the benchmark is reasonably warranted. Modification to the benchmark must be within the range of PGSP minus 0.5% and PGSP (e.g. 3.1% to 3.6%). Click here to access written testimony and hearing presentation. • March 15 2017: HPC held a public hearing and collected written comments on the proposed PIP regulation and draft instructions and forms. • March 29, 2017: HPC issued its final regulation governing PIPs (958 CMR 10.00) and its policy on processing PIPs and CMIRs. The final regulation took effect April 2017. • For CY2017–2018, the cost growth benchmark has been set to PGSP minus 0.5%, or 3.1%. • April 2017: CHIA issued its updated methodology for entities referred to HPC for review for whether to require a PIP. The revised methodology identified payers and providers based on their final TME data for one year of trend (rather than two years). *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Cost Growth Benchmark**					• April-October 2017: HPC conducted an initial review of CHIA-identified entities (14 providers and 6 payers) based on final 2013-2014 health status-adjusted TME growth and held follow-up meetings with a subset of these entities. • Fall 2017: HPC board will deliberate on whether to require PIP(s) for any of the 2017 CHIA-identified entities.
Total Health Care Expenditures (THCE)	• CHIA must calculate THCE, total annual per person medical spending in the state, used to measure performance against the cost growth benchmark (see above).	• THCE includes: – Expenditures from private health insurance, Medicare, MassHealth, and other state programs, – Cost sharing such as deductibles and co-pays, and – Private insurance administrative costs.	• CHIA	• August–September annually: CHIA publishes annual change in THCE (30 days prior to the HPC cost trends hearings).	• September 2016: CHIA published its final assessment of 2013-2014 THCE growth (+4.2%) and initial assessment of 2014-2015 THCE growth in its 2016 Annual Report on the Performance of the Massachusetts Health Care System. From 2014 to 2015 initial THCE grew by +4.1%, exceeding the 3.6% health care cost growth benchmark by 0.5%. • September 2017: CHIA published its final assessment of 2014-2015 THCE growth (+4.8%) and initial assessment of 2015-2016 THCE growth in its 2017 Annual Report on the Performance of the Massachusetts Health Care System. From 2015 to 2016 initial THCE grew by +2.8%, below the 3.6% health care cost growth benchmark by 0.8%.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Registration of Provider Organizations (RPOs)	• Chapter 224 requires HPC to develop and administer a RPO program. • The RPO database will include detailed information about provider organizations' ownership, governance and operational structure, clinical and corporate affiliates, affiliated providers, and facilities. • Provider organizations will be registered for two-year terms but will also submit related annual filings to CHIA regarding finances, business practices, organizational structure, and market share. • Only RPOs can contract with health plans and third-party administrators.	• Provider organizations with fewer than 15,000 patients or less than $25M in net patient service revenue are exempt from the registration process if they are not risk bearing. • In the first year of the program, only provider organizations that represent hospitals, physician groups, or inpatient and outpatient behavioral health providers were required to register. • All risk-bearing provider organizations (RBPOs) (see below) were required to register, regardless of organization type or net patient service revenue/patient panel. – Initial registration with HPC was split into two parts. This two-part process gave provider organizations an opportunity to familiarize themselves with the structure of and terms in the regulation and the data submission manual (DSM) before filing a full registration.	• HPC • CHIA		• September 2016: HPC and CHIA announced the establishment of a single Massachusetts Registration of Provider Organizations (MA-RPO) program, which incorporates the required reporting elements for both HPC and CHIA into a single annual filing. Click here for an overview of the MA-RPO program. • November 2016: MA-RPO program released the 2015 Initial Registration data for the 60 provider organizations that had completed the initial registration. Data release notes were included with the data release. • March 2017: HPC and CHIA released the 2017 DSM which outlines data elements and submission instructions for the 2017 filing by provider organizations. • June 2017: HPC hosted a series of training sessions on the 2017 filing requirements (slides from the training are available here). • September-October 2017: Online submission platform for the 2017 filing is open; 2017 filing materials are due by October 31, 2017. Click here for 2017 filing materials.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Notice of Material Change (MCN) and Cost and Market Impact Review (CMIR)	• Chapter 224 requires provider organizations to inform HPC, CHIA, and the AG before making material changes to their governance structure or operations (e.g., mergers, acquisitions, new contracting affiliations) by filing an MCN. • HPC can conduct a CMIR if the proposed change is likely to significantly impact the competitive market or the state's ability to meet the cost growth benchmark. • HPC can also conduct a CMIR of any provider identified by CHIA as having excessive cost growth that threatens the benchmark if the percentage change in that provider's THCE exceeded the health care cost growth benchmark in the previous calendar year.	• HPC has 30 days from receipt of a completed an MCN to determine whether to conduct a CMIR. • In a CMIR, HPC must identify any provider entity that: – Has a dominant market share for the services it provides, – Charges prices for services that are materially higher than the median prices charged by other providers, and – Has a health-status-adjusted TME materially higher than the median for other providers. • HPC shall refer to the AG any entity that meets the above three criteria. • The AG can conduct investigations to see if the provider organization has engaged in unfair competition or anti-competitive behavior, issue a report on its findings to HPC, and, as appropriate, take action to protect consumers in the health care market.	• HPC • AG • DPH	• As of January 1, 2013, providers and provider organizations must give at least 60 days' notice to HPC, CHIA, and the AG before making material changes to their governance structure or operations.	• January 2017: DPH issued a revised determination of need (DoN) regulation (105 CMR 100.000), effective January 27, 2017. The revised regulation includes a requirement that an MCN must be filed with or prior to a DoN to allow for the two processes to inform each other. • July 2017: Since April 2013, HPC has completed MCN reviews for 78 provider transactions and has conducted seven CMIRs. • Click here for additional information and for a list of MCNs and CMIR reports.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
PAYMENT AND DELIVERY SYSTEM INITIATIVES					
Risk-Bearing Provider Organization (RBPO) Certification	• Chapter 224 requires that each RBPO that enters into an alternative payment contract and accepts downside risk must file an application with the Division of Insurance (DOI) for a risk certificate so that DOI can understand why its alternative payment contracts will not threaten its financial solvency. • The risk certificate must be renewed annually. • RBPOs can apply for a risk certificate waiver if they can demonstrate to DOI that their alternative payment contracts do not have significant downside risk.	• DOI can conduct further investigations of provider organizations and their alternative payment agreements to ensure that the organizations can meet their risk-bearing responsibilities. • Certain integrated care organizations and senior care organizations are statutorily exempt from the requirement to obtain a risk certificate. • RBPOs must provide HPC with a risk certificate or risk certificate waiver. • Carriers cannot enter into alternative payment contracts with RBPOs unless the RBPOs have either a risk certificate or risk certificate waiver.	• DOI		• December 2016: DOI posted a list of organizations granted risk certificate waivers for the annual period March 1, 2017 – February 28, 2018. • January 2017: DOI posted a list of organizations granted risk certificates for the annual period March 1, 2017 – February 28, 2018. • May 2017: HPC and the Office of Patient Protection issued a bulletin extending the reporting schedule for the RBPO appeals process by six months. • June 2017: DOI posted a list of actuaries who have indicated interest in completing risk certification actuarial reviews for RBPOs. • Risk certificate and risk certificate waiver applications are available on the DOI website.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Alternative Payment Methodologies (APMs)	• Chapter 224 requires the Health Connector, the Group Insurance Commission (GIC), and MassHealth to implement APMs to the maximum extent possible. • The law requires EOHHS to seek a federal waiver to allow Medicare to participate in APMs. • Private health plans are required, to the maximum extent possible, to reduce the use of fee-for-service payments.	• MassHealth must increase payment rates by 2% to providers that accept APMs from MassHealth or MassHealth managed care organizations (MCOs). • CHIA reports on APM use in the Commonwealth on an annual basis. • Click here for a definition of APMs.	• EOHHS • GIC • Health Connector • MassHealth • CHIA • HPC	• MassHealth must, to the maximum extent feasible, achieve the following benchmarks: – By July 1, 2013, 25% of MassHealth enrollees to be enrolled in APMs. – By July 1, 2014, 50% of MassHealth enrollees to be enrolled in APMs. – By July 1, 2015, 80% of MassHealth enrollees to be enrolled in APMs.	• September 2016: CHIA reported on APM adoption in 2015 among payers within various insurance categories in its Annual Report on the Performance of the Massachusetts Health Care System. • September 2016–February 2017: MassHealth conducted a procurement for its ACO program and received 21 responses. • November 2016: MassHealth received approval from the Centers for Medicare and Medicaid Services (CMS) for its 1115 waiver, which will support the restructuring of MassHealth, including the implementation of ACOs. Click here for more information on the 1115 waiver approval. • December 2016: MassHealth launched its one-year ACO pilot program. Six organizations were selected to participate in the pilot program. • December 2016–April 2017: MassHealth conducted a procurement for MCOs. • February 2017: HPC issued its final 2016 Cost Trends Report, which includes recommendations to advance the adoption and alignment/improvement of APMs. • August 2017: MassHealth announced that 17 organizations have signed contracts to participate in its ACO program, covering more than 850,000 members. The ACO program is scheduled to launch in March 2018. MassHealth is requiring selected ACOs to obtain HPC certification by the start of the performance year. • August 2017: MassHealth announced the selection of 26 organizations to enter into contract negotiations as designated community partners (CPs), which will work with ACOs and MCOs to coordinate care for 60,000 members with complex behavioral health and long-term services and supports needs. • October 2017: MassHealth announced its MCO selections which will both partner with ACOs and continue to provide care through the traditional managed care program.

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Patient-Centered Medical Home (PCMH) Certification	• Chapter 224 tasks HPC, in collaboration with MassHealth, with developing and implementing standards for certifying PCMHs. • Certification is voluntary and will last for two years.	• Together, PCMH and ACO certification are being referred to as accountable care certification: "a unified framework for promoting, validating, and monitoring the adoption and impact of accountable care in the Commonwealth." • The HPC CDPST Committee developed the following high-value elements of patient-centered accountable care: care coordination, enhanced access, behavioral health integration, population health management, data systems/performance measurement, and resource stewardship.	• HPC • MassHealth	• January 1, 2014: HPC (with MassHealth) was to develop and implement standards for certifying PCMHs. • January 1, 2014: HPC was to develop a model payment system for PCMHs. • July 1, 2014: HPC and MassHealth were to establish a PCMH training. • December 31, 2016: ACOs, PCMHs, and RBPOs must have interoperable electronic health record (EHR) systems.	• March 2017: HPC launched its PCMH PRIME technical assistance (TA) program with 20 practices committed to participating in the first TA cohort. TA includes individual practice coaching, two day-long learning collaborative sessions, webinars, and peer to peer knowledge sharing sessions. • August 2017: A total of 98 practices are currently participating in PCMH PRIME. • Click here for PCMH PRIME eligibility and application materials.
Accountable Care Organization (ACO) Certification	• Chapter 224 tasks HPC with establishing a registration process for provider organizations to be certified as ACOs. • ACOs must be separate legal entities from the ACO participants and include a consumer representative in the governing structure. • Certification criteria will include requirements to be paid through APMs, to provide medical and behavioral health services across the continuum, and to allow for health care price transparency.	• HPC can develop additional standards for ACO certification given that it has certain goals, including reducing health care costs, improving quality of services, improving access to services, promoting APMs, improving access to primary care, and promoting the integration of behavioral health, among others.	• HPC	• December 31, 2016: ACOs, PCMHs, and RBPOs must have interoperable EHR systems.	• October 2016–March 2017: HPC engaged MassIT to design and build a web-based application platform. • January 2017: The revised DPH DoN regulation (105 CMR 100.000), effective January 27, 2017, encourages ACO certification by allowing for new ambulatory surgery capacity based on an organization's affiliation with an HPC-certified ACO and by providing certain DoN applications submitted by certified ACOs to be reviewed under the delegated process. • March 2017: HPC hosted a webinar to review the ACO certification application requirements and introduce the application system (see slides here). • March–June 2017: HPC conducted a beta testing phase of the online application system and two beta applicants received HPC ACO certification. • April 2017: HPC contracted with Bailit Health to conduct a TA needs assessment of Massachusetts ACOs and develop recommendations for the HPC ACO TA program. *(continued)*

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(continued) **Accountable Care Organization (ACO) Certification**					• June 2017: HPC released its Application Requirements and Platform User Guide for the ACO certification program. • June 2017: HPC issued ACO certifications to the two ACOs that participated in the program's beta launch. • June 2017: HPC fully launched the ACO certification program for all interested ACOs. The first applications for certification are expected over the summer and fall of 2017. Once approved, a certification is valid for two years. • June–July 2017:HPC hosted a series of in-person and web-based trainings for ACO certification applicants. Click here for more information on the training sessions. • October 1, 2017: Application submission deadline for MassHealth ACOs who are required by MassHealth to obtain HPC ACO certification before the start of their contract performance year. • January 1, 2018: HPC target date to issue certification decisions for MassHealth ACOs. • 2018: HPC will analyze and report on information received, implement a TA program, and continue processing certification applications as needed.

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REPORTING REQUIREMENTS					
Cost Trends Hearings and Annual Report	• Chapter 224 requires HPC to hold annual public hearings based on CHIA's Annual Report on the Performance of the Massachusetts Health Care System. • These hearings must examine health care provider/provider organization and private and public health care payer costs, prices, and cost trends, with special attention to factors that contribute to cost growth. • The law requires a comprehensive set of witnesses to testify under oath. • HPC must publish an annual report with cost-containment recommendations by December 31 annually.	• Similar to the DHCFP's cost trends hearings established by Ch. 305 of the Acts of 2008. • Public notice of these hearings must be given at least 60 days in advance. • The AG can intervene in these hearings, identify witnesses to testify, and examine and cross-examine the witnesses. • HPC report must describe spending trends and their underlying factors, as well as make recommendations for strategies to increase health care system efficiency. • The report must be based on HPC hearings and testimony as well as the annual CHIA report on the health care market.	• HPC • CHIA • AG	• HPC holds annual cost trends hearing in October. The report must be submitted to the chairs of the House and Senate committees on Ways and Means and the chairs of the Joint Committee on Health Care Financing, as well as made publicly available, by December 31 each year.	• October 2016: As part of its ongoing work to examine health care cost trends, the AG issued two reports focused on: 1) pharmaceutical spending and 2) distribution of health care spending in the commercial market. • October 2016: HPC hosted the 2016 health care cost trends hearing (view hearing documents here). • February 2017: HPC issued its 2016 Cost Trends Report. • September 2017: CHIA released its fifth Annual Report on the Performance of the Massachusetts Health Care System. • October 2-3, 2017: HPC hosted the 2017 health care cost trends hearings (view hearing documents here).
Report on the Impact of Chapter 224	• The law charges the state auditor with issuing a study on the impact of Chapter 224 on health care payment and delivery systems, health care consumers, and the health care workforce.	• The review must include an investigation of the impact on health care costs; access to health care services and quality of care in different regions of the state and for different populations; access and quality of care for specific services (primary care, behavioral health, substance use disorders, and mental health services); the health care workforce; and public health. • The law requires the state auditor to use data from CHIA, HPC, and DPH to the extent feasible.	• Office of the State Auditor	• March 31, 2017: The state auditor must file the report on the impact of Chapter 224 and any draft legislation with the House and Senate committees on Ways and Means and the Joint Committee on Public Health, as well as post the report on the state auditor's website.	• December 2016: The Office of the State Auditor issued a series of additional reports that provide further data and information on the impact of Chapter 224 on the health care workforce. • June 2017: The Office of the State Auditor issued a report on the impact of Chapter 224, Evaluation of the 2012 Health Care Cost Containment Law in Massachusetts. • Click here for more information on the Office of the State Auditor's ongoing evaluation of Chapter 224.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
All Payer Claims Database (APCD)	• Chapter 224 tasks CHIA with managing the state's APCD and adds new requirements for reporting of APMs, including the risk-adjusted monthly or yearly budgets that health plans pay to providers and their measures of provider performance. • Chapter 224 also requires that health plans, when reporting data to the APCD, attribute every member to a primary care provider.	• Public and private health plans must continue to report claims data to the APCD, along with other previously collected detailed information on premiums, benefits, prices, and costs. • As a result of the 2016 Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Company*, the Employee Retirement Income Security Act invalidates state APCD reporting requirements for self-funded employee health plans. • CHIA makes the APCD available to government and non-government researchers via a data application process.	• CHIA		• September 2016: CHIA released an updated overview of the APCD. • February 2017: CHIA issued an administrative bulletin outlining updates to the APCD fee schedule, including a revision of the criteria for fee waivers. • February 2017: CHIA posted a summary of changes to its data release procedures intended to expedite applications and the approval process for non-government applicants. • Fall 2017: Anticipated release of APCD version 6.0. • Application materials for government and non-government entities requesting APCD data is available here.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
TRANSPARENCY REQUIREMENTS					
Consumer Website	• Chapter 224 moves the consumer website on quality and cost from the Health Care Quality and Cost Council to CHIA. • The law also requires CHIA to make available actual costs and prices of health care services at provider organizations and specify whether providers have met the cost growth benchmark.	• The website must include a host of patient information and decision tools for selecting providers, insurance plans, and treatment options.	• CHIA		• June 2017: An overview of Phase 1 of the consumer health care transparency website was presented to the Statewide Quality Advisory Committee (SQAC). • October 2017: Anticipated launch date of a new consumer website that includes information on the prices of common medical procedures; safety and quality measures for hospitals; procedure-specific conversation guides that facilitate informed discussions between patients, their providers, and their plans; and general information about obtaining insurance and accessing care.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
FUNDS					
Distressed Hospital Fund (also known as the Community Hospital Acceleration, Revitalization, and Transformation [CHART] Investment Program)	• New fund created by Chapter 224 and administered by HPC. • Financed through a one-time assessment on health plans and acute care hospitals with more than $1B in net assets and <50% revenue from public payers. • Initial funding projection was $135M from 2013 to 2016 (60% of assessment funds).[1] • Funds to be dispersed to eligible acute care hospitals through a competitive grant process.	• The purposes of the fund are as follows: – Improve provision of efficient and effective care, – Advance adoption of HIT, – Accelerate health information exchange (HIE) ability, – Support infrastructure investments to transition to APMs, – Develop capacity necessary for ACO certification, and – Improve affordability and quality of care.	• HPC	• June 30, 2013, 2014, 2015, and 2016: Health plans and hospitals paid a one-time surcharge to support this fund, either in a lump sum or in four annual installments. • HPC must create guidelines for an annual progress review and report on fund expenditures by January 31 each year.	• October 2016: HPC hosted the first CHART Phase 2 statewide convening and featured panels on readmission reduction programs, emergency department (ED) and/or inpatient high utilization programs, and ED behavioral health programs (10 regional meetings had been held prior to this statewide meeting). • March 2017: HPC released a CHART Phase 1 factsheet. • October 2017: HPC hosted a second CHART Phase 2 statewide learning and dissemination event to highlight the achievements and insights of the CHART Program. Click here for a summary of the CHART Phase 2 convening. • Fall 2017: Anticipated release of an interim report by Boston University School of Public Health on the evaluation of CHART Phase 2. • January 2018: Anticipated release of Chart Phase 2 final evaluation report.

[1] Sec. 241(f)(1)

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Prevention and Wellness Trust Fund (PWTF)	• New fund created by Chapter 224 and administered by DPH in collaboration with the newly created Prevention and Wellness Advisory Board. • Financed through a one-time assessment on health plans and acute care hospitals with more than $1B in net assets and <50% revenue from public payers. • Initial funding projection was $60M from 2013 to 2016 (23.66% of assessment funds).[2] • DPH Commissioner must award at least 75% of the fund each year through a competitive grant process to community-based organizations, providers, plans, municipalities, and regional planning agencies.	• All activities paid for by the fund must support the goal of meeting the cost growth benchmark and have at least one of the following functions: – Reduce rates of common preventable health conditions, – Increase healthy habits, – Increase adoption of effective health management and workplace wellness programs, – Address health disparities, or – Build evidence of effective prevention programming. • The Prevention and Wellness Advisory Board is tasked with evaluating the effectiveness of the fund.	• DPH	• June 30, 2013, 2014, 2015, and 2016: Health plans and hospitals paid a one-time surcharge to support this fund, either in a lump sum or in four annual installments. • DPH must annually report on fund expenditures and strategy for administration/ allocation of funds by January 31. • The Prevention and Wellness Advisory Board must evaluate the effectiveness of the fund and produce a report by January 31, 2017.	• September 2016: PWTF Advisory Board approved the recommendations developed by the Prevention and Wellness Advisory Board Sustainability Committee for sustaining the PWTF. • September 2016: 63 employers applied to participate in Cohort 4 of Working on Wellness. • DPH has provided the State Auditor's Office with data from four major surveillance systems dating back as far as 2006. • October 2016: Working on Wellness held an event for participating employers to share best practices and lessons learned. • December 2016: PWTF released an interim evaluation report on the PWTF Working on Wellness program. • December 2016: Harvard Catalyst presented a summary of findings from its evaluation of the nine PWTF communities to the PWTF Advisory Board. • December 2016: University of Massachusetts Lowell and University of Massachusetts Medical School presented findings from the Working on Wellness evaluation to the PWTF Advisory Board. • January 2017: DPH issued its final evaluation and PWTF sustainability recommendation report. • June 2017: Harvard Catalyst issued a supplemental evaluation report on the PWTF. • July 2017: PWTF partnerships continue into FY2018 at 50 percent capacity. • Click here to view materials from past Prevention and Wellness Advisory Board meetings.

[2] Sec. 241(f)(2)

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Health Care Workforce Transformation Fund	• Health Care Workforce Transformation Fund planning grants are designed to support planning to address workforce challenges. • Specific goals include: – Support the development and implementation of programs to enhance worker retention rates, – Address critical workforce shortages, – Improve employment in the health care industry for low-income individuals and low-wage earners, – Provide training, educational, or career-ladder services for currently employed or unemployed health care workers who are seeking new positions or responsibilities, and – Provide training or educational services for health care workers in emerging fields of care delivery.	• $20M was appropriated for the Health Care Workforce Transformation Fund. • $4M was directed to DPH to support a loan-forgiveness program for primary care providers. • $1.88M was awarded for planning grants in April 2014.	• Executive Office of Labor and Workforce Development (EOLWD) • Commonwealth Corporation • DPH	• July 2014: Training proposals were due. Training grants support activities for up to two years.	• December 2016: Commonwealth Corporation issued a summary report on the Health Care Workforce Transformation Fund Training Grants. • December 2016: DPH issued Massachusetts Health Professions Data Series: Dentists 2014. This brief provides a summary of demographic, education, and employment data on dentists licensed to practice in the state in 2014. • February 2017: Commonwealth Corporation issued a report and addenda to the administration and legislature summarizing the status of initiatives supported by the Health Care Workforce Transformation Fund as of September 2016. • April 2017: 59 organizations completed their grant activity to support training efforts for health care providers. • April 2017: Over $1.3M was awarded to 6 pipeline partnerships to support health care job training for long-term unemployed individuals. • Click here for a list of Health Care Workforce Transformation Fund advisory board members.
Massachusetts eHealth Institute (MeHI) Fund	• Chapter 224 supplements existing fund with additional funding. Initial funding projection was $30M. • The fund is financed through a one-time assessment on health plans and acute care hospitals with more than $1B in net assets and <50% of revenue from public payers. • This fund will continue to be administered by MeHI and expanded to encourage the adoption of HIT.	• Chapter 224 charged MeHI with using this fund to support the following purposes: – Complete the implementation of EHRs in all provider settings, – Help providers connect EHRs to the state's health information exchange—the Mass HIway, – Identify and promote technologies with the potential to improve the quality and reduce the cost of health care, – Help providers continue to evolve their use of EHRs to comply with Meaningful Use stages, and – Promote understanding of the benefits of health IT to providers, patients, and the public.	• MeHI	• June 30, 2013, 2014, 2015, and 2016: Health plans and hospitals paid a one-time surcharge to support this fund, either in a lump sum or in four annual installments	• June 2017: MeHI released a report that summarizes the findings from a survey of Massachusetts family caregivers, identifies key challenges faced by caregivers, and highlights focus areas where digital health solutions could benefit family caregivers.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
COUNCILS, COMMITTEES, COMMISSIONS, AND TASK FORCES					
Statewide Quality Advisory Committee (SQAC)	• Created by Chapter 288 of the Acts of 2010 and reestablished by Chapter 224 under CHIA. • Tasked with developing a standard quality measures set (SQMS), or a uniform set of health care quality measures for all health care facilities, medical groups, and provider groups in the state. • Chaired by the executive director of CHIA.	• Chapter 224 also allows DOI to use the SQMS in its oversight of selective and tiered network products and directs carriers offering tiered network products to tier providers based on quality performance measured by the SQMS.	• CHIA • DOI	• By November 1 annually: The SQAC must recommend to CHIA any updates to the SQMS.	• October 2016: The SQAC released its Year 5 final report and voted to add six additional measures to the SQMS. • November 2016: CHIA reported on many of the 2016 SQMS measures in its 2016 Focus on Provider Quality report. • Click here to view the 2017 SQMS. • See the SQAC website for more information, including annual reports and meeting dates.
Price Variation Commission **REPEALED**	• Chapter 224 creates an 18-member special commission to examine provider price variation.	• The commission was charged with identifying acceptable and unacceptable factors that lead to price variation, proposing steps to reduce price variation, and recommending the maximum reasonable adjustment to an insurer's rate for acceptable factors.	• HPC • CHIA	• January 1, 2014: The commission was to file results of the analysis and any draft legislation with HPC and the House and Senate clerks. • The House and Senate clerks were to forward a copy of the study to the House and Senate committees on Ways and Means and the Joint Committee on Health Care Financing.	• March 2017:The Special Commission on Provider Price Variation issued a final report with recommendations to reduce unwarranted provider price variation.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
HEALTH CARE WORKFORCE					
Did You Know? **Chapter 224 makes changes to the professional-scope-of-practice laws for physician assistants (PAs) and nurse practitioners (NPs):** **Physician Assistants** **Chapter 224:** • Removes the limit on the maximum number of PAs who can be supervised by a single physician, • Removes the requirement that a physician must sign off on any prescriptions written by the PA, and • Requires health plans to include participating PAs in their searchable list of primary care providers (PCPs) and allows consumers to choose a PA as their PCP. **Nurse Practitioners** **Chapter 224:** • Allows NPs to sign for, certify, stamp, verify, or endorse documents that used to require a physician's signature, and • Promotes the use of limited service clinics, in which "limited services" are defined as services that can be provided within the scope of practice of an NP.					
Nurse Staffing Requirements	• Chapter 224 states that a nurse cannot be required to work mandatory overtime except in emergency situations, the definition of which has been determined by HPC. • Hospitals are now required to report all instances of mandatory overtime. • Chapter 224 states that a nurse may not work more than 16 hours in a 24-hour period; if a nurse does work more than 16 consecutive hours (e.g., due to an emergency), that nurse must be given at least eight consecutive hours off.		• HPC • DPH		• September 2016: DPH issued updated guidance governing the certification process of mandated acuity tools for all remaining acute care hospital intensive care units (ICUs) and all neonatal ICUs. • April 2017: DPH completed certification of all ICU acuity tools. • August 2017: DPH has collected nurse staffing ratio data from academic medical center ICUs, neonatal intensive care unit (NICUs), and all other ICUs.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
HEALTH INFORMATION TECHNOLOGY					
Health Information Technology (HIT)	• Chapter 224 largely moves responsibility for the design, implementation, and operation of the state's HIE from MeHI to EOHHS. • Chapter 224 also moves the existing HIT Council (which advises the state on HIE implementation) from MeHI to EOHHS and expands the council from nine to 21 members. • Chapter 224 creates the Massachusetts Health Information Exchange Fund within EOHHS to finance the development of the statewide HIE. • Chapter 224 gives MeHI new duties pertaining to EHR system implementation. • Chapter 224 sets new deadlines for physician HIT proficiency, development and implementation of interoperable EHR systems, and patient access to EHRs (see "Timing" section for specific deadlines).	• Consistent with its current duties, the HIT Council must annually prepare and update a statewide HIE implementation plan, and file an annual report describing progress in developing a statewide HIE and recommending legislative action if necessary. • EOHHS must determine the penalty for providers who do not develop interoperable EHR systems. • The law also establishes a protocol for unauthorized access or disclosure of patient health information in the HIE, including penalties and standards for notifying affected individuals. • Massachusetts has received $22.3M from the federal government to create the HIE.	• EOHHS • MeHI • Board of Registration in Medicine (BORIM)	• By January 30 annually: HIT Council must file its annual report describing the progress in developing a statewide HIE. • January 1, 2015: Proficiency in HIT (computerized physician order entry, e-prescribing, and EHRs) will be a requirement for physician licensure by BORIM. • December 31, 2016: ACOs, PCMHs, and RBPOs must have interoperable EHR systems. • January 1, 2017: Every patient must have electronic access to his or her health records, and all providers must have fully implemented interoperable EHR systems that connect to the statewide HIE.	• September – December 2016: MeHI facilitated a learning collaborative among 19 organizations to develop tools to support providers in communicating the benefits of sharing patient information in behavioral health settings. • HIT Council released its 2017 meeting schedule. • February 2017: EOHHS issued final Mass HIway regulations (101 CMR 20.00), which establish requirements for organizations that use the MassHIway and implement key requirements of M.G.L. Chapter 118I. Click here for a summary of the regulations. • February 2017: MeHI awarded $193,000 to four EHR vendors to develop interfaces for Child and Adolescent Needs and Strengths reporting for the Commonwealth's Children's Behavioral Health Initiative to support behavioral health providers. • April 2017: More than 1,100 participant organizations were signed up for the Mass HIway (see list of organizations here). • July 2017: In collaboration with the Executive Office of Elder Affairs and the Massachusetts Coalition on Serious Illness Care, MeHI issued a Request for Information for Sharing of Advance Care Planning (ACP) Documents electronically. Responses were due September 15, 2017.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
EMPLOYERS					
Health Plan Wellness Programs	• Chapter 224 creates a wellness program tax credit for small businesses. • Under this program, businesses can receive a tax credit equal to 25% of the costs associated with implementing a qualified wellness program, up to $10,000 per year. • DPH is responsible for establishing the eligibility criteria for the tax credit. • The law requires that employers receive a premium rate discount based on employee participation in wellness programs, among other criteria set forth by DOI.	• DPH, in collaboration with DOI, must analyze and report on wellness plan and health management program best practices in order to create a model wellness guide for payers, employers, and consumers. • Chapter 224 requires that the Commissioner of Revenue, in collaboration with DPH and the Office of Commonwealth Performance, Accountability, and Transparency, review the wellness program tax credit to determine if it has been effective in achieving its public policy goals.	• DPH • DOI • DOR • Council on the Underground Economy	• January 2013: DPH was to produce a report providing wellness plan and health management program best practices. • January 2013: The wellness program tax credit went into effect. • December 31, 2017: The wellness program tax credit ends. • January 1, 2017: The Commissioner of Revenue must file a report on the effectiveness of the wellness program tax credit and any legislative recommendations.	• May 2017: The application for certifying a wellness program for tax year 2017 was made available to employers. • A summary of the annual utilization of the wellness tax credit is available here. • A model wellness guide providing best practices is available here. • A guide to certifying a wellness program for a wellness tax credit is available here.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
INSURANCE MARKET CHANGES					
Tiered Health Plans	• Chapter 224 increases the minimum premium savings for tiered or selective network plans from 12% to 14% (the Commissioner of Insurance must annually determine a base premium rate discount of at least 14% for reduced, selective, or tiered network plans). • The law allows for "smart tiering" plans, defined as products that offer differences in cost sharing based on services rather than the facilities providing services. • If a medically necessary covered service is available at five or fewer facilities in the state, health plans cannot put that service into the most expensive cost-sharing tier. • DOI must report annually and provide legislative recommendations on findings pertaining to tiered products.	• The law requires CHIA's annual cost trends report to present information about the impact of health care payment and delivery reform efforts on costs, including the development of limited and tiered networks.	• DOI	• April 2013: Provisions pertaining to smart tiering plans took effect.	• April 2017: DOI held a hearing to receive public comments on 211 CMR 152.00.
Administrative Simplification	• Chapter 224 seeks to simplify administrative processes for providers by requiring that all health plans use standardized forms for prior authorizations, eligibility determination, and claims statements.	• DOI is charged with developing and implementing uniform prior authorization forms that meet certain criteria (not to exceed two pages, must be made electronically available, etc.).	• DOI	• October 2013: DOI was to develop and implement the uniform prior authorization forms.	• September 2017: DOI issued a bulletin that standardizes prior authorization forms for Hepatitis C medication, non-OB ultrasound services, and SYNAGIS (a therapy used to prevent serious lung disease caused by respiratory syncytial virus in infants).

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Mental Health Parity	• Chapter 224 strengthens reporting and implementation requirements for health plans—both commercial and Medicaid—with regard to compliance with state and federal mental health parity laws.	• The Commissioner of Insurance is responsible for implementing and enforcing federal and state mental health parity laws. • DOI and MassHealth must promulgate regulations requiring carriers and their contractors to comply with applicable federal and state mental health parity laws. • The AG is responsible for enforcing federal and state mental health parity laws under Chapter 93A and can ask the DOI to hold a public hearing on the matter (see Section 254 of Chapter 224).	• DOI • MassHealth • AG	• January 2013: DOI and MassHealth were to promulgate regulations regarding carrier compliance with mental health parity laws. • July 2013: These regulations were to be implemented as part of any provider contract and carriers' health benefit plans. • July 2014: Carriers and their contractors were required to begin submitting annual reports to DOI and the AG, and MassHealth was required to submit an annual report to the Joint Committee on Health Care Financing and the Joint Committee on Mental Health and Substance Abuse, the House and Senate clerks, and the AG, certifying that and explaining how their health plans are in compliance with mental health parity laws.	• July 2017: MassHealth submitted a report to the legislature and the AG certifying MassHealth's contracted health benefit plans' compliance with mental health parity.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
CARE DELIVERY CHANGES					
Waiver of Three-Day Rule	• Chapter 224 requires EOHHS to seek a waiver from the Medicare rule requiring that admission to a skilled nursing facility be preceded by a hospital stay of at least three days ("Skilled Nursing Facility Three-Day Rule").		• EOHHS		• June 2017: CMS released a list of 26 Medicare Shared Savings Program ACOs approved to use the three-day rule waiver, including three Massachusetts-based ACOs.

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