CHAPTER 224 TRACKING TOOL

A REVIEW OF 2012–2017 ACTIVITY

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FOUNDATION
MASSACHUSETTS

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 Tracking Tool seeks to provide a detailed description of key components of Chapter 224, highlighting the progress the state has made in implementing the law since the law's passage in 2012. Please note: an abbreviated Tracking Tool, highlighting progress since the last release of this Tool in September 2016, is also 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.	• For CY2015–2016, the cost growth benchmark has been set to PGSP, or 3.6%. • December 2015: CHIA identified 25 providers (physician groups) and eight payers as having excessive cost growth and threatening the health care cost growth benchmark. Entities were identified if they had growth of greater than 3.6% in health status-adjusted TMEs based on 2012 and 2013 final data submitted to CHIA by payers, as well for 2013 final and 2014 preliminary data submitted to CHIA by payers. • For CY2016–2017, the cost growth benchmark has been set to PGSP, or 3.6%. • March 2016: HPC issued a bulletin with interim guidance for payers and providers that may be required to file a PIP. The interim guidance also notes that HPC has the option to conduct a CMIR of providers identified by CHIA where the state has exceeded the cost growth benchmark (see CMIR, below). • 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. • 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). • 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. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Cost Growth Benchmark**					• March 8, 2017: HPC held a public hearing on the potential modification of the 2018 cost growth (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–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).	• December 2013: CHIA published a methodology white paper describing the calculation of THCE and published preliminary 2011 calculations for illustrative purposes. • September 2014: CHIA published its Annual Report on the Performance of the Massachusetts Health Care System. From 2012 to 2013 initial THCE grew by +2.3%, below the 3.6% health care cost growth benchmark. • October 2014: CHIA published a technical note describing the differences between THCE and State Health Expenditure Accounts — two distinct measures of state-level health care spending. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Total Health Care Expenditures (THCE)**					• August 2015: CHIA published a report describing the data and methodology used to calculate THCE and its growth. • September 2015: CHIA published its final assessment of 2012-2013 THCE growth (+2.4%) and initial assessment of 2013-2014 THCE growth in its 2015 Annual Report on the Performance of the Massachusetts Health Care System. From 2013 to 2014 initial THCE grew by +4.8%, exceeding the 3.6% health care cost growth benchmark by 1.2%. • November 2015–March 2016: CHIA published a series of reports that explore in greater detail topics covered at a high level in the 2015 Annual Report (e.g. Alternative Payment Models, Total Medical Expenses). • 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		• December 2013: HPC published proposed RPO regulations. • January–April 2014: Public comment period on proposed RPO regulations. • April 2014: HPC released draft DSM for public comment. • July 2014: HPC issued its final RPO regulations (958 CMR 6.00) and the Part 1 DSM for provider organizations required to register in the first year of the program. • October–November 2014: Registration window for initial registration Part 1. • Winter/Spring 2015: HPC completed review process of RPO Part 1 materials. • April 2015: HPC released revised draft DSM for public comment. • June 2015: HPC issued the Part 2 DSM. • July–August 2015: HPC hosted a series of training sessions that gave an overview of the registration program framework and the process for completing Part 2 and using the online submission platform. • July–October 2015: Registration window for initial registration Part 2. Part 2 materials were due on October 30, 2015. • September 2015: HPC and CHIA launched online submission platform for provider organizations to submit their RPO materials. Future HPC registration cycles and annual filings with CHIA will occur through this single online platform. • 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. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Registration of Provider Organizations (RPOs)**					• 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.	• March 2013: HPC issued a bulletin providing interim guidance for providers and provider organizations regarding the requirement to submit a notice of material change to HPC. • January 2015: HPC issued its final regulation (958 CMR 7.00) governing MCNs and CMIRs. The final regulation was accompanied by a technical bulletin, which includes additional methodological guidance. • July 2015: HPC issued a Frequently Asked Questions document clarifying the timing and filing requirements for certain types of transactions requiring an MCN. HPC also established a listserv to inform interested stakeholders of both receipt of MCNs and determinations as to whether to initiate a CMIR. • December 2015: HPC issued an additional Frequently Asked Questions document clarifying filing requirements for discount arrangements and application of the financial threshold. • May 2016: HPC issued an updated Notice of Material Change form to be completed by any provider or provider organization filing a proposed material change. • July 2016: HPC issued an additional Frequently Asked Questions document clarifying filing requirements for ACOs. • 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		• November 2012: DOI issued a bulletin granting a transition period in which provider organizations and carriers could enter into or continue to participate in alternative payment contracts with downside risk if the provider organization applies for and receives a transition period waiver from DOI (application requirements for the transition period waiver are listed here). • Fall 2013: DOI issued a proposed regulation for RBPOs. • January 2014: DOI issued a second bulletin extending the transition period to June 2014. • June 2014: DOI requested final comments on the proposed regulation as well as comments on a bulletin concerning the certification of RBPOs; comments were due June 23, 2014. • August 2014: DOI issued its final regulation (211 CMR 155.00) for RBPOs, as well as a bulletin extending the transition period to March 1, 2015. • July 2015: DOI issued additional guidance pertaining to the timeline and materials required as part of the RBPO application requirements. • August 2015: DOI hosted a series of informational webinars to address any questions pertaining to applications for risk certificates or risk certificate waivers. • August 2015: DOI issued a Frequently Asked Questions document for those applying for a risk certificate or risk certificate waiver. • October 2015: DOI posted a list of organizations granted risk certificate waivers for the annual period March 1, 2016 – February 28, 2017. • May 2016: DOI posted a list of organizations granted risk certificates for the annual period March 1, 2016 – February 28, 2017. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Risk-Bearing Provider Organization (RBPO) Certification**					• May 2016: HPC and the Office of Patient Protection issued a bulletin with interim guidance for RBPO/ACO appeals process, as well as an RBPO appeals sample notice. • July 2016: HPC and the Massachusetts Hospital Association hosted two information sessions on the RBPO/ACO appeals process (slides available here). • July 2016: HPC and the Office of Patient Protection issued a bulletin extending the appeals process implementation deadline by one month (to October 1, 2016). • August 2016: DOI issued an informational presentation to assist RBPOs with the application process. • August 2016: HPC and the Office of Patient Protection issued a Frequently Asked Questions document providing additional guidance to RBPOs/ACOs in establishing an appeals process. • 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.

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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.	• December 2013: CHIA released the report Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 Data). • HPC's July 2014 Report provides additional information on APMs. • The GIC has been moving forward with its Integrated Risk Bearing Organization project, which requires its plans to meet specific numerical targets for percentage of members covered by risk-based provider contracts by FY2016. • MassHealth is advancing the adoption of APMs. – January 2014: MassHealth launched Primary Care Payment Reform (PCPR) Initiative. – June 2014: MassHealth initiated a stakeholder engagement process related to ACO development. – October–December 2014: MassHealth established and consulted with a technical advisory group to inform the development of a MassHealth ACO initiative. – May 2015: MassHealth highlighted payment and care delivery reform among its top priorities and hosted a series of regional public stakeholder sessions on this topic, with the goal of reaching 80% APM target in the next three years. • January 2015: CHIA released its report Adoption of Alternative Payment Methods in Massachusetts (2012–2013), which provides new data on APM adoption among MassHealth MCOs, Commonwealth Care, and Medicare Advantage plans, as well as an update on previously reported commercial data. • January–July 2015: EOHHS conducted stakeholder listening sessions around the state and established principles for MassHealth restructuring anchored around payment reform. • August 2015: CHIA released a methodology paper on methods used in calculating APM utilization levels and trends. • August 2015–February 2016: EOHHS convened eight stakeholder workgroups to advise on *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Alternative Payment Methodologies (APMs)**					partners (CPs) for behavioral health and long-term services and supports. • 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 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
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.	• CY2013 Q3–Q4: Development of PCMH standards and criteria, payer engagement, payment model design, reporting and monitoring methods, and PCMH pilot and evaluation design. • March–April 2014: HPC solicited public comment on the proposed PCMH certification program and received 38 written comments. • MassHealth included language that allows for acceptance of HPC PCMH certification as part of the PCPR contract. • February 27, 2015: HPC released a proposed framework for its PCMH certification program and received 40 written public comments through April 10, 2015. • September 2015: HPC issued final revised HPC/National Committee for Quality Assurance (NCQA) program design with focus on enhanced behavioral health integration. Eligible practices must meet at least seven of 13 behavioral health criteria to achieve PCMH PRIME certification. • November 2015: HPC approved final PCMH PRIME certification program. • January 2016: HPC launched its PCMH PRIME certification program. • April 2016–June 2017: HPC/NCQA host a series of web-based and in-person trainings to introduce health care practices to the PCMH PRIME certification program and the application process. Click here for more information on the training sessions. • May 2016: HPC recognizes the first PCMH PRIME certified practice. • June 2016: Over 40 applications have been submitted for PCMH PRIME certification. • July 2016: HPC contracted with Health Management Associates to design and implement its PCMH PRIME technical assistance (TA) program. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Patient-Centered Medical Home (PCMH) Certification**					• August 2016–August 2018: HPC will develop and deliver a TA program for PCMH PRIME. • March 2017: HPC launched its PCMH PRIME 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.	• 2013: The HPC CDPST Committee developed high-level accountable care values. • June 2015: HPC finalized proposed ACO regulations and design for public comment. • November 2015: HPC issued draft ACO certification criteria for public comment. • December 2015–January 2016: HPC issued a request for public comment on the proposed ACO certification standards and received 52 written comments. • April 2016: Following board approval, HPC issued final ACO certification standards. These standards were developed in collaboration with MassHealth and GIC to promote alignment of payment reform efforts. • May 2016–March 2017: HPC developed ACO certification documentation requirements, evaluation criteria, and an application manual. • 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 *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Accountable Care Organization (ACO) Certification**					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. • 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
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.	• August 2013: CHIA released the first Annual Report on the Massachusetts Health Care Market. • October 2013: HPC hosted the 2013 health care cost trends hearing (view hearing documents here). • December 2013: HPC issued preliminary cost trends findings. • January 2014: HPC issued final 2013 Cost Trends Report. • July 2014: HPC issued a Supplement to the 2013 Cost Trends Report. • September 2014: CHIA released its second Annual Report on the Performance of the Massachusetts Health Care System. • October 2014: HPC hosted the 2014 cost trends hearing (view hearing documents here). • January 2015: HPC issued its 2014 Cost Trends Report. • June 2015: The AG issued a report examining behavioral health care cost trends and cost drivers. • September 2015: CHIA released its third Annual Report on the Performance of the Massachusetts Health Care System. • September 2015: The AG issued a report examining health care cost growth in Massachusetts and its impact on consumers. • October 2015: HPC hosted the 2015 health care cost trends hearing (view hearing documents here). • January 2016: HPC issued its 2015 Cost Trends Report. • January 2016: HPC issued a special report on provider price variation examining unwarranted variation in prices among health care providers. • March 2016: Based on recommendations made in the 2015 Cost Trends Report, HPC issued a policy brief on out-of-network billing. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Cost Trends Hearings and Annual Report**					• September 2016: CHIA released its fourth Annual Report on the Performance of the Massachusetts Health Care System. • 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).

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
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.	• The auditor has convened a Chapter 224 advisory committee to assist with the study on the impact of the law. • July 2014: Advisory committee held its first meeting. • FY2015 budget included $431,250 to support the study of the impact of health care payment and delivery systems in Massachusetts. • October 2014: The auditor provided an update on the approach used to evaluate the impact of Chapter 224 at the 2014 cost trends hearing. • October 2015: The Office of the State Auditor issued a summary outlining the specific research methods it is using to evaluate Chapter 224. • October 2015: The Office of the State Auditor issued a report summarizing the results of its Chapter 224 stakeholder survey. • 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		• June 2013: Preliminary data release. • January 2014: CHIA released APCD version 2.0. • March 2014: CHIA released an overview of the APCD. • May 2014: CHIA released APCD version 2.1. • Summer 2014: CHIA and HPC released preliminary statistics on APCD claims from the three largest commercial carriers. • July 2014: HPC and CHIA released an Almanac using APCD data. • April 2015: CHIA released APCD version 3.0 (CY2009–2013 data). • November 2015: CHIA released APCD version 4.0 (CY2010–2014 data). • May 2016: CHIA released MassHealth Baseline Statistics from the APCD. The analysis is based on enhanced eligibility data that MassHealth began submitting to the APCD in 2015. • July 2016: CHIA issued a bulletin to provide notice of the availability of APCD version 5.0 and to highlight new, reclassified, and deleted data elements within the 5.0 release. • July 2016: CHIA released APCD version 5.0 (CY2011–2015 data). • 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		• 2014: CHIA launched the consumer website healthcarehelpmass.gov, with future enhancements identified. • 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.
Price and Data Transparency: Health Plans, Providers, and Utilization Review Organizations	• As of October 1, 2013, health plans must disclose patient-level data to in-network providers for the purpose of care coordination and treatment plans. • This patient-level data must include health care service utilization, medical expenses, and demographic information. • For the purposes of referrals, insurers, non-profit hospital service corporations, medical service corporations, and HMOs must make in-network health care prices available to any provider with whom they have entered into an APM.	• Chapter 224 also requires that health plans fully disclose policies relating to in- and out-of-network cost sharing in evidence-of-coverage documentation.	• DOI	• October 1, 2013: Health plans were to disclose patient-level data to in-network providers for the purpose of care coordination and treatment plans. • October 1, 2013: Health plans and utilization review organizations were to make determinations about the medical necessity of a proposed service within seven days. • August 1, 2014: Health plans and utilization review organizations were to keep up-to-date utilization review criteria on an easy-to-use website.	• November 2014: DOI and HPC issued a joint bulletin regarding carriers' required disclosure of medical necessity criteria.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Price Transparency Toll-Free Number and Website	• Chapter 224 requires all health plans and third-party administrators to offer a toll-free phone number and a website that allows consumers to obtain information on the estimated price for a proposed admission, procedure, or service and the estimated cost sharing that the consumer will be responsible for (including fees, co-pays, and deductibles).	• The cost estimate provided by insurers or third-party administrators is a binding estimate; insurers are prohibited from requiring consumers to pay more than the amount disclosed for the covered services (though insurers can impose cost sharing for any unanticipated services).	• DOI	• As of October 2013, all health plans and third-party administrators were required to offer a toll-free phone number and a website that allow consumers to obtain price and cost-sharing information.	• December 2013: DOI issued a bulletin regarding Chapter 224 consumer price transparency requirements for insurers. • September 2014: DOI released a chart detailing the ways in which consumers can access a given insurer's cost estimator. • Additional health care consumer guide materials are available on the DOI website.
Provider and Referral Information	• Chapter 224 requires that within two working days of a patient's request, providers must disclose the allowed amount of or charge for an admission, procedure, or service. • For insured patients, network providers must tell patients about the toll-free phone number and website available through their insurer and give them enough detailed information to use it. • If a provider refers a patient to another provider within the same provider organization, the provider must disclose that relationship to the patient.		• EOHHS	• As of January 2014, these provider and referral requirements are to be implemented.	

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.	• HPC CHICI Committee tasked with overseeing grant program. • Due to $9.17M in mitigation awarded to hospitals, actual funding—$119.08M over four years—was lower than the initial funding projection. • $39.9M was deposited into the fund by June 2013; this was the total amount available for distribution until the next installment in June 2014. • Renamed the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. • October 2013: Issued Distressed Hospital Trust Fund regulations. • January 2014: $9.2M in initial grants awarded (the average grant was $355,559). • June 2014: Issued CHART Phase 2 request for proposals, for up to $60M (30 acute care hospitals were eligible to receive funds). • September 2014: HPC issued a CHART Leadership Summit Proceedings Paper. • October 2014: HPC awarded $60M in grants to 25 hospitals for CHART Phase 2 (awardees included individual hospitals and joint hospital projects). • February 2015: HPC issued the first in a series of case study reports highlighting lessons learned from three of its CHART Phase 1 hospitals. • March 2015: HPC issued the second in a series of case study reports highlighting the role of strong leadership to drive improvement during CHART Phase 1. • June 2015: HPC released its CHART Phase 1 final report. • June 2015: HPC released its CHART Phase 1 Hospital Factbook. *(continued)*

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

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Distressed Hospital Fund (also known as the Community Hospital Acceleration, Revitalization, and Transformation [CHART] Investment Program)**					• September 1, 2015–February 1, 2016: On a rolling basis, all 25 CHART Phase 2 projects launched. • July 2016: HPC contracted with Boston University School of Public Health (BUSPH) to undertake a mixed-methods evaluation of CHART Phase 2. • August 2016: HPC released its CHART Phase 2 Hospital Factbook. • 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 BUSPH on the evaluation of CHART Phase 2. • January 2018: Anticipated release of Chart Phase 2 final evaluation report.

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.	• June 2013: Prevention and Wellness Advisory Board held its first meeting (see list of members here). • July 2013: DPH held four listening sessions to offer input on a request for responses to allow partnerships (which must each include at least a municipality, a community-based organization, and a health provider) to apply for funds. • December 2013: DPH presented annual progress report to the Prevention and Wellness Advisory Board. • January 2014: Nine communities were awarded grants up to $250,000 through the PWTF for the first phase of their work and will receive additional funding of $900,000–$1.5M for each of the next three years. • Click here for more information on the awards and a list of grantees. • FY2015 budget added the House and Senate chairs of the Joint Committee on Public Health and the House and Senate chairs of the Joint Committee on Health Care Financing to the Prevention and Wellness Advisory Board. • February 2014: DPH issued the 2013 PWTF Legislative Report. • January 2015: DPH issued the 2014 PWTF Legislative Report. • March 2015: DPH awarded an independent evaluation contract to Harvard Catalyst. • June 2015: DPH awarded funds for development of a large-scale worksite wellness training (Working on Wellness) and a technical assistance program for businesses across the state. • July 2015: DPH awarded funds to the University of Massachusetts Medical School and University of Massachusetts at Lowell, which will serve as the external evaluators of the worksite wellness training and technical assistance program. • July 2015: DPH awarded funds to the University of Massachusetts Medical School and University of Massachusetts at Lowell, which will serve as the *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Prevention and Wellness Trust Fund (PWTF)**					external evaluators of the worksite wellness training and technical assistance program. • July 2015: Grantees were required to establish electronic linkages between clinical sites and community-based organizations in their partnership. This linkage, referred to as an e-Referral, is initiated by a clinical provider sending a message through an electronic medical record to a community-based organization that can provide a necessary intervention. Eight communities had achieved e-Referral connections between clinical and community sites, over 200 referrals had been made using e-Referral, and 63 community health workers had been hired and trained. • August 2015: Working on Wellness launched and began accepting employer applications for Cohort 1 via the program website. • October 2015: 30 employers were accepted to Cohort 1 of Working on Wellness. Cohort 1 ran through July 2016. • January 2016: As of January 2016, all nine communities achieved at least one e-Referral connection between clinical and community sites and in total, the communities made over 4,000 referrals from clinical sites to community-based organizations. • January 2016: DPH issued the 2015 PWTF Legislative Report. • March 2016: 62 employers were accepted to Cohort 2 of Working on Wellness. Cohort 2 will run from April 2016 through January 2017. • March 2016: Since January 2015, a total of 8,865 referrals had been made from clinics to community organizations, including 1,344 e-Referrals and 4,285 patients enrolled in community programs. • May 2016: Working on Wellness launched an expert series to introduce employers to topics in worksite wellness and safety. *(continued)*

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

(continued) **Prevention and Wellness Trust Fund (PWTF)**					• June 2016: Prevention and Wellness Advisory Board Sustainability Committee finalized recommendations on PWTF. • June 2016: Joint Committee on Public Health holds informational hearing on PWTF. • June 2016: PWTF Summit on Sustainability. • June 2016: 52 employers were accepted to Cohort 3 of Working on Wellness. Cohort 3 will run from July 2016 through April 2017. • July–September 2016: Recruitment of employers for the final cohort (Cohort 4) of Working on Wellness. Cohort 4 anticipated to launch October 2016. • 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Health Care Payment Reform Trust Fund	• Created and financed by Chapter 194 of the Acts of 2011, the state's 2011 casino bill. • Funded by a portion of revenues associated with new casino licensing fees. Initial funding projection was $40M–$50M. • Chapter 224 charges HPC with monitoring the fund. • Fund can be used to support HPC's activities and to "foster innovation in health care payment and service delivery."	• HPC is responsible for creating a competitive process to award grants, technical assistance, incentives, evaluation assistance, or partnerships to develop, test, and evaluate innovative payment and delivery models.	• HPC	• By January 31 annually, HPC must submit a report on the fund's expenditures. • Until June 30, 2016, the Health Care Payment Reform Trust Fund funded HPC.	• February 2015: HPC reported on FY2014 fund expenditures. • March 2016: HPC reported on FY2015 fund expenditures. • June 2016: HPC issued a proposed regulation (958 CMR 9.00) to collect an annual assessment from certain health care providers and surcharge payers. • July 2016: HPC held a public hearing on proposed annual assessment regulation. • July 27, 2016: HPC board authorized a final regulation (958 CMR 9.00) to collect an annual assessment from certain health care providers and surcharge payers.
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.	• March 2014: Commonwealth Corporation, which is situated under EOLWD, issued a request for proposals to support training of health care providers to improve patient service and reduce health care costs. Planning grantees were eligible to apply for training grants. However, an entity was not required to have had a planning grant to be eligible to apply for a training grant. Proposals were due on July 31, 2014. Training grants do not exceed $250,000 and are for grant periods of no more than two years. • April 2014: $1.88M was awarded to 51 organizations to support planning efforts. This was the first stage of funding. Grant recipients used the funds to evaluate the training and other needs of their current workers in order to prepare for the varying demands of the health care industry, specifically in light of cost-containment changes and quality improvement goals. • FY2015: Health Care Workforce Center made 13 awards to health professionals supporting their practice in high-need areas. • FY2015: Massachusetts League of Community Health Centers made 11 awards for health professional loan repayment. • October 2014: Commonwealth Corporation released a final summary listing of the planning grants. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Health Care Workforce Transformation Fund**					• October 2014: Commonwealth Corporation issued a brief summarizing key findings and trends identified through an evaluation of the planning grant grantees. • December 2014: Over $12M was awarded to over 50 organizations to support training efforts for health care providers. • February 2015: Training grant contracts began. All contracts are set to end by March 31, 2017. • February 2015: Commonwealth Corporation funded a health information technology (IT) workforce training program administered by the Massachusetts eHealth Institute (MeHI) to develop and pilot a health IT curriculum for home health aides and certified nursing assistants. • April–June 2016: Pilot health IT workforce training program implemented. • April 2016: DPH issued Massachusetts Health Professions Data Series: Physicians 2014. This brief provides a summary of demographic, education, and employment data on physicians licensed to practice in the state in 2014. • April 2016: Commonwealth Corporation issued a report to the administration and legislature summarizing the status of initiatives that had been supported by the Health Care Workforce Transformation Fund as of the end of CY2015. • August 2016: DPH issued an update to the Massachusetts Health Professions Data Brief: Registered Nurses 2014. • 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. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Health Care Workforce Transformation Fund**					• 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	• MeHI's strategic and operating plans guide the expenditure of the e-Health Institute Fund. • July 2014: MeHI released its 2014 MeHI Provider and Consumer Health IT Research Study, which examined the use of, need for, and attitudes toward health IT among health care providers and consumers, and identified key drivers for e-Health adoption. • March 2016: MeHI issued a report to the legislature providing an update on its work as required by Chapter 224. • 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					
Health Planning Council	• Chapter 224 creates a new 10-member Health Planning Council within EOHHS to develop a state health plan. • EOHHS and the Health Planning Council must have at least five public hearings to obtain input on the state health plan. • The state health plan must include an inventory of all health resources, such as health care professionals and facilities, including their location, distribution, and type. • The state health plan will guide decisions made by DPH regarding determination of need applications.	• The plan must make recommendations about the appropriate supply and distribution of resources based on projected need for the first five years and the desire to achieve goals relating to cost containment, payment reform, quality of care, and access to community-based and patient-centered preventive and primary care, among other factors. • Chapter 224 allows DPH to require determination of need applicants to provide an independent cost analysis, conducted at the expense of the applicant, to demonstrate that the application is consistent with state cost-containment goals.	• EOHHS	• January 1, 2014: The Health Planning Council was charged with developing the state health plan.	• Visit the Health Planning Council website here. • April 2013: Held first meeting. • May 2013: Appointed 13-member advisory committee. • October 2013: Developed analytic plan and selected behavioral health as a focus area for the first year of work. • December 2013: Published first deliverable, including behavioral health service maps. • March 2014: Provided second deliverable of key service definitions. • May 2014: Provided inventory data for mental health and substance use services and provided summary findings from interviews. • December 2014: The Health Planning Council released its state health plan on behavioral health.
Behavioral Health Integration Task Force	• Chapter 224 creates a 19-member special commission to study payment systems for behavioral health and substance use disorders and integration with primary care.	• The law requires this task force to "examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems."	• DMH	• July 1, 2013: The task force was to submit a report and any proposed legislation and regulatory changes to HPC, the House and Senate clerks, and the House and Senate chairs of the Joint Committee on Health Care Financing.	• July 2013: The task force submitted its report and recommendations to HPC and the legislature (read the report here).
Public Payer Commission	• Chapter 224 creates a 13-member special commission to review public payer health care reimbursement rates and payment systems and their impact on health care providers and private premiums.	• The commission will "examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care."	• EOHHS	• April 1, 2013: Public Payer Commission was to file the results of its analysis and any draft legislation.	• Visit the commission's website here. • January 2014: Commission held its first meeting, after which it met monthly until fall 2014. • December 2014: Commission released report summarizing its findings and recommendations. The report included two supporting documents: Letter from the Massachusetts Association of Health Plans and Home Care Alliance of Massachusetts Principles on ACOs and MassHealth.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
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.	• The advisory committee currently consists of 11 members (view a list of members here). • November 2014: The SQAC released its Year 3 final report. Of the 56 measures nominated in 2014, the SQAC voted to add 28 measures to the SQMS. • April 2015: Committee released Stakeholders' Perspectives on Quality Measurement and Reporting in the Commonwealth. • June 2015: Committee released a brief, Summary of Research and Stakeholders' Perspectives on Quality Measurement and Reporting of Obstetric Care in the Commonwealth. • November 2015: CHIA reported on many of the 2015 SQMS measures in its 2015 Focus on Provider Quality report. • November 2015: The SQAC released its Year 4 final report and voted to add 21 additional measures 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
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.	• February 2015: CHIA released a brief providing additional analysis of commercial provider price variation data from 2013. • January 2016: In conjunction with the release of the 2015 Cost Trends Report, HPC issued a special report on price variation among providers. • February 2016: CHIA released a chart book with data on provider price variation among acute care hospitals and physician groups in the Commonwealth (2013–2014 data). • March–May 2016: HPC hosted a series of stakeholder discussions on potential policy options to address unwarranted price variation. • May 2016: HPC published *Health Affairs Blog*, Addressing Price Variation in Massachusetts. • May 2016: Passage of new price variation legislation, An Act Relative to Equitable Health Care Pricing (c.115 of the Acts of 2016). New legislation repealed this section (Section 279) of Chapter 224 and created a 23-member special commission comprising legislators, governor's appointees, and representatives from diverse stakeholder groups charged with developing recommendations to address price variation. The commission must convene no later than September 15, 2016, and must report on its findings and any proposed legislation by March 15, 2017. • June 2016: HPC released summary report on provider price variation stakeholder sessions. • 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
Pharmaceutical Cost Commission	• Chapter 224 creates a 16-member pharmaceutical cost-containment commission to examine ways to lower prescription drug costs for both public and private payers, including the options of bulk and aggregate purchasing and establishing a single-payer prescription drug system.		• Massachusetts Senate and House of Representatives	• August 2013: The commission was to report any findings and legislative, programmatic, and funding recommendations to the House and Senate clerks. • The House and Senate clerks were to forward a copy of the report to the House and Senate committees on Ways and Means and the Joint Committee on Health Care Financing.	
Diagnostic Accuracy Task Force	• Chapter 224 creates a nine-member special task force to study the prevalence of inaccurate medical diagnoses and their impact on patients and health care costs.	• The law requires the task force to investigate and report on the following: "(i) the extent to which diagnoses in the Commonwealth are accurate and reliable, including the extent to which different diagnoses and inaccurate diagnoses arise from the biological differences between the sexes; (ii) the underlying systematic causes of inaccurate diagnoses; (iii) an estimation of the financial cost to the state, insurers, and employers of inaccurate diagnoses; (iv) the negative impact on patients caused by inaccurate diagnoses; and (v) recommendations to reduce or eliminate the impact of inaccurate diagnoses."	• EOHHS		

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Graduate Medical Education (GME) Commission	• Chapter 224 creates a 13-member special commission to study the economic, social, and educational value of GME to the state and provide recommendations for sustainable funding solutions for GME.	• The commission is tasked with investigating and reporting on the following issues: – The role of residents and medical faculty in the provision of health care in the state and the U.S., – The relationship of GME to the state's physician workforce and emerging models of care delivery, – The current availability and adequacy of all sources of revenue to support GME and potential additional or alternate sources of funding for GME, and – Approaches taken by other states to fund GME.	• EOHHS	• April, 2013: The GME Commission was to file a report and any draft legislation with the House and Senate clerks. • April 2013: The House and Senate clerks were to forward a copy of the report to the House and Senate committees on Ways and Means and the Joint Committee on Health Care Financing.	• The commission held a series of five meetings in 2013. • July 2013: The commission approved and published its final report.
Commission on the Adoption of Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Flexible Spending Accounts (FSAs)	• Chapter 224 creates a 12-member commission at the Department of Revenue (DOR) to examine the feasibility of creating a pilot program to increase the use of HRAs, HSAs, FSAs, and similar programs.	• The law states that the scope of the commission's study should include identifying: – The barriers to full implementation of HRAs, HSAs, FSAs, and other tax-favored health plans, – How to provide greater consumer choice, and – Incentives to increase utilization of HRAs, HSAs, FSAs, and other tax-favored health plans.	• DOR • HPC	• April 2013: The commission was to file a report with recommendations and any draft legislation with the House and Senate clerks, the House and Senate committees on Ways and Means, and the Joint Committee on Health Care Financing.	• April 2013: HPC released a report providing a review of the national and Massachusetts literature on consumer-driven health plans.

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		• June 2013: HPC board approved Guidelines on Mandatory Overtime for Nurses in a Hospital Setting, which limit mandatory nurse overtime to emergency situations (government-declared emergencies, catastrophic events, hospital emergencies). • August 2013: DPH began collecting nurse overtime data, and continues to do so. • June 2014: Chapter 155 of the Acts of 2014, An Act Relative to Patient Limits in All Hospital Intensive Care Units (ICUs), was signed into law. The law, which establishes patient assignment limits for registered nurses in ICUs in acute care hospitals, became effective on September 28, 2014. • January 2015: HPC board approved proposed ICU nurse staffing regulation for public comment. • March 2015: HPC's QIPP committee released proposed nurse staffing quality measures for public comment. • March–April 2015: Public comment period for proposed regulations. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Nurse Staffing Requirements**					• May 2015: HPC released recommended final regulation. • June 2015: HPC board authorized final regulation on patient assignment limits for nurses in ICUs in acute care hospitals. • November 2015: DPH issued guidance governing the certification process of mandated acuity tools for all academic medical center ICUs, excluding neonatal ICUs. • November 2015: HPC issued a bulletin outlining the ICU-related quality measures to be collected and reported by acute care hospitals. • April 2016: First-quarter nurse staffing ratio data for all academic medical center ICUs, excluding neonatal ICUs, submitted to DPH. • July 2016: Second-quarter nurse staffing ratio data was due to DPH. • September 2016: DPH issued updated guidance governing the certification process of mandated acuity tools for all remaining acute care hospital 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.	• October 2012: the state's HIE, also known as the Mass Hlway, went live (see press release). • Oversight for the HIT Council was transitioned from MeHI to EOHHS in December 2012. The 2012, 2013, 2014, 2015, and 2016 annual reports on the HIE and on the activities of MeHI have been submitted to the legislature. • January 2014: Governor Patrick launched the next phase of the Mass Hlway: New tools to allow providers to locate, request, and retrieve medical records from other participating health care providers across the state. • November 2014: MeHI launched the eQuality Incentive Program, focused on EHR adoption in behavioral health and long-term/post-acute care settings. • EOHHS and MeHI continue administering the Medicaid Electronic Health Care Record Incentive Program that has helped bring more than $309M in federal incentive payments to Medicaid providers and hospitals. • Virtually all acute care hospitals in Massachusetts have adopted EHRs. • More than 90% of ambulatory care providers, including more than 95% of PCPs, report that they have adopted EHRs (see 2014 MeHI Provider and Consumer Health IT Research Study). • April 2015: EOHHS reviewed results from a three-month strategic redesign and performance improvement effort for the Mass Hlway at the April HIT Council meeting. • June 2015: The Mass Hlway connects over 447 organizations. It is implementing an outreach team to further adoption in the Commonwealth and working to fully operationalize the Mass Hlway. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Health Information Technology (HIT)**					• June 2015: MeHI launched its Connected Communities Implementation Grant Program, which is designed to strengthen collaborative technology-based connections between health care settings in regions across the state. • November 2015: EOHHS presented the strategic initiatives underway at the Mass HIway to address challenges identified through ongoing stakeholder engagement efforts led by MeHI, HPC, and MassHealth. The initiatives include: – A fast-track initiative to simplify the onboarding process, – A consent initiative to pursue consent workgroup recommendations, and – An event notifications service as a pilot for enhanced functionality. • HIT Council has released its 2016 meeting schedule. • May 2016: More than 650 participant organizations were signed up for the Mass HIway (see list of organizations here). • June 2016: EOHHS presented plans for Mass HIway Regulations to the HIT Council, including a review of proposed approaches for key aspects of the regulations. The regulations are targeted to become effective January 1, 2017. • June 2016: The Mass HIway has seen significant growth in its use by providers for public health reporting, at about 4 million transactions per month. • June 2016: Under the eQuality Incentive Program, MeHI has awarded over $2M in grants to 39 organizations since 2014. As of June 2017, grantees had received $1,864,500 in payments for reaching initial program milestones. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Health Information Technology (HIT)**					• June 2016: Under Connected Communities, MeHI awarded over $3M to eight lead organizations and their 65 collaborators to support projects that drive community-level collaboration among health care providers using innovative technologies. As of June 2017, grantees received $791,837 in payments for reaching program milestones. • 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 2013: Massachusetts wellness tax credit was implemented. • 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.
Fair Share Contribution **REPEALED**	• Chapter 224 changes the fair share contribution so that as of July 1, 2013, employers with 21 or more full-time employees (FTEs) are subject to the fair share requirements. Previously, employers with 11 or more FTEs were subject to the fair share contribution requirements.	• Chapter 224 states that employees with health insurance from other sources will now be counted when determining whether an employer has made a fair share contribution.	• Health Connector	• July 1, 2013: Employers with 21 or more FTEs are subject to fair share requirements.	• The state FY2014 budget eliminated the fair share contribution (and employee health insurance responsibility disclosure requirement) in anticipation of adopting the federal employer responsibility provisions. • Federal employer responsibility provisions were delayed until January 1, 2015, for employers with 100 or more employees; and until January 1, 2016, for employers with 50–99 employees.

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.	• DOI is revising its small-group health insurance regulation (211 CMR 66.00) to establish standards for smart tiering products. • 2016: DOI has developed changes to its small-group health insurance regulation (211 CMR 66.00) to establish standards for smart tiering products. In addition, DOI has developed changes to its health benefit plans using limited/tiered networks regulation (211 CMR 152.00), which applies to the design and marketing of insured health plans that make use of tiered networks, to expand the application of the regulation to smart tiering products. • 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.	• November 2015: DOI issued a bulletin to inform health plans about the use of standard prior authorization forms when reviewing requests for behavioral health services. • July 2016: DOI is working with the Massachusetts Health Care Administrative Simplification Collaborative, consisting of payers and providers, to develop a prior authorization forms that meets the requirements of the various parties. • August 2016: DOI issued a bulletin that standardizes prior authorization forms for medications and imaging services. • 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.	• March 2013: DOI hosted a public hearing on proposed regulations. • May 2013: DOI issued a bulletin on compliance with state and federal mental health parity laws. • Final mental health parity regulations (211 CMR 154) can be accessed here. • March 2013: MassHealth issued draft emergency regulations and held a public hearing. • May 2013: MassHealth emergency regulations finalized. • July 2015: MassHealth submitted a report to the legislature certifying MassHealth's contracted health benefit plans' compliance with mental health parity. • DOI has received carriers' submitted certification materials for CY2012, 2013, and 2014 and reviewed them for consistency of reporting across all payers. DOI is currently reviewing the 2015 reports, which were submitted on July 1, 2016. • The AG receives and reviews the annually submitted certification materials for compliance with state and federal mental health parity laws. • July 2016: MassHealth submitted a report to the legislature and the AG certifying MassHealth's contracted health benefit plans' compliance with mental health parity. • 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					
End-of-Life Care	• Chapter 224 requires that hospitals, nursing facilities, health centers, and assisted living facilities distribute information regarding palliative care and end-of-life options to the appropriate patients, including those diagnosed with a terminal illness. • DPH must consult with the Hospice and Palliative Care Federation of Massachusetts to develop necessary additional materials, rules, and regulations.		• DPH		• October 2013: DPH presented draft regulations regarding end-of-life and palliative care to the Public Health Council. • November 2014: DPH presented final regulations regarding end-of-life and palliative care information to the Public Health Council. • December 2014: DPH regulations regarding end-of-life and palliative care become effective. • See draft regulations and stakeholder testimony here and final regulations here (105 CMR 130.1901).
Checklists of Care	• Chapter 224 encourages checklists of care and requires DPH to develop model checklists. • Health care facilities are required to report data pertaining to use or non-use of checklists to DPH and the BLC.		• DPH • BLC		• 2014: DPH met with content experts and stakeholders to develop an evidence-based checklist for stage 3, stage 4, and unstageable pressure ulcers. • January 2015: DPH began a pilot utilizing the pressure ulcer model checklist in reporting. • 2016: DPH conducting outreach and continued engagement with clinical partners to identify expert consensus documents on standardized best practices.
Telemedicine	• Chapter 224 defines telemedicine and allows insurers to limit coverage to approved networks and charge cost sharing for telemedicine services, so long as cost sharing is not higher than charges for in-person visits. • Chapter 224 tasks DOI, in collaboration with BORIM, with producing a report on the possibility of out-of-state physicians practicing telemedicine in Massachusetts.		• DOI • BORIM	• July 1, 2013: DOI was to produce a report on the possibility of out-of-state physicians practicing telemedicine in Massachusetts.	• DOI has consulted with BORIM on the issues concerning telemedicine in the Commonwealth and is reviewing materials developed by the Federation of State Medical Boards, which has been considering ways that telemedicine should be monitored and regulated across the country. • July 2015: The FY2016 budget directs the HPC to implement a one-year regional pilot program on telemedicine, authorizing the use of up to $500,000 from the Distressed Hospital Fund to implement this pilot. • January 2016: HPC board approved a one-year regional telemedicine pilot program design and authorized the issuance of a request for proposals. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Telemedicine**					• March 2016: HPC issued a request for proposals for a telemedicine pilot program designed to enhance access to behavioral health care. • April 2016: DOI held three information sessions to allow interested parties to present comments and concerns about telemedicine for DOI to include in a report to be submitted to the legislature. • May 2016: HPC deadline to submit telemedicine proposals—11 proposal in total were submitted. • July 2016: HPC announced that it is funding four telemedicine pilots. Awards range from $340,000 to $500,000, for a 12-month period of performance.
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		• July 2013: Waiver request submitted to the U.S. Department of Health and Human Services. • September 2013: CMS notified EOHHS of its intention to make a waiver available to Pioneer ACOs. • April 2014: CMS approved a waiver of the three-day rule for Pioneer ACOs. • June 2015: CMS issued a series of regulations for ACOs participating in the Medicare Shared Savings Program, including provision that beginning in 2017, ACOs may elect to apply for a waiver of the three-day rule. • 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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