

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 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.

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 (HPC)

The 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 is funded by the Healthcare Payment Reform Trust Fund until June 30, 2016, and subsequently by an 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 trend hearings (by October 1), and publishing an annual cost trends report (by December 31);
- Registering provider organizations (RPOs), as well as certifying Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs);
- Conducting Cost and Market Impact Reviews (CMIRs) of material changes to a provider organization’s operations or governance structure;
- Administering the Healthcare Payment Reform Trust Fund and the Distressed Hospital Trust Fund; and
- Overseeing the Office of Patient Protection (OPP).

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 (CHIA)

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; in November 2012, [Aron Boros](#) was appointed as CHIA's Executive Director. This agency is funded by an assessment on hospitals, ambulatory surgical centers (ASCs), and certain purchasers of hospital and ASC services (such as commercial health plans).

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 health care market](#), 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.

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 (BLC)

Chapter 224 re-established the 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), MassHealth, the Department of Public Health (DPH), and the Department of Mental Health (DMH), among other agencies, have many important new responsibilities under Chapter 224. These responsibilities include:

- Adopting alternative payment methodologies within MassHealth;
- Convening a number of boards and commissions, including the Health Information Technology Council, the Public Payer Commission, and the Special Commission on Graduate Medical Education;
- Developing a state health plan;
- Administering the Prevention and Wellness Trust Fund; and
- Implementing changes to the regulation of the delivery system, including limited service clinics and determination of need.

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

Office of the Attorney General (AG)

The attorney general 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 [here](#)). 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 shall 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 determination of need hearings (see [M.G.L. Chapter 111, Section 25C](#), as amended by Section 71 of Chapter 224).

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. This tool is designed for policymakers, advocates, and other stakeholders who wish to track when and how state leaders may address 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 will be updated regularly. If you have any suggested additions or corrections, please email the Blue Cross Blue Shield of Massachusetts Foundation policy team at policy@bcbsmafoundation.org.*

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.

Status Update: Actions taken or progress that has been made.

[Glossary of Chapter 224 Terms](#)

- ACOs: Accountable Care Organizations
- AG: Office of the Attorney General
- ANF: Executive Office for Administration and Finance
- APCD: All Payer Claims Database
- APMs: Alternative Payment Methodologies
- CHART: Community Hospital Acceleration, Revitalization, and Transformation Investment Program
- CHIA: Center for Health Information and Analysis
- CMIR: Cost and Market Impact Review
- DOI: Division of Insurance
- DPH: Department of Public Health
- EOHHS: Executive Office of Health and Human Services
- HPC: Health Policy Commission
- MCN: Material Change Notice
- PCMHs: Patient Centered Medical Homes
- RPOs: Registered Provider Organizations

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

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
COST CONTAINMENT REQUIREMENTS					
Cost Growth Benchmark	<ul style="list-style-type: none"> 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). HPC will notify all health care entities (hospitals, physician groups, ACOs, payers) that exceed the cost growth benchmark each year. Beginning in 2015, HPC may require entities that exceed the benchmark to file and implement performance improvement plans, which must identify the factors that led to cost growth and include specific cost-saving measures for the entity to undertake within 18 months. 	<ul style="list-style-type: none"> Chapter 224 set PGSP for 2013 at 3.6%. For calendar years (CY) 2013 – 2017, the benchmark is equal to PGSP. For CY 2018 – 2022, the benchmark is equal to PGSP – 0.5%, but may be modified up to PGSP. For CY 2023 and beyond, the benchmark is set to PGSP but can be modified to any figure. If HPC identifies (through its cost trend hearings, CHIA's annual report, or any other relevant source) a health care entity that is exceeding the health care cost growth benchmark, HPC can require the entity to submit a performance improvement plan. HPC will post on its website the names of entities implementing performance improvement plans. Entities can be fined up to \$500,000 for failure to submit, implement, or report on their performance improvement plans. 	<ul style="list-style-type: none"> HPC ANF House and Senate Ways and Means committees 	<ul style="list-style-type: none"> By January 15 (annually): the Secretary of the Executive Office for Administration and Finance and the House and Senate Ways and Means committees 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. 2015 and beyond: HPC can require performance improvement plans. 	<ul style="list-style-type: none"> For CY 2014, the cost growth benchmark has been set to PGSP, or 3.6%.

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Total Health Care Expenditures (THCE)	<ul style="list-style-type: none"> • CHIA must calculate THCE, total annual per person medical spending in the state, used to measure performance against the Cost Growth Benchmark (see above). 	<p>THCE includes:</p> <ul style="list-style-type: none"> • Expenditures from private health insurance, Medicare, Medicaid (MassHealth), and other state programs; • Cost sharing such as deductibles and co-pays; and • Private insurance administrative costs. 	<ul style="list-style-type: none"> • CHIA 	<ul style="list-style-type: none"> • August-September (annually): CHIA publishes annual change in THCE (30 days prior to the HPC cost trends hearings). • CHIA will publish 2012–2013 THCE on September 2, 2014. 	<ul style="list-style-type: none"> • December 2013: CHIA published a methodology white paper describing the calculation of THCE and published preliminary 2011 calculations for illustrative purposes.
Registration of Provider Organizations (RPO)	<ul style="list-style-type: none"> • Chapter 224 requires HPC to develop and administer a provider registration program. • The RPO database will include detailed information about provider organizations' structure and finances. • Provider organizations will be registered for two-year terms but will submit annual filings to CHIA. • Only registered provider organizations can contract with health plans and third-party administrators. 	<ul style="list-style-type: none"> • Provider organizations with fewer than 15,000 patients or less than \$25 million 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 are required to register. • All risk-bearing provider organizations (see below) must register, regardless of organization type or NPSR/patient panel. • CHIA will collect additional financial and other data from provider organizations on an ongoing basis. 	<ul style="list-style-type: none"> • HPC • CHIA 		<ul style="list-style-type: none"> • Proposed timeline for registering provider organizations: <ul style="list-style-type: none"> – December 2013: HPC published proposed RPO regulations – January-April 2014: Public comment period – April 2014: HPC releases draft Data Submission Manual for public comment – July 2014: Finalize regulations – Fall 2014: Registration set to begin

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<p>Material Change Notices (MCNs) and Cost and Market Impact Reviews (CMIRs)</p>	<ul style="list-style-type: none"> Chapter 224 requires provider organizations to inform HPC, CHIA, and the AG before making material changes to their governance structure or operations (mergers, acquisitions, etc.). HPC can conduct a CMIR if: <ul style="list-style-type: none"> The proposed change is likely to significantly impact the competitive market or the state's ability to meet the cost growth benchmark, or The percentage change in THCE exceeded the health care cost growth benchmark in the previous calendar year as identified in the annual CHIA report on the health care market. 	<ul style="list-style-type: none"> HPC to issue a preliminary report of the CMIR and identify any provider entity that: <ul style="list-style-type: none"> 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 health-status-adjusted TME that is materially higher than the median for other providers. HPC shall refer to the AG any entity that meets the above 3 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. 	<ul style="list-style-type: none"> HPC AG 	<ul style="list-style-type: none"> Beginning January 1, 2013: 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. 	<ul style="list-style-type: none"> 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 the HPC. Fall 2014: HPC anticipates issuing draft regulations governing MCNs and CMIRs. Click here 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	<ul style="list-style-type: none"> Chapter 224 requires that each RBPO that enters into an alternative payment contract and accepts downside risk must file an application with 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. 	<ul style="list-style-type: none"> 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 the 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. 	<ul style="list-style-type: none"> DOI 		<ul style="list-style-type: none"> November 2012: DOI issued a bulletin granting a transition period in which provider organizations and carriers could enter into and/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 due June 23, 2014. August 2014: DOI is currently in the process of promulgating regulation 211 CMR 155.00 and guidance bulletins governing the RBPO certification process, along with application deadlines and certificate and waiver annual terms.

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<p>Alternative Payment Methodologies (APMs)</p>	<ul style="list-style-type: none"> Chapter 224 requires the Health Connector, the Group Insurance Commission (GIC), and the Office of Medicaid 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. 	<ul style="list-style-type: none"> The Office of Medicaid must increase payment rates by 2% to providers that accept APMs from the Office of Medicaid or Medicaid Managed Care Organizations. CHIA reports on APM use in the Commonwealth on an annual basis. Click here for a definition of APMs. 	<ul style="list-style-type: none"> EOHHS GIC Health Connector Office of Medicaid CHIA HPC 	<ul style="list-style-type: none"> Office of Medicaid must, to the maximum extent feasible, achieve the following benchmarks: <ul style="list-style-type: none"> By July 1, 2013, 25% of Medicaid enrollees to be enrolled in APMs. By July 1, 2014, 50% of Medicaid enrollees to be enrolled in APMs. By July 1, 2015, 80% of Medicaid Enrollees to be enrolled in APMs. 	<ul style="list-style-type: none"> December 2013: CHIA released the report Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 Data). HPC July 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 FY 2016. It is in the second year of the project, and its plans are scheduled to meet the third program milestone by September 30, 2014. MassHealth has met its APM targets and continues to work to advance the adoption of APMs. MassHealth launched Primary Care Payment Reform (PCPR) in January 2014 and recently kicked off a stakeholder engagement process related to ACO development.

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Patient Centered Medical Home (PCMH) Certification	<ul style="list-style-type: none"> Chapter 224 tasks HPC, in collaboration with the Office of Medicaid, with developing and implementing standards for certifying PCMHs. Certification is voluntary and will last for two years. 	<ul style="list-style-type: none"> 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 Care Delivery and Payment System Transformation 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. 	<ul style="list-style-type: none"> HPC Office of Medicaid 	<ul style="list-style-type: none"> January 1, 2014: HPC (with the Office of Medicaid) 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 the Office of Medicaid was to establish a PCMH training. December 31, 2016: ACOs, PCMHs, and risk-bearing provider organizations must have interoperable EHR systems. 	<ul style="list-style-type: none"> CY Q3-Q4 2013: Development of PCMH standards & 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. HPC considering pilot program and evaluating validation criteria and measurement. MassHealth included language that allows for acceptance of HPC PCMH certification as part of the Primary Care Payment Reform (PCPR) contract. FY 2015 budget includes a \$2M reserve for HPC to foster behavioral health integration within PCMHs.
Accountable Care Organization (ACO) Certification	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> HPC can develop additional standards for ACO certification given that they have 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 mental health, among others. 	<ul style="list-style-type: none"> HPC 	<ul style="list-style-type: none"> December 31, 2016: ACOs, PCMHs, and risk-bearing provider organizations must have interoperable EHR systems. 	<ul style="list-style-type: none"> 2013: The HPC Care Delivery and Payment System Transformation Committee developed high-level accountable care values. ACO standards & measures and ACO program design are under development.

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REPORTING REQUIREMENTS					
Cost Trends Hearings and Annual Report	<ul style="list-style-type: none"> Chapter 224 requires HPC to hold annual public hearings based on CHIA's annual report on the Massachusetts health care market. 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. 	<ul style="list-style-type: none"> Similar to the Division of Health Care Finance and Policy'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. The report must describe spending trends and their underlying factors, as well as recommendations for strategies to increase health care system efficiency. The report must be based on HPC commission hearings and testimony as well as the annual CHIA report on the health care market. 	<ul style="list-style-type: none"> HPC CHIA AG 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> August 14, 2013: CHIA released the first Annual Report on the Massachusetts Healthcare Market. October 1-2, 2013: HPC hosted the 2013 cost trends hearing (view hearing documents here). December 2013: HPC issued preliminary cost trend findings. January 2014: HPC issued final 2013 Cost Trends Report. July 2014: HPC issued a Supplement to the 2013 Cost Trends Report. September 2, 2014: CHIA to release the second Annual Report on the Massachusetts Healthcare Market. October 6-7, 2014: 2014 cost trends hearing scheduled.

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Report on the Impact of Chapter 224	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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, 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. 	<ul style="list-style-type: none"> Office of the State Auditor 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. FY 2015 budget included \$431,250 to support the study of the impact of health care payment and delivery in Massachusetts.
All Payer Claims Database (APCD)	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. CHIA makes the APCD available to researchers and others via a data application process (view here). 	<ul style="list-style-type: none"> CHIA 		<ul style="list-style-type: none"> June 2013: Preliminary Data Release December 2013: Data Release version 2.0. March 2014: CHIA released an overview of the APCD. April 2014: CHIA released APCD version 2.1. Summer 2014: CHIA and HPC release preliminary statistics on APCD claims from the three largest commercial carriers. HPC issued a Preliminary Cost Trends Report (December 2013) and a Supplement (July 2014) using APCD data. July 2014: HPC and CHIA released an Almanac using APCD data.

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TRANSPARENCY REQUIREMENTS					
Consumer Website	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The website must also include a host of patient information and decision tools for selecting providers, insurance plans, and treatment options. 	<ul style="list-style-type: none"> CHIA 		<ul style="list-style-type: none"> Preliminary launch scheduled for winter 2014-2015.
Price and Data Transparency: Health Plans, Providers, and Utilization Review Organizations	<ul style="list-style-type: none"> 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, nonprofit 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. 	<ul style="list-style-type: none"> Chapter 224 also requires that health plans fully disclose policies relating to in- and out-of-network cost sharing in evidence-of-coverage documentation. 	<ul style="list-style-type: none"> DOI 	<ul style="list-style-type: none"> 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. 	

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Price Transparency Toll Free Number and Website	<ul style="list-style-type: none"> 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 paying (including fees, co-pays, or deductibles). 	<ul style="list-style-type: none"> The cost estimate provided by insurers or third-party administrators is a binding estimate; insurers will be 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). Carriers have two business days to provide consumers with the cost estimate. 	<ul style="list-style-type: none"> DOI 	<ul style="list-style-type: none"> As of October 1, 2013, all health plans and third-party administrators must offer a toll-free phone number and website that allow consumers to obtain price and cost-sharing information. 	<ul style="list-style-type: none"> December 2013: DOI issued a bulletin regarding Chapter 224 consumer price transparency requirements for insurers. January 2014: DOI released a chart detailing the way in which consumers can access a given insurer's cost estimator. Carriers have submitted plans to make transparency information available in real time, and most have either already made this available or are on track for January 1, 2015, implementation.
Provider and Referral Information	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> EOHHS 	<ul style="list-style-type: none"> As of January 1, 2014, within two working days of a patient's request, providers must disclose the allowed amount of or charge for an admission, procedure, or service, including any fees. For insured patients, network providers must give the patient, upon request, information about the toll-free phone number available through the patient's insurer. 	<ul style="list-style-type: none"> December 2013: EOHHS posted a price transparency memorandum.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
FUNDS					
Distressed Hospital Fund (also known as Community Hospital Acceleration, Revitalization, and Transformation [CHART] Investment Program)	<ul style="list-style-type: none"> • New fund, created by Chapter 224 and administered by HPC. • Financed through the one-time assessment on health plans and acute hospitals with more than \$1B in net assets and <50% revenue from public payers. • Initial funding projection is \$135M from 2013 to 2016 (60% of assessment funds).¹ • Funds to be dispersed to eligible acute hospitals through competitive grant process. 	<ul style="list-style-type: none"> • The purposes of the fund are as follows: <ul style="list-style-type: none"> – Improve provision of efficient and effective care, – Advance adoption of HIT, – Accelerate HIE ability, – Support infrastructure investments to transition to APMs, – Develop capacity necessary for ACO certification, and – Improve affordability and quality of care. 	<ul style="list-style-type: none"> • HPC 	<ul style="list-style-type: none"> • June 30, 2013, 2014, 2015, and 2016: health plans and hospitals must pay a one-time surcharge that supports this fund, either in a lump sum or in four installments. The first installment was due by June 30, 2013. • HPC must create guidelines for an annual progress review and report on fund expenditures by January 31 each year. 	<ul style="list-style-type: none"> • CHICI Committee tasked with overseeing grant program. • Due to \$9.17M in mitigation awarded to hospitals, actual funding, \$119.08M estimated over four years, is lower than the initial funding projection. • \$39.9M was deposited into the fund by June 30, 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 8, 2014: \$9.95M in initial grants awarded to 28 hospitals (the average grant was \$355,559). • June 17, 2014: issued Request for Proposals for CHART Phase 2, for up to \$60M.

¹ Sec. 241(f)(1)

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Prevention and Wellness Trust Fund	<ul style="list-style-type: none"> • New fund, created by Chapter 224 and administered by DPH in collaboration with the newly created Prevention and Wellness Advisory Board. • Financed through the one-time assessment on health plans and acute hospitals with more than \$1B in net assets and <50% revenue from public payers. • Initial funding projection is \$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 CBOs, providers, plans, municipalities, and regional planning agencies. 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – 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. 	<ul style="list-style-type: none"> • DPH 	<ul style="list-style-type: none"> • June 30, 2013, 2014, 2015, and 2016: health plans and hospitals must pay a one-time surcharge that supports this fund, either in a lump sum or in four installments. The first installment was due by June 30, 2013. • 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. 	<ul style="list-style-type: none"> • 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 an RFR to allow partnerships (which must each include at least a municipality, CBO, and health provider) to apply for funds. • August 2013: DPH posted RFR. • November 2013: applications were due. • December 2013: DPH presented annual progress report to Prevention and Wellness Advisory Board. • January 2014: nine communities were awarded funds up to \$250,000 for the 1st phase of their work and will receive additional funding between \$900,000 and \$1.5M for each of the next three years. • Click here for more information on the awards and a list of grantees. • FY 2015 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.

² Sec. 241(f)(2)

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Healthcare Payment Reform Trust Fund	<ul style="list-style-type: none"> • 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 is about \$40-\$50 million. • 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." 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • HPC 	<ul style="list-style-type: none"> • By January 31 (annually), HPC must submit a report on the fund's expenditures. • Until June 30, 2016, HPC will be funded through the Healthcare Payment Reform Fund. 	

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
<p>Health Care Workforce Transformation Fund</p>	<ul style="list-style-type: none"> • Health Care Workforce Transformation Fund Planning Grants are designed to support planning to address workforce challenges. • Specific goals include: <ul style="list-style-type: none"> – 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. 	<ul style="list-style-type: none"> • \$20 million was appropriated for the Health Care Workforce Transformation Fund. • \$4 million was directed to the Department of Public Health to support a loan-forgiveness program for primary-care providers. • \$1.88 million was awarded for planning grants in April 2014. 	<ul style="list-style-type: none"> • Executive Office of Labor and Workforce Development • Commonwealth Corporation • DPH 	<ul style="list-style-type: none"> • July 31, 2014: training proposals due. Training grants will support activities for up to two years. 	<ul style="list-style-type: none"> • \$1.88 million was awarded to 51 organizations to support planning efforts. This is the first stage of funding. Grant recipients will use 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. • On March 5, 2014, Commonwealth Corporation issued a request for proposals to support training. Planning grantees are eligible to apply for training grants. However, an entity is not required to have had a planning grant to be eligible to apply for a training grant. Letters of intent were due on June 27, 2014; proposals were due on July 31, 2014. Training grants will not exceed \$250,000 and will be for grant periods of no more than two years. • The Health Care Workforce Center made 12 awards to health professionals supporting their practice in high-need areas. • The Massachusetts League of Community Health Centers made 11 awards for health professional loan repayment.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
<p>Massachusetts e-Health Institute (MeHI) Fund</p>	<ul style="list-style-type: none"> • Chapter 224 supplements existing fund with additional funding. Initial funding projection is \$30 million. • Funding is financed through a one-time assessment on health plans and acute hospitals with more than \$1 billion 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 health information technology. 	<ul style="list-style-type: none"> • Chapter 224 charged MeHI with using the e-Health Institute Fund to support the following purposes: • Complete the implementation of electronic health records (EHRs) in all provider settings; • Help providers connect these EHRs to the Commonwealth'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 future Meaningful Use stages; and • Promote understanding of the benefits of health IT to providers, patients, and the public. 	<ul style="list-style-type: none"> • MeHI 	<ul style="list-style-type: none"> • June 30, 2013, 2014, 2015, and 2016: health plans and hospitals must pay a one-time surcharge that supports this fund, either in a lump sum or in four installments. The first installment was due by June 30, 2013. 	<ul style="list-style-type: none"> • MeHI's Strategic and Operating Plans guide the expenditure of the e-Health Institute Fund.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
COUNCILS, COMMITTEES, COMMISSIONS, AND TASK FORCES					
Health Planning Council	<ul style="list-style-type: none"> 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 (DON) applications. 	<ul style="list-style-type: none"> The plan must make recommendations about the appropriate supply and distribution of resources based on projected need for the next 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 DON 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. 	<ul style="list-style-type: none"> EOHHS DPH 	<ul style="list-style-type: none"> January 1, 2014: The Health Planning Council must develop the state health plan. 	<ul style="list-style-type: none"> April 24, 2013: held first meeting. May 23, 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 abuse services and provided summary findings from interviews. Visit the Health Planning Council website here.
Behavioral Health Integration Task Force	<ul style="list-style-type: none"> Chapter 224 creates a 19-member special commission to study payment systems for behavioral health and substance use disorders and integration with primary care. 	<ul style="list-style-type: none"> 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.” 	<ul style="list-style-type: none"> DMH 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The task force submitted its report and recommendations to HPC and the Legislature in July 2013 (read the report here). HPC Behavioral Health Agenda developed.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Public Payer Commission	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.” 	<ul style="list-style-type: none"> EOHHS 	<ul style="list-style-type: none"> April 1, 2013: public payer commission was to file the results of its analysis and any draft legislation. 	<ul style="list-style-type: none"> January 6, 2014: commission held its first meeting (see agenda here) The commission is meeting monthly until fall 2014. Visit its website here.
Statewide Quality Advisory Committee (SQAC)	<ul style="list-style-type: none"> 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 each health care facility, medical group, and provider group in the state. Chaired by the Executive Director of CHIA. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> CHIA DOI 	<ul style="list-style-type: none"> By November 1 (annually): SQAC must recommend to CHIA any updates to the SQMS. 	<ul style="list-style-type: none"> The advisory committee currently includes 13 members (view here). The SQAC is currently in its third cycle of SQMS development and is considering additional measures for 2014. See website for more information, including annual reports and 2014 meeting dates.
Price Variation Commission	<ul style="list-style-type: none"> Chapter 224 creates an 18-member special commission to examine provider price variation. 	<ul style="list-style-type: none"> The commission must identify acceptable and unacceptable factors that lead to price variation, propose steps to reduce price variation, and recommend the maximum reasonable adjustment to an insurer’s rate for acceptable factors. 	<ul style="list-style-type: none"> HPC/CHIA 	<ul style="list-style-type: none"> January 1, 2014: the commission was to file results of the analysis and any draft legislation with the 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. 	

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Pharmaceutical Cost Commission	<ul style="list-style-type: none"> 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. 		<ul style="list-style-type: none"> Massachusetts Senate and House of Representatives 	<ul style="list-style-type: none"> August 6, 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.” 	<ul style="list-style-type: none"> EOHHS 		

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Graduate Medical Education (GME) Commission	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The commission is tasked with investigating and reporting on the following issues: <ul style="list-style-type: none"> The role of residents and medical faculty in the provision of health care in MA and the US, 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 state to fund GME. 	<ul style="list-style-type: none"> EOHHS 	<ul style="list-style-type: none"> April 1, 2013: the GME Commission was to file a report and any draft legislation with the House and Senate clerks. April 1, 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. 	<ul style="list-style-type: none"> The commission held a series of meetings in 2013 (on February 25, March 29, May 13, June 18, and July 30). July 30, 2013: the commission approves and publishes its final report.
Commission on the Adoption of HRAs, HSAs, and FSAs	<ul style="list-style-type: none"> 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 health reimbursement arrangements (HRAs), health savings accounts (HSAs), flexible spending accounts (FSAs), and similar programs. 	<ul style="list-style-type: none"> The law states that the scope of the commission's study should include identifying: <ul style="list-style-type: none"> The barriers to full implementation of FSAs, HRAs, HSAs, and other tax-favored health plans, How to provide greater consumer choice, and Incentives to increase utilization of FSAs, HRAs, and HSAs or other tax-favored health plans. 	<ul style="list-style-type: none"> DOR 	<ul style="list-style-type: none"> April 1, 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. 	

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
HEALTH CARE WORKFORCE					
<p><i>Did You Know?</i></p> <p>Chapter 224 makes changes to the professional-scope-of-practice laws for Physician Assistants (PAs) and Nurse Practitioners (NPs):</p> <div style="display: flex; justify-content: space-between;"> <div data-bbox="285 516 1045 776" style="width: 48%;"> <p><u>Physician Assistants</u> Chapter 224:</p> <ul style="list-style-type: none"> • Removes the limit on the maximum number of PAs that 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 PCPs and allows consumers to choose a PA as their PCP. </div> <div data-bbox="1050 516 1810 776" style="width: 48%;"> <p><u>Nurse Practitioners</u> Chapter 224:</p> <ul style="list-style-type: none"> • 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. </div> </div>					
Nurse Staffing Requirements	<ul style="list-style-type: none"> • Chapter 224 states that a nurse cannot be required to work mandatory overtime except in emergency situations, the definition of which will be determined by HPC. • Hospitals will now be required to report all instances of mandatory overtime. • Chapter 224 states that a nurse must 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 have at least 8 consecutive hours off. 		<ul style="list-style-type: none"> • HPC • DPH 		<ul style="list-style-type: none"> • June 19, 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). • DPH began to collect data on nurse overtime in August 2013. The first annual report is expected in 2014.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
HEALTH INFORMATION TECHNOLOGY					
Health Information Technology (HIT)	<ul style="list-style-type: none"> Chapter 224 largely moves responsibility for the design, implementation, and operation of the state's health information exchange (HIE) from the Massachusetts e-Health Institute (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 created the Massachusetts Health Information Exchange (HIE) Fund within EOHHS to finance the development of the statewide HIE. Chapter 224 gives MeHI new duties pertaining to electronic health record (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). 	<ul style="list-style-type: none"> Consistent with its current duties, the HIT council must annually prepare and update a statewide HIE implementation plan and file an annual report describing the 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. MA has received \$22.3M from the federal government to create the Hlway. 	<ul style="list-style-type: none"> EOHHS MeHI The Board of Registration in Medicine (BORIM) 	<ul style="list-style-type: none"> 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 risk-bearing provider organizations 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. 	<ul style="list-style-type: none"> October 2012: the state's HIE, also known as the Massachusetts Hlway, went live (see press release). January 8, 2014: Governor Patrick launched the next phase of the Hlway: new tools to allow providers to locate, request, and retrieve medical records from other participating health care providers across the state. As of August 2014, the Hlway has over 150 organizations connected and is implementing an outreach team to further adoption in the Commonwealth and working to fully operationalize the Hlway. Support for the HIT council was transitioned from MeHI to EOHHS in December 2012. The 2012 and 2013 annual reports on the HIE and on the activities of MeHI have been submitted to the legislature; the 2014 reports will be prepared and submitted in January-February 2015. EOHHS and MeHI continue administering the Medicaid Meaningful Use program that has helped bring more than \$180 million in federal Meaningful Use incentive payments to Medicaid providers. Virtually all acute hospitals in Massachusetts have adopted electronic health records.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
<p><i>(continued)</i></p> <p>Health Information Technology (HIT)</p>					<ul style="list-style-type: none"> • More than 90% of ambulatory providers, including more than 95% of primary care providers report that they have adopted electronic health records (see 2014 MeHI Provider and Consumer Health IT Research Study). • MeHI has launched programs focused on EHR adoption in behavioral health and long-term/post-acute care settings. • MeHI is in the planning phase of a Connected Communities program that leverages some of the community hospital investments through the CHART program and is designed to support close integration between these hospitals and the natural referral circles surrounding them.
EMPLOYERS					
<p>Health Plan Wellness Programs</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 health care 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. 	<ul style="list-style-type: none"> • DPH • DOI 	<ul style="list-style-type: none"> • January 1, 2013: DPH was to produce a report providing wellness plan and health management program best practices, • January 1, 2013: the wellness program tax credit goes 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. 	<ul style="list-style-type: none"> • The Massachusetts wellness tax credit has been implemented (more information available here). • The application for Tax Year 2014 credits is live. • A Model Wellness Guide is available here.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Fair Share Contribution	<ul style="list-style-type: none"> 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.) 	<ul style="list-style-type: none"> Chapter 224 also states that employees with health insurance from other sources will now be counted when determining whether an employer has made a Fair Share Contribution. 	<ul style="list-style-type: none"> Health Connector 	<ul style="list-style-type: none"> July 1, 2013: employers with 21 or more FTEs subject to Fair Share Requirements. 	<ul style="list-style-type: none"> The state FY 2014 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.
INSURANCE MARKET CHANGES					
Tiered Health Plans	<ul style="list-style-type: none"> Chapter 224 increases the minimum premium savings for tiered or select network plans from 12% to 14% (the Commissioner of Insurance must annually determine a base premium rate discount of at least 14% for the reduced, selective, or tiered network plan). The law allows for “smart tiering” plans, defined as products that offer differences in cost sharing based on services rather than facilities providing services. If a medically necessary covered service is available at only 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. 	<ul style="list-style-type: none"> The law also requires CHIA’s annual cost trends report to include information about the impact of health care payment and delivery reform efforts on costs, including the development of limited and tiered networks, among others. 	<ul style="list-style-type: none"> DOI 	<ul style="list-style-type: none"> April 1, 2013: provisions pertaining to smart tiering plans took effect. 	<ul style="list-style-type: none"> DOI has been developing changes to its small group health insurance regulation (211 CMR 66.00) to establish standards for “smart tiering” products.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Administrative Simplification	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.). 	<ul style="list-style-type: none"> DOI 	<ul style="list-style-type: none"> October 1, 2013: DOI was to develop and implement the uniform prior authorization forms. 	<ul style="list-style-type: none"> DOI has been working with the Massachusetts Health Care Administrative Simplification Collaborative, a collaborative of payers and providers, to develop a prior authorization form that meets the requirements of the various parties.
Mental Health Parity	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The Commissioner of Insurance is responsible for implementing and enforcing federal and state mental health parity laws. DOI and the Office of Medicaid 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). 	<ul style="list-style-type: none"> DOI Office of Medicaid AG 	<ul style="list-style-type: none"> January 1, 2013: DOI and the Office of Medicaid were to promulgate regulations regarding carrier compliance with mental health parity laws. July 31, 2013: these regulations were to be implemented as part of any provider contract and carrier's health benefit plans. July 1, 2014: carriers and their contractors must begin submitting an annual report to DOI and the AG, and the Office of Medicaid must 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 clerk, and the AG, certifying and explaining how their health plans are in compliance with mental health parity laws. 	<ul style="list-style-type: none"> 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. DOI has received and is reviewing the annually submitted certification materials for consistency of reporting across all payers. The AG has received and is reviewing the annually submitted certification materials for compliance with state and federal mental health parity laws. March 2013: MassHealth issued draft emergency regulations and held a public hearing. May 2013: MassHealth emergency regulations finalized. July 2014: MassHealth submitted the first annual report to the legislature certifying how its health plans are in compliance with mental health parity laws.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
CARE DELIVERY CHANGES					
End of Life Care	<ul style="list-style-type: none"> 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 MA to develop necessary additional materials, rules, and regulations. 		<ul style="list-style-type: none"> DPH 		<ul style="list-style-type: none"> October 16, 2013: DPH presented its draft regulations regarding end-of-life and palliative care information at the Public Health Council meeting. See the draft regulations and stakeholder testimony here. Regulations are currently being finalized. Materials have been developed and will be released when regulation is finalized.
Checklists of Care	<ul style="list-style-type: none"> 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 Betsy Lehman Center. 		<ul style="list-style-type: none"> DPH Betsy Lehman Center 		
Telemedicine	<ul style="list-style-type: none"> 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. DOI, in collaboration with BORIM, was to produce a report by July 1, 2013 on the possibility of out-of-state physicians practicing telemedicine in Massachusetts. 		<ul style="list-style-type: none"> DOI BORIM 	<ul style="list-style-type: none"> July 1, 2013: DOI was to produce a report on the possibility of out-of-state physicians practicing telemedicine in Massachusetts. 	<ul style="list-style-type: none"> The 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 that has been considering ways that telemedicine should be monitored and regulated across the country.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Waiver of 3-day rule	<ul style="list-style-type: none"> Chapter 224 requires EOHHS to seek a waiver from the Medicare rule requiring that admission to a skilled nursing facility be preceded by a three-day hospital stay. 		<ul style="list-style-type: none"> EOHHS 		<ul style="list-style-type: none"> July 2013: waiver request submitted to HHS September 2013: CMS notified EOHHS of its intention to make a waiver available to Pioneer ACOs.