CHAPTER 224 TRACKING TOOL

A FOCUS ON 2015–2016 ACTIVITY

LAST UPDATED SEPTEMBER 2016

FOUNDATION
MASSACHUSETTS

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BACKGROUND: CHAPTER 224 OF THE ACTS OF 2012

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

CHAPTER 224 TRACKING TOOL

This abbreviated Tracking Tool highlights progress the state has made in implementing key components of Chapter 224 since the last release of this Tool in August 2015. A more comprehensive Tracking Tool, which documents progress the state has made in implementing the law since its passage in 2012 is available here. These tools are designed for policymakers, advocates, and other stakeholders who wish to track when and how state leaders have addressed policy issues that pertain to Chapter 224. The goal is to provide a basic overview and timeline of Chapter 224-related requirements being implemented by state leaders. *This Tracking Tool is a living document and is updated regularly. If you have any suggested additions or corrections, please email the Blue Cross Blue Shield of Massachusetts Foundation policy team at policy@bluecrossmafoundation.org.*

IMPLEMENTING CHAPTER 224: KEY AGENCIES

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

Health Policy Commission

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

The HPC has several key responsibilities, including:

- Establishing the annual cost growth benchmark (by April 15), monitoring progress through annual cost trends hearings (by October 1), and publishing an annual cost trends report (by December 31);
- Registration of provider organizations (RPOs), as well as the certification of accountable care organizations (ACOs) and patient-centered medical homes (PCMHs);
- Analyzing material changes to a provider organization's operations or governance structure 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. DPH is in the process of amending the determination of need regulations so they more closely align 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 Centers 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 determination of need 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 & 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 retirement 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 –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.	• 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). • March–July 2016: HPC conducted an initial review of all CHIA-identified entities to determine whether a PIP or CMIR is required. • Fall 2016: HPC will receive new list of payers and providers from CHIA based upon final 2014 data and preliminary 2015 data and will begin initial review process.
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).	• 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 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 THCE grew by +4.8%, exceeding the 3.6% health care cost growth benchmark by 1.2%. *(continued)*

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Total Health Care Expenditures (THCE)**					• November 2015–March 2016: CHIA published a series of seven individual 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 and initial assessment of 2014-2015 THCE growth in its 2016 Annual Report on the Performance of the Massachusetts Health Care System.
Registration of Provider Organizations (RPOs)	• Chapter 224 requires HPC to develop and administer an 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		• August 2015: HPC issued a user manual for online submission of RPO materials. • 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. • April 2016: 50 of 60 provider organizations had completed initial registration Part 2. By June 2016, 59 of 60 provider organizations had completed initial registration Part 2. • CHIA will collect additional financial and other data from RPOs on an annual basis.

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 a 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 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	• 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.	• December 2015: HPC issued an updated Notice of Material Change form to be completed by any provider or provider organization filing a proposed material change. • December 2015: HPC issued an additional Frequently Asked Questions document clarifying filing requirements for discount arrangements and application of the financial threshold. • 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		• 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. • May 2016: HPC and the Office of Patient Protection issued a bulletin with interim guidance for RBPO/ACO appeals process. • Risk certificate and risk certificate waiver applications are available on the DOI website.
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.	• 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 restructuring the MassHealth program around accountable care. • September 2015: CHIA reported on APM adoption in 2014 among payers within various insurance categories in its Annual Report on the Performance of the Massachusetts Health Care System. *(continued)*

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(continued) **Alternative Payment Methodologies (APMs)**					• 2015: HPC, CHIA, and AG worked together to align definitions of APMs and to enhance reporting requirements. CHIA implemented annual supplemental data collection, examining global payment arrangements and upside/downside risk borne by providers. • January 2016: HPC issued its final 2015 Cost Trends Report, which includes several recommendations to advance the adoption of APMs. • March 2016: CHIA released a chart book on the adoption of APMs in Massachusetts from 2012 to 2014 by insurance category and payer. • April 2016: MassHealth publicly released detailed information on its restructuring efforts, which include its ACO initiative and its proposal for a Delivery System Reform Incentive Payment (DSRIP) program to support the transition to accountable care. • May–July 2016: MassHealth conducted a procurement for a pilot ACO program, with a planned launch date of December 2016. • June 2016: MassHealth released its 1115 waiver proposal for public comment, which includes details on MassHealth's ACO initiative and DSRIP proposal. • July 2016: MassHealth submitted its 1115 waiver proposal to the Centers for Medicare & Medicaid Services (CMS) for restructuring of MassHealth, which includes adoption of APMs and delivery system reform through ACOs and community partners for behavioral health and long-term services and supports.

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Patient-Centered Medical Home (PCMH) Certification	• Chapter 224 tasks HPC, in collaboration with MassHealth, with developing and implementing standards for certifying PCMHs. • Certification is voluntary and will last for two years.	• Together, PCMH and ACO certification are being referred to as accountable care certification: "a unified framework for promoting, validating, and monitoring the adoption and impact of accountable care in the Commonwealth." • The HPC CDPST Committee developed the following high-value elements of patient-centered accountable care: care coordination, enhanced access, behavioral health integration, population health management, data systems/performance measurement, and resource stewardship.	• HPC • MassHealth	• January 1, 2014: HPC (with MassHealth) was to develop and implement standards for certifying PCMHs. • January 1, 2014: HPC was to develop a model payment system for PCMHs. • July 1, 2014: HPC and MassHealth were to establish a PCMH training. • December 31, 2016: ACOs, PCMHs, and RBPOs must have interoperable electronic health record (EHR) systems.	• September 2015: HPC issued final revised HPC/ National Committee for Quality Assurance (NCQA) program design with focus on enhanced behavioral health integration. • 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. • August 2016–August 2018: HPC will develop and deliver a technical assistance program for PCMH PRIME. • Click here for PCMH PRIME eligibility and application materials.

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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.	• 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–September 2016: HPC will draft ACO documentation requirements, evaluation criteria, and an application manual. • October–December 2016: HPC will develop and test a web-based application platform. • January 2017: Anticipated soft launch of ACO certification program. • Spring 2017: Anticipated time frame for ACOs seeking to contract with MassHealth for October 1, 2017, start date to submit applications for certification.

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REPORTING REQUIREMENTS					
Cost Trends Hearings and Annual Report	• Chapter 224 requires HPC to hold annual public hearings based on CHIA's Annual Report on the Performance of the Massachusetts Health Care System.t. • 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.	• 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 final 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. • September 2016: CHIA released its fourth Annual Report on the Performance of the Massachusetts Health Care System. • October 17–18, 2016: HPC will host the 2016 health care cost trends hearing (view pre-filed testimony here).
Report on the Impact of Chapter 224	• The law charges the state auditor with issuing a study on the impact of Chapter 224 on health care payment and delivery systems, health care consumers, and the health care workforce.	• The review must include an investigation of the impact on health care costs; access to health care services and quality of care in different regions of the state and for different populations; access and quality of care for specific services (primary care, behavioral health, substance use disorders, and mental health services); the health care workforce; and public health. • The law requires the state auditor to use data from CHIA, HPC, and DPH to the extent feasible.	• Office of the State Auditor	• March 31, 2017: The state auditor must file the report on the impact of Chapter 224 and any draft legislation with the House and Senate committees on Ways and Means and the Joint Committee on Public Health, as well as post the report on the state auditor's website.	• October 2015: The Office of the State Auditor issued a summary outlining the specific research methods it used to evaluate Chapter 224. • October 2015: The Office of the State Auditor issued a report summarizing the results of its Chapter 224 stakeholder survey. • Click here for more information on the Office of the State Auditor's ongoing evaluation of Chapter 224.

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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. • CHIA makes the APCD available to government and non-government researchers via a data application process. • The APCD serves an important role in enabling the state's implementation of the federal risk adjustment program for the small- and non-group market. CHIA has enabled the Health Connector to utilize these data to calculate carrier risk scores.	• CHIA		• November 2015: CHIA released APCD version 4.0 (CY2010–2014 data). • March 2016: As a result of the 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. In response to this, CHIA shared a brief summarizing some of the key regulatory issues facing states following this Supreme Court decision and describing why participating in the APCD is essential to controlling health care costs in the state. • 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).

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.	• July 2015: HPC released its CHART Phase 1 final report. • September 1, 2015–February 1, 2016: On a rolling basis, all 25 CHART Phase 2 projects launched. • July 2016: HPC launched a mixed-methods evaluation of CHART Phase 2.
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.	• 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.

(continued)

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

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

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
(continued) **Prevention and Wellness Trust Fund (PWTF)**					• 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. • 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. • DPH has provided the State Auditor's Office with data from four major surveillance systems dating back as far as 2006. • Click here to view materials from past Prevention and Wellness Advisory Board meetings.
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.	• 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
Health Care Workforce Transformation Fund	• Health Care Workforce Transformation Fund planning grants are designed to support planning to address workforce challenges. • Specific goals include: – Support the development and implementation of programs to enhance worker retention rates, – Address critical workforce shortages, – Improve employment in the health care industry for low-income individuals and low-wage earners, – Provide training, educational, or career-ladder services for currently employed or unemployed health care workers who are seeking new positions or responsibilities, and – Provide training or educational services for health care workers in emerging fields of care delivery.	• $20M was appropriated for the Health Care Workforce Transformation Fund. • $4M was directed to DPH to support a loan-forgiveness program for primary care providers. • $1.88M was awarded for planning grants in April 2014.	• Executive Office of Labor and Workforce Development (EOLWD) • Commonwealth Corporation • DPH	• July 2014: Training proposals were due. Training grants support activities for up to two years.	• February 2015: Training grant contracts began. All contracts are set to end by March 31, 2017. • February 2015: Commonwealth Corporation funded a health 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 program implemented with final report scheduled to be delivered in October 2016. • 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. • Fall 2016 (expected): DPH will issue an update to the Massachusetts Health Professions Data Brief: Registered Nurses. • Click here for a list of Health Care Workforce Transformation Fund advisory board members.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
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	• March 2016: MeHI issued a report to the legislature providing an update on its work as required by Chapter 224. • Fall/Winter 2016: MeHI will release its Consumer and Caregiver Engagement survey and report.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
COUNCILS, COMMITTEES, COMMISSIONS, AND TASK FORCES					
Statewide Quality Advisory Committee (SQAC)	• Created by Chapter 288 of the Acts of 2010 and reestablished by Chapter 224 under CHIA. • Tasked with developing a standard quality measures set (SQMS), or a uniform set of health care quality measures for all health care facilities, medical groups, and provider groups in the state. • Chaired by the executive director of CHIA.	• Chapter 224 also allows DOI to use the SQMS in its oversight of selective and tiered network products and directs carriers offering tiered network products to tier providers based on quality performance measured by the SQMS.	• CHIA • DOI	• By November 1 annually: The SQAC must recommend to CHIA any updates to the SQMS.	• June 2015: Committee released a brief, Summary of Research and Stakeholder 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. • Click here to view the 2016 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.	• 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
HEALTH CARE WORKFORCE					
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		• Fall 2015: DPH issued guidance governing the certification process of mandated acuity tools for all academic medical center intensive care units (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. • Fall 2016 (expected): DPH will issue guidance governing the certification process of mandated acuity tools for all remaining hospital 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.	• 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 awarded over $2M in grants to 39 organizations. As of June, grantees had received $655,875 in payments for reaching initial program milestones. • June 2016: Under Connected Communities, MeHI awarded over $3M to eight lead organizations and their 90 collaborators to support projects that drive community-level collaboration among health care providers using innovative technologies.

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.	• 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. • July 2016: DOI held a hearing to receive comments on 211 CMR 66.00. • Late summer/fall 2016: DOI plans to present 211 CMR 152.00 for public comment.
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.

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.	• 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.

CH. 224 TOPIC	CH. 224 REQUIREMENTS	ADDITIONAL INFORMATION	STATE PLAYERS	TIMING	STATUS UPDATE
CARE DELIVERY CHANGES					
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		• 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.	• January 2016: HPC board approved a one-year regional telemedicine pilot program design and authorized the issuance of a request for proposals. • 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.

15 years

FOUNDATION
MASSACHUSETTS