CHAPTER 224: WHAT DOES IT MEAN FOR CLINICIANS?

FOUNDATION
MASSACHUSETTS

NOVEMBER 2012

GREATER AUTHORITY FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

The law seeks to expand access to primary care by broadening the scope of practice of nurse practitioners (NPs) and physician assistants (PAs) and their ability to act as primary care providers. Doctors will still supervise NPs and PAs, but the law removes the limit on the maximum number of PAs that one physician can supervise and the requirement that the physician sign off on certain NP and PA services, including the writing of prescriptions by PAs. Health plans are required to allow PAs to act as primary care providers and to list them in provider directories.

WORKFORCE INVESTMENTS

The law establishes a variety of mechanisms to help develop the health care workforce needed to ensure access to high quality care in Massachusetts. These include a Health Care Work Force Transformation Fund for education and training of workers in areas of critical need, expansion of the state's health care loan repayment program, financial support for primary care providers at teaching community health centers, and new directives to the Department of Public Health's Health Care Workforce Center to focus on issues in specific areas of need. There is a particular focus in many of these provisions on expanding the state's workforce in behavioral health, substance use disorders, and mental health care services, which are areas of critical need across the state.

ENCOURAGEMENT OF APOLOGY AS A MEANS TO REDUCE MEDICAL MALPRACTICE LITIGATION

Apology by providers can be a powerful force for healing and equitable resolution in cases where patients are harmed by unanticipated outcomes of medical care. The law protects providers' statements of apology and error from discovery and admissibility in malpractice suits and creates a 182-day "cooling off period" before any legal action can be commenced.

CONTINUED INVESTMENTS IN HEALTH INFORMATION TECHNOLOGY

The Mass e-Health Institute will expand efforts to implement electronic health records and enable providers to achieve compliance with federal meaningful use standards. The law establishes a fund to provide no-interest loans to certain types of providers in order to implement health information technology.

COMPETENCY IN HEALTH INFORMATION TECHNOLOGY AS A CONDITION OF PHYSICIAN LICENSURE

Starting in 2015, physicians must demonstrate that they are proficient in the use of electronic health records, computerized physician order entry, e-prescribing, and any other form of technology the Board of Registration in Medicine requires in its licensing standards. This provision recognizes that skills in using health information technology have become core competencies for physicians if they are to provide high quality and safe care, particularly in a delivery system that is increasingly focused on population health, integrated care, and affordability.

PROHIBITION OF MANDATORY OVERTIME BY NURSES

The law prohibits the use of mandatory overtime for registered nurses except in emergency situations to be determined by the Health Policy Commission. Hospitals are required to report instances of the use of mandatory overtime. These provisions are intended to protect the health of nurses and the quality and safety of patient care.

ATTEMPTS TO SIMPLIFY ADMINISTRATIVE PROCESSES AND INCREASE TRANSPARENCY

Several provisions of the law address clinician concerns about the administrative complexity and costs of dealing with multiple private payers. The Division of Insurance is required to develop standardized forms for prior authorization and summary of payment, and also a standardized process for determining a patient's eligibility for services. Utilization review criteria must also be available on a health plan's website, and any proprietary criteria must be furnished to providers or plan members upon request.

CHAPTER 224: WHAT DOES IT MEAN FOR CONSUMERS?

FOUNDATION
MASSACHUSETTS

NOVEMBER 2012

THE POTENTIAL FOR MORE AFFORDABLE HEALTH CARE

Consumers will be the ultimate beneficiaries of success in moderating the growth of health care spending in the Commonwealth, since they ultimately pay for much of the increase in health spending, through higher taxes, premium contributions, and out-of-pocket spending, as well as slower wage growth.

A STRONG CONSUMER VOICE IN NEW STATE POLICYMAKING BODIES AND PROVIDER ORGANIZATIONS

Consumers will be represented on many of the new bodies created by the law, including having a seat on the board of the Health Policy Commission, the most powerful entity created by the new law. Accountable Care Organizations (ACOs) will also be required to include a patient or consumer representative in their governance structures.

ENCOURAGEMENT OF PATIENT-CENTERED MEDICAL HOMES AND OTHER NEW CARE DELIVERY MODELS

Many provisions of the law are designed to encourage the development of new delivery models that seek to improve access to and quality and affordability of care for patients. These range from provisions promoting Patient-Centered Medical Homes (PCMHs) and ACOs to expanding the scope of practice for nurse practitioners and physician assistants and encouraging the use of limited-service clinics.

MORE RESTRICTIONS ON CHOICE OF PROVIDER

While many of the new care models have the potential to improve access to care, particularly primary care services; enhance coordination and integration of care; and improve quality and outcomes, one means of achieving these goals will be to reduce patient choice of provider. ACOs that assume substantial financial risk will, for example, have strong financial incentives to manage care more tightly, including limiting patient access to providers that are not part of the ACO. The continued push for limited network and tiered network health insurance products will also limit provider choice, either by the use of narrower networks or through financial incentives that encourage consumers to use certain providers.

STRENGTHENED CONSUMER PROTECTIONS IN MANY AREAS, INCLUDING NEW MODELS OF CARE

Along with encouraging the growth of new models of care, the law also greatly strengthens consumer protections by establishing tougher regulatory oversight in many areas, including for ACOs, PCMHs, and risk-bearing provider organizations.

INFORMATION, INFORMATION, INFORMATION … MORE TRANSPARENCY

Consumers will have access to more reliable information about care outcomes and quality and also easier access to information about the price of medical care, including real-time information from health insurers about the out-of-pocket costs they will incur if they obtain specific health care services from specific providers.

A RENEWED COMMITMENT TO FUNDING PUBLIC HEALTH AND COMMUNITY HEALTH

The law has a focus on prevention and wellness, including $60 million for the Prevention and Wellness Trust Fund. Small businesses that implement wellness programs will receive tax credits and premium discounts. ACOs will also be encouraged to promote community-based wellness programs and to form partnerships with community health workers.

MORE COUNSELING ON PALLIATIVE AND END OF LIFE CARE

Providers, including hospitals, physicians, skilled nursing facilities, community health centers, and assisted living facilities, have new obligations to provide information and counseling on palliative and end-of-life care to patients.

STRONGER ENFORCEMENT OF FEDERAL AND STATE MENTAL HEALTH PARITY LAWS

The Division of Insurance is given express authority to enforce the provisions of federal and state laws regarding parity for mental health.

CHAPTER 224: WHAT DOES IT MEAN FOR HEALTH PLANS?

FOUNDATION
MASSACHUSETTS

NOVEMBER 2012

CONTINUED PUBLIC REVIEW OF PREMIUMS AND MEDICAL EXPENSE TRENDS

Health plans will be subject to the annual health care cost growth benchmark under the new law. Any health plan whose cost growth rate exceeds the benchmark (measured in terms of the change in per capita health-status-adjusted total medical expenses) may be required to file a performance improvement plan with the Health Policy Commission (HPC) and will be listed on a public website. Health plans that fail to engage in the reporting or performance improvement process will be subject to fines of up to $500,000.

A CONTINUED PUSH FOR TRANSPARENCY AND ADMINISTRATIVE SIMPLIFICATION

Health plans will be required to provide consumers with real-time, provider-specific estimates of their actual out-of-pocket costs for a proposed service or procedure. Barring unforeseen events, these estimates will be binding, and health plans will be prohibited from requiring consumers to pay more than estimated. Health plans must now also provide consumers with easy access to up-to-date utilization review criteria and clearly state policies about costs for in- and out-of-network care. Health insurers must comply with new Division of Insurance requirements about standardized forms for prior authorization and summary of payment, and about a standardized process for determining a patient's eligibility for services.

A RELAXATION OF STANDARDS FOR MEDICAL EXPENSE RATIOS

Health plans will be permitted to spend a smaller proportion of premiums on medical expenses than they are permitted under current law, with the medical loss ratio for individual and small employer plans falling from 90% to 88% over the next three years.

INTENSIFIED PUBLIC ANALYSIS OF CONTRACTS BETWEEN HEALTH PLANS AND PROVIDERS

Several provisions of the new law focus additional review on the terms of contracts between health plans and providers. They mandate, among other things, more reporting about alternative payment arrangements and price variation, and the formation of a special commission to review variation in prices among providers. The provisions are designed to enable policymakers to better understand the impact of market changes, including provider consolidation and new delivery models like ACOs, on market power and leverage, and particularly on the ability of health care entities to meet the state's cost growth benchmark. This could lead to more intense scrutiny of contracts between plans and providers.

MORE ENCOURAGEMENT OF LIMITED AND TIERED NETWORK PRODUCTS

As means of making health coverage more affordable, health plans will be required to offer a wider range of products with selective or tiered provider networks and offer premiums for them that are at least 14% lower than those of their regular network products. The law encourages the development of so-called "smart tiering" products, in which cost-sharing tiers are developed for individual services rather than for all services offered by providers. The smart tiering approach will need to be reconciled with other provisions of the law that seek to encourage the development of more integrated systems of care.

LESS REGULATORY SCRUTINY OF PREMIUM RATES FOR PLANS OFFERED THROUGH GROUP PURCHASING COOPERATIVES

Group purchasing cooperatives, which were authorized in a limited way in 2010 under Chapter 288, are allowed to offer premium discounts of up to 10% without prior regulatory review or approval by the Division of Insurance. This provision, which permits coops to offer lower rates without demonstrating the basis for the discounts, could give coops a competitive advantage over other products that will be subject to stricter regulatory review and approval.

ADDITIONAL DIVISION OF INSURANCE REVIEW TO LOOK BEYOND THE HEALTH PLAN FOR CERTAIN TYPES OF ALTERNATIVE PAYMENT ARRANGEMENTS

The law imposes some oversight by the Division of Insurance on providers that assume insurance risk from health plans. Providers that enter into alternative payment arrangements under which they bear significant downside financial risk will be required to obtain a certificate from the Division of Insurance that attests to their financial solvency and the adequacy of their reserves.

MORE INCENTIVES THROUGH HEALTH INSURANCE FOR EMPLOYEE WELLNESS PROGRAMS

The continued growth of workplace wellness programs will be encouraged by requirements that insurers give premium rate discounts to individuals and small businesses that use state-approved wellness programs, and by state tax credits for employers that offer such programs.

CHAPTER 224: WHAT DOES IT MEAN FOR HOSPITALS AND HOSPITAL SYSTEMS?

FOUNDATION MASSACHUSETTS

NOVEMBER 2012

SIGNIFICANT NEW OVERSIGHT AND REVIEW OF INDIVIDUAL HOSPITALS, HOSPITAL SYSTEMS, AND AFFILIATED PROVIDERS

Hospitals will be subject to a wide range of new state oversight. They will be required to register with the newly created Health Policy Commission (HPC) every two years and to report regularly, in more detail than they do now, on their financial, market, cost, and quality performance, and organizational structure. These new reporting requirements will make it much easier for policymakers and the public to understand and analyze the composition and performance of individual institutions and hospital and health systems.

INTENSE PUBLIC SCRUTINY OF INDIVIDUAL HOSPITAL EXPENSES AND EXPENSE GROWTH

The cost performance of individual hospitals will receive more intense public scrutiny, with the goal of increasing pressure to control costs. Any hospital whose cost growth rate (measured in terms of the change in per capita health-status-adjusted total medical expenses) exceeds the annual health care cost growth benchmark may be required to file a performance improvement plan with the HPC and will be listed on a public website. Hospitals that fail to engage in the reporting or performance improvement process will be subject to fines of up to $500,000.

NEW STANDARDS FOR ASSESSING HOSPITAL MARKET POWER AND MARKET DOMINANCE

The law allows the state to undertake cost and market impact studies in certain situations, such as when a provider proposes to make significant changes in its operations or governance. The law also permits such studies of any provider that exceeds the state's cost growth benchmark. Providers whose market conduct raises concerns can be referred to the Attorney General's (AG's) office for investigation of unfair business practices or anticompetitive behavior. The statute also requires the AG to monitor market trends, including provider consolidation, payer contracting trends, and access and quality issues for patients. These provisions provide an opportunity for the state to articulate and apply new standards for defining the existence of potentially problematic market power.

ENCOURAGEMENT OF ALTERNATIVE PAYMENT ARRANGEMENTS

The law seeks to encourage the growth of alternatives to fee-for-service payment by public and private payers. Private payers are directed to reduce the use of fee-for-service payment methods to the maximum extent possible. Public payers, including Medicaid, the Group Insurance Commission, and the Connector, are required to develop and adopt alternative payment methods, and the state will seek a federal waiver to allow Medicare to participate in such arrangements. Medicaid will increase rates slightly for hospitals that accept alternative payment arrangements. Hospitals and other providers that enter into alternative payment arrangements under which they bear significant downside financial risk will be required to obtain a certificate from the Division of Insurance that attests to their financial solvency and the adequacy of their reserves. These provisions will likely accelerate the growth of alternatives to fee-for-service that is already well under way in the state.

FINANCIAL INCENTIVES TO PARTICIPATE IN ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

HPC is directed to develop a process for ACO certification, including standards for conferring "model ACO" status on organizations that adopt best practices for quality improvement, cost control, and patient protection. While no provider organization is required to become an ACO, the law encourages ACOs to receive state certification by giving preferential treatment to certified ACOs in state-funded health programs.

NEW FINANCIAL SUPPORT FOR HOSPITALS TO ADAPT TO THE CHANGING ENVIRONMENT

The law establishes several new funds to help hospitals and other providers adapt to the changes under way in the health care system. Certain hospitals, including those that receive relatively low rates of payment, will be eligible to compete for funding from a new Distressed Hospital Trust Fund and the e-Health Institute Fund, both financed by an assessment on payers and certain hospitals. Funds will be available to help hospitals invest in health information technology, including electronic medical records, and develop the infrastructure needed to succeed under global payment and other alternative payment arrangements. A new Healthcare Payment Reform Fund will support hospital efforts to comply with the health care cost growth benchmarks.

ATTEMPTS TO SIMPLIFY ADMINISTRATIVE PROCESSES BETWEEN PROVIDERS AND PAYERS

Several provisions of the law address provider concerns about the administrative complexity and costs of dealing with multiple private payers. The Division of Insurance is required to develop standardized forms for prior authorization and summary of payment, and also a standardized process for determining a patient's eligibility for services.

SUMMARY OF CHAPTER 224 OF THE ACTS OF 2012

SEPTEMBER 2012

FOUNDATION
MASSACHUSETTS

Anna Gosline
and Elisabeth Rodman
Blue Cross Blue Shield of Massachusetts Foundation

INTRODUCTION

Six years after the passage of the landmark Massachusetts health care coverage reform law, the state has enacted a law with the ambitious goal of bringing health care spending growth in line with growth in the state's overall economy. Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation," builds on two previous laws enacted in 2008 and 2010 that expanded data transparency and reporting on cost trends and drivers and aimed to control premium growth in the merged individual and small group health insurance market. In addition to cementing and expanding many of the provisions of earlier laws, Chapter 224 seeks to tame health care cost growth through:

- The creation of new commissions and agencies to monitor and enforce the benchmark for health care cost growth, placing new scrutiny on health care market power, price variation, and cost growth at individual health care entities;
- Wide adoption of alternative payment methodologies by both public and private payers, including specific targets for Medicaid;
- Increased price transparency for consumers;
- A focus on wellness and prevention, through public investments and adoption of workplace wellness programs;
- Expansion of the primary care workforce;
- A focus on health resource planning;
- Financing and otherwise supporting the expansion of electronic health records and the state health information exchange;
- Medical malpractice reforms; and
- Numerous other provisions including ones pertaining to mental health parity and integration, administrative simplification, and health insurance premium rates.

The law's major investments in prevention and wellness ($60 million), health information technology ($30 million), and struggling community hospitals ($135 million) are financed through an assessment on health plans and acute hospitals with more than $1 billion in net assets and less than 50 percent of revenue generated by public payers.

Much of the new work of Chapter 224 is concentrated in two newly created entities: the Health Policy Commission (HPC), a quasi-independent state agency, charged with establishing and monitoring the state's health care cost growth benchmark; and the Center for Health Information and Analysis (CHIA). Along with many new responsibilities, CHIA assumes many of the functions now performed by the Division of Health Care Finance and Policy, which was eliminated by the law.

The law also touches numerous other existing agencies, mandating changes at and new roles for the Department of Public Health (DPH), the Division of Insurance (DOI), the Office of Medicaid,[1] the Commonwealth Health Insurance Connector Authority, and the Department of Revenue, and cementing and expanding the Attorney General's work on monitoring health care cost trends and the health care market. See Appendix A: Summary of Organizational Changes (page 16).

For an overview of key implementation dates, see Appendix B (page 17).

I. THE HEALTH POLICY COMMISSION (HPC)

The law creates the Health Policy Commission (HPC), a quasi-independent entity that resides within, but not under the control of, the Executive Office for Administration and Finance. Governed by a diverse 11-member board,[2] with input from an advisory council, HPC is charged with establishing the annual cost growth benchmark and monitoring progress through annual cost trends hearings. The Commission will also register provider organizations, certify Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs), and administer the Healthcare Payment Reform Fund, which was established in 2011.[3]

Until June 30, 2016, HPC will be funded through the Healthcare Payment Reform Fund itself.[4] Effective July 1, 2016, HPC will be funded through assessments on hospitals, ambulatory surgical centers, and surcharge payers.

The Benchmark

By April 15 each year, HPC must set the state's health care cost growth benchmark: the target growth rate for *average total per person* medical spending in the state[5] for the next calendar year. The health care cost growth benchmark is tied to growth in the state's economy—specifically the potential gross state product (PGSP)[6]—as outlined in the table below. Beginning in 2018, HPC can adjust the annual cost growth benchmark after following protocols that give the Legislature time to comment and intervene.

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1 For a more detailed discussion of Chapter 224's impacts on MassHealth and the Office of Medicaid, see "Chapter 224 of the Acts of 2012: Implications for MassHealth," MMPI, September 2012.

2 The 11 members of the HPC board will consist of the Secretary for Administration and Finance (ex-officio); the Secretary of Health and Human Services (ex-officio); three members appointed by the governor: the chair of the board, who must have expertise in health care delivery, health care management, or health care finance and administration, an expert in health plan administration and finance, and a primary-care physician; three members appointed by the Attorney General: 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; three members appointed by the Auditor: a health care workforce labor leader, one with expertise as a purchaser of health insurance representing business management or health benefits administration, and an expert in the development and use of innovative technologies and treatments. The board will elect an executive director by a majority vote. Board members will not be compensated and must not have any financial stake in or affiliation with a health care entity.

3 For a discussion of Accountable Care Organizations, Patient Centered Medical Homes, and the Payment Reform Fund, see Section IV: Payment Reform and ACOs.

4 The HPC board can use funds from the Healthcare Payment Reform Fund, funds from any other source, and funds appropriated by the general court for its annual budget. HPC does not need approval from any other executive agency to create and administer its budget.

5 The cost growth benchmark sets the target growth rate for total per capita medical expenditures including all spending from public and private sources, all categories of medical expenses, all non-claims-related payments to providers, all patient cost-sharing amounts, and the net cost of private health insurance.

6 Potential gross state product is the highest level of economic growth that can be sustained over the long term without an increase in inflation; it is also equal to the economic output under full employment. Potential GSP provides a more stable measure of economic growth than actual GSP.

CALENDAR YEARS	COST GROWTH BENCHMARK
2013-2017	Potential Gross State Product (PGSP)
2018-2022	PGSP –0.5% (may be modified up to PGSP)
2023 and beyond	PGSP (may be modified to any figure)

By January 15 of each year, 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. The law set PGSP for 2013 at 3.6 percent.

HPC will notify all health care entities—hospitals, physician groups, ACOs, and payers—that exceed the cost growth benchmark each year. Beginning in 2015, HPC may require health care entities that exceed the benchmark to file and implement performance improvement plans.[7] Performance improvement plans must identify the factors that led to cost growth and include specific cost-saving measures for the entity to undertake within 18 months. HPC will post on its website those entities that are implementing performance improvement plans. Entities will be removed from the website upon successful completion of the plan. An entity can be fined up to $500,000 for failure to submit, implement, or report on its performance improvement plan.

Provider Registration

The law creates a provider organization registration program, to be developed and administered by HPC. Organizations will be required to provide detailed information about their operations, including information on their organizational structure and finances. They will be registered for two-year terms. Risk-bearing provider organizations must provide HPC with a risk certificate from the Department of Insurance (DOI). Only registered provider organizations can contract with health plans and third-party administrators.[8]

Cost and Market Impact Reviews

The law requires that beginning October 1, 2013, providers and provider organization must give 60 days' notice to HPC, the new Center for Health Information and Analysis (CHIA), and the Attorney General (AG) before making material changes to their governance structure or operations (such as mergers or acquisitions). If the proposed changes are likely to significantly impact the competitive market or the state's ability to meet the cost growth benchmark, HPC can conduct a Cost and Market Impact Review. Should actual health care cost growth exceed the benchmark in a given year, HPC can also conduct a Cost and Market Impact Review on any organization identified by CHIA in its annual cost trends reporting.

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7 In 2015, when considering whether certain health care entities must file performance improvement plans, HPC will compare the benchmark against the actual cost growth for the two previous calendar years combined (2013 and 2014). Starting in 2016, the comparison will be based on the benchmark and the actual cost growth for the previous calendar year only. Entities can apply for a waiver from filing and implementing a performance improvement plan. HPC will consider several factors when deciding whether to waive or delay the requirement including demonstrated improvement in the entity's health-status-adjusted total medical expenses, ongoing investments in efficiency, and whether the excessive cost growth can reasonably be considered to be outside of the entity's control, among others.

8 Physicians or 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.

HPC will issue a report on the review, identifying any provider entity that it determines 1) has a dominant share for the services it provides, 2) charges prices for services that are higher than the median prices charged by all other providers, and 3) has health-status-adjusted total medical expenses (TME) that are higher than the median for all other providers. HPC can refer to the AG any entity that meets all three criteria. The AG can conduct investigations to see if the provider organization has engaged in unfair competition or anti-competitive behavior. The AG can issue a report and take action to protect consumers.

Cost Trends Hearings

By October 1 each year, HPC must hold public hearings based on the annual cost trends report produced by CHIA (see Section II). Similar to the current cost trends hearings established by Chapter 305 of the Acts of 2008 under the Division of Health Care Finance and Policy, the HPC hearings will delve into health care cost growth and underlying factors. HPC will call a representative set of witnesses from across the Massachusetts health care system. The law sets out a comprehensive list of required witnesses that must be called at a minimum. As part of the hearing process, HPC must publish an annual report with cost-containment recommendations by December 31.

Distressed Hospital Fund

The law creates the Distressed Hospital Trust Fund, which will be administered by HPC. The Fund will be financed through a one-time assessment on health plans and acute hospitals with more than $1 billion in net assets and less than 50 percent of revenue from public payers. The expected funding is approximately $135 million from 2013 to 2016.

Through a competitive grant process, HPC will disburse funds to eligible acute hospitals in accordance with goals relating to the hospital's adoption of health information technology, to improvements in quality and efficiency, to abilities around adopting alternative payment methodologies, and to standards needed for ACO certification. Teaching hospitals, hospitals that charge higher-than-average prices, and for-profit hospital are not eligible for this funding. When reviewing applications, HPC will consider the financial health of the hospital and needs of the region and population served, the anticipated return on investment, and whether the investment will support innovative health care delivery and payment models.

HPC must create guidelines for an annual progress review and annually report on expenditures from the fund on or before January 31 each year.

II. CENTER FOR HEALTH INFORMATION AND ANALYSIS (CHIA)

Chapter 224 creates the Center for Health Information and Analysis (CHIA), an independent state agency. CHIA takes over the majority of responsibilities of the Division of Health Care Finance and Policy (DHCFP), which was eliminated by the law. These include compiling the state's annual cost trends reports, managing the state's All-Payer Claims Database (APCD), monitoring the performance and financial stability of hospitals and health plans, and analyzing total medical expenses in the Commonwealth. The law expands these efforts to include greater data collection and more reporting on both health plans and provider organizations.

CHIA will be funded through a mechanism similar to that which currently funds DHCFP: assessments on hospitals, ambulatory care surgical centers, and surcharge payers.

Provider and Health Plan Data Collection and Reporting

CHIA is tasked with extensive collection of detailed data from both providers and payers relating to costs, financial performance, utilization, and total medical expenses, largely consistent with the current responsibilities of DHCFP. Chapter 224 does create some significant new requirements for providers and payers, as well as new reporting requirements for CHIA itself.

- CHIA may now require institutional providers (largely hospitals) to submit data that includes information about their parent organizations, other affiliated entities, and physician groups. It also expands reporting requirements for hospitals and other institutional providers—for example, data relating to payroll and salaries of top earners.
- Registered provider organizations, a designation created by Chapter 224 as described above, must now submit extensive information about their organizational structure, number of affiliated and employed health care providers, licensed facilities, patient referral practices, and also comprehensive financial information. This will be the first time that physician groups are required to submit such data.
- Health plans—both public and private—must continue to report claims data to the APCD, along with other previously collected detailed information on premiums, benefits, prices, and costs. The law adds new requirements for reporting of alternative payment methodologies, including the risk-adjusted monthly or yearly budgets that health plans pay to providers and their measures of provider performance. The law also requires that health plans, when reporting data to the APCD, attribute every member to a primary care provider.
- CHIA must report on its website provider-specific information on health-status-adjusted total medical expenses (TME) by service category, payment methodology, relative prices, and hospital inpatient and outpatient costs.

Annual Cost Report and Referral of Health Care Entities with Excessive Cost Growth

Similar to the annual cost trends reports currently compiled by DHCFP, CHIA must publish an annual report based on data submitted by public and private payers, provider organizations, and institutional providers, and data from HPC's Cost and Market Impact Reviews. The report must compare total health care expenditures and associated growth rates with the health care cost growth benchmark, including detailed information on price variation among health care providers. CHIA must publish this report 30 days before HPC's annual hearings.

In addition to the annual public reporting, CHIA will perform ongoing analysis of health plan and provider data to identify health care entities whose increases in health-status-adjusted total medical expenses are considered excessive and threaten the state's ability to achieve the cost growth benchmark. CHIA will confidentially provide a list of these entities to HPC, which may pursue further action.

Other Major Changes and Provisions

CHIA will take over the consumer website from the Health Care Quality and Cost Council, which was eliminated by the law. The law adds many new required features to the consumer website,

such as reporting of actual prices of services at individual provider organization and whether providers have met the cost growth benchmark. The website must also include a host of patient information and decision tools for selecting providers, insurance plans, and treatment options.

In addition to existing requirements to manage the overall APCD operations, the law adds new requirements about releasing data in a timely manner to payers, providers, and consumers themselves.

CHIA is also charged with commenting on Determination of Need applications, with creating a public, searchable provider database in collaboration with DPH and the boards of registration for health care providers, and with setting up a continuing program of study around the uninsured and underinsured. Additionally, the advisory committee tasked with recommending a Standard Quality Measure Set must now report any updates to CHIA by November 1 each year.[9] The Betsy Lehman Center for Patient Safety and Medical Error Reduction will be relocated to CHIA from DPH.

III. ATTORNEY GENERAL

Building on responsibilities set forth in Chapter 305 of the Acts of 2008, the AG will continue to monitor trends in the health care market, have authority to collect health care data submitted to state agencies, and participate in the annual health care costs trends hearings.

Chapter 224 also gives the AG new responsibilities, notably responsibility for investigating any provider organization referred by HPC through the Cost and Market Impact Review process. The AG can also intervene 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.

IV. PAYMENT REFORM AND ACOs

Adoption of Alternative Payment Methodologies

The law requires that the Commonwealth Health Insurance Connector Authority (Connector), the Group Insurance Commission (GIC), and the Office of Medicaid implement, to the maximum extent possible, alternative payment methodologies. The Executive Office of Health and Human Services (EOHHS) must seek a federal waiver to allow Medicare to participate in alternative payment methodologies. Private health plans are required, to the maximum extent possible, to reduce the use of fee-for-service payments.

The law establishes requirements and deadlines for the Office of Medicaid to enroll its members in alternative payment contracts, with the goal of shifting 80 percent of its members, excluding those with other insurance such as Medicare or private insurance, into alternative payment contracts by July 1, 2015. The Office of Medicaid must increase by two percent payment rates to

9 Previously, Standard Quality Measure Set updates were reported to the Executive Office of Health and Human Services.

providers that accept alternative payment methodologies from the Office of Medicaid or Medicaid managed care organizations.[10]

Also, to the extent that MassHealth, the GIC, and the Connector determine that ACOs offer cost-effective, high-quality health care, they must give priority to ACOs for the delivery of publicly funded care. The state can only contract with registered ACOs (see below).

Certifying Risk-Bearing Provider Organizations and ACOs

Effective October 1, 2013, every provider organization that enters into or renews an alternative payment contract in which the provider organization accepts downside risk must apply for a risk certificate through the Division of Insurance. Health plans cannot enter into or continue an alternative payment contract involving downside risk with a provider that does not have a risk certificate. The Commissioner of Insurance must examine a risk-bearing provider organization and its ability to meet its risk-bearing duties at least once every three years.

HPC must establish a registration process for provider organizations to be certified as Accountable Care Organizations (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 alternative payment methodologies, to provide medical and behavioral health services across the continuum, and to allow for health care price transparency, among others.[11] Registration will be for two-year terms. HPC will create a process to identify "model ACOs" that demonstrate excellence in adopting best practices. HPC must also establish rules for appeals submitted by patients of ACOs as part of its new role operating the Office of Patient Protection (OPP).[12]

Patient Centered Medical Home Certification

HPC, in collaboration with the Office of Medicaid, must develop and implement standards for certifying Patient Centered Medical Homes (PCMHs)[13] by January 1, 2014. Certification will be voluntary and will last for two years. HPC and the Office of Medicaid must establish a PCMH training by July 1, 2014, which may be a requirement for certification. HPC must develop a model payment system for PCMHs by January 1, 2014.

Healthcare Payment Reform Fund

The law begins to flesh out the details of the state's Healthcare Payment Reform Fund, which was created and financed in the state's 2011 Casino Bill (Chapter 194 of the Acts of 2011). The fund

10 For a more detailed discussion of Chapter 224's impacts on MassHealth and the Office of Medicaid, see "Chapter 224 of the Acts of 2012: Implications for MassHealth," MMPI, September 2012.

11 HPC can develop additional standards for ACO certification, with goals including reducing health care costs; improving quality of services; improving access to services; promoting alternative payment methodologies; improving access to primary care; improving access to health care services and improving quality of care for vulnerable populations; promoting the integration of mental health, substance use disorder, and behavioral health services with primary care services; promoting patient-centeredness; and demonstrating excellence in managing chronic disease and care coordination.

12 The Office of Patient Protection was previously part of the DPH.

13 The law defines a patient-centered medical home as "a model of health care delivery designed to provide a patient with a single point of coordination for all their health care, including primary, specialty, post-acute and chronic care, which is (i) patient-centered; (ii) comprehensive, integrated and continuous; and (iii) delivered by a team of health care professionals to manage a patient's care, reduce fragmentation, and improve patient outcomes."

receives a portion of revenues associated with new casino license fees, expected to be between $40 million and $50 million.[14]

HPC is responsible for administering the Payment Reform Fund and must create a competitive process to award grants, technical assistance, incentives, evaluation assistance, or partnerships to develop, test, and evaluate innovative payment or delivery models. Such initiatives must help Massachusetts meet its cost growth benchmark as well as quantify cost and quality outcomes. HPC must create vehicles for the sharing of best practices among providers and will be required to submit an annual fund expenditure report by January 31 each year.

Price and Data Transparency

As of October 1, 2013, health plans must disclose patient-level data to providers in their network for the purpose of care coordination and treatment plans. 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 alternative payment contract.

V. CONSUMER DATA TRANSPARENCY

The law seeks to increase transparency around health care costs and quality, and also to provide consumers with a greater level of information about the costs of their care, existing consumer protections, and utilization management decisions by health plans.

Cost Sharing Toll-Free Number and Website

As of October 1, 2013, all health plans and third-party administrators must 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 to pay, including fees, co-pays, or deductibles. This 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.

Provider and Referral Information

At the patient's request, within two working days of a 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.

Disclosure of Cost-Sharing Information and Utilization Review Criteria

The law requires that health plans fully disclose policies relating to in- and out-of-network cost sharing in evidence-of-coverage documentation. By October 1, 2015, health plans and utilization

14 Kowalczyk, Liz, "Casino bill has $50m for health overhaul," *The Boston Globe*, November 19, 2011.

review organizations must keep up-to-date utilization review criteria on an easy-to-use public website. Health plans cannot change review policies unless the website has also been updated. Furthermore, the law requires that by October 1, 2013, health plans and utilization review organizations make determinations about the medical necessity of a proposed service within seven days.

VI. WELLNESS

The law creates and finances a new Prevention and Wellness Trust Fund. It also creates a new tax credit to encourage employers to establish wellness programs and tasks DPH and DOI with the creation of a model wellness guide.

Prevention and Wellness Trust Fund

The law creates the Prevention and Wellness Trust Fund, administered by DPH in collaboration with the Prevention and Wellness Advisory Board, which was also created by the law. The fund will be financed through a one-time assessment on health plans and acute hospitals with more than $1 billion in net assets and less than 50 percent of revenue from public payers. The expected funding is about $60 million from 2013 to 2016.

All activities paid for by the fund must support Massachusetts's goal to meet the health care cost growth benchmark and have at least one of the following functions: reduce the rates of common preventable health conditions; increase healthy habits; increase the adoption of effective health management and workplace wellness programs; address health disparities; and build evidence of effective prevention programming.

The Commissioner of DPH must award at least 75 percent of the fund each year through a competitive grant process to community-based organizations, health care providers, health plans, municipalities, and regional planning agencies. The Commissioner can give priority to proposals in geographic areas with high need.

DPH must report annually, by January 31, on fund expenditures and its strategy for administering and allocating funds. There will be a 20-member commission on prevention and wellness responsible for evaluating the effectiveness of the Prevention and Wellness Trust Fund, and the commission must produce a report by June 30, 2015.

Health Plan Wellness Programs

The law creates a wellness program tax credit aimed at smaller businesses effective January 1, 2013, to December 31, 2017. Under the program, businesses can receive a tax credit equal to 25 percent 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 and creating a wellness plan qualification process in collaboration with DOI. The law requires that employers receive a premium-rate discount based on employee participation in wellness programs, among other criteria set forth by DOI. DPH, in collaboration with DOI, must analyze and report on wellness plan and health management program best practices in order to create a model wellness guide for payers, employers, and health care consumers. The report and recommendations must be filed by January 1, 2013.

The law 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. The Commissioner of Revenue must file a report and any legislative recommendations by January 1, 2017.

VII. PRIMARY CARE AND WORKFORCE

Chapter 224 makes changes to the professional-scope-of-practice laws for Physician Assistants (PAs) and Nurse Practitioners (NPs) and creates new funds for investing in primary-care capacity. The law requires that, to the maximum extent possible, public and private payers assign each member to a primary care provider (PCP), a term also redefined in the law to include both PAs and NPs.

Physician Assistants and Nurse Practitioners

Chapter 224 changes the meaning of the term "PCP" from primary care *physician* to primary care *provider* in many places in existing Massachusetts law. The law removes the limit on the maximum number of PAs that can be supervised by a single physician[15] as well as the requirement that a physician must sign off on any prescriptions written by the PA. The law also requires health plans to include participating PAs in their searchable list of PCPs and to allow consumers to choose a PA as their PCP. The law allows NPs to sign for, certify, stamp, verify, or endorse what used to require a physician's signature. The law also 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.

Health Care Workforce Investments

The law updates details of the administration of the state's Health Care Workforce Transformation Fund, which was created by an earlier 2012 appropriations law.[16] The fund is administered by the Secretary of Labor and Development in collaboration a new Health Care Workforce Trust Fund Advisory Board.

DPH will receive 20 percent of the available funds each year for three programs: the existing Health Care Workforce Loan Repayment Program; the new Primary Care Residency Grant Program, established to finance the training of PCPs at community health centers; and the new Primary Care Workforce Development and Loan Forgiveness Grant Program, designed to enhance recruitment and retention of PCPs and other clinicians at community health centers.

The law also amends language in the context of the existing Health Care Workforce Center, Health Care Workforce Advisory Council, and Health Care Workforce Loan Repayment Program to include behavioral health, mental health, and substance abuse disorder health providers.

15 Previous law required that a physician must supervise no more than four PAs at one time.

16 Financing for the fund will be dependent on final FY2012 tax revenues and spending.

VIII. HEALTH PLANNING

The law creates a new 10-member Health Planning Council[17] within the Executive Office of Health and Human Services (EOHHS) to develop a "state health plan" by January 1, 2014. 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 plan must then 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.

The state health plan will guide decisions made by DPH regarding Determination of Need (DON) applications. The law allows HPC, CHIA, and other state agencies to provide input to DPH on DON applications. The law allows DPH to require applicants to provide an independent cost analysis, conducted at the expense of the applicant, to demonstrate that the application is consistent with Massachusetts's cost-containment goals.

IX. HEALTH INFORMATION TECHNOLOGY

Chapter 224 shifts organizational roles and responsibilities for health information technology and dedicates new funds for the expansion and adoption of electronic health records (EHRs) and the statewide health information exchange (HIE). The law also imposes new HIT requirements for providers and creates protocols around unauthorized release of patient data.

HIT Governance and Responsibilities

The law largely moves responsibilities for the design, implementation, and operation of the state's health information exchange (HIE) from the Massachusetts e-Health Institute (MeHI) to the Executive Office of Health and Human Services (EOHHS). It also moves the existing HIT council, charged with advising the state on HIE implementation, from MeHI to EOHHS and expands the council from nine to 21 members.[18] Consistent with its current duties, the council must annually prepare and update a statewide HIE implementation plan and file an annual report by January 30 describing the progress in developing a statewide HIE and recommending legislative action if necessary.

The law gives MeHI new duties relating to the implementation of EHR systems, such as helping health care providers comply with meaningful use standards (beyond Stage 1) established by the U.S. Department of Health and Human Services; promoting the benefits of interoperable EHR

17 The Health Planning Council will comprise the Secretary of Health and Human Services (chair), the Commissioner of Public Health, the Director of the Office of Medicaid, the Commissioner of Mental Health, the Secretary of Elder Affairs, the Executive Director of CHIA, the Executive Director of HPC, and three members appointed by the governor: one health economist, one health policy and planning expert, and one health care market planning and service line analysis expert.

18 The law increases the number of members appointed by the Governor to the HIT council from four to 14, adding representation from academic medical centers, community hospitals, community health centers, long-term care facilities, both large and small physician group practices, health plans as well as a registered nurse and a representative from a behavioral health, substance abuse disorder, or mental health services organization.

systems for care delivery, care coordination, improved quality, and cost containment; and promoting implementation of evidence-based best-practice clinical decision support tools for advanced diagnostic imaging services. In addition, MeHI must create a pilot with community colleges or vocational schools to support health information technology curriculum development and workforce development, which will be funded through the Health Care Workforce Transformation Fund.

HIT Financing

The law infuses the existing e-Health Institute Fund, which will continued to be administered by MeHI, with $30 million. The funding will be financed through a one-time assessment on health plans and acute hospitals with more than $1 billion in assets and less than 50 percent of their revenue from public payers. The law updates eligibility and grant requirements for the fund, which will continue to defray the cost to eligible providers of adopting EHR systems.

The law creates the Massachusetts Health Information Technology Revolving Loan Fund[19] to provide zero-interest loans to health care providers and community-based behavioral health organizations in order to implement HIT that complies with federal and state standards. Loans must be paid back within five years. The Fund will be administered by MeHI.

The law also establishes the Massachusetts HIE Fund within EOHHS to finance the development of the statewide HIE. The fund will be financed through the e-Health Institute Fund and through agreements and grants with the U.S. Office of the National Coordinator.

Provider HIT Requirements

The law requires that by January 1, 2017, every patient have electronic access to his or her health records, and all providers fully implement interoperable EHR systems that connect to the statewide HIE. EOHHS must determine the penalty for providers who do not develop interoperable EHR systems.[20] By December 31, 2016, ACOs, PCMHs, and risk-bearing provider organizations must have interoperable EHR systems. In addition, beginning on January 1, 2015, proficiency in HIT (computerized physician order entry, e-prescribing, and EHRs) will be a requirement for physician licensure by the Board of Registration in Medicine.

Protocol for Unauthorized Disclosure of Patient Information

The law establishes a protocol for unauthorized access or disclosure of patient health information in the HIE, including penalties and standards for notifying affected individuals.

X. MEDICAL MALPRACTICE REFORMS

The law creates a 182-day "cooling off period" to promote settlement of medical malpractice suits,[21] with required data access and exchanges between parties during this period. The law further allows a provider to admit to or apologize for a medical mistake or error, and such apology cannot be used as evidence against the provider in court.

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19 Financing for the fund is subject to future appropriations, bond notes, awards, and other sources of funds.

20 Providers in geographic areas without broadband Internet access can apply for a waiver so that they do not have to implement interoperable EHR systems that connect with the statewide HIE.

21 Specifically, no person can commence legal action against a health care provider without first giving 182 days' written notice.

The law creates an independent task force with up to 11 members to study the practice of defensive medicine and medical overutilization. The task force must file a report and any legislative recommendations by November 5, 2013.

XI. OTHER SIGNIFICANT PROVISIONS

Tiered Health Plans

The law increases the minimum premium savings for tiered or selective plans (compared with non-tiered/non-selective plans) from 12 percent to 14 percent.[22] The law allows for, though does not require, "smart tiering" plans, which are defined as products that offer differences in cost sharing based on *services*, rather than *facilities* providing services. In addition, if a medically necessary covered service is available at only five or fewer facilities in Massachusetts, 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.

Group Cooperative Purchasing

The law changes provisions about the rates to be offered by group purchasing cooperative plans, which were created by Chapter 288 of the Acts of 2010. The earlier law required cooperative rates to be based on the rates in the merged individual and small group market, and it permitted rate variations only for differences in covered benefits and expected experience, and only with the prior approval of the Division of Insurance. The new law permits rates also to be discounted up to 10 percent based on any other rate adjustment factor without prior written approval from the Commissioner of Insurance.

Administrative Simplification

The law seeks to simplify administrative processes for providers by requiring that all health plans use standardized forms for prior authorizations, eligibility determination, and claims statements.

Medical Loss Ratio and Rate Increase Limits

The law reduces the minimum medical loss ratio from 90 percent to 89 percent from April 1, 2014, to April 1, 2015, and to 88 percent from April 1, 2015, onward. The law extends until July 1, 2015, the rate-shock limits, which limit premium-rate increases in the merged small and individual group market to an amount established annually by the Commissioner of Insurance.

Mental Health Parity

The law strengthens reporting and implementation requirements for health plans with regard to compliance with state and federal mental health parity laws.

Fair Share Contribution

The law changes the Fair Share Contribution so that beginning on July 1, 2013, employers with 21 or more full-time employees will be subject to the Fair Share Contribution requirements.[23] The

22 The Commissioner of Insurance can apply waivers to the 14 percent premium-rate-discount requirement for health plans that receive at least 80 percent of their income from government programs or whose service areas don't include Suffolk or Middlesex county.

23 Previously, employers with 11 or more full-time employees were subject to the Fair Share Contribution requirements.

law 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.

Nurse Staffing Requirements

The law 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. The law 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, that nurse must have at least eight consecutive hours off.

End of Life Care

The law requires that hospitals, nursing facilities, health centers, and assisted living facilities distribute information regarding palliative care and end-of-life options to the appropriate patients, including those diagnosed with a terminal illness. DPH must consult with the Hospice and Palliative Care Federation of Massachusetts to develop necessary educational materials, rules, and regulations.

Checklists of Care

The law 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 at CHIA.

Telemedicine

The law 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 the Board of Registration in Medicine, must produce a report by July 1, 2013, on the possibility of out-of-state physicians practicing telemedicine in Massachusetts.

XII. STUDIES, COMMISSIONS AND TASK FORCES

Behavioral Health Integration Task Force

The law creates a 19-member special task force to study payment systems for behavioral and substance use disorders and integration with primary care. The task force must file a report and any proposed legislation by July 1, 2013.

Public Payer Commission

The law creates a 13-member special commission to review public payer health care reimbursement rates and payment systems and their impact on health care providers and private premiums. The commission must file the results of its analysis and any draft legislation by April 1, 2013.

Price Variation Commission

The law creates an 18-member special commission to examine provider price variation. 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. Results of the analysis and any draft legislation must be filed by January 1, 2014.

Pharmaceutical Cost Commission

The law 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 purchasing and establishing a single-payer prescription drug system. By August 6, 2013, the commission must report any findings and legislative, programmatic, and funding recommendations.

Diagnostic Accuracy Task Force

The law creates a nine-member special task force to study the prevalence of inaccurate medical diagnoses and their impact on patients and health care costs.

Graduate Medical Education Commission

The law creates a 13-member special commission to study the value of graduate medical education (GME) in Massachusetts and provide recommendations for sustainable funding solutions for GME. The commission must submit a report and any draft legislation by April 1, 2013.

Commssion on the Adoption of HRAs, HSAs, and FSAs

The law creates a 12-member commission at the Department of Revenue 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 other similar programs. The commission must submit a report with recommendations and any draft legislation by April 1, 2013.

Report on the Impact of Chapter 224

The State Auditor is charged with issuing a study, by March 31, 2017, on the impact of the law on health care payment and delivery systems, health care consumers, and the health care workforce.

APPENDIX A: SIGNIFICANT STATE ORGANIZATIONAL CHANGES

CURRENT FUNCTION	MOVED FROM	MOVED TO
Annual Cost Trends Hearings	Division of Health Care Finance and Policy (DHCFP)	Health Policy Commission (HPC)
Annual Cost Trends Report	DHCFP	Center for Health Information and Analysis (CHIA)
All-Payer Claims Database	DHCFP	CHIA
Statewide Quality Advisory Committee	DHCFP	CHIA
Consumer website on quality and cost	Health Care Quality and Cost Council	CHIA
Betsy Lehman Center for Public Safety	Department of Public Health (DPH)	CHIA
Office of Patient Protection	DPH	CHIA
Student Health Plan	DHCFP	Commonwealth Health Insurance Connector Authority (Connector)
Employer Responsibilities • Fair Share • Free Rider Surcharge • Health information Responsibility Disclosure	DHCFP	Connector
Medicaid provider rate setting	DHCFP	Office of Medicaid
Health Safety Net Office	DHCFP	Office of Medicaid
HIE development, implementation, and operation	Mass e-Health Institute	Executive Office of Health and Human Services (EOHHS)
HIT Council	Mass e-Health Institute	EOHHS

APPENDIX B: KEY IMPLEMENTATION DATES

NOVEMBER 5, 2012	• Provisions of Chapter 224 of the Acts of 2012 take effect, unless otherwise noted
DECEMBER 31, 2012	• HPC must establish the one-time surcharge percentage that applies to health plans and acute hospitals with $1 billion in assets and less than 50% of revenue from public payers
JANUARY 1, 2013	• Wellness program tax credit goes into effect • DPH, in collaboration with DOI, must write a report and provide recommendations on wellness plan and health management program best practices in order to create a model wellness guide for payers, employers, and health care consumers • All providers must give at least 60 days' notice to HPC, CHIA, and the AG before making any material changes to their operations or governing structure
APRIL 1, 2013	• The special commission on public payer rates must file the results of its analysis and any draft legislation on public payer health care reimbursement rates and payment systems and their impact on providers and premiums • Reports, recommendations, and any draft legislation are due from the commission on graduate medical education and the commission studying adoption of HRAs, HSAs and FSAs • Provisions pertaining to smart tiering plans take effect
JUNE 30, 2013	• Health plans and acute hospitals with more than $1 billion in net assets and less than 50% of revenue from public payers must pay at least the first installment of their assessment; entities assessed can either pay the full amount by this day or pay in equal installments each June 30 until 2016; funds will be transferred to the Distressed Hospital Fund (60%), the Prevention and Wellness Trust Fund (23.66%), and the e-Health Institute Fund (13.33%)
JULY 1, 2013	• The Office of Medicaid must have at least 25% of enrollees in alternative payment contracts • The special task force on behavioral health integration created by the law must file a report and any proposed legislation pertaining to its study on behavioral, substance use disorder, and mental health treatment; service delivery; integration of behavioral health and primary care; and behavioral, substance use disorder, and mental health reimbursement systems
JULY 31, 2013	• Regulations requiring health plans and contractors to comply with mental health parity laws must be included in any provider contract and health plan
AUGUST 6, 2013	• The commission on pharmaceutical cost containment must report any findings and legislative, programmatic, and funding recommendations pertaining to ways to lower prescription drug costs for both public and private payers
OCTOBER 1, 2013	• Health plans must disclose patient-level data to providers in their network for the purpose of care coordination and treatment plans • Risk-bearing provider organizations must apply for a risk certificate with the Division of Insurance by this date • All health plans must create a website and a toll-free phone number that allow consumers to obtain information about health care service costs • An insurer or utilization review organization must determine whether a proposed service is medically necessary within seven working days
JANUARY 1, 2014	• The Health Planning Council must submit the State Health Plan • HPC, with the Office of Medicaid, must develop and implement standards for certifying Patient Centered Medical Homes (PCMHs) • HPC must develop a model payment system for PCMHs • The special commission on price variation must file the results of its analysis and any draft legislation pertaining to acceptable and unacceptable factors that lead to price variation, proposed steps to reduce price variation, and proposed maximum reasonable adjustments to an insurer's rate for acceptable price variation • 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 and website available through the patient's insurer

APPENDIX B: KEY IMPLEMENTATION DATES *(continued)*

JUNE 30, 2014	• Unless already paid fully, installments are due from health plans and acute hospitals with more than $1 billion in net assets and less than 50% of revenue from public payers; funds will be transferred to the Distressed Hospital Fund (60%), the Prevention and Wellness Trust Fund (23.66%), and the e-Health Institute Fund (13.33%)
JULY 1, 2014	• The Office of Medicaid must have at least 50% of enrollees in alternative payment contracts • MassHealth, GIC, and any other state funded insurance programs must implement alternative payment methodologies to the "maximum extent feasible" • HPC, with the Office of Medicaid, must establish a PCMH training
OCTOBER 1, 2014	• All health plans must create a website and a toll-free phone number that allow consumers to obtain information about health care service costs in real time
2015	• HPC can begin requiring health care entities to file and implement performance improvement plans if it finds that they have exceeded the health care cost growth benchmark
JANUARY 1, 2015	• HIT proficiency (computerized physician order entry, e-prescribing, and EHRs) will be a requirement of licensure by the Board of Registration in Medicine
JUNE 30, 2015	• The commission on prevention and wellness must report on the effectiveness of the Prevention and Wellness Trust Fund • Unless already paid fully, installments are due from health plans and acute hospitals with more than $1 billion in net assets and less than 50% of revenue from public payers; funds will be transferred to the Distressed Hospital Fund (60%), the Prevention and Wellness Trust Fund (23.66%), and the e-Health Institute Fund (13.33%)
JULY 1, 2015	• The Office of Medicaid must have at least 80% of enrollees in alternative payment contracts
OCTOBER 1, 2015	• Utilization review criteria must be applied consistently and made easily accessible to the public and kept up-to-date on a health plan or utilization review organization's website
JUNE 30, 2016	• Unless already paid fully, installments are due from health plans and acute hospitals with more than $1 billion in net assets and less than 50% of revenue from public payers; funds will be transferred to the Distressed Hospital Fund (60%), the Prevention and Wellness Trust Fund (23.66%), and the e-Health Institute Fund (13.33%)
JULY 1, 2016	• From this point forward, HPC is funded by assessments on hospitals and ambulatory surgical centers and surcharge payers
DECEMBER 31, 2016	• ACOs, PCMHs, and risk-bearing provider organizations must have interoperable EHR systems
JANUARY 1, 2017	• The Commissioner of Revenue, in collaboration with DPH and the Office of Commonwealth Performance, Accountability, and Transparency, must publish a report and any legislative recommendations on the effectiveness of the wellness tax credit in achieving its public policy goals • Every patient must have electronic access to his or her health records • All providers must fully implement interoperable EHR systems that connect to the statewide HIE
MARCH 31, 2017	• The State Auditor must report on the impact of Chapter 224
DECEMBER 31, 2017	• Wellness program tax credit ends