HOUSE DOCKET, NO. 992 FILED ON: 1/15/2019

HOUSE . . . . . No. 1186

The Commonwealth of Massachusetts

PRESENTED BY:

David M. Nangle

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act strengthening HPC and CHIA market oversight.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
David M. Nangle	*17th Middlesex*	*1/15/2019*

HOUSE DOCKET, NO. 992 FILED ON: 1/15/2019

HOUSE . . . . . No. 1186

By Mr. Nangle of Lowell, a petition (accompanied by bill, House, No. 1186) of David M. Nangle relative to oversight of the market by the Health Policy Commission and the Center for Health Information and Analysis. Health Care Financing.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

An Act strengthening HPC and CHIA market oversight.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 6D of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by striking section 13 in its entirety and replacing it with the following new language: -

Section 13. (a) Every provider or provider organization shall, before making any material change to its operations or governance structure, submit notice to the commission, the center and the attorney general of such change, not fewer than 60 days before the date of the proposed change. Material changes shall include, but not be limited to: a corporate merger, acquisition or affiliation of a provider or provider organization and a carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of insolvent provider organizations; and mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region.

Within 30 days of receipt of a notice filed under the commission's regulations, the commission shall conduct a preliminary review to determine whether the material change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 9, or on the competitive market. If the commission finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, or on the competitive market, the commission shall conduct a cost and market impact review under this section.

(b) In addition to the grounds for a cost and market impact review set forth in subsection (a), if the commission finds, based on the center's annual report, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the commission shall conduct a cost and market impact review of any provider organization identified by the center under section 16 of chapter 12C.

(c) The commission shall initiate a cost and market impact review by sending the provider or provider organization notice of a cost and market impact review which shall explain the basis for the review and the factors that the commission seeks to examine through the review. The provider organization shall submit to the commission, within 21 days of the commission's notice, a written response to the notice, including, but not limited to, any information or documents sought by the commission which are described in the commission's notice.

(d) A cost and market impact review may examine factors relating to the provider or provider organization's business and its relative market position, including, but not limited to:

(i) the provider or provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) the provider

or provider organization's prices for services, including its relative price compared to other providers for the same services in the same market; (iii) the provider or provider organization's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar providers; (iv) the quality of the services it provides, including patient experience; (v) provider cost and cost trends in comparison to total health care expenditures statewide; (vi) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider or provider organization within its primary service areas and dispersed service areas; (vii) the provider or provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (viii) the methods used by the provider or provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (ix) the methods used by the provider or provider organization to direct patient care to the appropriate and lowest-cost setting within its system and to eliminate unnecessary duplication of health care services within the system; (x) the role of the provider or provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (xi) the role of the provider or provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (xii) consumer concerns, including but not limited to, complaints or other allegations that the provider or provider organization has engaged

in any unfair method of competition or any unfair or deceptive act or practice; and (xiii) any other factors that the commission determines to be in the public interest.

(e) The commission shall make factual findings and issue a preliminary report on the cost and market impact review within 180 days. If the Commission finds in its review that the provider organization's request: (i) has resulted or is likely to result in any unfair method of competition;(ii) has resulted or is likely to result in any unfair or deceptive act or practice, (iii) has resulted or is likely to result in increased health care costs that threaten the health care cost growth benchmark; (iv) will substantially lessen competition, or otherwise violate antitrust laws; (v) will not result in or produce increased efficiencies, higher quality of care and lower costs for payers and patients; or (vi) there is no persuasive evidence that the proposed lower costs, efficiencies, and improvements to quality can only be achieved through this transaction, the Commission may deny the provider's request for a material change. At any time during its review, the Commission may refer its findings, together with any supporting documents, data or information to the attorney general for further review and action.

(f) Within 30 days after issuance of a preliminary report, the provider or provider organization may respond in writing to the findings in the report. The commission shall then issue its final report. If the commission approves the transaction the commission shall forward its decision to the attorney general, who shall make an independent legal determination as to whether the transaction satisfies the requirements of state and federal antitrust law and any and all guidance issued by the U.S. Department of Justice and the Federal Trade Commission.

(g) Any provider organization aggrieved by any such decision by the Commission to deny a request for a material change may request an adjudicatory hearing pursuant to chapter thirty A within twenty-one days of the Commission's decision. The Commission shall notify the attorney general and the division of insurance upon receipt of such hearing request. Said hearing shall be conducted within thirty days of the Commission's receipt of the hearing request. The attorney general may intervene in a hearing under this subsection and may require the production of additional information or testimony. The Commission shall issue a written decision within thirty days of the conclusion of the hearing.

(h) A provider organization aggrieved by said written decision may, within twenty days of said decision, file a petition for review in the supreme judicial court for Suffolk County. Review by the supreme judicial court on the merits shall be limited to the record of the proceedings before the commissioner and shall be based upon the standards set forth in paragraph (7) of section fourteen of chapter thirty A.

(i) When the commission, under subsection (f), refers a report on a provider or provider organization to the attorney general, the attorney general may: (i) conduct an investigation to determine whether the provider or provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law; (ii) report to the commission in writing the findings of the investigation and a conclusion as to whether the provider or provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law; and (iii) if appropriate, take action under chapter 93A or any other law to protect consumers in the health care market. The commission's final report may be evidence in any such action.

(j) Nothing in this section shall limit the authority of the attorney general to protect consumers in the health care market under any other law.

(k) The commission shall adopt regulations for conducting cost and market impact reviews and for administering this section. These regulations shall include definitions of material change and non-material change, primary service areas, dispersed service areas, dominant market share, materially higher prices and materially higher health status adjusted total medical expenses, and any other terms as necessary. All regulations promulgated by the commission shall comply with chapter 30A.

(l) Nothing in this section shall limit the application of other laws or regulations that may be applicable to a provider or provider organization, including laws and regulations governing insurance.

SECTION 2. Section 8 of Chapter 6D of the General Laws, as appearing in the Official Edition, is hereby amended by inserting after the last sentence in paragraph (b), the following new language:

“Any provider or provider organization that has been identified by the center under section 18 of chapter 12C as exceeding the heath care cost growth benchmark for any given year shall be prohibited by the commission from making any material change to its operations or governance structure that would otherwise require notice to the commission pursuant to section 13 of this chapter. The commission may exclude a provider or provider organization from this prohibition if the market share of the provider or provider organization is below a threshold as determined by the commission, or if the provider or provider organization’s total medical expenses or relative price are below the statewide median. The prohibition shall continue until

the center has determined that the provider or provider organization has lowered its relative price and total medical expenses to a level at or below the cost growth benchmark.

SECTION 3. Section 8 of Chapter 6D of the General Laws, as appearing in the Official Edition, is hereby amended by inserting after paragraph (f), the following new language:

(g) As part of the annual public hearings established herein, the commission shall conduct an annual review of the status of all the commission-approved material changes pursuant to section 13 of this chapter, to determine whether the benefits providers have given as the reasons for coming together, such as lower costs, better integration or improved quality, have been realized. The commission shall collect written testimony from relevant parties and identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the commission, the executive director of the center and attorney general at the public hearing in a manner and form to be determined by the commission. Testimony may include, but not be limited to: (i) the impact of the material change on the relative price and total medical expenses; (ii) the impact of the material change on insurer reimbursement rates; (iii) the quality of the services provided; (iv) the impact of the material change on consumer access to services; (v) the extent to which the material change resulted in measurable increases in efficiencies, coordination of care or other benefits of integration; (vi) the impact of the material change on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization’s expansion, affiliation,

merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (vii) any other factors that the commission determines to be in the public interest.

The commission shall issue a report that details the findings of the public hearing, including any and all oral and written testimony and shall include any actions taken by the commission against any provider or provider organization. The report shall be posted on the commission's website and shall be filed with the house of representatives and senate clerks, the house and senate committees on ways and means, and the joint committee on health care financing.

If the commission finds that an approved material change has failed to produce the stated benefits, the commission may: (i) subject the provider or provider organization to enhanced review, including but not limited to a new cost and market impact review, (ii) require the provider or provider organization to complete a corrective action plan, or (iii) prohibit the provider or provider organization from making any additional material changes to its operating or governance structure for one year following a reevaluation and approval by the commission.

If the commission finds that an approved material change has failed to produce the stated benefits and the provider or provider organization has exceeded the health care cost growth benchmark, the commission shall notify the Center for Health Information and Analysis of the extent by which the provider or provider organization has exceeded the health care cost growth benchmark. The Center for Health Information and Analysis shall calculate an amount that reflects the cost to the Commonwealth of that excess and that amount shall be used to either reduce the Health Safety Net payments to that provider or provider organization or to increase the payments by that provider or provider organization to the Health Safety Net, or a

combination of both to achieve the result. The Center for Health Information and Analysis shall develop a method for collecting data from providers or provider organizations necessary to make the calculations mandated by this section and the methodology used in determining the amount by which the provider or provider organization's participation in Health Safety Net payments or assessments will be affected.