

# HOUSE . . . . . No. 5159

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## The Commonwealth of Massachusetts

The committee of conference on the disagreeing votes of the two branches with reference to the Senate amendments (striking out all after the enacting clause and inserting in place thereof the text contained in Senate document numbered 2881; and by striking out the title and inserting in place thereof the following title: “An Act enhancing the health care market review process.”) of the House Bill enhancing the market review process (House, No. 4653), reports recommending passage of the accompanying bill (House, No. 5159). December 27, 2024.

John J. Lawn, Jr.	Cindy F. Friedman
Frank A. Moran	John J. Cronin
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**HOUSE . . . . . No. 5159**

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**The Commonwealth of Massachusetts**

**In the One Hundred and Ninety-Third General Court  
(2023-2024)**

An Act enhancing the market review process.

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

1           SECTION 1. Section 16 of chapter 6A of the General Laws, as appearing in the 2022  
2 Official Edition, is hereby amended by striking out, in lines 24 to 26, inclusive, the words “, the  
3 division of medical assistance and the Betsy Lehman center for patient safety and medical error  
4 reduction” and inserting in place thereof the following words:- and the division of medical  
5 assistance.

6           SECTION 2. Section 16D of said chapter 6A, as so appearing, is hereby amended by  
7 striking out, in lines 22 to 23, inclusive, the words “in the department of public health established  
8 by section 217 of chapter 111” and inserting in place thereof the following words:- within the  
9 health policy commission established by section 16 of chapter 6D.

10           SECTION 3. Section 16N of said chapter 6A of the General Laws is hereby repealed.

11           SECTION 4. Section 16T of said chapter 6A of the General Laws is hereby repealed.

12 SECTION 5. Section 1 of chapter 6D of the General Laws, as appearing in the 2022  
13 Official Edition, is hereby amended by inserting after the definition of “Health care provider” the  
14 following 2 definitions:-

15 “Health care real estate investment trust”, a real estate investment trust, as defined by 26  
16 U.S.C section 856, whose assets consist of real property held in connection with the use or  
17 operations of a provider or provider organization.

18 “Health care resource”, any resource, whether personal or institutional in nature and  
19 whether owned or operated by any person, the commonwealth or political subdivision thereof,  
20 the principal purpose of which is to provide, or facilitate the provision of, services for the  
21 prevention, detection, diagnosis or treatment of those physical and mental conditions, which  
22 usually are the result of, or result in, disease, injury, deformity or pain; provided, however, that  
23 the term “treatment”, as used in this definition, shall include custodial and rehabilitative care  
24 incident to infirmity, developmental disability or old age.

25 SECTION 6. Said section 1 of said chapter 6D, as so appearing, is hereby further  
26 amended by inserting after the definition of “Health care services” the following 2 definitions:-

27 “Health disparities”, preventable differences in the burden of disease, injury, violence or  
28 opportunities to achieve optimal health that are experienced by socially disadvantaged  
29 populations.

30 “Health equity”, the state in which a health system offers the infrastructure, facilities,  
31 services, geographic coverage, affordability and all other relevant features, conditions and  
32 capabilities that will provide all people with the opportunity and reasonable expectation that they  
33 can reach their full health potential and well-being and are not disadvantaged in access to health

34 care by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation,  
35 social class, intersections among these communities or identities, or their socially determined  
36 circumstances.

37 SECTION 7. Said section 1 of said chapter 6D, as so appearing, is hereby further  
38 amended by inserting after the definition of “Hospital service corporation” the following  
39 definition:-

40 “Management services organization”, a corporation that provides management or  
41 administrative services to a provider or provider organization for compensation.

42 SECTION 8. Said section 1 of said chapter 6D, as so appearing, is hereby further  
43 amended by striking out the definition of “Payer” and inserting in place thereof the following  
44 definition:-

45 “Payer”, any entity, other than an individual, that pays providers for the provision of  
46 health care services; provided, however, that “payer” shall include both governmental and  
47 private entities; and provided further, that “payer” shall include self-insured plans to the extent  
48 allowed under the Employee Retirement Income Security Act of 1974.

49 SECTION 9. Said section 1 of said chapter 6D, as so appearing, is hereby further  
50 amended by inserting after the definition of “Performance penalty” the following 2 definitions:-

51 “Pharmaceutical manufacturing company”, an entity engaged in the: (i) production,  
52 preparation, propagation, compounding, conversion or processing of prescription drugs, directly  
53 or indirectly, by extraction from substances of natural origin, independently by means of  
54 chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging,

55 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that  
56 “pharmaceutical manufacturing company” shall not include a hospital licensed under section 51  
57 of chapter 111, a wholesale drug distributor licensed under section 36B of chapter 112 or a retail  
58 pharmacist registered under section 39 of said chapter 112.

59 “Pharmacy benefit manager”, as defined in section 1 of chapter 176Y.

60 SECTION 10. Said section 1 of said chapter 6D, as so appearing, is hereby further  
61 amended by inserting after the definition of “Primary care provider” the following definition:-

62 “Private equity company”, any company that collects capital investments from  
63 individuals or entities and purchases, as a parent company or through another entity that the  
64 company completely or partially owns or controls, a direct or indirect ownership share of a  
65 provider, provider organization or management services organization; provided, however, that  
66 “private equity company” shall not include venture capital firms exclusively funding startups or  
67 other early-stage businesses.

68 SECTION 11. Said section 1 of said chapter 6D, as so appearing, is hereby further  
69 amended by inserting after the definition of “Shared decision-making” the following definition:-

70 “Significant equity investor”, (i) any private equity company with a financial interest in a  
71 provider, provider organization or management services organization; or (ii) an investor, group  
72 of investors or other entity with a direct or indirect possession of equity in the capital, stock or  
73 profits totaling more than 10 per cent of a provider, provider organization or management  
74 services organization; provided, however, that “significant equity investor” shall not include  
75 venture capital firms exclusively funding startups or other early-stage businesses.

76 SECTION 12. Section 2 of said chapter 6D, as so appearing, is hereby amended by  
77 striking out subsections (b) and (c) and inserting in place thereof the following 2 subsections:-

78 (b)(1) There shall be a board, with duties and powers established by this chapter, which  
79 shall govern the commission. The board shall consist of 11 members: 1 of whom shall be the  
80 secretary of health and human services, or a designee; 1 of whom shall be the commissioner of  
81 insurance, or a designee; 6 of whom shall be appointed by the governor, 1 of whom shall serve as  
82 chairperson, 1 of whom shall be selected from a list of 3 nominees submitted by the president of  
83 the senate and 1 of whom shall be selected from a list of 3 nominees submitted by the speaker of  
84 the house or representatives; and 3 of whom shall be appointed by the attorney general. All  
85 appointed members shall serve for a term of 5 years, but a person appointed to fill a vacancy  
86 shall serve only for the remainder of the unexpired term. An appointed member of the board  
87 shall be eligible for reappointment; provided, however, that no appointed member shall hold full  
88 or part-time employment in the executive branch of state government. The board shall annually  
89 elect 1 of its members to serve as vice-chairperson. Each member of the board shall be a resident  
90 of the commonwealth.

91 (2) The person appointed by the governor to serve as chairperson shall have demonstrated  
92 expertise in health care administration, finance and management at a senior level. The second  
93 person appointed by the governor, shall have demonstrated expertise in representing hospitals or  
94 hospital health systems. The third person appointed by the governor shall have demonstrated  
95 expertise in health plan administration and finance. The fourth person appointed by the governor  
96 shall be a registered nurse with expertise in the delivery of care and development and utilization  
97 of innovative treatments in the practice of patient care. The fifth person appointed by the  
98 governor, from the list of nominees submitted by the president of the senate, shall have

99 demonstrated expertise in representing the health care workforce as a leader in a labor  
100 organization. The sixth person appointed by the governor, from the list of nominees submitted by  
101 the speaker of the house of representatives, shall have demonstrated expertise in health care  
102 innovation, including pharmaceuticals, biotechnology or medical devices. The first person  
103 appointed by the attorney general shall be a health economist. The second person appointed by  
104 the attorney general shall have demonstrated expertise in health care consumer advocacy. The  
105 third person appointed by the attorney general shall have expertise in behavioral health,  
106 substance use disorder, mental health services and mental health reimbursement systems.

107 (c) Six members of the board shall constitute a quorum, and the affirmative vote of 6  
108 members of the board shall be necessary and sufficient for any action taken by the board. No  
109 vacancy in the membership of the board shall impair the right of a quorum to exercise all the  
110 rights and duties of the commission. The appointed members of the board shall receive a stipend  
111 in an amount not more than 10 per cent of the salary of the secretary of administration and  
112 finance under section 4 of chapter 7; provided, however, that the chairperson shall receive a  
113 stipend in an amount not more than 12 per cent of the salary of the secretary of administration  
114 and finance under said section 4 of said chapter 7. The secretary of health and human services  
115 and the commissioner of insurance, or their designees, shall not receive a stipend for their service  
116 as board members. A member of the board shall not be employed by, a consultant to, a member  
117 of the board of directors of, affiliated with, have a financial stake in or otherwise be a  
118 representative of a health care entity while serving on the board.

119 SECTION 13. Section 5 of said chapter 6D, as so appearing, is hereby amended by  
120 striking out, in line 10, the words “and (vii)” and inserting in place thereof the following words:-

121 ; (vii) monitor the location and distribution of health care services and health care resources; and  
122 (viii).

123 SECTION 14. Said chapter 6D is hereby further amended by striking out section 6, most  
124 recently amended by section 5 of chapter 140 of the acts of 2024, and inserting in place thereof  
125 the following section:-

126 Section 6. (a) For the purposes of this section, “non-hospital provider organization” shall  
127 mean a provider organization required to register under section 11 that is: (i) a non-hospital-  
128 based physician practice with not less than \$500,000,000 in annual gross patient service revenue;  
129 (ii) a clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated urgent care  
130 centers.

131 (b) Each acute hospital, ambulatory surgical center, non-hospital provider organization,  
132 pharmaceutical manufacturing company and pharmacy benefit manager shall pay to the  
133 commonwealth an amount for the estimated expenses of the commission.

134 (c) The assessed amount for acute hospitals, ambulatory surgical centers and non-hospital  
135 provider organizations shall be not less than 30 per cent nor more than 40 per cent of the amount  
136 appropriated by the general court for the expenses of the commission minus amounts collected  
137 from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching  
138 revenues received for these expenses or received retroactively for expenses of predecessor  
139 agencies; provided, however, that, to the maximum extent permissible under federal law, non-  
140 hospital provider organizations shall be assessed not less than 3 per cent nor more than 8 per cent  
141 of the total assessed amount for acute hospitals, ambulatory surgical centers and non-hospital  
142 provider organizations. Each acute hospital, ambulatory surgical center and non-hospital

143 provider organization shall pay such assessed amount multiplied by the ratio of the acute  
144 hospital's, ambulatory surgical center's or non-hospital provider organization's gross patient  
145 service revenues to the total gross patient service revenues of all such hospitals, ambulatory  
146 surgical centers and non-hospital provider organizations. Each acute hospital, ambulatory  
147 surgical center and non-hospital provider organization shall make a preliminary payment to the  
148 commission on October 1 of each year in an amount equal to 1/2 of the previous year's total  
149 assessment. Thereafter, each acute hospital, ambulatory surgical center and non-hospital provider  
150 organization shall pay, within 30 days' notice from the commission, the balance of the total  
151 assessment for the current year based upon its most current projected gross patient service  
152 revenue. The commission shall subsequently adjust the assessment for any variation in actual and  
153 estimated expenses of the commission and for changes in acute hospital, ambulatory surgical  
154 center and non-hospital provider organization gross patient service revenue. Such estimated and  
155 actual expenses shall include an amount equal to the cost of fringe benefits and indirect  
156 expenses, as established by the comptroller under section 5D of chapter 29. In the event of late  
157 payment by any such acute hospital, ambulatory surgical center or non-hospital provider  
158 organization, the treasurer shall advance the amount of due and unpaid funds to the commission  
159 prior to the receipt of such monies in anticipation of such revenues up to the amount authorized  
160 in the then current budget attributable to such assessments and the commission shall reimburse  
161 the treasurer for such advances upon receipt of such revenues. This section shall not apply to any  
162 state institution or to any acute hospital which is operated by a city or town.

163 (d) To the maximum extent permissible under federal law, and provided that such  
164 assessment will not result in any reduction of federal financial participation in Medicaid, the  
165 assessed amount for pharmaceutical manufacturing companies shall be not less than 5 per cent

166 nor more than 10 per cent of the amount appropriated by the general court for the expenses of the  
167 commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the  
168 commission; and (iii) federal matching revenues received for these expenses or received  
169 retroactively for expenses of predecessor agencies. Each pharmaceutical manufacturing company  
170 shall pay such assessed amount multiplied by the ratio of MassHealth's net spending for the  
171 manufacturer's prescription drugs used in the MassHealth rebate program to MassHealth's total  
172 pharmacy spending.

173 (e) To the maximum extent permissible under federal law, and provided that such  
174 assessment will not result in any reduction of federal financial participation in Medicaid, the  
175 assessed amount for pharmacy benefit managers shall be not less than 5 per cent nor more than  
176 10 per cent of the amount appropriated by the general court for the expenses of the commission  
177 minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission;  
178 and (iii) federal matching revenues received for these expenses or received retroactively for  
179 expenses of predecessor agencies. Each pharmacy benefit manager shall pay such assessed  
180 amount multiplied by the ratio of the claims paid by the pharmacy benefit manager attributed to  
181 residents of the commonwealth for whom it manages pharmaceutical benefits on behalf of  
182 carriers to the total of all such claims paid by all pharmacy benefit managers attributed to  
183 residents of the commonwealth for whom they manage pharmaceutical benefits on behalf of  
184 carriers.

185 (f) Each pharmaceutical manufacturing company and each pharmacy benefit manager  
186 shall make a preliminary payment to the commission annually on October 1 in an amount equal  
187 to 1/2 of the previous year's total assessment. Thereafter, each pharmaceutical manufacturing  
188 company and each pharmacy benefit manager shall pay, within 30 days of receiving notice from

189 the commission, the balance of the total assessment for the current year as determined by the  
190 commission.

191 SECTION 15. Section 7 of said chapter 6D, as appearing in the 2022 Official Edition, is  
192 hereby amended by striking out, in line 35, the words “and (vi)” and inserting in place thereof  
193 the following words:- (vi) advance health equity; and (vii).

194 SECTION 16. Subsection (a) of section 8 of said chapter 6D, as so appearing, is hereby  
195 amended by striking out the second sentence and inserting in place thereof the following  
196 sentence:- The hearings shall examine the costs, prices and cost trends of health care providers,  
197 provider organizations, private and public health care payers, pharmaceutical manufacturing  
198 companies and pharmacy benefit managers and any relevant impact of significant equity  
199 investors, health care real estate investment trusts, management services organizations on such  
200 costs, prices and cost trends, with particular attention to factors that contribute to cost growth  
201 within the commonwealth's health care system and trends in annual primary care and behavioral  
202 health expenditures.

203 SECTION 17. Said section 8 of said chapter 6D, as so appearing, is hereby further  
204 amended by inserting after the word “payers” in line 16, the following words:- , significant  
205 equity investors, health care real estate investment trusts, management services organizations,  
206 pharmaceutical manufacturing companies, pharmacy benefit managers.

207 SECTION 18. Said section 8 of said chapter 6D, as so appearing, is hereby further  
208 amended by striking out, in lines 29 through 34, inclusive, the words “(x) at least 4 provider  
209 organizations, at least 2 of which shall be certified as accountable care organizations, 1 of which  
210 has been certified as a model ACO, which shall be from diverse geographic regions of the

211 commonwealth; and (xi) any witness identified by the attorney general or the center” and  
212 inserting in place thereof the following words:- (x) at least 4 provider organizations which shall  
213 be from diverse geographic regions of the commonwealth, at least 2 of which shall be certified as  
214 accountable care organizations and 1 of which shall be certified as a model ACO; (xi) any  
215 significant equity investor, health care real estate investment trust or management services  
216 organization associated with a provider or provider organization; (xii) a representative from the  
217 division of insurance; (xiii) the executive director of the commonwealth health insurance  
218 connector authority; (xiv) the assistant secretary for MassHealth; (xv) not less than 2  
219 representatives of the pharmacy benefit management industry; (xvi) not less than 3  
220 representatives of pharmaceutical manufacturing companies, 1 of whom shall be a representative  
221 of a publicly traded company that manufactures specialty drugs, 1 of whom shall be a  
222 representative of a company that manufactures generic drugs and 1 of whom shall be a  
223 representative of a company that has been in existence for fewer than 10 years; and (xvii) any  
224 witness identified by the attorney general or the center. The commission shall also request  
225 testimony from officials representing the federal Centers for Medicare and Medicaid Services.

226 SECTION 19. Said section 8 of said chapter 6D, as so appearing, is hereby further  
227 amended by striking out, in line 49, the first time it appears, the word “and”.

228 SECTION 20. Said section 8 of said chapter 6D, as so appearing, is hereby further  
229 amended by inserting after the word “commission”, in line 60, the first time it appears, the  
230 following words:- ; (iii) in the case of the assistant secretary for MassHealth, testimony  
231 concerning the structure, benefits, eligibility, caseload and financing of MassHealth and other  
232 Medicaid programs administered by the office of Medicaid or in partnership with other state and  
233 federal agencies and the agency’s activities to align or redesign those programs in order to

234 encourage the development of more integrated and efficient health care delivery systems; (iv) in  
235 the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony  
236 concerning factors underlying prescription drug costs and price increases, the impact of  
237 aggregate manufacturer rebates, discounts and other price concessions on net pricing; provided,  
238 however, that such testimony shall be suitable for public release and not likely to compromise  
239 the financial, competitive or proprietary nature of any information or data; and (v) in the case of  
240 significant equity investors, health care real estate investment trusts or management services  
241 organization associated with a provider or provider organization, testimony concerning health  
242 outcomes, prices charged to insurers and patients, staffing levels, clinical workflow, financial  
243 stability and ownership structure of an associated provider or provider organization, dividends  
244 paid out to investors, compensation including, but not limited to, base salaries, incentives,  
245 bonuses, stock options, deferred compensations, benefits and contingent payments to officers,  
246 managers and directors of provider organizations in the commonwealth acquired, owned or  
247 managed, in whole or in part, by said significant equity investors, health care real estate  
248 investment trusts or management services organizations.

249 SECTION 21. Said section 8 of said chapter 6D, as so appearing, is hereby further  
250 amended by striking out subsection (g) and inserting in place thereof the following subsection:-

251 (g) The commission shall compile an annual report concerning spending trends, including  
252 primary care and behavioral health expenditures, and the underlying factors influencing said  
253 spending trends. The report shall be based on the commission's analysis of information provided  
254 at the hearings by witnesses, providers, provider organizations and payers, registration data  
255 collected pursuant to section 11, data collected or analyzed by the center pursuant to sections 8 to  
256 10A, inclusive, of chapter 12C and any other available information that the commission

257 considers necessary to fulfill its duties under this section, as defined in regulations promulgated  
258 by the commission. The report shall be submitted to the house and senate committees on ways  
259 and means and the joint committee on health care financing and shall be published and available  
260 to the public not later than December 31 of each year. The report shall include recommendations  
261 for strategies to increase the efficiency of the health care system and promote affordability for  
262 individuals and families, recommendations on the specific spending trends that impede the  
263 commonwealth's ability to meet the health care cost growth benchmark and draft legislation  
264 necessary to implement said recommendations.

265 SECTION 22. Section 11 of chapter 6D, as so appearing, is hereby amended by inserting  
266 after the word "affiliates", in line 17, the following words:- , significant equity investors, health  
267 care real estate investment trusts, management services organizations.

268 SECTION 23. Section 12 of said chapter 6D, as so appearing, is hereby amended by  
269 striking out, in lines 8 and 9, the words "carriers or third party administrators" and inserting in  
270 place thereof the following word:- payers.

271 SECTION 24. Said chapter 6D is hereby further amended by striking out section 13, as  
272 so appearing, and inserting in place thereof the following section:-

273 Section 13. (a) Every provider or provider organization shall, before making any material  
274 change to its operations or governance structure, submit notice to the commission, the center and  
275 the attorney general of such change, not fewer than 60 days before the date of the proposed  
276 change. Material changes shall include, but not be limited to: (i) significant expansions in a  
277 provider or provider organization's capacity; (ii) a corporate merger, acquisition or affiliation of  
278 a provider or provider organization and a carrier; (iii) mergers or acquisitions of hospitals or

279 hospital systems; (iv) acquisition of insolvent provider organizations; (v) transactions involving a  
280 significant equity investor which result in a change of ownership or control of a provider or  
281 provider organization; (vi) significant acquisitions, sales or transfers of assets including, but not  
282 limited to, real estate sale lease-back arrangements; (vii) conversion of a provider or provider  
283 organization from a non-profit entity to a for-profit entity; and (viii) mergers or acquisitions of  
284 provider organizations which will result in a provider organization having a dominant market  
285 share in a given service or region.

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

293           (b) In addition to the grounds for a cost and market impact review set forth in subsection  
294 (a), if the commission finds, based on the center's annual report under section 16 of chapter 12C,  
295 that the percentage change in total health care expenditures exceeded the health care cost growth  
296 benchmark in the previous calendar year, the commission may conduct a cost and market impact  
297 review of any provider organization identified by the center under section 18 of said chapter  
298 12C.

299           (c)(1) The commission shall initiate a cost and market impact review by sending the  
300 provider or provider organization notice of a cost and market impact review, which shall explain

301 the basis for the review and the particular factors that the commission seeks to examine through  
302 the review. The provider or provider organization shall submit to the commission, within 21 days  
303 of the commission's notice, a written response to the notice, including, but not limited to, any  
304 information or documents sought by the commission that are described in the commission's  
305 notice. The commission may require that any provider, provider organization, significant equity  
306 investor, or other party involved in a given transaction submit documents and information in  
307 connection with a notice of material change or a cost and market impact review under this  
308 section. The commission shall keep confidential all nonpublic information and documents  
309 obtained under this section and shall not disclose the information or documents to any person  
310 without the consent of the provider or payer that produced the information or documents, except  
311 in a preliminary report or final report under this section if the commission believes that such  
312 disclosure should be made in the public interest after taking into account any privacy, trade  
313 secret or anti-competitive considerations. The confidential information and documents shall not  
314 be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of  
315 chapter 4 or section 10 of chapter 66.

316 (2) For any material change involving a significant equity investor, the commission may  
317 specify certain information required to be submitted as part of the notice, including, but not  
318 limited to, information regarding the significant equity investor's capital structure, general  
319 financial condition, ownership and management structure and audited financial statements.

320 (3) The commission may also require, for a period of 5 years following the completion of  
321 a material change, that any provider or provider organization submit data and information  
322 necessary for the commission to assess the post-transaction impacts of a material change.

323 (d) A cost and market impact review may examine factors relating to the provider or  
324 provider organization's business and its relative market position, including, but not limited to: (i)  
325 the provider or provider organization's size and market share within its primary service areas by  
326 major service category, and within its dispersed service areas; (ii) the provider or provider  
327 organization's prices for services, including its relative price compared to other providers for the  
328 same services in the same market; (iii) the provider or provider organization's health status  
329 adjusted total medical expense, including its health status adjusted total medical expense  
330 compared to similar providers; (iv) the quality of the services provided by the provider or  
331 provider organization, including patient experience; (v) provider cost and cost trends in  
332 comparison to total health care expenditures statewide; (vi) the availability and accessibility of  
333 services similar to those provided, or proposed to be provided, through the provider or provider  
334 organization within its primary service areas and dispersed service areas; (vii) the provider or  
335 provider organization's impact on competing options for the delivery of health care services  
336 within its primary service areas and dispersed service areas including, if applicable, the impact  
337 on existing service providers of a provider or provider organization's expansion, affiliation,  
338 merger or acquisition, to enter a primary or dispersed service area in which it did not previously  
339 operate; (viii) the methods used by the provider or provider organization to attract patient volume  
340 and to recruit or acquire health care professionals or facilities; (ix) the role of the provider or  
341 provider organization in serving at-risk, underserved and government payer patient populations,  
342 including those with behavioral, substance use disorder and mental health conditions, within its  
343 primary service areas and dispersed service areas; (x) the role of the provider or provider  
344 organization in providing low margin or negative margin services within its primary service  
345 areas and dispersed service areas; (xi) consumer concerns, including but not limited to,

346 complaints or other allegations that the provider or provider organization has engaged in any  
347 unfair method of competition or any unfair or deceptive act or practice; (xii) the size and market  
348 share of any corporate affiliates or significant equity investors of the provider or provider  
349 organization; (xiii) the inventory of health care resources maintained by the department of public  
350 health, pursuant to section 25A of chapter 111; (xiv) any related data or reports from the office of  
351 health resource planning, established in section 22; and (xv) any other factors that the  
352 commission determines to be in the public interest.

353 (e) The commission shall make factual findings and issue a preliminary report on the cost  
354 and market impact review. In the report, the commission shall identify any provider or provider  
355 organization that meets all of the following criteria: (i) the provider or provider organization has,  
356 or likely will have as a result of the proposed material change, a dominant market share for the  
357 services it provides; (ii) the provider or provider organization charges, or likely will charge as a  
358 result of the proposed material change, prices for services that are materially higher than the  
359 median prices charged by comparable providers for the same services in the same market; and  
360 (iii) the provider or provider organization has, or likely will have as a result of the proposed  
361 material change, a health status adjusted total medical expense that is materially higher than the  
362 median total medical expense of comparable providers in the same market.

363 (f) Within 30 days after issuance of a preliminary report, the provider or provider  
364 organization may respond in writing to the findings in the report. The commission shall then  
365 issue its final report. The commission shall refer to the attorney general its report on any provider  
366 or provider organization that meets all 3 criteria under subsection (e). The commission shall  
367 issue its final report on the cost and market impact review within 185 days from the date that the  
368 provider or provider organization has submitted a completed notice to the commission; provided,

369 that the provider or provider organization has certified substantial compliance with the  
370 commission's requests for data and information pursuant to subsection (c) within 21 days of the  
371 commission's notice, or by a later date set by mutual agreement of the provider or provider  
372 organization and the commission.

373 (g) Nothing in this section shall prohibit a proposed material change under subsection (a);  
374 provided, however, that any proposed material change shall not be completed: (i) until at least 30  
375 days after the commission has issued its final report; or (ii) if the attorney general brings an  
376 action under chapter 93A or any other law related to the material change, while such action is  
377 pending and prior to a final judgment being issued by a court of competent jurisdiction,  
378 whichever is later.

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

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

390 (j) The commission shall adopt regulations for conducting cost and market impact  
391 reviews and for administering this section. These regulations shall include definitions of material  
392 change and non-material change, primary service areas, dispersed service areas, dominant market  
393 share, materially higher prices and materially higher health status adjusted total medical  
394 expenses, and any other terms as necessary to provide market participants with appropriate  
395 notice. These regulations may identify filing thresholds in connection with this section; provided,  
396 however, that any financial threshold identified by the commission shall be adjusted annually  
397 based on any inflation index established by the United States Department of Health and Human  
398 Services or similarly reliable national index, as set forth by the commission. All regulations  
399 promulgated by the commission shall comply with chapter 30A.

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

403 (l) Upon issuance of its final report pursuant to subsection (f), the commission shall  
404 provide a copy of said final report to the department of public health. The final report shall be  
405 included in the written record and considered by the department of public health during its  
406 review of an application for determination of need and considered where relevant in connection  
407 with licensure or other regulatory actions involving the provider or provider organization.

408 SECTION 25. Said chapter 6D is hereby further amended by adding the following  
409 section:-

410 Section 22. (a)(1) There shall be within the commission an office for health resource  
411 planning. The office shall develop a state health resource plan to identify: (i) the anticipated

412 needs of the commonwealth for health care services, providers, programs and facilities; (ii) the  
413 existing health care resources, providers, programs and facilities available to meet those needs;  
414 (iii) the projected resources, including the health care workforce, necessary to meet those  
415 anticipated needs; (iv) recommendations for the appropriate supply and distribution of resources,  
416 workforce, programs, capacities, technologies and services on a statewide and regional basis; (v)  
417 the priorities for addressing those needs; and (vi) recommendations for any further legislative,  
418 regulatory or other state action to assist the commonwealth in achieving the recommendations  
419 identified in the plan.

420 (2) The state health resource plan developed by the office shall be a forecast of  
421 anticipated demand, production, supply and distribution of health care resources on a state-wide  
422 and regional basis during a 5-year planning period, and shall include the location, distribution  
423 and nature of all health care resources in the commonwealth, including: (i) acute care units; (ii)  
424 non-acute care units; (iii) specialty care units, including, but not limited to, burn, coronary care,  
425 cancer care, neonatal care, post-obstetric and post-operative recovery care, pulmonary care, rare  
426 diseases care, renal dialysis and surgical, including trauma and intensive care units; (iv) skilled  
427 nursing facilities; (v) assisted living facilities; (vi) long-term care facilities; (vii) ambulatory  
428 surgical centers; (viii) office-based surgical centers; (ix) urgent care centers; (x) home health;  
429 (xi) adult and pediatric behavioral health and mental health services and supports; (xii) substance  
430 use disorder treatment and recovery services; (xiii) emergency care; (xiv) ambulatory care  
431 services; (xv) primary care resources; (xvi) pediatric care services; (xvii) pharmacy and  
432 pharmacological services; (xviii) family planning services; (xix) obstetrics and gynecology and  
433 maternal health services; (xx) allied health services including, but not limited to, optometric care,  
434 chiropractic services, oral health care and midwifery services; (xxi) federally qualified health

435 centers and free clinics; (xxii) numbers of technologies or equipment defined as innovative  
436 services or new technologies by the department of public health pursuant to section 25C of  
437 chapter 111; (xxiii) hospice and palliative care service; (xxiv) health screening and early  
438 intervention services; and (xxv) any other service or resource identified by the office.

439 (3) The goal of the state health resource plan shall be to promote the appropriate and  
440 equitable distribution of health care resources across geographic regions of the commonwealth  
441 based on the needs of the population on a statewide basis and the needs of particular geographic  
442 and demographic groups The recommendations shall support, at a minimum, the  
443 commonwealth's goals of: (i) maintaining and improving the quality of and access to health care  
444 services; (ii) ensuring a stable and adequate health care workforce; (iii) meeting the health care  
445 cost growth benchmark established pursuant to section 9; (iv) supporting innovative health care  
446 delivery and alternative payment models as identified by the commission; (v) avoiding  
447 unnecessary duplication of health care resources; (vi) advancing health equity and addressing  
448 health disparities; (vii) integrating oral health, mental health, behavioral health and substance use  
449 disorder treatment services with overall medical care; (viii) aligning housing, health care and  
450 home care to improve overall health outcomes and reduce costs; (ix) tracking trends in utilization  
451 and promoting the best standards of care; and (x) ensuring equitable access to health care  
452 resources across geographic regions of the commonwealth.

453 (b)(1) In addition to the state health resource plan, the office may conduct focused  
454 assessments of health care resource supply, distribution and capacity in relation to projected  
455 need. Each assessment shall be conducted in consultation with the board, the advisory council  
456 established pursuant to section 4 and other state agencies as appropriate, including, but not  
457 limited to, the executive office, the executive office of economic development, the board of

458 higher education, the department of public health, the department of mental health, the office of  
459 Medicaid, the division of insurance, the center for health information and analysis, the  
460 Massachusetts Life Sciences Center, the executive office of elder affairs, the board of  
461 registration in medicine, the bureau of health professions licensure and the office of health equity  
462 established under section 16AA of chapter 6A. All such agencies shall provide data and  
463 information necessary for the office to conduct the assessment. The office shall consider  
464 available state and national data and academic research on health service supply and need and  
465 relevant community health needs assessments by non-profit hospitals and other organizations  
466 and other individual and community statements of need.

467 (2) Each focused assessment may present findings that include, but are not limited to: (i)  
468 the extent to which supply, distribution and capacity of a given health care resource aligns with  
469 projected need at the statewide or regional level; (ii) health system factors driving any  
470 documented health disparities; (iii) services or providers, including in a specific geographic area,  
471 that are critical to the proper functioning of the health care system; (iv) estimates of where and  
472 how many additional units of service would be needed in the state or in a specific geographic  
473 area to meet projected need; (v) an analysis of health care workforce needs; (vi) identification of  
474 barriers impacting accessibility of available health care resources by specific populations; and  
475 (vii) legislative, regulatory or other policy recommendations to address the drivers of health  
476 disparities, access barriers and areas of misalignment of need and supply, distribution and  
477 capacity.

478 (c) The office shall provide direction to the department of public health to establish and  
479 maintain on a current basis an inventory of all such health care resources together with all other  
480 reasonably pertinent information concerning such resources. Agencies of the commonwealth that

481 license, register, regulate or otherwise collect cost, quality or other data concerning health care  
482 resources shall cooperate with the office and the department of public health in coordinating such  
483 data and information collected pursuant to this section and section 25A of chapter 111. The  
484 inventory compiled pursuant to this section and said section 25A of said chapter 111 and all  
485 related information shall be maintained in a form usable by the general public and shall  
486 constitute a public record; provided, however, that any item of information which is confidential  
487 or privileged in nature under any other law shall not be regarded as a public record pursuant to  
488 this section.

489 (d) In developing the state health resource plan, the office shall conduct no fewer than 1  
490 annual public hearing seeking input on the development of the plan and any focused assessment  
491 under development, and shall give interested persons an opportunity to submit their views orally  
492 and in writing. In addition, the office may create and maintain a website to allow members of the  
493 public to submit comments electronically and review comments submitted by others.

494 (e) The office shall publish analyses, reports and interpretations of information collected  
495 pursuant to this section to promote awareness of the distribution and nature of health care  
496 resources in the commonwealth.

497 (f) Annually, not later than January 1, the office shall file a report with the joint  
498 committee on health care financing concerning the activities of the office in general and, in  
499 particular, describing the progress to date in developing the state health resource plan and any  
500 focused assessment produced to date or under development, and recommending such further  
501 legislative action as it considers appropriate.

502 (g) Nothing in this section shall be construed to impose caps on health care resources in  
503 the commonwealth or a particular region in the commonwealth.

504 SECTION 26. Section 5A of chapter 12 of the General Laws, as appearing in the 2022  
505 Official Edition, is hereby amended by striking out, in line 26, the words “or “knowingly” and  
506 inserting in place thereof the following words:- , “knowingly” or “knows”.

507 SECTION 27. Said section 5A of said chapter 12, as so appearing, is hereby further  
508 amended by inserting after the definition of “Overpayment” the following definition:-

509 “Ownership or investment interest”, any: (1) direct or indirect possession of equity in the  
510 capital, stock or profits totaling more than 10 per cent of an entity; (2) interest held by an  
511 investor or group of investors who engages in the raising or returning of capital and who invests,  
512 develops or disposes of specified assets; or (3) interest held by a pool of funds by investors,  
513 including a pool of funds managed or controlled by private limited partnerships, if those  
514 investors or the management of that pool or private limited partnership employ investment  
515 strategies of any kind to earn a return on that pool of funds.

516 SECTION 28. Section 5B of said chapter 12, as so appearing, is hereby amended by  
517 striking out, in line 29, the word “or”, the second time it appears.

518 SECTION 29. Said section 5B of said chapter 12, as so appearing, is hereby further  
519 amended by inserting after the word “applicable” in lines 38 and 39, the following words:- ; or  
520 (11) has an ownership or investment interest in any person who violates clauses (1) through (10),  
521 knows about the violation, and fails to disclose the violation to the commonwealth or a political  
522 subdivision thereof within 60 days of identifying the violation.

523 SECTION 30. Section 11N of said chapter 12, as so appearing, is hereby amended by  
524 striking out, in line 7, the words “or provider organization” and inserting in place thereof the  
525 following words:- , provider organization, significant equity investor, health care real estate  
526 investment trust or management services organization.

527 SECTION 31. Section 1 of chapter 12C of the General Laws, as so appearing, is hereby  
528 amended by inserting after the definition of “Health care cost growth benchmark”, the following  
529 definition:-

530 “Health care real estate investment trust”, a real estate investment trust, as defined by 26  
531 U.S.C section 856, whose assets consist of real property held in connection with the use or  
532 operations of a provider or provider organization.

533 SECTION 32. Said section 1 of said chapter 12C, as so appearing, is hereby further  
534 amended by inserting after the definition of “Health care services” the following 2 definitions:-

535 “Health disparities”, preventable differences in the burden of disease, injury, violence or  
536 opportunities to achieve optimal health that are experienced by socially disadvantaged  
537 populations.

538 “Health equity”, the state in which a health system offers the infrastructure, facilities,  
539 services, geographic coverage, affordability and all other relevant features, conditions and  
540 capabilities that will provide all people with the opportunity and reasonable expectation that they  
541 can reach their full health potential and well-being and are not disadvantaged in access to health  
542 care by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation,  
543 social class, intersections among these communities or identities or their socially determined  
544 circumstances.

545 SECTION 33. Said section 1 of said chapter 12C, as so appearing, is hereby further  
546 amended by inserting after the definition of “Major service category” the following definition:-

547 “Management services organization”, a corporation that provides management or  
548 administrative services to a provider or provider organization for compensation.

549 SECTION 34. Said section 1 of said chapter 12C, as so appearing, is hereby further  
550 amended by inserting after the definition of “Patient-centered medical home” the following 3  
551 definitions:-

552 “Payer”, any entity, other than an individual, that pays providers for the provision of  
553 health care services; provided, however, that “payer” shall include both governmental and  
554 private entities; and provided further, that “payer” shall include self-insured plans to the extent  
555 allowed under the Employee Retirement Income Security Act of 1974.

556 “Pharmaceutical manufacturing company”, an entity engaged in the: (i) production,  
557 preparation, propagation, compounding, conversion or processing of prescription drugs, directly  
558 or indirectly, by extraction from substances of natural origin, independently by means of  
559 chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging,  
560 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that  
561 “pharmaceutical manufacturing company” shall not include a hospital licensed under section 51  
562 of chapter 111, a wholesale drug distributor licensed under section 36B of chapter 112 or a retail  
563 pharmacist registered under section 39 of said chapter 112.

564 “Pharmacy benefit manager”, as defined in section 1 of chapter 176Y.

565 SECTION 35. Said section 1 of said chapter 12C, as so appearing, is hereby further  
566 amended by inserting after the definition of “Primary service area” the following definition:-

567 “Private equity company”, any company that collects capital investments from  
568 individuals or entities and purchases, as a parent company or through another entity that the  
569 company completely or partially owns or controls, a direct or indirect ownership share of a  
570 provider, provider organization or management services organization; provided, however, that  
571 “private equity company” shall not include venture capital firms exclusively funding startups or  
572 other early-stage businesses.

573 SECTION 36. Said section 1 of said chapter 12C, as so appearing, is hereby further  
574 amended by inserting after the definition of “Self-insured group” the following definition:-

575 “Significant equity investor”, (i) any private equity company with a financial interest in a  
576 provider, provider organization or management services organization; or (ii) an investor, group  
577 of investors or other entity with a direct or indirect possession of equity in the capital, stock or  
578 profits totaling more than 10 per cent of a provider, provider organization or management  
579 services organization; provided, however, that “significant equity investor” shall not include  
580 venture capital firms exclusively funding startups or other early-stage businesses.

581 SECTION 37. Section 2A of said chapter 12C, as so appearing, is hereby further  
582 amended by inserting after the word “cybersecurity”, in line 9, the following words:- and 1 of  
583 whom shall have experience in health equity advocacy.

584 SECTION 38. Said chapter 12C is hereby further amended by striking out section 7, as  
585 amended by section 18 of chapter 140 of the acts of 2024, and inserting in place thereof the  
586 following section:-

587 Section 7. (a) For the purposes of this section, “non-hospital provider organization” shall  
588 mean a provider organization required to register under section 11 under chapter 6D that is: (i) a  
589 non-hospital-based physician practice with not less than \$500,000,000 in annual gross patient  
590 service revenue; (ii) a clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated  
591 urgent care centers.

592 (b) Each acute hospital, ambulatory surgical center, non-hospital provider organization,  
593 pharmaceutical manufacturing company and pharmacy benefit manager shall pay to the  
594 commonwealth an amount for the estimated expenses of the center and for the other purposes  
595 described in this chapter which shall include any transfer made to the Community Hospital  
596 Reinvestment Trust Fund established in section 2TTTT of chapter 29.

597 (c) The assessed amount for acute hospitals, ambulatory surgical centers and non-hospital  
598 provider organizations shall be not less than 30 per cent nor more than 40 per cent of the amount  
599 appropriated by the general court for the expenses of the center and for the other purposes  
600 described in this chapter which shall include any transfer made to the Community Hospital  
601 Reinvestment Trust Fund established in section 2TTTT of chapter 29 minus amounts collected  
602 from: (i) filing fees; (ii) fees and charges generated by the center’s publication or dissemination  
603 of reports and information; and (iii) federal matching revenues received for these expenses or  
604 received retroactively for expenses of predecessor agencies; provided, however, that, to the  
605 maximum extent permissible under federal law, non-hospital provider organizations shall be  
606 assessed not less than 3 per cent nor more than 8 per cent of the total assessed amount for acute  
607 hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute  
608 hospital, ambulatory surgical center and non-hospital provider organization shall pay such  
609 assessed amount multiplied by the ratio of the acute hospital’s, ambulatory surgical center’s or

610 non-hospital provider organization's gross patient service revenues to the total gross patient  
611 services revenues of all such hospitals, ambulatory surgical centers and non-hospital provider  
612 organizations. Each acute hospital, ambulatory surgical center and non-hospital provider  
613 organization shall make a preliminary payment to the center on October 1 of each year in an  
614 amount equal to 1/2 of the previous year's total assessment. Thereafter, each acute hospital,  
615 ambulatory surgical center and non-hospital provider organization shall pay, within 30 days'  
616 notice from the center, the balance of the total assessment for the current year based upon its  
617 most current projected gross patient service revenue. The center shall subsequently adjust the  
618 assessment for any variation in actual and estimated expenses of the center and for changes in  
619 acute hospital, ambulatory surgical center and non-hospital provider organization gross patient  
620 service revenue. Such estimated and actual expenses shall include an amount equal to the cost of  
621 fringe benefits and indirect expenses, as established by the comptroller under section 5D of  
622 chapter 29. In the event of late payment by any such acute hospital, ambulatory surgical center or  
623 non-hospital provider organization, the treasurer shall advance the amount of due and unpaid  
624 funds to the center prior to the receipt of such monies in anticipation of such revenues up to the  
625 amount authorized in the then current budget attributable to such assessments and the center shall  
626 reimburse the treasurer for such advances upon receipt of such revenues. This section shall not  
627 apply to any state institution or to any acute hospital which is operated by a city or town.

628 (d) To the maximum extent permissible under federal law, and provided that such  
629 assessment will not result in any reduction of federal financial participation in Medicaid, the  
630 assessed amount for pharmaceutical manufacturing companies shall be not less than 5 per cent  
631 nor more than 10 per cent of the amount appropriated by the general court for the expenses of the  
632 center minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the

633 center's publication or dissemination of reports and information; and (iii) federal matching  
634 revenues received for these expenses or received retroactively for expenses of predecessor  
635 agencies. Each pharmaceutical manufacturing company shall pay such assessed amount  
636 multiplied by the ratio of MassHealth's net spending for the manufacturer's prescription drugs  
637 used in the MassHealth rebate program to MassHealth's total pharmacy spending.

638 (e) To the maximum extent permissible under federal law, and provided that such  
639 assessment will not result in any reduction of federal financial participation in Medicaid, the  
640 assessed amount for pharmacy benefit managers shall be not less than 5 per cent nor more than  
641 10 per cent of the amount appropriated by the general court for the expenses of the center minus  
642 amounts collected from: (i) filing fees; (ii) fees and charges generated by the center's publication  
643 or dissemination of reports and information; and (iii) federal matching revenues received for  
644 these expenses or received retroactively for expenses of predecessor agencies. Each pharmacy  
645 benefit manager shall pay such assessed amount multiplied by the ratio of the claims paid by the  
646 pharmacy benefit manager attributed to residents of the commonwealth for whom it manages  
647 pharmaceutical benefits on behalf of carriers to the total of all such claims paid by all pharmacy  
648 benefit managers attributed to residents of the commonwealth for whom they manage  
649 pharmaceutical benefits on behalf of carriers.

650 (f) Each pharmaceutical manufacturing company and each pharmacy benefit manager  
651 shall make a preliminary payment to the center annually on October 1 in an amount equal to 1/2  
652 of the previous year's total assessment. Thereafter, each pharmaceutical manufacturing company  
653 and each pharmacy benefit manager shall pay, within 30 days' notice from the center, the  
654 balance of the total assessment for the current year as determined by the center.

655 SECTION 39. Section 8 of said chapter 12C, as appearing in the 2022 Official Edition, is  
656 hereby amended by inserting after the word “entities”, in line 5, the following words:- including  
657 significant equity investors, health care real estate investment trusts and management services  
658 organizations.

659 SECTION 40. Said section 8 of said chapter 12C, as so appearing, is hereby further  
660 amended by inserting after the word “statements”, in line 23, the following words:- , including  
661 the audited financial statements of the parent organization’s out-of-state operations, significant  
662 equity investors, health care real estate investment trusts and management services  
663 organizations,.

664 SECTION 41 Said section 8 of said chapter 12C, as so appearing, is hereby further  
665 amended by striking out, in line 49, the words “and (6)” and inserting in place thereof the  
666 following words:- (6) margins, including margins by payer type; (7) investments; (8) information  
667 on any relationships with significant equity investors, health care real estate investment trusts  
668 and management service organizations; and (9).

669 SECTION 42. Said chapter 12C is hereby further amended by striking out section 9, as so  
670 appearing, and inserting in place thereof the following section:-

671 Section 9. (a) The center, in consultation with the commission, shall promulgate  
672 regulations to require that provider organizations registered under section 11 of chapter 6D shall  
673 annually report the data as the center considers necessary to better protect the public interest in  
674 monitoring the financial conditions, organizational structure, business practices, clinical services  
675 and market share of each registered provider organization. The center may assess administrative  
676 fees on provider organizations in an amount to help defray the center’s costs in complying with

677 this section. The center may specify, by regulation, uniform reporting standards and reporting  
678 thresholds as it determines necessary.

679 (b) The center shall require registered provider organizations to annually report  
680 information necessary to achieve the goals described in subsection (a) which shall include, but  
681 shall not be limited to: (i) organizational charts showing the ownership, governance and  
682 operational structure of the provider organization, including any clinical affiliations and  
683 community advisory boards; (ii) the number of affiliated health care professional full-time  
684 equivalents by license type, specialty, name and address of practice locations and whether the  
685 professional is employed by the organization; (iii) the name and address of licensed facilities by  
686 license number, license type and capacity in each major service category; (iv) the name, address  
687 and capacity of all other locations where the provider organization, or any of its affiliates,  
688 delivers health care services, including those services listed in subsection (a) of section 22 of  
689 chapter 6D; (v) a comprehensive financial statement, including information on parent entities,  
690 including their out-of-state operations, and corporate affiliates, including significant equity  
691 investors, health care real estate investment trusts and management services organizations as  
692 applicable, and including details regarding annual costs, annual receipts, realized capital gains  
693 and losses, accumulated surplus and accumulated reserves; (vi) information on stop-loss  
694 insurance and any non-fee-for-service payment arrangements; (vii) information on clinical  
695 quality, care coordination and patient referral practices; (viii) information regarding expenditures  
696 and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-  
697 taxes and other non-clinical functions; (ix) information regarding charitable care and community  
698 benefit programs; (x) for any risk-bearing provider organization, a certificate from the division of  
699 insurance under chapter 176U; (xi) information regarding other assets and liabilities that may

700 affect the financial condition of the provider organization or the provider organization's facilities  
701 including, but not limited to, real estate sale-leaseback arrangements with health care real estate  
702 investment trusts; and (xii) such other information as the center considers appropriate as set forth  
703 in the center's regulations; provided, however, that the center shall coordinate with the  
704 commission and the division of insurance to obtain information directly from the commission or  
705 division; and provided further, that the center shall consider the administrative burden of  
706 reporting when developing reporting requirements. The center may, in consultation with the  
707 division of insurance and the commission, merge similar reporting requirements where  
708 appropriate.

709 (c) Annual reporting shall be in a form provided by the center. The center shall  
710 promulgate regulations that define criteria for waivers from certain annual reporting  
711 requirements under this section. Criteria for waivers may include operational size of the provider  
712 organization, the provider organization's annual net patient service revenue, the degree of risk  
713 assumed by the provider organization and other criteria as the center considers appropriate.

714 (d) Notwithstanding the annual reporting requirements under this section, the center may  
715 require in writing, at any time, such additional information as it deems reasonable and necessary  
716 to determine the organizational structure, business practices, clinical services, market share or  
717 financial condition of a registered provider organization, including information related to its total  
718 adjusted debt and total adjusted earnings. The center may: (i) modify uniform reporting  
719 requirements; (ii) require registered provider organizations with private equity investment to  
720 report required information quarterly; or (iii) require the disclosure of relevant information from  
721 any significant equity investor associated with a registered provider organization.

722 (e) The center may enter into interagency agreements with the commission and other  
723 state agencies to effectuate the goals of this section.

724 SECTION 43. Section 11 of said chapter 12C, as so appearing, is hereby amended by  
725 striking out the second to fifth sentences, inclusive, and inserting in place thereof the following 6  
726 sentences:-

727 The center shall notify entities required to submit data under this chapter of any  
728 applicable reporting deadlines. The center shall notify, in writing, an entity required to submit  
729 data under this chapter that has failed to meet a reporting deadline and shall notify such entity  
730 that failure to respond within 2 weeks of the receipt of the notice may result in penalties. The  
731 center may assess a penalty against an entity required to submit data under this chapter that fails,  
732 without just cause, to provide the requested information within 2 weeks following receipt of the  
733 written notice required under this paragraph, of not more than \$25,000 per week for each week  
734 of delay after the 2-week period following the reporting entity's receipt of the written notice.  
735 Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund  
736 established in section 100 of chapter 194 of the acts of 2011. The center shall notify the  
737 commission and the department of public health if a provider or provider organization fails to  
738 timely report in accordance with this section or if the center has assessed a penalty under this  
739 section. Such notification shall be considered by the commission in a cost and market impact  
740 review under section 13 of chapter 6D, and by the department in determining licensure and  
741 suitability in accordance with section 51 of chapter 111 and for a determination of need under  
742 section 25C of chapter 111.

743 SECTION 44. Said chapter 12C is hereby further amended by striking out section 14, as  
744 so appearing, and inserting in place thereof the following section:-

745 Section 14. (a)(1) The center, in consultation with the statewide advisory committee  
746 established pursuant to subsection (c), shall, not later than March 1 in each even-numbered year,  
747 establish a standard set of measures of health care provider quality and health system  
748 performance, hereinafter referred to as the “standard quality measure set”, for use in: (i) contracts  
749 between payers, including the commonwealth and carriers, and health care providers, provider  
750 organizations and accountable care organizations, which incorporate quality measures into  
751 payment terms, including the designation of a set of core measures and a set of non-core  
752 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)  
753 consumer transparency websites and other methods of providing consumer information; and (iv)  
754 monitoring systemwide performance.

755 (2) The standard quality measure set shall designate: (i) core measures that shall be used  
756 in contracts that incorporate quality measures into payment terms between payers, including the  
757 commonwealth and carriers, and health care providers, including provider organizations and  
758 accountable care organizations, and shall meet the core criteria set by the statewide advisory  
759 committee pursuant to paragraph (3) of subsection (c); and (ii) a menu of non-core measures that  
760 may be used in such contracts. The standard quality measure set shall allow for innovation and  
761 the development of outcome measures for quality and safety. If the standard quality measure set  
762 established by the center differs from the recommendations of the statewide advisory committee,  
763 the center shall issue a written report detailing each area of disagreement and the rationale for the  
764 center’s decision.

765 (b) The center shall develop uniform reporting requirements for the standard quality  
766 measure set for each health care provider facility, medical group or provider group in the  
767 commonwealth.

768 (c)(1) The center shall convene a statewide advisory committee which shall make  
769 recommendations for the standard quality measure set to: (i) ensure consistency in the use of  
770 quality and safety measures in contracts between payers, including the commonwealth and  
771 carriers, and health care providers in the commonwealth; (ii) ensure consistency in methods for  
772 the assignment of tiers to providers in the design of any health plan; (iii) improve quality and  
773 safety of care; (iv) improve transparency for consumers and employers; (v) improve health  
774 system monitoring and oversight by relevant state agencies; and (vi) reduce administrative  
775 burden.

776 (2) The statewide advisory committee shall consist of commissioner of insurance and the  
777 executive director of the health policy commission, or their designees, who shall serve as co-  
778 chairs, and shall include the following members or their designees: the executive director of the  
779 center; the executive director of the Betsy Lehman center for patient safety and medical error  
780 reduction; the executive director of the group insurance commission; the secretary of elder  
781 affairs; the assistant secretary for MassHealth; the commissioner of public health; the  
782 commissioner of mental health; and 11 members to be appointed by the governor, 1 of whom  
783 shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom  
784 shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of  
785 whom shall be a representative the Massachusetts Medical Society, 1 of whom shall be a  
786 registered nurse licensed to practice in the commonwealth who practices in a patient care setting,  
787 1 of whom shall be a representative of a labor organization representing health care workers, 1 of

788 whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and  
789 services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of  
790 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of  
791 Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider and 1 of  
792 whom shall be a representative for consumers. Members appointed to the statewide advisory  
793 committee shall have experience with and expertise in health care quality measurement.

794 (3) The statewide advisory committee shall meet quarterly to develop recommendations  
795 for the core measure and non-core measures to be adopted in the standard quality measure set for  
796 use in: (i) contracts between payers, including the commonwealth and carriers, and health care  
797 providers, provider organizations and accountable care organizations, including the designation  
798 of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care  
799 providers in the design of any health plan; (iii) consumer transparency websites and other  
800 methods of providing consumer information; and (iv) monitoring systemwide performance.

801 (4) In developing its recommendations for the standard quality measure set, the statewide  
802 advisory committee shall incorporate recognized quality and safety measures including, but not  
803 limited to, measures used by the Centers for Medicare and Medicaid Services, the group  
804 insurance commission, carriers and providers and provider organizations in the commonwealth  
805 and other states, as well as other valid measures of health care provider performance and  
806 outcomes, including patient-reported outcomes and functional status, patient experience, health  
807 disparities and population health. The statewide advisory committee shall consider measures  
808 applicable to primary care providers, specialists, hospitals, provider organizations, accountable  
809 care organizations, oral health providers and other types of providers and measures applicable to  
810 different patient populations.

811 (5) The statewide advisory committee shall, not later than January 1 in each even-  
812 numbered year, submit to the center its recommendations on the core measures and non-core  
813 measures to be adopted, changed or updated by the center in the standard quality measure set,  
814 along with a report in support of its recommendations.

815 SECTION 45. Section 15 of said chapter 12C, as so appearing, is hereby amended by  
816 striking out, in line 4, the word “injury” and inserting in place thereof the following word:- harm.

817 SECTION 46. Said section 15 of said chapter 12C, as so appearing, is hereby further  
818 amended by striking out the definition of “Board” and inserting in place thereof the following 3  
819 definitions:-

820 “Agency”, any agency of the executive branch of the commonwealth, including, but not  
821 limited to, any constitutional or other office, executive office, department, division, bureau,  
822 board, commission or committee thereof, or any authority created by the general court to serve a  
823 public purpose, having either statewide or local jurisdiction.

824 “Board”, the patient safety and medical errors reduction board.

825 “Healthcare-associated infection”, an infection that a patient acquires during the course of  
826 receiving treatment for other conditions within a health care setting.

827 SECTION 47. Said section 15 of said chapter 12C, as so appearing, is hereby further  
828 amended by inserting after the definition of “Patient safety” the following definition:-

829 “Patient safety information”, data and information related to patient safety, including  
830 adverse events, incidents, medical errors or health care-associated infections, that is collected or  
831 maintained by agencies.

832 SECTION 48. Said section 15 of said chapter 12C, as so appearing, is hereby further  
833 amended by striking out subsection (f) and inserting in place thereof the following 3  
834 subsections:-

835 (f) Notwithstanding any general or special law to the contrary, the Lehman center and  
836 any agency, provider organization, department, division, commission, board, authority or other  
837 public or quasi-public entity in the commonwealth that collects or maintains patient safety  
838 information may transmit such information, including personal data as defined in section 1 of  
839 chapter 66A, and shall transmit such information to the Lehman center upon request from the  
840 Lehman center; provided, however, that transmission of such information shall be governed by  
841 an agreement, which may be an interagency service agreement, between the party transmitting  
842 the information and the Lehman center; provided further, that such agreement shall provide for  
843 any safeguards necessary to protect the privacy and security of the information; and provided  
844 further, that the transmission of such information shall be consistent with federal law.

845 (g) The Lehman center may adopt rules and regulations necessary to carry out the  
846 purpose of this section. The Lehman center may contract with any federal, state or municipal  
847 entity or other public institution or with any private individual, partnership, firm, corporation,  
848 association or other entity to manage its affairs or carry out the purpose of this section.

849 (h) The Lehman center shall report annually to the joint committee on health care  
850 financing regarding the progress made in improving patient safety and medical error reduction.  
851 The Lehman center shall seek federal and foundation support to supplement state resources to  
852 carry out the Lehman center's patient safety and medical error reduction goals.

853 SECTION 49. Said chapter 12C is hereby further amended by striking out section 17, as  
854 so appearing, and inserting in place thereof the following section:-

855 Section 17. The attorney general may review and analyze any information submitted to  
856 the center by a provider, provider organization, significant equity investor, health care real estate  
857 investment trust, management services organization or payer pursuant to sections 8, 9 and 10 and  
858 to the health policy commission under section 8 of chapter 6D. The attorney general may require  
859 that such entities produce documents, answer interrogatories and provide testimony under oath  
860 related to health care costs and cost trends, factors that contribute to cost growth within the  
861 commonwealth's health care system and the relationship between provider costs and payer  
862 premium rates. The attorney general shall keep confidential all nonpublic information and  
863 documents obtained under this section and shall not disclose the information or documents to any  
864 person without the consent of the entity that produced the information or documents; provided,  
865 however that the attorney general may disclose such information or documents during: (i) the  
866 annual hearing conducted under section 8 of chapter 6D; (ii) a rate hearing before the division of  
867 insurance; or (iii) in a case brought by the attorney general, if the attorney general believes that  
868 such disclosure will promote the health care cost containment goals of the commonwealth and  
869 that the disclosure would be in the public interest after taking into account any privacy, trade  
870 secret or anti-competitive considerations. The confidential information and documents shall not  
871 be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of  
872 chapter 4 and section 10 of chapter 66.

873 SECTION 50. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby  
874 amended by striking out the last paragraph and inserting in place thereof the following  
875 paragraph:-

876           The board shall adopt, and may amend or rescind, such rules and regulations as it deems  
877 necessary to carry out this chapter; provided, however, that prior to adoption, amendment or  
878 rescission, any rule or regulation shall be submitted to the commissioner of public health for  
879 approval. The board may, subject to the approval of the commissioner of public health, appoint  
880 appropriate staff, including an executive director, legal counsel and any such other assistants as  
881 the board may require. The board may also make contracts and arrangements for the  
882 performance of administrative and similar services required, or appropriate, in the performance  
883 of the duties of the board.

884           SECTION 51. Said chapter 13 is hereby further amended by striking out section 10A, as  
885 so appearing, and inserting in place thereof the following section:-

886           Section 10A. The commissioner of public health shall review and approve any rule or  
887 regulation proposed by the board of registration in medicine pursuant to section 10. Such rule or  
888 regulation shall be deemed disapproved unless approved within 30 days after submission to the  
889 commissioner pursuant to said section 10.

890           SECTION 52. Section 9-609 of chapter 106 of the General Laws, as so appearing, is  
891 hereby amended by adding the following subsection:-

892           (d) Notwithstanding subsection (a), in the case of a debtor that is a hospital licensed by  
893 the department of public health under section 51 of chapter 111, and collateral that is a medical  
894 device, a secured party shall send notice to the debtor and the department of public health 60  
895 days prior to taking possession of the collateral, rendering equipment unusable or disposing of  
896 the collateral on the debtor's premises pursuant to subsection (a). For the purposes of this

897 subsection, “medical device” shall have the same meaning as that term is defined in section 1 of  
898 chapter 111N.

899 SECTION 53. The first paragraph of section 25A of chapter 111 of the General Laws, as  
900 so appearing, is hereby amended by striking out the first sentence and inserting in place thereof  
901 the following sentence:- Under the direction of the office of health resource planning established  
902 in section 22 of chapter 6D, the department shall establish and maintain, on a current basis, an  
903 inventory of all health care resources and all other reasonably pertinent information concerning  
904 such resources, in order to identify the location, distribution and nature of all such resources in  
905 the commonwealth.

906 SECTION 54. Said section 25A of said chapter 111, as so appearing, is hereby further  
907 amended by striking out, in lines 16 and 17, the words “in a designated office of the department”  
908 and inserting in place thereof the following words:- as determined by the office of health  
909 resource planning established in section 22 of chapter 6D.

910 SECTION 55. Said section 25A of said chapter 111, as so appearing, is hereby further  
911 amended by striking out the fourth paragraph.

912 SECTION 56. Section 25B of said chapter 111, as so appearing, is hereby amended by  
913 inserting after the definition of “Outpatient services” the following definition:-

914 “Party of record”, during the pendency of an application for a determination of need: (i)  
915 an applicant for a determination of need; (ii) the attorney general; (iii) the center for health  
916 information and analysis; (iv) the health policy commission; any government agency with  
917 relevant oversight or licensure authority over the proposed project or components therein; or (v)  
918 any 10 taxpayers of the commonwealth organized as a group.

919 SECTION 57. Section 25C of said chapter 111, as so appearing, is hereby amended by  
920 striking out subsection (g) and inserting in place thereof the following subsection:-

921 (g) The department, in making any determination of need, shall encourage appropriate  
922 allocation of private and public health care resources and the development of alternative or  
923 substitute methods of delivering health care services so that adequate health care services will be  
924 made reasonably available to every person within the commonwealth at the lowest reasonable  
925 aggregate cost. The department, in making any determination of need, shall consider: (i) the state  
926 health resource plan developed pursuant to section 22 of chapter 6D; (ii) the commonwealth's  
927 cost containment goals; (iii) the impacts on the applicant's patients, including considerations of  
928 health equity, the workforce of surrounding health care providers and on other residents of the  
929 commonwealth; and (iv) any comments and relevant data from the center for health information  
930 and analysis, the health policy commission including, but not limited to, any cost and market  
931 impact review report submitted pursuant to subsection (l) of section 13 of chapter 6D and any  
932 other state agency. The department may impose reasonable terms and conditions on the approval  
933 of a determination of need as the department determines are necessary to achieve the purposes  
934 and intent of this section. The department may also recognize the special needs and  
935 circumstances of projects that: (i) are essential to the conduct of research in basic biomedical or  
936 health care delivery areas or to the training of health care personnel; (ii) are unlikely to result in  
937 any increase in the clinical bed capacity or outpatient load capacity of the facility; and (iii) are  
938 unlikely to cause an increase in the total patient care charges of the facility to the public for  
939 health care services, supplies and accommodations, as such charges shall be defined from time to  
940 time in accordance with section 5 of chapter 409 of the acts of 1976.

941 SECTION 58. Said section 25C of said chapter 111, as so appearing, is hereby further  
942 amended by inserting after the word “applicant”, in line 129, the following words:- by an entity  
943 selected by the department from a list of 3 entities submitted by the applicant.

944 SECTION 59. Said section 25C of said chapter 111, as so appearing, is hereby further  
945 amended by striking out subsection (i) and inserting in place thereof the following subsection:-

946 (i) Except in the case of an emergency situation determined by the department as  
947 requiring immediate action to prevent further damage to the public health or to a health care  
948 facility, the department shall not act upon an application for such determination unless: (i) the  
949 application has been on file with the department for at least 30 days; (ii) the center for health  
950 information and analysis, the health policy commission, the state and appropriate regional  
951 comprehensive health planning agencies and, in the case of long-term care facilities only, the  
952 department of elder affairs, or in the case of any facility providing inpatient services for  
953 individuals with intellectual or developmental disabilities, the department of mental health and  
954 the department of developmental services, respectively, have been provided copies of such  
955 application and supporting documents and given reasonable opportunity to supply required  
956 information and comment on such application; and (iii) a public hearing has been held on such  
957 application when requested by the applicant, the state or appropriate regional comprehensive  
958 health planning agency, any 10 taxpayers of the commonwealth and any other party of record. If,  
959 in any filing period, an individual application is filed that would implicitly decide any other  
960 application filed during such period, the department shall not act only upon an individual  
961 application.

962 SECTION 60. Said section 25C of said chapter 111, as so appearing, is hereby further  
963 amended by striking out subsection (j) and inserting in place thereof the following subsection:-

964 (j) The department shall approve or disapprove, in whole or in part, each such application  
965 for a determination of need within 4 months after filing with the department; provided, however,  
966 that the department may, on 1 occasion only, delay the action for up to 2 months after the  
967 applicant has provided information which the department has reasonably requested; and provided  
968 further, that the period for review of an application for which an independent cost-analysis is  
969 required pursuant to subsection (h) shall be stayed until a completed independent cost-analysis is  
970 received and accepted by the department. Any determination of need issued to a holder that is  
971 subject to a cost and market impact review under section 13 of chapter 6D shall not go into effect  
972 until a minimum of 30 days after the issuance of a final report under subsection (f) of said  
973 section 13 of said chapter 6D. Any determination of need issued to a holder that is subject to a  
974 performance improvement plan pursuant to section 10 of said chapter 6D shall not go into effect  
975 until 30 days after a determination by the health policy commission that the holder is  
976 implementing or has implemented said performance improvement plan; provided, however, that  
977 the health policy commission may rescind its determination that the holder is implementing a  
978 performance improvement plan at any time prior to successful completion of the performance  
979 improvement plan. Applications remanded to the department by the health facilities appeals  
980 board under section 25E shall be acted upon by the department within the same time limits  
981 provided in this section for the department to approve or disapprove applications for a  
982 determination of need. If an application has not been acted upon by the department within such  
983 time limits, the applicant may, within a reasonable period of time, bring an action in the nature of  
984 mandamus in the superior court to require the department to act upon the application.

985 SECTION 61. Said section 25C of said chapter 111, as so appearing, is hereby further  
986 amended by adding the following subsection:-

987 (o) A party of record may review an application for determination of need for which it is  
988 appropriately registered and provide written comment or specific recommendations for  
989 consideration by the department, including written comment by a party of record as it relates to  
990 any independent cost-analyses made pursuant to subsection (h). Whenever a party of record  
991 submits written materials concerning an application for determination of need, the department  
992 shall provide copies of such materials to all other parties of record.

993 SECTION 62. Section 25F of said chapter 111, as so appearing, is hereby amended by  
994 inserting after the word “care”, in line 7, the following word:- financing.

995 SECTION 63. Section 51G of said chapter 111, as so appearing, is hereby further  
996 amended by striking out paragraph (4) and inserting in place thereof the following paragraph:-

997 (4) Any hospital shall inform the department 90 days prior to the closing of the hospital  
998 or the discontinuance of any essential health service provided therein. The department shall by  
999 regulation define the words “essential health service” for the purposes of this section. The  
1000 department shall, in the event that a hospital proposes to discontinue an essential health service  
1001 or services, conduct a public hearing on the closure of said essential services or of the hospital,  
1002 and the department may seek an analysis of the impact of the closure from the health policy  
1003 commission. The department shall determine whether any such discontinued services are  
1004 necessary for preserving access and health status in the hospital’s service area and shall require  
1005 hospitals to submit a plan for assuring access to such necessary services following the hospital’s  
1006 closure of the service and assure continuing access to such services in the event that the

1007 department determines that their closure will significantly reduce access to necessary services.  
1008 The department shall conduct a public hearing prior to a determination on the closure of said  
1009 essential services or of the hospital. No original license shall be granted to establish or maintain  
1010 an acute-care hospital, as defined in section 25B, unless the applicant submits a plan, to be  
1011 approved by the department, for the provision of community benefits, including the identification  
1012 and provision of essential health services. In approving the plan, the department may take into  
1013 account the applicant's existing commitment to primary and preventive health care services and  
1014 community contributions as well as the primary and preventive health care services and  
1015 community contributions of the predecessor hospital. The department may waive this  
1016 requirement, in whole or in part, at the request of the applicant that has provided or at the time  
1017 the application is filed, is providing, substantial primary and preventive health care services and  
1018 community contributions in its service area.

1019 SECTION 64. Said section 51G of said chapter 111, as so appearing, is hereby further  
1020 amended by adding the following 2 paragraphs:-

1021 (7)(a) No original license shall be granted, or renewed, to establish or maintain an acute-  
1022 care hospital, as defined in section 25B, if the main campus of the acute-care hospital is leased  
1023 from a health care real estate investment trust, as defined in section 1 of chapter 6D; provided,  
1024 however, that any acute-care hospital that, as of April 1, 2024, is leasing its main campus from a  
1025 health care real estate investment trust shall be exempt from the requirements of this subsection.  
1026 An exempt acute-care hospital under this subsection shall maintain its exempt status after a  
1027 transfer to any transferee and subsequent transferees. A transferee or subsequent transferee of an  
1028 acute-care hospital that is exempt from the requirements of this subparagraph shall be issued a  
1029 license if the transferee otherwise satisfies all other requirements for licensure under this chapter.

1030 For the purposes of this subsection, “main campus” shall mean the licensed premises within  
1031 which the majority of inpatient beds are located.

1032 (b) No original license shall be granted, or renewed, to establish or maintain an acute-care  
1033 hospital unless all documents related to any lease, master lease, sublease, license or any other  
1034 agreement for the use, occupancy or utilization of the premises occupied by the acute-care  
1035 hospital are disclosed to the department upon application for licensure.

1036 (8) No original license shall be granted, or renewed, to establish or maintain an acute-care  
1037 hospital, as defined in section 25B, unless the applicant is in compliance with the reporting  
1038 requirements established in sections 8, 9 and 10 of chapter 12C.

1039 SECTION 65. Section 51H of said chapter 111, as so appearing, is hereby amended by  
1040 striking out the definition of “Facility” and inserting in place thereof the following definition:-

1041 “Facility”, a hospital, institution for the care of unwed mothers, clinic providing  
1042 ambulatory surgery as defined in section 25B, limited service clinic licensed pursuant to section  
1043 51J, office-based surgical center licensed pursuant to section 51N or urgent care center licensed  
1044 pursuant to section 51O.

1045 SECTION 66. Said section 51H of said chapter 111, as so appearing, is hereby further  
1046 amended by inserting after the definition of “Healthcare-associated infection” the following  
1047 definition:-

1048 “Operational impairment event”, any action, or notice of impending action, including a  
1049 notice of financial delinquency, concerning the repossession of medical equipment or supplies  
1050 necessary for the provision of patient care.

1051 SECTION 67. Subsection (b) of said section 51H of said chapter 111, as so appearing, is  
1052 hereby amended by adding the following paragraph:-

1053 An operational impairment event shall be reported by a facility not later than 1 calendar  
1054 day after it occurs. Notwithstanding any general or special law to the contrary, no contract  
1055 between a facility and a lessor of medical equipment shall authorize the repossession of medical  
1056 equipment or supplies unless the lessor provides a notice of financial delinquency to the  
1057 department not less than 60 days prior to repossession of any medical equipment or supplies  
1058 necessary for the provision of patient care. Any provision of any contract or other document  
1059 between a lessor of medical equipment and a facility which does not comply with this paragraph  
1060 shall be void as against the public policy of the commonwealth.

1061 SECTION 68. Said chapter 111 is hereby further amended by inserting after section 51M  
1062 the following 2 sections:-

1063 Section 51N. (a) As used in this section, the following words shall have the following  
1064 meanings unless the context clearly requires otherwise:

1065 “Deep sedation”, a drug-induced depression of consciousness during which: (i) the  
1066 patient cannot be easily awakened but responds purposefully following repeated painful  
1067 stimulation; (ii) the patient’s ability to maintain independent ventilatory function may be  
1068 impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous  
1069 ventilation may be inadequate; and (iv) the patient’s cardiovascular function is usually  
1070 maintained without assistance.

1071 “General anesthesia”, a drug-induced depression of consciousness during which: (i) the  
1072 patient is not able to be awakened, even by painful stimulation; (ii) the patient’s ability to

1073 maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often  
1074 requires assistance in maintaining a patent airway and positive pressure ventilation may be  
1075 required because of depressed spontaneous ventilation or drug-induced depression of  
1076 neuromuscular function; and (iv) the patient’s cardiovascular function may be impaired.

1077 “Minimal sedation”, a drug-induced state during which: (i) patients respond normally to  
1078 verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory  
1079 and cardiovascular functions are unaffected.

1080 “Minor procedures”, (i) procedures that can be performed safely with a minimum of  
1081 discomfort where the likelihood of complications requiring hospitalization is minimal; (ii)  
1082 procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less  
1083 than 500cc of fat under un-supplemented local anesthesia.

1084 “Moderate sedation”, a drug-induced depression of consciousness during which: (i) the  
1085 patient responds purposefully to verbal commands, either alone or accompanied by light tactile  
1086 stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous  
1087 ventilation is adequate; and (iv) the patient’s cardiovascular function is usually maintained  
1088 without assistance.

1089 “Office-based surgical center”, an office, group of offices, a facility or any portion  
1090 thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice,  
1091 however organized, whether conducted for profit or not for profit, which is advertised,  
1092 announced, established or maintained for the purpose of providing office-based surgical services;  
1093 provided, however, that “office-based surgical center” shall not include: (i) a hospital licensed  
1094 under section 51 or by the federal government; (ii) an ambulatory surgical center as defined

1095 pursuant to section 25B and licensed under said section 51; or (iii) a surgical center performing  
1096 services in accordance with section 12M of chapter 112.

1097 “Office-based surgical services”, an ambulatory surgical or other invasive procedure  
1098 requiring: (i) general anesthesia; (ii) moderate sedation; or (iii) deep sedation and any liposuction  
1099 procedure, excluding minor procedures and procedures requiring minimal sedation, where such  
1100 surgical or other invasive procedure or liposuction is performed by a practitioner at an office-  
1101 based surgical center.

1102 (b) The department shall establish rules, regulations and practice standards for the  
1103 licensing of office-based surgical centers. In determining rules, regulations and practice  
1104 standards necessary for licensure as an office-based surgical center, the department may, at its  
1105 discretion, determine which regulations applicable to an ambulatory surgical center, as defined in  
1106 section 25B, shall apply to an office-based surgical center. The department shall consult with the  
1107 board of registration in medicine prior to promulgating regulations or establishing rules or  
1108 practice standards pursuant to this section.

1109 (c) The department shall issue for a term of 2 years and renew for a like term, a license to  
1110 maintain an office-based surgical center to an entity or organization that demonstrates to the  
1111 department that it is responsible and suitable to maintain such a center. An office-based surgical  
1112 center license shall list the specific locations on the premises where surgical services are  
1113 provided. In the case of the transfer of ownership of an office-based surgical center, the  
1114 application of the new owner for a license, when filed with the department on the date of transfer  
1115 of ownership, shall have the effect of a license for a period of 3 months.

1116 (d) An office-based surgical center license shall be subject to suspension, revocation or  
1117 refusal to issue or to renew for cause if, in its reasonable discretion, the department determines  
1118 that the issuance of such license would be inconsistent with the best interests of the public health,  
1119 welfare or safety. Nothing in this subsection shall limit the authority of the department to require  
1120 a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to renew  
1121 a license issued pursuant to subsection (c).

1122 (e) Initial application and renewal fees for the license shall be established pursuant to  
1123 section 3B of chapter 7.

1124 (f) The department may impose a fine of up to \$10,000 on a person or entity that  
1125 advertises, announces, establishes or maintains an office-based surgical center without a license  
1126 granted by the department. The department may impose a fine of not more than \$10,000 on a  
1127 licensed office-based surgical center for violations of this section or any rule or regulation  
1128 promulgated pursuant to this section. Each day during which a violation continues shall  
1129 constitute a separate offense. The department may conduct surveys and investigations to enforce  
1130 compliance with this section.

1131 (g) Notwithstanding any general or special law or rule to the contrary, the department  
1132 may issue a 1-time provisional license to an applicant for an office-based surgical center licensed  
1133 pursuant to this section if such office-based surgical center holds: (i) a current accreditation from  
1134 the Accreditation Association for Ambulatory Health Care, American Association for  
1135 Accreditation of Ambulatory Surgery Facilities, Inc., or the Joint Commission, or (ii) a current  
1136 certification for participation in either Medicare or Medicaid. The department may approve such  
1137 a provisional application upon a finding of responsibility and suitability and that the office-based

1138 surgical center meets all other licensure requirements as determined by the department. Such  
1139 provisional license issued to an office-based surgical center shall not be extended or renewed.

1140 Section 51O. (a) As used in this section, the following words shall have the following  
1141 meanings unless the context clearly requires otherwise:

1142 “Emergency services”, as defined in section 1 of chapter 6D.

1143 “Urgent care center”, a clinic owned or operated by an entity that is not corporately  
1144 affiliated with a hospital licensed under section 51, however organized, whether conducted for  
1145 profit or not for profit, that is advertised, announced, established or maintained for the purpose of  
1146 providing urgent care services in an office or a group of offices, or any portion thereof, or an  
1147 entity that is advertised, announced, established or maintained under a name that includes the  
1148 words “urgent care” or that suggests that urgent care services are provided therein; provided,  
1149 however, that an urgent care center shall not include: (i) a hospital licensed under said section 51  
1150 or operated by the federal government or by the commonwealth; (ii) a clinic licensed under said  
1151 section 51; (iii) a limited service clinic licensed under section 51J; or (iv) a community health  
1152 center receiving a grant under 42 U.S.C. 254b.

1153 “Urgent care services”, a model of episodic care for the diagnosis, treatment,  
1154 management or monitoring of acute and chronic disease or injury that is: (i) for the treatment of  
1155 illness or injury that is immediate in nature but does not require emergency services; (ii)  
1156 provided on a walk-in basis without a prior appointment; (iii) available to the general public  
1157 during times of the day, weekends or holidays when primary care provider offices are not  
1158 customarily open; and (iv) is not intended and should not be used for preventative or routine  
1159 services.

1160 (b) The department shall establish rules, regulations, and practice standards for the  
1161 licensing of urgent care centers. In determining regulations and practice standards necessary for  
1162 licensure as an urgent care center, the department may, at its discretion determine which  
1163 regulations applicable to a clinic licensed under section 51, shall apply to an urgent care center.

1164 (c) The department shall issue for a term of 2 years and renew for a like term, a license to  
1165 maintain an urgent care center to an entity or organization that demonstrates to the department  
1166 that it is responsible and suitable to maintain such an urgent care center. In the case of the  
1167 transfer of ownership of an urgent care center, the application of the new owner for a license,  
1168 when filed with the department on the date of transfer of ownership, shall have the effect of a  
1169 license for a period of 3 months.

1170 (d) An urgent care center license shall be subject to suspension, revocation or refusal to  
1171 issue or to renew for cause if, in its reasonable discretion, the department determines that the  
1172 issuance of such license would be inconsistent with or opposed to the best interests of the public  
1173 health, welfare or safety. Nothing in this subsection shall limit the authority of the department to  
1174 require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to  
1175 renew a license issued pursuant to subsection (c).

1176 (e) Initial application and renewal fees for the license shall be established pursuant to  
1177 section 3B of chapter 7.

1178 (f) The department may impose a fine of up to \$10,000 on a person or entity that  
1179 advertises, announces, establishes or maintains an urgent care center without a license granted by  
1180 the department. The department may impose a fine of not more than \$10,000 on a licensed  
1181 urgent care center for violations of this section or any rule or regulation promulgated pursuant to

1182 this section. Each day during which a violation continues shall constitute a separate offense. The  
1183 department may conduct surveys and investigations to enforce compliance with this section.

1184 (g) Notwithstanding any general or special law or rule to the contrary, the department  
1185 may issue a 1-time provisional license to an applicant for an urgent care center if such urgent  
1186 care center holds: (i) a current accreditation from the Accreditation Association for Ambulatory  
1187 Health Care, Urgent Care Association of America or the Joint Commission; or (ii) a current  
1188 certification for participation in either Medicare or Medicaid. The department may approve such  
1189 provisional application upon a finding of responsibility and suitability and that the urgent care  
1190 center meets all other licensure requirements as determined by the department. Such provisional  
1191 license issued to an urgent care center shall not be extended or renewed.

1192 SECTION 69. Section 218 of said chapter 111, as appearing in the 2022 Official Edition,  
1193 is hereby amended by striking out, in line 28, the words “Maintenance Organizations” and  
1194 inserting in place thereof the following word:- Plans.

1195 SECTION 70. Section 7 of chapter 111D of the General Laws, as so appearing, is hereby  
1196 amended by striking out, in line 51, the word “three” and inserting in place thereof the following  
1197 figure:- 5.

1198 SECTION 71. The sixth paragraph of section 2 of chapter 112 of the General Laws, as so  
1199 appearing, is hereby amended by striking out the last sentence and inserting in place thereof the  
1200 following sentence:- The renewal application shall be accompanied by a fee determined under  
1201 the aforementioned provision and shall include the physician’s name, license number, home  
1202 address, office address, specialties, the principal setting of their practice and whether they are an  
1203 active or inactive practitioner.

1204 SECTION 72. Section 9C of chapter 118E of the General Laws, as so appearing, is  
1205 hereby amended by striking out, in line 161, the words “committee on health care” and inserting  
1206 in place thereof the following words:- joint committee on health care financing.

1207 SECTION 73. The fourth paragraph of section 5 of chapter 176A of the General Laws, as  
1208 so appearing, is hereby amended by inserting after the fourth sentence the following sentence:-  
1209 For the purposes of the review of rates of payment under this section, “not excessive” shall  
1210 include considerations of affordability for consumers and purchasers of health insurance  
1211 products; provided, however, that such review shall adhere to principles of solvency and  
1212 actuarial soundness.

1213 SECTION 74. The second paragraph of section 6 of said chapter 176A, as so appearing,  
1214 is hereby amended by adding the following sentence:- For the purposes of the review of rates of  
1215 payment under this section, whether a contract is not excessive shall include considerations of  
1216 affordability for consumers and purchasers of health insurance products; provided, however, that  
1217 such review shall adhere to principles of solvency and actuarial soundness.

1218 SECTION 75. The third paragraph of section 10 of said chapter 176A, as so appearing, is  
1219 hereby amended by inserting after the first sentence the following sentence:- For the purposes of  
1220 the review of rates of payment under this section, whether a contract is not excessive shall  
1221 include considerations of affordability for consumers and purchasers of health insurance  
1222 products; provided, however, that such review shall adhere to principles of solvency and  
1223 actuarial soundness.

1224 SECTION 76. The second paragraph of section 4 of chapter 176B of the General Laws,  
1225 as so appearing, is hereby amended by inserting after the second sentence the following

1226 sentence:- For the purposes of the review of rates of payment under this section, whether an  
1227 agreement is not excessive shall include considerations of affordability for consumers and  
1228 purchasers of health insurance products; provided, however, that such review shall adhere to  
1229 principles of solvency and actuarial soundness.

1230 SECTION 77. The first paragraph of section 16 of chapter 176G of the General Laws, as  
1231 so appearing, is hereby amended by inserting after the second sentence the following sentence:-  
1232 For the purposes of the review of rates of payment under this section, whether a contract is not  
1233 excessive shall include considerations of affordability for consumers and purchasers of health  
1234 insurance products; provided, however, that such review shall adhere to principles of solvency  
1235 and actuarial soundness.

1236 SECTION 78. Subsection (c) of section 6 of chapter 176J of the General Laws, as so  
1237 appearing, is hereby amended by inserting after the second sentence the following sentence:- For  
1238 the purposes of the review of rates of payment under this section, whether the proposed changes  
1239 to base rates are excessive shall include considerations of affordability for consumers and  
1240 purchasers of health insurance products; provided, however, that such review shall adhere to  
1241 principles of solvency and actuarial soundness.

1242 SECTION 79. The second paragraph of subsection (g) of section 7 of chapter 176K of the  
1243 General Laws, as so appearing, is hereby amended by adding the following sentence:- For the  
1244 purposes of the review of rates of payment under this section, whether rates are excessive shall  
1245 include considerations of affordability for consumers and purchasers of health insurance  
1246 products; provided, however, that such review shall adhere to principles of solvency and  
1247 actuarial soundness.

1248 SECTION 80. There shall be a task force to: (i) study primary care access, delivery and  
1249 payment in the commonwealth; (ii) develop and issue recommendations to stabilize and  
1250 strengthen the primary care system and the increase of recruitment and retention in the primary  
1251 care workforce; and (iii) increase the financial investment in and patient access to primary care  
1252 across the commonwealth.

1253 (b) The task force shall consist of: the secretary of health and human services or a  
1254 designee, who shall serve as co-chair; the executive director of the health policy commission or a  
1255 designee, who shall serve as co-chair; the assistant secretary for MassHealth or a designee; the  
1256 executive director of the center for health information and analysis or a designee; the  
1257 commissioner of insurance or a designee; the chairs of the joint committee on health care  
1258 financing or their designees; 1 member from the American Academy of Family Physicians Mass  
1259 Chapter, Inc.; 1 member from the Massachusetts chapter of the American Academy of  
1260 Pediatrics; 1 member from a rural health care practice with expertise in primary care; 1 member  
1261 from Community Care Cooperative, Inc.; 1 member from the Massachusetts Medical Society  
1262 with expertise in primary care; 1 member from the Massachusetts Coalition of Nurse  
1263 Practitioners, Inc. with expertise in primary care or in delivering care in a community health  
1264 center; 1 member from the Massachusetts Association of Physician Associates, Inc. with  
1265 expertise in primary care; 1 member from the Massachusetts chapter of the National Association  
1266 of Social Workers, Inc. with expertise in behavioral health in a primary care setting; 1 member  
1267 from the Massachusetts League of Community Health Centers, Inc.; 1 member from the  
1268 Massachusetts Health and Hospital Association, Inc.; 1 member from the Massachusetts  
1269 Association of Health Plans, Inc.; 1 member from Blue Cross and Blue Shield of Massachusetts,  
1270 Inc.; 1 member from the Associated Industries of Massachusetts, Inc.; 1 member from the

1271 Retailers Association of Massachusetts, Inc.; 1 member from Health Care For All, Inc.; 1  
1272 member from the Massachusetts Chapter of the American College of Physicians; 1 member from  
1273 the Massachusetts Primary Care Alliance for Patients; and 1 member from Massachusetts Health  
1274 Quality Partners, Inc.

1275 (c) The task force shall develop recommendations to: (i) define primary care services,  
1276 codes and providers; (ii) develop a standardized set of data reporting requirements for private  
1277 and public health care payers, providers and provider organizations to enable the commonwealth  
1278 and private and public health care payers to track payments for primary care services including,  
1279 but not limited to, fee-for-service, prospective payments, value-based payments and grants to  
1280 primary care providers, fees levied on a primary care provider by a provider organization or  
1281 hospital system of which the primary care provider is affiliated and provider spending on  
1282 primary care services; (iii) establish a primary care spending target for private and public health  
1283 care payers that reflects the cost to deliver evidence-based, equitable and culturally competent  
1284 primary care; (iv) propose payment models to increase private and public reimbursement for  
1285 primary care services; (v) assess the impact of health plan design on health equity and patient  
1286 access to primary care services; (vi) monitor and track the needs of and service delivery to  
1287 residents of the commonwealth; and (vii) create short-term and long-term workforce  
1288 development plans to increase the supply and distribution of and improve working conditions of  
1289 primary care clinicians and other primary care workers. The task force may make additional  
1290 recommendations and propose legislation necessary to carry out its recommendations.

1291 (d) The task force shall, in consultation with the center for health information and  
1292 analysis, define the data required to satisfy the contents of this section. The center for health  
1293 information and analysis shall adopt regulations to require providers and private and public

1294 health care payers to submit data or information necessary for the task force to fulfill its duties  
1295 under this section. Any data collected shall be public and available through the Massachusetts  
1296 Primary Care Dashboard maintained by the center and Massachusetts Health Quality Partners,  
1297 Inc.

1298 (e) Not later than September 15, 2025, the task force shall issue its report of the findings  
1299 and recommendations under clauses (i) and (ii) of subsection (c) with the clerks of the house of  
1300 representatives and the senate, the house and senate committees on ways and means, the joint  
1301 committee on health care financing, the center for health information and analysis, the health  
1302 policy commission and the division of insurance.

1303 (f) Not later than December 15, 2025, the task force shall issue its report of the findings  
1304 and recommendations under clause (iii) of subsection (c) with the clerks of the house of  
1305 representatives and the senate, the house and senate committees on ways and means, the joint  
1306 committee on health care financing, the center for health information and analysis, the health  
1307 policy commission and the division of insurance.

1308 (g) Not later than March 15, 2026, the task force shall issue its report of the findings and  
1309 recommendations under clauses (iv) and (v) of subsection (c) with the clerks of the house of  
1310 representatives and the senate, the house and senate committees on ways and means, the joint  
1311 committee on health care financing, the center for health information and analysis, the health  
1312 policy commission and the division of insurance.

1313 (h) Not later than May 15, 2026, the task force shall issue its report of the findings and  
1314 recommendations under clauses (vi) and (vii) of subsection (c) with the clerks of the house of  
1315 representatives and the senate, the house and senate committees on ways and means, the joint

1316 committee on health care financing, the center for health information and analysis, the health  
1317 policy commission and the division of insurance.

1318 SECTION 81. The assessments in section 6 of chapter 6D of the General Laws, as  
1319 amended by section 14, and in section 7 of chapter 12C of the General Laws, as amended by  
1320 section 38, shall apply to the budgets for the health policy commission and the center for health  
1321 information and analysis, respectively, beginning in fiscal year 2026; provided, however, that  
1322 each pharmaceutical manufacturing company and each pharmacy benefit manager shall make a  
1323 preliminary payment to the commission on October 1, 2025 in an amount equal to 1/2 of the  
1324 initial year's total assessment, as determined by the commission and center, respectively, and  
1325 thereafter shall pay, within 30 days of receiving notice, the balance of the total assessment for the  
1326 initial year.

1327 SECTION 82. Notwithstanding any general or special law to the contrary, the office of  
1328 health resource planning established in section 22 of chapter 6D of the General Laws shall  
1329 submit a state health resource plan to the governor and the general court as required by said  
1330 section 22 of said chapter 6D not later than January 1, 2027.

1331 SECTION 83. The department of public health, in consultation with the board of  
1332 registration in medicine, shall promulgate regulations establishing the requirements for licensure  
1333 as an office-based surgical center pursuant to section 51N of chapter 111 of the General Laws  
1334 not later than October 1, 2025.

1335 SECTION 84. The department of public health, in consultation with the board of  
1336 registration in medicine, shall promulgate regulations establishing the requirements for licensure

1337 as an urgent care center pursuant to section 51O of chapter 111 of the General Laws not later  
1338 than October 1, 2025.

1339 SECTION 85. Notwithstanding any general or special law to the contrary, the department  
1340 of public health may issue a 1-time provisional license for a period of not more than 1 year to an  
1341 applicant for an initial office-based surgical center license pursuant to section 51N of chapter 111  
1342 of the General Laws, which is not in full compliance with applicable requirements but the  
1343 department finds it is in substantial compliance with such requirements and demonstrates  
1344 potential for achieving full compliance within the provisional licensure period. A provisional  
1345 license issued to an office-based surgical center shall not be extended or renewed.

1346 SECTION 86. Notwithstanding any general or special law to the contrary, the department  
1347 of public health may issue a 1-time provisional license for a period of not more than 1 year to an  
1348 applicant for an initial an urgent care center license pursuant to section 51O of chapter 111 of the  
1349 General Laws, which is not in full compliance with applicable requirements but the department  
1350 finds it is in substantial compliance with such requirements and demonstrates potential for  
1351 achieving full compliance within the provisional licensure period. A provisional license issued to  
1352 an urgent care center shall not be extended or renewed.

1353 SECTION 87. (a) Notwithstanding any general or special law to the contrary, members  
1354 of the board of the health policy commission appointed pursuant to section 2 of chapter 6D of the  
1355 General Laws and serving as of the effective date of this act, shall continue to serve until the  
1356 expiration of the terms for which they were appointed or until June 30, 2025, whichever first  
1357 occurs.

1358 (b) Any vacancy on the board that results from the resignation, removal or expiration of a  
1359 board member's term shall be filled in accordance with subsection (b) of section 2 of chapter 6D  
1360 of the General Laws.

1361 (c) In making the original appointments to the health policy commission established in  
1362 section 2 of chapter 6D of the General Laws, the governor shall appoint 2 members for a term of  
1363 2 years, 2 members for a term of 3 years and 2 members for a term of 4 years. As each member's  
1364 term expires thereafter, their successor shall be appointed for a term of 5 years. The governor  
1365 shall make all appointments not later than July 1, 2025.

1366 (d) In making the original appointments to the health policy commission established in  
1367 section 2 of chapter 6D of the General Laws, the attorney general shall appoint 1 member for a  
1368 term of 2 years, 1 member for a term of 3 years and 1 member for a term of 4 years. As each  
1369 member's term expires thereafter, their successor shall be appointed for a term of 5 years. The  
1370 attorney general shall make all appointments not later than July 1, 2025.

1371 (e) The health policy commission may issue guidance to ensure the orderly transition of  
1372 the board in accordance with this act.

1373 SECTION 88. Section 12 shall take effect on July 1, 2025.