HOUSE DOCKET, NO. 3147 FILED ON: 1/16/2025

HOUSE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Mark J. Cusack

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

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

An Act strengthening oversight of health care facility spending.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Mark J. Cusack	*5th Norfolk*	*1/15/2025*

HOUSE DOCKET, NO. 3147 FILED ON: 1/16/2025

HOUSE . . . . . No.

[Pin Slip]

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act strengthening oversight of health care facility spending.

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

SECTION 1. Section 8 of chapter 6D of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after subsection (f), the following new subsection:-

(g) As part of the annual public hearings established herein, the commission shall conduct an annual review of the status of all the commission-approved material changes pursuant to section 13 of this chapter, to determine whether the benefits providers have given as the reasons for coming together, such as lower costs, better integration, or improved quality, have been realized. The commission shall collect written testimony from relevant parties and identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the commission, the executive director of the center and attorney general at the public hearing in a manner and form to be determined by the commission. Testimony may include, but not be limited to: (i) the impact of the material change on the relative price and total medical expenses; (ii) the impact of the material change on insurer

reimbursement rates; (iii) the quality of the services provided; (iv) the impact of the material change on consumer access to services; (v) the extent to which the material change resulted in measurable increases in efficiencies, coordination of care or other benefits of integration; (vi) the impact of the material change on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; and (vii) any other factors that the commission determines to be in the public interest.

SECTION 2. Section 10 of chapter 6D of the General Laws, as so appearing, is hereby amended by striking out subsection (a) in its entirety and inserting in place thereof the following subsection:-

(a) For the purposes of this section, "health care entity" shall mean a clinic, hospital, health system, ambulatory surgical center, physician organization, accountable care organization, or payer; provided, however, that physician contracting units with a patient panel of 15,000 or fewer, or which represents providers who collectively receive less than $25,000,000 in annual net patient service revenue from carriers shall be exempt.

SECTION 3. Said section 10 of chapter 6D, as so appearing, is hereby further amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) In addition to the notice provided under subsection (b), the commission may require any health care entity that is identified by the center under section 16 of chapter 12C as exceeding the health care cost growth benchmark established under section 9, having a relative price that exceeds 1.3, or having a total medical expense in excess of the statewide average

physician group health status adjusted total medical expense to file a performance improvement plan with the commission. The commission shall provide written notice to such health care entity or provider that they are required to file a performance improvement plan. Within 45 days of receipt of such written notice, the health care entity shall either:

(1) file a performance improvement plan with the commission; or

(2) file an application with the commission to waive or extend the requirement to file a performance improvement plan.

SECTION 4. Said section 10 of chapter 6D, as so appearing, is hereby further amended by striking out subsection (i) and inserting in place thereof the following subsection:-

(i) A health care entity shall file a performance improvement plan: (1) within 45 days of receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (3) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall be generated by the health care entity and shall identify the causes of the entity's cost growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance and meet the goal of reducing the health care entity’s relative price below 1.3 and closer to the statewide average relative price. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

SECTION 5. Said chapter 6D of the General Laws, as so appearing. is hereby amended by striking out section 13, as so appearing, and inserting in place thereof the following section:-

Section 13. (a) Every provider or provider organization shall, before making any material change to its operations or governance structure, submit notice to the commission, the center and the attorney general of such change, not fewer than 60 days before the date of the proposed change. Material changes shall include, but not be limited to: (i) significant expansions in a provider or provider organization's capacity; (ii) a corporate merger, acquisition or affiliation of a provider or provider organization and a carrier; (iii) mergers or acquisitions of hospitals or hospital systems; (iv) acquisition of insolvent provider organizations; (v) transactions involving a significant equity investor which result in a change of ownership or control of a provider or provider organization; (vi) significant acquisitions, sales or transfers of assets including, but not limited to, real estate sale lease-back arrangements; (vii) the application for issuance of a new freestanding ambulatory surgery center license or a clinic license, or a new satellite facility under an existing license; (viii) conversion of a provider or provider organization from a non-profit entity to a for-profit entity; and (ix) mergers or acquisitions of provider organizations which will result in a provider organization having a dominant market share in a given service or region.

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

(b) In addition to the grounds for a cost and market impact review set forth in subsection (a), if the commission finds, based on the center's annual report under section 16 of chapter 12C,

that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the commission shall conduct a cost and market impact review of any health care entity identified by the center under section 18 of said chapter 12C.

(c)(1) The commission shall initiate a cost and market impact review by sending the provider or provider organization notice of a cost and market impact review, which shall explain the basis for the review and the particular factors that the commission seeks to examine through the review. The provider or provider organization shall submit to the commission, within 21 days of the commission's notice, a written response to the notice, including, but not limited to, any information or documents sought by the commission that are described in the commission's notice. The commission may require that any provider, provider organization, significant equity investor, or other party involved in a given transaction submit documents and information in connection with a notice of material change or a cost and market impact review under this section. The commission shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the provider or payer that produced the information or documents, except in a preliminary report or final report under this section if the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

(2) For any material change involving a significant equity investor, the commission may specify certain information required to be submitted as part of the notice, including, but not

limited to, information regarding the significant equity investor's capital structure, general financial condition, ownership and management structure and audited financial statements.

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

(d) A cost and market impact review may examine factors relating to the provider or provider organization's business and its relative market position, including, but not limited to: (i) the provider or provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) the provider or provider organization's prices for services, including its relative price compared to other providers for the same services in the same market; (iii) the provider or provider organization's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar providers; (iv) the quality of the services provided by the provider or provider organization, including patient experience; (v) provider cost and cost trends in comparison to total health care expenditures statewide; (vi) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider or provider organization within its primary service areas and dispersed service areas; (vii) the provider or provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (viii) the methods used by the provider or provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (ix) the methods used by the

provider or provider organization to direct patient care to the appropriate and lowest-cost setting within its system and to eliminate unnecessary duplication of health care services within the system; (x) the role of the provider or provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (xi) the role of the provider or provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (xii) consumer concerns, including but not limited to, complaints or other allegations that the provider or provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; (xiii) the size and market share of any corporate affiliates or significant equity investors of the provider or provider organization; (xiv) the inventory of health care resources maintained by the department of public health, pursuant to section 25A of chapter 111; (xv) any related data or reports from the office of health resource planning, established in section 22; and (xvi) any other factors that the commission determines to be in the public interest.

(e) The commission shall make factual findings and issue a preliminary report on the cost and market impact review within 180 days. In the report, the commission shall identify any provider or provider organization that: (i) has, or likely will have as a result of the proposed material change, a dominant market share for the services it provides; (ii) charges, or likely will charge as a result of the proposed material change, prices for services that are materially higher than the median prices charged by comparable providers for the same services in the same market; or (iii) has, or likely will have as a result of the proposed material change, a health status adjusted total medical expense that is materially higher than the median total medical expense of comparable providers in the same market. If the commission finds in its review that the provider

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

Any provider or provider organization that has been identified by the center under section 18 of chapter 12C as exceeding the health care cost growth benchmark for any given year, having a relative price above the statewide median or above 1.3 S-RP, having a total medical expense in excess of the statewide average physician group health status adjusted total medical expense, or is subject to a performance improvement plan pursuant to section 10, shall be prohibited by the commission from making any material change to its operations or governance structure that would otherwise require notice to the commission pursuant to this section. The commission may exclude a provider or provider organization from this prohibition if the market share of the provider or provider organization is below a threshold as determined by the commission, or if the provider or provider organization's total medical expenses or relative price are below the statewide median. The prohibition shall continue until the center has determined

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

(f) Within 30 days after issuance of a preliminary report, the provider or provider organization may respond in writing to the findings in the report. The commission shall then issue its final report. The commission shall refer to the attorney general its report on any provider or provider organization that meets the criteria under subsection (e). The commission shall issue its final report on the cost and market impact review within 185 days from the date that the provider or provider organization has submitted a completed notice to the commission; provided, that the provider or provider organization has certified substantial compliance with the commission's requests for data and information pursuant to subsection (c) within 21 days of the commission's notice, or by a later date set by mutual agreement of the provider or provider organization and the commission. If the commission approves a proposed material change, the commission shall refer its report to the attorney general who shall make an independent legal determination as to whether the transaction satisfies the requirements of state and federal antitrust law and any and all guidance issued by the U.S. Department of Justice and the Federal Trade Commission.

(g) Any proposed material change shall not be completed: (i) until at least 30 days after the commission has issued its final report; or (ii) if the attorney general brings an action under chapter 93A or any other law related to the material change, while such action is pending and prior to a final judgment being issued by a court of competent jurisdiction, whichever is later.

(h) When the commission, under subsection (f), refers a report on a provider or provider organization to the attorney general, the attorney general may: (i) conduct an investigation to

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

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

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

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

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

SECTION 6. Said chapter 6D, as so appearing, is hereby further amended by inserting after section 13 the following section:-

Section 13A. (a) The commission shall issue a report annually that details the findings of the annual public hearing and review of the status of all commission-approved material changes conducted pursuant to section 8 of chapter 6D, including any and all oral and written testimony, and shall include any actions taken by the commission against any provider or provider organization. The report shall be posted on the commission's website and shall be filed with the house of representatives and senate clerks, the house and senate committees on ways and means, and the joint committee on health care financing.

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

(c) If the commission finds that an approved material change has failed to produce the stated benefits and the provider or provider organization has exceeded the health care cost

growth benchmark, the commission shall notify the center for health information and analysis of the extent by which the provider or provider organization has exceeded the health care cost growth benchmark. The center shall calculate an amount that reflects the cost to the commonwealth of that excess and that amount shall be used to either reduce the Health Safety Net Trust Fund payments to that provider or provider organization or to increase the payments by that provider or provider organization to the Health Safety Net Trust Fund, or a combination of both to achieve the result. The center shall develop a method for collecting data from providers and provider organizations necessary to make the calculations mandated by this section and the methodology used in determining the amount by which the provider or provider organization's participation in Health Safety Net Trust Fund payments or assessments will be affected.

SECTION 7. Section 16 of chapter 12C of the General Laws, as so appearing in the 2022 Official Edition, is hereby amended by striking out the first sentence in subsection (a) and inserting in place thereof the following sentence:-

(a) The center shall publish an annual report based on the information submitted under sections 8, 9 and 10 concerning health care provider, provider organization, hospital, health system, and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data.

SECTION 8. Said chapter 12C of the General Laws, as so appearing, is hereby further amended by striking out section 18 and inserting in place thereof the following section:-

Section 18. The center shall perform ongoing analysis of data it receives under sections 6, 9 and 10 to identify any payers, providers or provider organizations, hospitals, or health systems

whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark established by the health policy commission under section 10 of chapter 6D. The center shall confidentially provide a list of the payers, providers or provider organizations, hospitals, or health systems to the health policy commission such that the authority may pursue further action under section 10 of chapter 6D.

SECTION 9. Section 25C of chapter 111 of the General Laws, as so appearing in the 2022 Official Edition, is hereby amended by striking out subsections (h) and (i) and inserting in place thereof the following subsections:-

(h) Applications for such determination shall be filed with the department, together with other forms and information as shall be prescribed by, or acceptable to, the department. A duplicate copy of any application together with supporting documentation for such application, shall be a public record and kept on file in the department. The department may require a public hearing on any application at its discretion or at the request of the health policy commission or the attorney general. The health policy commission and the attorney general may intervene in any hearing under this section. A reasonable fee, established by the department, shall be paid upon the filing of such application; provided, however, that in no event shall such fee exceed 0.2 per cent of the capital expenditures, if any, proposed by the applicant. The department may also require the applicant to provide an independent cost-analysis, conducted at the expense of the applicant, to demonstrate that the application is consistent with the commonwealth's efforts to meet the health care cost-containment goals established by the commission.

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

SECTION 10. Said section 25C of chapter 111 of the General Laws, as so appearing, is further amended by striking out subsection (k) and inserting in place thereof the following subsection:-

(k) Determinations of need shall be based on the written record compiled by the department during its review of the application and on such criteria consistent with sections 25B to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such

record the department shall confine its requests for information from the applicant to matters which shall be within the normal capacity of the applicant to provide. In reviewing an application, the department shall take into consideration the recommendations made by the health policy commission regarding the impact of the proposed project on health care costs in the commonwealth. In each case the action by the department on the application shall be in writing and shall set forth the reasons for such action; and every such action and the reasons for such action shall constitute a public record and be filed in the department.

SECTION 11. Said chapter 111 of the General Laws is further amended by inserting after section 51L the following new section:-

Section 51M. (a) As used in this section, the following terms shall have the following meanings:

"Facility", any hospital, satellite facility, ambulatory surgical center, or clinic which receives a separate on-site review survey by the Joint Commission on the Accreditation of Healthcare Organizations.

"Facility of primary licensure", the single physical structure and location where the majority of the hospital's licensed beds or where most of the physician practices are located.

(b) Every health care entity that provides any services at a location other than its facility of primary licensure is prohibited from operating a secondary facility pursuant to the original license of the facility of primary licensure and is hereby required to obtain from the department a new license for that location if the facility constitutes a secondary facility. A facility constitutes a secondary facility if:

The facility is physically located a distance greater than 500 yards, or

The facility requires or maintains separate heating, cooling, electric, or sewer systems from the facility of primary licensure.

(c) A licensed secondary facility shall obtain a separate National Provider Identification Number from the federal Centers for Medicare and Medicaid Services.

(d) A licensed secondary facility shall establish a contract negotiating team and shall negotiate contracts separately from the facility of primary licensure with carriers. A licensed secondary facility shall establish a firewall mechanism that prevents the separate contract negotiating teams from sharing any information that would inhibit competition with another licensed facility. Separate negotiations shall apply for both inpatient and outpatient services. A licensed facility shall negotiate under the requirements of this section at the time of renewal or expiration of their current contracts with payers.

(e) No contract between a facility and a carrier may require a carrier to enter into an additional contract with another facility.

(f) No contract between a facility and a carrier may make the availability of any price or term contingent on the carrier entering into a contract with another facility.

(g) Every licensed facility shall bill all carriers for services using the National Provider Identification Number assigned to the specific facility and physical locations where the services were provided.

(h) No carrier shall be required to pay a claim billed by a facility not billed in accordance with this section.

(i) Subject to any agreement between the parties, a secondary facility shall bill a carrier for services at a rate negotiated by the parties separately from the rates for the facility of primary licensure or in the absence of an agreement, 110% of Medicare.

(j) Notwithstanding the provisions of this chapter, the department shall not grant a license to any secondary facility unless there is a determination by the department that there is a need for such a facility pursuant to section 25C. Secondary facilities in operation as of the effective date of this section shall be exempt from the department's determination of need requirements for purposes of obtaining licensure as a secondary facility.

(k) The department may grant exemptions from the requirements of this section if a facility of primary licensure and licensed secondary facilities demonstrates to the satisfaction of the department that the facility of primary licensure and licensed secondary facilities are integrated pursuant to regulations the department, in consultation with the division of insurance, shall adopt. In promulgating said regulations, the department shall consider as factors of integration whether a facility of primary licensure and licensed secondary facilities:

receives over 50 percent of its revenue from alterative payment arrangements;

has fully implemented one unifying, interoperable electronic medical record system across all facilities;

has implemented quality improvement initiatives with demonstrable improvements in quality of care provided;

has successfully implemented programs to direct care to the appropriate and lowest cost facility; and

has implemented appropriate measures to eliminate unnecessary duplication of health care services.

(j) Health care facilities shall negotiate under the requirements of this section at the time of renewal or expiration of their current contracts with payers.

(k) The department, along with the office of the attorney general, shall have the authority to enforce the requirements of this section.