HOUSE DOCKET, NO. 3798 FILED ON: 1/17/2025

HOUSE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

John J. Lawn, Jr.

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 updating the health care cost growth benchmark and associated market oversight activities.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
John J. Lawn, Jr.	*10th Middlesex*	*1/17/2025*

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HOUSE . . . . . No.

[Pin Slip]

The Commonwealth of Massachusetts

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

An Act updating the health care cost growth benchmark and associated market oversight activities.

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 1 of chapter 6D of the General Laws, most recently amended by sections 5 through 11, inclusive, of chapter 343 of the acts of 2024, is hereby further amended by inserting after the definition of "Alternative payment methodologies or methods" the following definition:-

"Benchmark cycle", a fixed, predetermined period of 3 consecutive calendar years during which the projected average annual percentage change in total health care expenditures in the commonwealth is calculated pursuant to section 9 and monitored pursuant to section 10.

SECTION 2. Said section 1 of said chapter 6D, as so amended, is hereby further amended by striking out the definition of "Health care cost growth benchmark" and inserting in place thereof the following definition:-

"Health care cost growth benchmark", the projected average annual percentage change in total health care expenditures in the commonwealth during a benchmark cycle, as established in section 9.

SECTION 3. Said section 1 of said chapter 6D, as so amended, is hereby further amended by inserting after the definition of "Surcharge payor" the following definition:-

"Technical advisory committee", the technical advisory committee of the health policy commission established by section 4A.

SECTION 4. Said chapter 6D is hereby further amended by inserting after section 4 the following section:-

Section 4A. (a) There is hereby established a technical advisory committee consisting of appointed members with demonstrated experience in a broad range of provider sectors and public and private health care payers. The technical advisory committee shall: (i) establish the adjustment factor as part of the health care cost growth benchmark setting process pursuant to subsection (c) of section 9; (ii) provide technical advice to the commission upon request; (iii) provide the commission with operational, policy, regulatory or legislative recommendations for the commission's consideration; and (iv) produce an annual report and other reports pursuant to subsection (c).

(b) The technical advisory committee shall consist of the following 16 members: the executive director of the commission, who shall serve as non-voting chairperson; the assistant secretary for MassHealth, or a designee; the executive director of the commonwealth health insurance connector authority, or a designee; the executive director of the group insurance commission, or a designee; and 12 members appointed by the executive director of the

commission for their technical experience in specific health care sectors, 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Hospital Association, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Senior Care Association, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Medical Society, 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Biotechnology Council, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Association of Health Plans, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by Blue Cross Blue Shield of Massachusetts, Inc., and 5 of whom shall be selected by the executive director from applications submitted by candidates with demonstrated experience in health care delivery, health equity advocacy, health care economics, health care data analysis, clinical research and innovation in health care delivery, health care benefits management or expertise in behavioral health, substance use disorder, mental health services and mental health reimbursement systems. In selecting members, the executive director shall ensure that the composition of the committee reflects a diversity of expertise in health care providers, purchasers, and consumer advocacy groups. Each member of the committee shall serve without compensation for a term of 3 years, or until a successor is appointed; provided, that no member shall serve more than 2 consecutive terms. Members of the committee shall be special state employees subject to chapter 268A. The technical advisory committee shall meet at least quarterly or at other times as specified by the commission and shall annually elect 1 of its members to serve as vice-chairperson.

(c) The technical advisory committee shall report a summary of its activities to the commission at least annually, and shall submit additional reports with technical recommendations, as requested by the commission. In developing any reports or recommendations to the commission, the technical advisory committee shall consider the availability, timeliness, quality and usefulness of existing data, including the data collected by the center under chapter 12C, and assess the need for additional investments in data collection, data validation or data analysis capacity to support the committee in performing its duties.

SECTION 5. Subsection (a) of section 8 of said chapter 6D, most recently amended by section 16 of chapter 343 of the acts of 2024, is hereby further amended by striking out the words “for the previous calendar year” and inserting in place thereof the following words:- established under section 9.

SECTION 6. Subsection (f) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in the first sentence, the words “exceeded the health care cost benchmark in the previous calendar year” and inserting in place thereof the following words:- in the previous calendar year exceeded the average annual growth established in the health care cost growth benchmark.

SECTION 7. Said section 8 of said chapter 6D, most recently amended by section 29 of chapter 343 of the acts of 2024 , is hereby further amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The commission shall compile an annual health care cost growth progress report concerning spending trends, including primary care and behavioral health expenditures, and the underlying factors influencing said spending trends. The commission shall issue a final

benchmark cycle report after the third year of a benchmark cycle which shall analyze spending trends for the entire benchmark cycle. The reports shall be based on the commission's analysis of information provided at the hearings by witnesses, providers, provider organizations and payers, registration data collected pursuant to section 11, data collected or analyzed by the center pursuant to sections 8 to 10A, inclusive, of chapter 12C and any other available information that the commission considers necessary to fulfill its duties under this section, as defined in regulations promulgated by the commission. The reports shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The reports shall include recommendations for strategies to increase the efficiency of the health care system and, in the case of annual progress reports, recommendations on the specific spending trends that impede the commonwealth's ability to meet the health care cost growth benchmark and draft legislation necessary to implement said recommendations.

SECTION 8. Said chapter 6D is hereby further amended by striking out sections 9 and 10, as appearing in the 2022 Official Edition, and inserting in place thereof the following 2 sections:-

Section 9. (a) The board shall establish a health care cost growth benchmark for the average annual growth in total health care expenditures in the commonwealth during a period of 3 consecutive calendar years. The commission shall establish the health care cost growth benchmark not later than April 15 of the year immediately preceding the first calendar year of a benchmark cycle.

(b) The health care cost growth benchmark shall be equal to the growth rate of potential gross state product established under section 7H½ of chapter 29, plus the adjustment factor adopted by the commission upon the recommendation of the technical advisory committee pursuant to subsections (c) and (d). The commission shall establish procedures to prominently publish the health care cost growth benchmark on the commission's website.

(c) The technical advisory committee shall recommend an adjustment factor to the commission not later than February 15 of the year immediately preceding the first calendar year of the benchmark cycle; provided, that the adjustment factor shall not be greater than 1 per cent or less than minus 1 per cent. The adjustment factor shall be based on economic and market factors specific to the health care industry including, but not limited to, the following factors: (i) medical inflation as measured by the medical care index within the consumer price index calculated by the United States Bureau of Labor Statistics; (ii) labor and workforce development costs; (iii) the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) historical growth rate in the commonwealth's gross state product; and (v) any other factors as determined by the technical advisory committee. The recommended adjustment factor shall be approved by a majority vote of the technical advisory committee; provided, however, that should the technical advisory committee fail to approve a recommended adjustment factor, the adjustment factor shall be 0 per cent. The technical advisory committee shall submit its recommendation to the commission in a public report that shall include an analysis supporting the technical advisory committee's recommended adjustment factor.

(d) The commission shall hold a public hearing prior to accepting or rejecting the technical advisory committee's recommended adjustment factor. The public hearing shall be based on the report submitted by the technical advisory committee pursuant to subsection (c), the

report submitted by the center pursuant to section 16 of chapter 12C, any other data provided by the technical advisory committee and the center, and such other pertinent information or data as may be available to the commission. The commission shall provide public notice of such hearing at least 45 days prior to the date of the hearing, including notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing. The hearing shall examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system, and whether, based on the testimony, information and data presented at the hearing, it is appropriate to accept the recommended adjustment factor.

(e) The commission shall approve the recommended adjustment factor by a majority vote of the board.

Section 10. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Health care entity", a clinic, hospital, ambulatory surgical center, physician organization, or accountable care organization required to register under section 11.

(b) The commission shall provide notice to a health care entity identified by the center under section 18 of chapter 12C that the commission may analyze the cost growth and the health

care spending performance of the individual health care entity and that the commission may require certain actions, as established in this section, from health care entities so identified.

(c) If the commission finds, based on the center's benchmark cycle report issued under subsection (d) of section 16, that the percentage change in total health care expenditures during the benchmark period exceeded the health care cost growth benchmark, the commission may require certain health care entities to file and implement a performance improvement plan, subject to the factors in subsection (f).

(d) In addition to the notice provided under subsection (b), the commission shall provide written notice to a health care entity it determines must 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.

(e) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application; provided, however, that such information shall be made public at the discretion of the commission.

(f) The commission may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under

subsection (d) in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the baseline spending and trends relative to cost, price, utilization and payer mix of the health care entity over time, independently and as compared to similar entities, and any demonstrated improvement to reduce health status adjusted total medical expenses;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but shall not be limited to, age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses, medical device expenses and labor costs;

(4) the overall financial condition of the health care entity;

(5) a significant difference between the growth rate of potential gross state product and the growth rate of actual gross state product, as determined under section 7H½ of chapter 29; and

(6) any other factors the commission considers relevant.

(g) If the commission declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the commission shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(h) A health care entity shall file a performance improvement plan: (1) within 45 days of receipt of a notice under subsection (d); (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. 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 3 years.

(i) The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the health care entity’s cost growth and has a reasonable expectation for successful implementation.

(j) If the board determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission; provided, however, that all aspects of the performance improvement plan shall be proposed by the health care entity and the commission shall not require specific elements for approval.

(k) Upon approval of the proposed performance improvement plan, the commission shall notify the health care entity to begin implementation of the performance improvement plan. Public notice shall be provided by the commission on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the commission. The commission shall provide

assistance to the health care entity in the successful implementation of the performance improvement plan.

(l) All health care entities shall, in good faith, work to implement the performance improvement plan. A health care entity may file amendments to the performance improvement plan at any point during the implementation of the performance improvement plan, subject to approval of the commission.

(m) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the commission regarding the outcome of the performance improvement plan. If the commission finds that the performance improvement plan was unsuccessful, the commission shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity to submit a new performance improvement plan, including requiring specific elements for approval, notwithstanding the limitation in subsection (j) on the commission's authority during its review of an initial plan proposal; (iv) waive or delay the requirement to file any additional performance improvement plans; or (v) conduct a cost and market impact review of the health care entity under section 13.

(n) Upon the successful completion of the performance improvement plan, the identity of the health care entity shall be removed from the list of entities currently implementing a performance improvement plan on the commission's website.

(o) The commission may submit recommendations and draft legislation necessary to implement said recommendations to the joint committee on health care financing if the

commission determines that further legislative authority is needed to achieve the commonwealth's health care quality and spending sustainability objectives, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section.

(p) If the commission determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the commission within 45 days as required under subsection (d); (ii) failed to file an acceptable performance improvement plan in good faith with the commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or knowingly falsified the same, the commission may: (i) assess a civil penalty to the health care entity of not more than $500,000 for a first violation, not more than $750,000 for a second violation and not more than $1,000,000 for a third or subsequent violation; (ii) stay consideration of any material change notice submitted under section 13 by the health care entity until the commission determines that the health care entity is in compliance with this section; and (iii) notify the department of public health that the health care entity, if applying for a notice of determination of need, is not in compliance with this section. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(q) The commission shall promulgate regulations necessary to implement this section; provided, however, that notice of any proposed regulations shall be filed with the joint committee on health care financing at least 180 days before adoption.

SECTION 9. Section 13 of said chapter 6D, most recently amended by section 24 of chapter 343 of the acts of 2024 , is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(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 final benchmark cycle report under subsection (d) of section 16 of chapter 12C, that the percentage change in total health care expenditures during the benchmark cycle exceeded the health care cost growth benchmark in the previous calendar year, the commission may conduct a cost and market impact review of any provider or provider organization identified by the center under section 18 of said chapter 12C.

SECTION 10. Section 1 of chapter 12C of the General Laws, most recently amended by sections 31 through 36, inclusive, of chapter 343 of the acts of 2024, is hereby further amended by inserting after the definition of "Ambulatory surgical center services", the following definition:-

"Benchmark cycle", a fixed, predetermined period of 3 consecutive calendar years during which the projected average annual percentage change in total health care expenditures in the commonwealth is calculated pursuant to section 9 of chapter 6D and monitored pursuant to section 10 of said chapter 6D.

SECTION 11. Said section 1 of said chapter 12C, as so amended, is hereby further amended by striking out the definition of "Health care cost growth benchmark" and inserting in place thereof the following definition:-

"Health care cost growth benchmark", the projected average annual percentage change in total health care expenditures in the commonwealth during a benchmark cycle, as established in section 9 of chapter 6D.

SECTION 12. Section 16 of said chapter 12C, most recently amended by section 25 of chapter 342 of the acts of 2024, is hereby further amended by inserting after subsection (c) the following subsection:-

(d) The center's report on the third year of a benchmark cycle shall be a final benchmark cycle report and shall compare the costs and cost trends for the entire benchmark cycle with the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D.

SECTION 13. Said chapter 12C is hereby further amended by striking out section 18 and inserting in place thereof the following section:-

Section 18. (a) For the purposes of this section, "health care entity" shall mean a clinic, hospital, ambulatory surgical center, physician organization or an accountable care organization required to register under section 11.

(b) The center shall perform ongoing analysis of data it receives under this chapter to identify any health care entity whose:

(1) contribution to health care spending growth, including but not limited to, spending levels and growth as measured by 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 9 of chapter 6D; provided, that the

center shall identify cohorts for similar health care entities and establish differential standards for excessive growth rates, based on a health care entity's baseline spending, pricing levels and payer mix; or

(2) data is not submitted to the center in a proper, timely or complete manner.

(c) The center shall confidentially provide a list of the health care entities to the health policy commission such that the commission may pursue further action under section 10 of chapter 6D. Confidential referrals under this section shall not preclude the center from using its authority to assess penalties for noncompliance under section 11.

SECTION 14. Subsection (b) of section 7H½ of chapter 29 of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- On or before January 15 in the year immediately preceding the start of a benchmark cycle, as defined in section 1 of chapter 6D, the secretary of administration and finance shall meet with the house and senate committees on ways and means and shall jointly develop a growth rate of potential gross state product for the ensuing benchmark cycle which shall be agreed to by the secretary and the committees.