Joint Committee on Health Care Financing
2025-2026 (194th) Bill Summary

Bill Number: House, No. 1355

Title: AN ACT STRENGTHENING OVERSIGHT OF HEALTH CARE FACILITY SPENDING

Sponsor: Representative Mark J. Cusack (Braintree)

Hearing Date: June 2, 2025

Reporting Deadline: August 1, 2025

Prior History: New Bill

Similar Matters: N/A

Current Law:

Chapter 6D of the Massachusetts General Laws (2025) establishes the Health Policy Commission (HPC) as an independent agency within the Executive Office of Administration and Finance to set health care cost growth goals, enhance provider organization transparency, monitor and review marketplace changes, and establish a health care cost growth benchmark for the average growth in total health care expenditures.

M.G.L. ch. 6D, § 8, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", directs the HPC to hold annual public hearings, based on the report submitted by the Center for Health Information and Analysis (CHIA) pursuant to section 16 of chapter 12C. The hearing examines the costs, prices and cost trends of health care providers, provider organizations, private and public health care payers, pharmaceutical manufacturing companies and pharmacy benefit managers and any relevant impact of significant equity investors, health care real estate investment trusts, management services organizations costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and trends in annual primary care and behavioral health expenditures. The HPC shall identify witnesses for the hearing, who shall give testimony under oath and be subject to examination and cross examination. Witnesses are required to provide testimony on specific subjects, including testimony concerning costs, payment systems, and relative prices. The HPC compiles an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system, 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. The report shall be submitted to the house and senate committees on ways and means and the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year.

M.G.L. Ch. 6D § 9, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", directs HPC board, not later than April 15 of every year, to establish a health care cost growth benchmark for the average growth in total health care expenditures. For calendar years 2023 and beyond, the health care cost growth benchmark shall be equal to the growth rate of potential gross state product established under said section 7H ½ of said chapter 29. The HPC may determine that an adjustment in the health care cost growth benchmark is reasonably warranted. The statue requires HPC to hold a public hearing to consider available

data, information, and testimony from market participants and other interested parties. The statute also grants the Joint Committee on Health Care Financing the right to participate in the public hearing.

M.G.L. Ch. 6D § 10 directs CHIA to notify the HPC of any health care entity identified by the center as exceeding the health care cost growth benchmark for any given year. The HPC may require that entity to file and implement a performance improvement plan to improve efficiency and reduce cost growth. In addition, if the HPC finds that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the HPC may require any entity to file a performance improvement plan.

M.G.L. Ch. 6D § 13 requires providers and provider organizations to provide the HPC, CHIA and the AGO with advance notice of any impending material change, which includes any of the following: a corporate merger or affiliation with, or acquisition of, a provider or provider organization and a carrier, hospital, or hospital system; an acquisition of an insolvent provider organization; a merger or acquisition resulting in a provider organization having a near-majority of market share in a given service or region. Section 13 also directs the HPC to determine whether a material change may affect the competitive market or significantly impede the Commonwealth's ability to meet the health care cost growth benchmark, in which case HPC may conduct a Cost and Market Impact Review (CMIR).

M.G.L. Ch. 12C § 1, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", defines certain terms as understood within the context of Chapter 12C, which governs the operations and activities of CHIA, an independent agency tasked with collecting and analyzing health care data and publishing annual reports on health care costs, cost trends, market power, and quality data in support of the annual health care cost trends hearings conducted by the HPC.

M.G.L. Ch. 12C § 8, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", governs data reporting requirements for institutional providers and their parent organizations and any other affiliated entities including significant equity investors, health care real estate investment trusts and management services organizations, non-institutional providers and provider organizations.

M.G.L. Ch. 12C § 9, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", governs data reporting requirements for registered provider organizations.

M.G.L. Ch. 12C § 10 governs data reporting requirements for private and public health care payers and third party administrators of information necessary to analyze trends in health insurance costs and utilization.

M.G.L. Ch. 12C § 10A inserted by chapter 342 of the acts of 2024, "*An relative to pharmaceutical access, costs and transparency [S3012]*", governs data reporting requirements for pharmacy benefit managers.

M.G.L. Ch. 12C §11, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", directs CHIA ensure the timely reporting of data and of information required under sections 8, 9, 10 and 10A od chapter 12C.

M.G.L. Chapter 12C § 16, as amended by chapter 343 of the acts of 2024, "*An Act enhancing the market review process [H5159]*", requires CHIA to publish an annual report on health care cost trends based on data collected from health care providers, provider organizations, private and public health care payers, pharmaceutical manufacturing companies and pharmacy benefit managers under sections 8 through 10A of chapter 12C, market power reviews as required under section 13 of chapter 6D, and quality data collected under section 15 of chapter 12C.

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M.G.L. Ch. 12C § 18 CHIA to perform an ongoing analysis of payers, providers or provider organizations whose increase in health status-adjusted total medical expense is excessive, and who threaten the Commonwealth's ability to meet the health care cost growth benchmark. CHIA is directed to identify such health care entities and confidentially provide a list to the HPC such that the HPC may pursue further action under section 10 of chapter 6D, the performance improvement plan statute.

M.G.L. Ch. 111 § 25C requires a person or agency of the commonwealth or any political subdivision thereof, except as provided in section 25C ½, to seek and receive a determination of need (DON) certificate from the Department of Public Health (DPH) before making substantial capital expenditures to construct a health care facility or substantially change the service of the facility.

M.G.L. Ch. 111 §§ 51 through 56, inclusive, governs the licensing of hospitals and clinics by DPH.

Summary:

SECTION 1 of the proposed legislation amends section 8 of chapter 6D by inserting a new subsection, subsection (g), which expands the purpose of the HPC annual cost trends hearings to include a new annual retrospective review of material changes, as defined in section 13 of chapter 6D, in order to determine if such activities have resulted in anticipated benefits, "such as lower costs, better integration, or improved quality." As part of its review, the HPC is instructed to collect relevant written testimony and solicit additional public testimony from witnesses on the impact of material changes. The subsection suggests, but does not dictate, that the scope of witness testimony considers the impact of material changes relative price, total medical expense, insurance reimbursement rates, service quality and access, and other factors contributing to system efficiencies and market competition.

SECTION 2 of the proposed legislation amends subsection (a) of section 10 of chapter 6D to expand the applicability of the HPC Performance Improvement Plan (PIP) process by amending the definition of "health care entity" to include a new class of entity subject to the provisions of section 10, "health system", which is not further defined in the proposed legislation.

SECTION 3 of the proposed legislation amends subsection (d) of section 10 of chapter 6D to expand applicability of the HPC Performance Improvement Plan (PIP) process by adding the following two additional statistical thresholds that may trigger the requirement that a health care entity file a PIP with the HPC:

- a relative price that exceeds 1.3; and
- a total medical expense in excess of the statewide average physician group health status adjusted total medical expense.

SECTION 4 of the proposed legislation amends subsection (i) of section 10 of chapter 6D to expand the required scope and content of a health care entity's PIP proposal to include strategies, adjustments and actions steps to be implemented to "meet the goal of reducing the health care entity's relative price below 1.3 and closer to the statewide average relative price."

SECTION 5 of the proposed legislation strikes section 13 of chapter 6D in its entirety and inserts a new section 13, making changes in the following subsections:

- In subsection (a), by adding to the list of transactions that necessitate the filing of a 60-day advance material change notice to HPC, CHIA & AGO applications for a "new freestanding ambulatory surgery center license or a clinic license, or a new satellite facility under an existing license", and also by making the initiation of a CMIR by the HPC a mandatory, not discretionary, action for any material change that the commission finds "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."
- In subsection (b), by changing the classification of entities subject to a CMIR in any year total health care expenditures exceed the cost growth benchmark established under section 9 of chapter 6D from "provider

organization" to "health care entity", and also by making the initiation of a CMIR by the HPC a mandatory, not discretionary, action under this subsection for any health care entity 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, as identified by CHIA under section 18 of chapter 12C.

- In subsection (d), by adding to the list of factors relating to the provider or provider organization's business and relative market position that the HPC may examine during a CMIR, "(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."
- In subsection (e), as follows:
    - Granting the HPC up to 185 days to issue the preliminary CMIR review.
    - Requiring the HPC's, in its preliminary CMIR review, to identify for referral to the AGO under subsection (f) providers or provider organizations that meets just 1, not all 3, of the following criteria: (i) has, or likely will have as a result of the material change, a dominant market share for its services; (ii) charges, or likely will charge as a result of the material change, service prices that are materially higher than the median prices charged by all other providers for the same services in the same market; and (iii) has, or likely will have as a result of the material change, a health status-adjusted total medical expense that is materially higher than the median total medical expense for all other providers for the same service in the same market.
    - Granting the HPC new authority to "deny" a material change if the commission finds in its preliminary CMIR review that the transaction has or is likely to result in specified unfair or anticompetitive conditions; that the transaction will not produce "increased efficiencies, higher quality of care and lower costs for payers and patients"; or that the provider or provider organization produced "no persuasive evidence that the proposed lower costs, efficiencies, and improvements to quality can only be achieved" by permitting the material change.
    - Requiring the HPC to prohibit a material change in the "operations or governance structure" of a provider or provider organization that is subject to a PIP under section 10 of chapter 6D or that meets any 1 of the following criteria: health care cost growth exceeding the cost growth benchmark; a relative price that exceeds 1.3; a total medical expense in excess of the statewide average physician group health status adjusted total medical expense. The HPC may, at its discretion, approved limited exemptions to this provision.
- In subsection (f), by requiring the AGO to review any HPC approval of a material change and "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."
- In subsection (g), by making a technical change related to the new subsection (e) authority for the HPC to deny or prohibit a material change.

SECTION 6 of the proposed legislation inserts into Chapter 6D a new Section 13A, consisting of the following 3 subsections:

- Subsection (a) requires the HPC to issue an annual report based upon the testimony and information received as part of the retrospective review of material changes under the proposed subsection (g) of section 8 of chapter 6D, inserted by SECTION 1 of the Act.
- Subsection (b) states that, in the event the HPC determines that a material changed failed to produce stated benefits, the commission may take one of 3 actions:
    - (i) subject the provider or provider organization to "enhanced review", including but not limited to a new CMIR
    - (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 for one year following a reevaluation and approval by the HPC.

- Subsection (c) states that, if HPC determines that a material changed failed to produce stated benefits and that the provider or provider organization's authorizes the HPC to access a financial penalty against a provider or provider organization that has exceeded the health care cost growth benchmark, then the HPC shall notify CHIA, and the center shall calculate the amount of excess cost growth attributable to the provider or provider organization, and the provider or provider organization's Health Safety Net assessments or payments shall be increased or decreased, as appropriate, by that amount.

SECTION 7 of the proposed legislation amends section 16 of chapter 12C to add "hospitals" and "health systems" as new and distinct classifications of entities analyzed by CHIA in its annual report on health care cost trends.

SECTION 8 of the proposed legislation amends section 18 of chapter 12C to add "hospitals" and "health systems" as new and distinct classifications of entities subject to referral to the HPC for a potential PIP for health status-adjusted total medical expense is excessive, and who threaten the Commonwealth's ability to meet the health care cost growth benchmark.

SECTION 9 of the proposed bill strikes subsections (h) and (i) of section 25C of chapter 111 in their entirety and inserts new subsections (h) and (i) and changing the existing statute as follows:

- In subsection (h), by adding the HPC as a public agency authorized to request a public hearing on a Determination of Need for construction of health care facility or change in service of facility application pending before DPH.
- In subsection (i), by adding to the se of procedures DPH must follow prior to acting on a pending Determination of Need for construction of health care facility or change in service of facility application to include an HPC report on the proposed project's impact on health care costs and on the health care cost growth benchmark.

SECTION 10 of the proposed legislation strikes subsection (k) section 25C of chapter 111 in its entirety and inserts a new subsection (k) and changing the existing statute as follows:

- In subsection (k), by directing DPH to consider HPC recommendations regarding a project's impact on health care costs when reviewing a pending Determination of Need for construction of health care facility or change in service of facility application.

SECTION 11 of the proposed legislation inserts into Chapter 111 a new Section 51M, consisting of the following 13 subsections:

- Subsection (a) defines the terms "Facility" and "Facility of primary licensure" as understood in the proposed Section 51M.
- Subsection (b) requires health care entities to obtain a new license from DPH for any location operating as a "secondary facility", defined as a facility located at a distance greater than 500 yards or a facility that maintains separate heating, cooling, electric, or sewer systems from the primary licensed facility
- Subsection (c) requires secondary facilities to obtain a unique federal National Provider Identification number.
- Subsection (d) requires a secondary facility to negotiate contracts with payers as a separate entity from primary facilities and prohibits the utilization of the same negotiating team and sharing information between primary and secondary facilities.
- Subsection (e) bans contract provisions between a facility and a carrier that require a carrier to also contract with another facility.
- Subsection (f) bans contract provisions between a facility and a carrier that make any price or term contingent upon the carrier also contracting with another facility.
- Subsection (g) requires facilities to bill carriers for services using the facility's unique federal National Provider Identification number.

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- Subsection (h) states that carriers are not obligated to pay claims that are billed by a facility but are not in compliance with this proposed Section 51M.
- Subsection (i) establishes a default non-contracted rate of 110% of Medicare rates for services provided to a carrier's insureds at a secondary facility.
- Subsection (j) requires future secondary facilities requiring licensure under this proposed Section 51M to also obtain, as a condition of licensure, a Determination of Need approval form DPH under section 25C of Chapter 111. This subsection exempts any existing facility subject to the new secondary facility licensure requirement from the additional requirements to undergo a Determination of Need.
- Subsection (k) authorizes DPH, in consultation with DOI to promulgate regulations establishing exemptions to the new requirements of this proposed Section 51M to facilities which demonstrate satisfactory compliance with the following factors of integration:
    - receives over 50% of its revenue from alterative payment arrangements;
    - implemented one unifying, interoperable electronic medical record system across all facilities;
    - implemented initiatives that resulted in demonstrable improvements in the quality of care provided;
    - implemented programs to direct care to the appropriate and lowest cost facility; and
    - implemented appropriate measures to eliminate unnecessary duplication of services.
- Subsection (j) makes the provisions of this proposed Section 51M applicable to health care facilities at the time of renewal or expiration of their current contracts with payers.
- Subsection (k) grants both DPH and the AGO the authority to enforce the provisions of this proposed Section 51M.