HOUSE DOCKET, NO. 2466   FILED ON: 1/19/2023

HOUSE . . . . No. 1185

The Commonwealth of Massachusetts

PRESENTED BY:

Paul J. Donato

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 market oversight of the Commonwealth's Health Care System.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Paul J. Donato	*35th Middlesex*	*1/19/2023*

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HOUSE . . . . No. 1185

By Representative Donato of Medford, a petition (accompanied by bill, House, No. 1185) of Paul J. Donato relative to market oversight in health care. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *1259* OF 2021-2022.]

The Commonwealth of Massachusetts

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

An Act strengthening market oversight of the Commonwealth's Health Care System.

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 8 of Chapter 6D of the General Laws, as appearing in the 2022
2 Official Edition, is hereby amended by inserting after the last sentence in paragraph (b), the
3 following new language:-

4 Any provider or provider organization that has been identified by the center under section
5 18 of chapter 12C as exceeding the heath care cost growth benchmark for any given year or is
6 subject to a performance improvement plan pursuant to section 10, shall be prohibited by the
7 commission from making any material change to its operations or governance structure that
8 would otherwise require notice to the commission pursuant to section 13 of this chapter. The
9 commission may exclude a provider or provider organization from this prohibition if the market
10 share of the provider or provider organization is below a threshold as determined by the

11 commission, or if the provider or provider organization's total medical expenses or relative price
12 are below the statewide median. The prohibition shall continue until the center has determined
13 that the provider or provider organization has lowered its relative price and total medical
14 expenses to a level at or below the cost growth benchmark.

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

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

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

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

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

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

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

60 SECTION 3. Section 10 of Chapter 6D of the General Laws is hereby amended by
61 striking paragraph (a) in its entirety and replacing it with the following new language:-

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

67 SECTION 4. Said section 10 of Chapter 6D is hereby further amended by striking
68 paragraph (d) in its entirety and replacing it with the following new language:-

69 (d) In addition to the notice provided under subsection (b), the commission may require
70 any health care entity that is identified by the center under section 16 of chapter 12C as
71 exceeding the health care cost growth benchmark established under section 9, any provider
72 whose relative price exceeds 1.3, or any provider who has a total medical expense in excess of
73 the statewide average physician group health status adjusted total medical expense to file a
74 performance improvement plan with the commission. The commission shall provide written
75 notice to such health care entity or provider that they are required to file a performance

76 improvement plan. Within 45 days of receipt of such written notice, the health care entity shall
77 either:

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

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

81 SECTION 5. Said section 10 of Chapter 6D is hereby further amended by striking
82 paragraph (i) in its entirety and replacing it with the following new language:-

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

94 SECTION 6. Said Chapter 6D is hereby further amended by striking section 13 in its
95 entirety and replacing it with the following new language:-

96 Section 13. (a) Every provider or provider organization shall, before making any material
97 change to its operations or governance structure, submit notice to the commission, the center and
98 the attorney general of such change, not fewer than 60 days before the date of the proposed
99 change. Material changes shall include, but not be limited to: (i) the application for issuance of a
100 new freestanding ambulatory surgery center license or a clinic license, or a new satellite facility
101 under an existing license; (ii) a corporate merger, acquisition or affiliation of a provider or
102 provider organization and a carrier; (iii) mergers or acquisitions of hospitals or hospital systems;
103 (iv) acquisition of insolvent provider organizations; and (v) mergers or acquisitions of provider
104 organizations which will result in a provider organization having a near-majority of market share
105 in a given service or region.

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

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

118 (c) The commission shall initiate a cost and market impact review by sending the
119 provider or provider organization notice of a cost and market impact review which shall explain
120 the basis for the review and the factors that the commission seeks to examine through the review.
121 The provider organization shall submit to the commission, within 21 days of the commission's

122 notice, a written response to the notice, including, but not limited to, any information or
123 documents sought by the commission which are described in the commission's notice. The
124 commission may require that any provider, provider organization or payer submit documents and
125 information in connection with a notice of material change or a cost and market impact review
126 under this section. The commission shall keep confidential all nonpublic information and
127 documents obtained under this section and shall not disclose the information or documents to any
128 person without the consent of the provider or payer that produced the information or documents,
129 except in a preliminary report or final report under this section if the commission believes that
130 such disclosure should be made in the public interest after taking into account any privacy, trade
131 secret or anti-competitive considerations. The confidential information and documents shall not
132 be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of
133 chapter 4 or section 10 of chapter 66.

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

136 (i) the provider or provider organization's size and market share within its primary
137 service areas by major service category, and within its dispersed service areas; (ii) the provider
138 or provider organization's prices for services, including its relative price compared to other
139 providers for the same services in the same market; (iii) the provider or provider organization's

140 health status adjusted total medical expense, including its health status adjusted total medical
141 expense compared to similar providers; (iv) the quality of the services it provides, including
142 patient experience; (v) provider cost and cost trends in comparison to total health care
143 expenditures statewide; (vi) the availability and accessibility of services similar to those
144 provided, or proposed to be provided, through the provider or provider organization within its
145 primary service areas and dispersed service areas; (vii) the provider or provider organization's
146 impact on competing options for the delivery of health care services within its primary service
147 areas and dispersed service areas including, if applicable, the impact on existing service
148 providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to
149 enter a primary or dispersed service area in which it did not previously operate; (viii) the
150 methods used by the provider or provider organization to attract patient volume and to recruit or
151 acquire health care professionals or facilities; (ix) the methods used by the provider or provider
152 organization to direct patient care to the appropriate and lowest-cost setting within its system and
153 to eliminate unnecessary duplication of health care services within the system; (x) the role of the
154 provider or provider organization in serving at-risk, underserved and government payer patient
155 populations, including those with behavioral, substance use disorder and mental health
156 conditions, within its primary service areas and dispersed service areas; (xi) the role of the
157 provider or provider organization in providing low margin or negative margin services within its
158 primary service areas and dispersed service areas; (xii) consumer concerns, including but not
159 limited to, complaints or other allegations that the provider or provider organization has engaged
160 in any unfair method of competition or any unfair or deceptive act or practice; and (xiii) any
161 other factors that the commission determines to be in the public interest.

162 (e) The commission shall make factual findings and issue a preliminary report on the cost
163 and market impact review within 180 days. If the Commission finds in its review that the
164 provider

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

176 (f) Within 30 days after issuance of a preliminary report, the provider or provider
177 organization may respond in writing to the findings in the report. The commission shall then
178 issue its final report. If the commission approves the transaction the commission shall forward its
179 decision to the attorney general, who shall make an independent legal determination as to
180 whether the transaction satisfies the requirements of state and federal antitrust law and any and
181 all guidance issued by the U.S. Department of Justice and the Federal Trade Commission. Any
182 proposed material change shall not be completed until at least 30 days after the commission has
183 issued a final report.

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

192 (h) A provider organization aggrieved by said written decision may, within twenty days
193 of said decision, file a petition for review in the supreme judicial court for Suffolk County.
194 Review by the supreme judicial court on the merits shall be limited to the record of the
195 proceedings before the commissioner and shall be based upon the standards set forth in
196 paragraph (7) of section fourteen of chapter 30A.

197 (i) When the commission, under subsection (f), refers a report on a provider or provider
198 organization to the attorney general, the attorney general may: (i) conduct an investigation to
199 determine whether the provider or provider organization engaged in unfair methods of
200 competition or anti-competitive behavior in violation of chapter 93A or any other law; (ii) report
201 to the commission in writing the findings of the investigation and a conclusion as to whether the
202 provider or provider organization engaged in unfair methods of competition or anti-competitive
203 behavior in violation of chapter 93A or any other law; and (iii) if appropriate, take action under
204 chapter 93A or any other law to protect consumers in the health care market. The commission's
205 report may be evidence in any such action. A proposed material change shall not be completed

206 while such action is under attorney general review and prior to a final judgment being
207 issued by a court of competent jurisdiction.

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

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

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

219 SECTION 7. Section 16 of Chapter 12C of the General Laws is hereby amended by
220 striking the first sentence in paragraph (a) in its entirety and replacing it with the following new
221 language:-

222 (a) The center shall publish an annual report based on the information submitted under
223 sections 8, 9 and 10 concerning health care provider, provider organization, hospital, health
224 systems, and private and public health care payer costs and cost trends.

225 SECTION 8. Said Chapter 12C of the General Laws is hereby further amended by
226 striking Section 18 in its entirety and replacing it with the following new language:-

227 Section 18. The center shall perform ongoing analysis of data it receives under sections 6,
228 9 and 10 to identify any payers, providers or provider organizations hospitals, or health systems
229 whose increase in health status adjusted total medical expense is considered excessive and who
230 threaten the ability of the state to meet the health care cost growth benchmark established by the
231 health care finance and policy commission under section 10 of chapter 6D. The center shall
232 confidentially provide a list of the payers, providers and provider organizations, hospitals, or
233 health systems to the health policy commission such that the authority may pursue further action
234 under section 10 of chapter 6D.

235 SECTION 9. Section 25C of Chapter 111 is hereby amended by striking paragraphs (h)
236 and (i) in their entirety and replacing it with the following new language:

237 (h) Applications for such determination shall be filed with the department, together with
238 other forms and information as shall be prescribed by, or acceptable to, the department. A
239 duplicate copy of any application together with supporting documentation for such application,
240 shall be a public record and kept on file in the department. The department may require a public
241 hearing on any application at its discretion or at the request of the health policy commission or
242 the attorney general. The health policy commission and the attorney general may intervene in
243 any hearing under this section. A reasonable fee, established by the department, shall be paid
244 upon the filing of such application; provided, however, that in no event shall such fee exceed 0.2
245 per cent of the capital expenditures, if any, proposed by the applicant. The department may also
246 require the

247 applicant to provide an independent cost-analysis, conducted at the expense of the
248 applicant, to demonstrate that the application is consistent with the commonwealth's efforts to
249 meet the health care cost-containment goals established by the commission.

250 (i) Except in the case of an emergency situation determined by the department as
251 requiring immediate action to prevent further damage to the public health or to a health care
252 facility, the department shall not act upon an application for such determination unless: (1) the
253 application has been on file with the department for at least 30 days; (2) the center for health care
254 information and analysis, the health policy commission, the state and appropriate regional
255 comprehensive health planning agencies and, in the case of long-term care facilities only, the
256 department of elder affairs, or in the case of any facility providing inpatient services for the
257 mentally ill or developmentally disabled, the departments of mental health or developmental
258 services, respectively, have been provided copies of such application and supporting documents
259 and given reasonable opportunity to comment on such application; (3) the health policy
260 commission has provide a report on the impact of the application on health care costs and the
261 impact on the cost growth benchmark and (4) a public hearing has been held on such application
262 when requested by the applicant, the attorney general's office, health policy commission, the
263 state or appropriate regional comprehensive health planning agency or any 10 taxpayers of the
264 commonwealth. If, in any filing period, an individual application is filed which would implicitly
265 decide any other application filed during such period, the department shall not act only upon an
266 individual.

267 SECTION 11. Section 25C of Chapter 111 is hereby amended by striking paragraph (k)
268 in its entirety and replacing it with the following new language:

269 (k) Determinations of need shall be based on the written record compiled by the
270 department during its review of the application and on such criteria consistent with sections 25B
271 to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such
272 record the department shall confine its requests for information from the applicant to matters
273 which shall be within the normal capacity of the applicant to provide. In reviewing an
274 application, the department shall take into consideration the recommendations made by the
275 health policy commission regarding the impact of the proposed project on health care costs in the
276 commonwealth. In each case the action by the department on the application shall be in writing
277 and shall set forth the reasons for such action; and every such action and the reasons for such
278 action shall constitute a public record and be filed in the department.