# *House Bill 4643 - An Act enhancing the market review process*

**Oversight of Significant Equity Investors, Health Care Real Estate Investment Trusts & Management Services Organizations**

- Added to list of entities invited to testify at the HPC annual cost trends hearing
- Subject to HPC Cost & Market Impact Review [CMIR]for transactions involving:
    - Change of ownership or control of a provider, provider organization or a carrier
    - Significant transfers of assets including, but not limited to, real estate sale lease-back arrangements;
    - Conversion of a provider or provider organization from a non-profit entity to a for-profit entity;
    - Mergers or acquisitions of provider organizations which will result in a provider organization having a dominant market share in a given service or region.
- Added to the ownership, governance and organizational information HPC collects from Registered Provider Organization [RPO]
- Subject to CHIA reporting authority, including hospital and RPO parent entities, including their out-of-state operations, and corporate affiliates, including significant equity investors, health care real estate investment trusts and management services organizations.
    - annually reporting from RPOs to CHIA to include information regarding other assets and liabilities that may affect the financial condition of the provider organization or the provider organization's facilities, including, but not limited to, real estate sale-leaseback arrangements with health care real estate investment trusts
    - hospitals to file with CHIA the audited financial statements of the out-of-state operations of parent companies and comply with reporting information used to monitor financial conditions of acute hospitals
- Prohibits DPH from issuing a license to establish or maintain an acute care hospital if the applicant leases the land on which their main camps is located, defined as the licensed premises within which the majority of its inpatient beds are located, from a health care real estate investment trust.
    - Acute care hospitals that, as of April 1, 2024, lease the land on which their main camps is located from a health care real estate investment trust are exempt from this provision for the purposes of both renewal or licensure and a transfer of ownership.
- Prohibits DPH from issuing a license to establish or maintain an acute care hospital unless the applicant discloses, as part of its application, all documents related to any lease, mast lease, sublease, license or any other agreement for the use, occupancy or utilization of the premises to be occupied by the acute care hospital.
- Increased penalties for failure to timely report required data from $1,000 to $25,000 per violation, strikes the cap on financial penalties.
    - Requires CHIA to notify HPC and DPH of failure to report to be considered during a by the HPC in the CMIR process, and by DPH when considering a determination of need application or when reviewing licensure and suitability.
- Expanded AGO's civil investigative demand authority for information reported to CHIA and the HPC include information submitted by significant equity investors, health care real estate investment trusts and management services organizations
    - Extends liability for False Claim Act (FCA) violations to anyone with (i) an "ownership or investment interest" in a person who violates the FCA, (ii) knows of the FCA violation, and (iii) fails to report the violation within 60 days of identifying the FCA violation.
    - Expands the AGO's civil investigative demand authority for health care transactions to include significant equity investors, health care real estate investment trusts and management services organizations.
    - Clarifies that the AGO may investigate any provider organization referred by the HPC for a CMIR, and may bring any appropriate action, including for injunctive relief, as necessary under Chapter 93A or any other law to restrain unfair methods of competition or unfair and deceptive trade practices.

**Patient Protections to Prevent Harms Caused by Repossession of Critical Medical Equipment**

- Requires secured creditors to notify DPH 60 days prior to repossession medical devices from debtor hospitals
- Bans contract terms between vendors and hospitals, free standing ambulatory surgical centers, limited service clinics, office-based surgical centers, and urgent care centers, that allow for repossession of medical or surgical equipment without 60-day prior notice to DPH and makes such terms void as against public policy of the commonwealth.
- Expands the list of health care facilities required to report health care associated infections, serious reportable events, and serious adverse drug events to include limited service clinics, office-based surgical centers, and urgent care centers.
- Requires hospitals, free standing ambulatory surgical centers, limited service clinics, office-based surgical centers, and urgent care center to notify DPH within 1 calendar day of receiving notice from a lessor of medical or surgical equipment of financial delinquency that threatens the continued use of the leased equipment.

**Updated Determination of Need Process at DPH**

- Expands the list of factors DPH shall consider in its review of an application for a Determination of Need certificate to include the following new factors:

    - in addition to comments, any relevant data from CHIA
    - in addition to comments, relevant data from the HPC, including any final CMIR report related to a provider or provider organization that files a DON application,
    - the Commonwealth's cost containment goals
    - the impact on the applicant's patients
    - the impact on the workforce of surrounding health care providers
    - the impact on other residents of the Commonwealth
- In the event DPH requires an applicant to provide an independent cost analyses (ICAs) to demonstrate that a proposed DON project is consistent with the Commonwealth's efforts to meet health care cost containment goals established by the HPC, the bill directs DPH to choose the entity conducting the ICA from a list of 3 entities submitted by the applicant.
- Expands the list of conditions that DPH must meet prior to taking final action on a DON application to include, in the case of applications for the construction of a freestanding ambulatory surgical center in the primary service area of an independent community hospital, holding a public hearing at the request of "party of record".
    - As with the existing list of conditions, this new condition may be waived in the case of an emergency situation determined by DPH as requiring immediate action to prevent further damage to the public health or to a health care facility.
- Expands the list of activities that trigger a stay or delay in the 4-month deadline for DPH to issue its decision on the approval or disapproval, in whole or in part, of a DON application to include:
- In the event DPH requires an applicant to provide an independent cost analyses (ICAs) to demonstrate that a proposed DON project is consistent with the Commonwealth's efforts to meet health care cost containment goals established by the HPC, the period of review is stayed pending the completion and submission to the department of the final ICA
- In the event that a DON applicant in subject to a CMIR conducted by the HPC, DPH shall not issue any final decision on a pending application for 30 days following the receipt of the issuance of the final CMIR report by the HPC
- In the event that a DON applicant in subject to a Performance Improvement Plan [PIP] conducted by the HPC, any decision by DPH to approve, in whole or in part, a DON application shall be stayed and shall not go into effect until 30 days following a determination by the HPC that the applicant in question is implementing or has implemented the required PIP.

**Enhanced Review for Closure of Hospitals, Discontinuance of Essential Services**,

- Authorizes HPC to conduct and submit to DPH an essential service closure impact assessment to analyze the impact of the proposed essential service closure on health care access, cost, quality or market function.
    - HPC may require the hospital to submit information concerning the essential service closure, including, but not limited to, the organizational structure, input costs, pricing, utilization, and revenue.
    - The service closure impact assessment shall evaluate factors that impact the hospital's ability to maintain the essential health service and shall include, but shall not be limited to, an analysis of the following: (i) the hospital's overall financial position and the financial position of the service line, including quality of earnings assessment; (ii) significant factors influencing the hospital's financial position, including those within and outside of the hospital's control; (iii) other operating conditions, including but not limited to staffing, supplies and patient demand; and (iv) the impact of the service closure on the functioning of the health care system, particularly on vulnerable populations and on the state health plan developed by the Health Planning Council.
    - The essential service closure impact assessment may include recommendations on an appropriate hospital plan for ensuring access following the essential service closure or recommendations to DPH concerning strategies to address challenges in maintaining such services.

**Registration of Physician Practices & Require Notice for Sale, Relocation or Closure of Clinics**

- Requires the Board of Registration in Medicine to register all wholly owned and controlled physician group practices of 10 or more physicians
- Practices that meet the requirements for registration shall file an application with BORM that shall include the following information:
    - (i) the identity of the applicant and of the physicians which constitute the practice;
    - (ii) the identity of any substantial equity investor of the practice;
    - (iii) any management services organization under contract with the practice;
    - (iv) a certified copy of the physician practice's certificate of organization, if any, as filed with the secretary of the commonwealth, or any applicable partnership agreement
- A provider organization registered pursuant to section 11 of chapter 6D is exempt from registration under this section.
- Requires licensed clinics and registered physician practices to notify DPH not less than 180 days prior to any sale, relocation, or closure.
    - Authorizes DPH to conduct a public hearing on the proposed clinic or registered physician practice sale, relocation, or closure to consider the potential impacts of the proposed transaction, including, but not limited to:
        - (i) the potential loss or change in access to services for the population served by the clinic in the 24 months immediately preceding the notice to sell, relocate or close;

    - (ii) alternative providers and locations where the population served by the clinic will be able to obtain the health services that were provided by the clinic during the 24 months following the sale, relocation, or closure;
    - (iii) options available to the department to mitigate the impact of the sale, relocation, or closure on health equity
- Requires licensed clinics and registered physician practice that intends to sell, relocate or close to notify their patients in writing not less than 90 days prior to the date of such sale, relocation or closure.
    - Notice under this section shall include offering patients resources to assist them in locating a substitute health care provider and include the information on the entity assuming responsibility for maintaining the patient's medical records.
- Requires licensed physicians to provide 90 days advance notice to their patients when they intend to terminate the physician-patient relationship or otherwise intend to sell, relocate or close a medical practice.
    - Notice under this section may be satisfied by the notification requirement for clinics and registered physicians practices.

**License Office-Based Surgical Centers & License Urgent Care Centers**

- Directs DPH to establish regulations & practice standards for licensing office-based surgical centers and may, at its discretion, determine which regulations applicable to an ambulatory surgical center shall apply; 2 year renewal cycle
- Directs DPH to establish regulations & practice standards for licensing urgent care centers

**Improving Financial Security of Independent Community Hospitals & Rate Equity Target**

- The new section 9A directs the HPC to establish a rate equity target for the equitable reimbursement by payers to independent community hospitals with an average statewide relative price across all carries during a 5-year period of less than 0.85.
    - For Benchmark Cycle 2026 to 2029, carriers must ensure in-network payment rates to such hospitals that are no less than 15% of their average in-network acute hospital relative price
    - For Benchmark Cycle 2029 to 2032, the average annual reimbursement rate increase from a carrier to such hospitals shall be not less than 2% above the applicable health care cost growth benchmark
    - For Benchmark Cycle 2032 to 2035, the average annual reimbursement rate increase from a carrier to such hospitals shall be not less than 1% above the applicable health care cost growth benchmark
    - For Benchmark Cycle 2035 to 2038, and in each benchmark cycle beyond, the average annual reimbursement rate increase from a carrier to such hospitals shall be not less than the applicable health care cost growth benchmark

**Realignment of the Health Policy Commission Governing Board**

- Amends composition of the Health Policy Commission. Total seats reduced from 11 to 9, as follows:
    - Secretary of EOHHS;
    - Commissioner of Health Insurance;
    - 5 members appointed by the Governor
        - A chairperson with expertise in health care administration, finance, and management at a senior level
        - 1 member with expertise in health systems or ambulatory care settings
        - 1 member with expertise in health plan administration, benefits management, or health insurance brokerage
        - 1 member from a list of nominees submitted by the president of the senate, with expertise in representing the health care workforce as a leader in a labor organization
        - 1 member from a list of nominees submitted by the speaker of the house of representatives, with expertise in health care innovation, including pharmaceuticals, biotechnology, or medical devices
    - 2 members appointed by the Attorney General
        - 1 health economist
    - 1 member with expertise in health care consumer advocacy or population health
- Appointed members shall receive a stipend in an amount not greater than 10% of the salary of the secretary of A&F, except the chairperson shall receive a stipend in an amount not greater than 12% of the salary of the secretary

**New Technical Advisory Committee for the Health Policy Commission**

- Establishes a Technical Advisory Committee within HPC, to be chaired by the HPC Executive Director as a non-voting member and comprised of the following 15 members:
    - Asst. Secretary for MassHealth;
    - Executive Director of the Connector;
    - Executive Director of the Group Insurance Commission;
    - 7 members selected by the HPC Executive Director, 1 from each list of nominees provided by the following organizations:
        - Massachusetts Hospital Association;
        - Massachusetts Senior Care Association;
        - Massachusetts Medical Society;
        - Massachusetts League of Community Health Centers;
        - Massachusetts Biotechnology Council;

        - Massachusetts Association of Health Plans; and
        - Blue Cross Blue Shield of Massachusetts
    - 5 members named by the HPC Executive Director from applications submitted by candidates with demonstrated experience in health care delivery, health care economics, health care data analysis, clinical research and innovation in health care delivery, or health care benefits management.
- Appointed members shall have demonstrated experience in a broad range of provider sectors and public and private health care payers.
- Appointed members shall be special state employees subject to chapter 268A and serve without compensation for a term of 3 years and for no more than 2 consecutive terms
- The Technical Advisory Committee is charged with:
    - (i) establishing adjustment factors as part of the redesigned health care cost growth benchmark;
    - (ii) provide technical advice to HPC upon request;
    - (iii) provide HPC with operational, policy, regulatory or legislative recommendations; and
    - (iv) produce an annual report and other reports as requested by HPC.

**Redesigned Health Care Cost Growth Benchmark; Modification**

- The redesigned health care cost growth benchmark shall measure the average annual growth in total health care expenditures in the commonwealth during a period of 3 consecutive calendar years, referred to as a benchmark cycle.
- For each 3 year benchmark cycle, the base benchmark shall be set at PGSP plus the adjustment factor approved by HPC upon the recommendation of the technical advisory committee
    - Adjustment shall be limited to a range of 1% above to 1 % below PGSP, and shall be based on economic and market factors specific to the health care industry including, but not limited to, the following factors:
        - (i) medical CPI 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 in the Commonwealth's GSP, and
        - (v) any other factors as determined by the Technical Advisory Committee.
- Any recommended adjustment shall be approved by a majority vote of the Technical Advisory Committee, followed by a majority vote of the HPC.
    - If the Technical Advisory Committee fails to approve an adjustment recommendation, the adjustment factor shall default to zero.
- Technical Advisory Committee, adjustment recommendations shall be submitted to the HPC in a public report and shall include an analysis supporting such recommendation.

**Health Care Cost Growth Benchmark & Health Care Cost Trend Examinations**

- The HPC shall hold a public hearing prior to accepting or rejecting an adjustment recommendation of the Technical Advisory Committee.
- Adds the following to the list of stakeholders required to testify at the HPC's annual cost trends hearing:
    - Significant equity investors, health care real estate investment trusts, or management services organizations associated with a provider or provider organization;
    - A representative from the division of health insurance;
    - Executive director of the commonwealth health insurance connector authority
    - Assistant secretary for MassHealth
- Directs HPC to request testimony from officials representing CMS
- HPC may identify additional witnesses for the cost trends hearing if the statewide percentage change in total health care expenditures in the previous calendar year exceeds the average annual growth established for the applicable health care cost growth benchmark cycle
- Amends the directive that the HPC produce an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system as follows:
- Changes annual reports to annual cost growth progress reports when produced within applicable health care cost growth benchmark cycle
- Requires HPC to produce a final benchmark cycle report after the 3rd year of the applicable benchmark cycle analyzing spending trends for the entire 3-year benchmark cycle
- Expands the scope of spending trends examined to include primary care spending
- Expands the Registered Provider Organization reporting threshold to include revenue generated from all payers, not just commercial payer revenue.

**Updated HPC Performance Improvement Plan**

- Expands the applicability of the HPC Performance Improvement Plan (PIP) process by including any entity identified by CHIA excessive health hare expenditure growth as follows:
    - Defines "health care entity" to include a clinic, hospital, ambulatory surgical center, physician organization, carrier or an accountable care organization required to register as an RPO under section 11 of chapter 6D
    - Directs CHIA to identify and report to the HPC health care entities whose:
        - 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, or
        - data is not submitted to CHIA in a proper, timely, or complete manner
    - Directs CHIA to identify cohorts of 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
- CHIA shall identify and report to the HPC health care entities whose 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, or who fail to submit required data to CHIA in a proper, timely or complete manner
- Amends CHIA's health care cost trends statute to incorporate a new final benchmark cycle report to compare costs and cost trends for the entire benchmark cycle with the applicable 3-year benchmark established by HPC.
- HPC shall examine not just a health care entity's cost growth, but also its health care spending performance, and may require a health care entity to undergo a PIP if the HPC finds, based on the CHIA's final benchmark cycle report that a health care entity's percentage change in total health care expenditures during the benchmark period exceeded the health care cost growth benchmark
- Clarifies that carriers may be subject to a PIP if they both exceed the cost growth benchmark and fail to meet the rate equity target established in section 9A.
- Amends certain factors that the HPC may consider in reviewing a waiver or delay of a PIP to capture baseline and trends in cost price, utilization as well as payer mix over time, both of the health care entity, and as compared to similar entities
- In keeping with the 3-year benchmark cycle, the PIP period is extended from the current 18 months to 3 years.
- The names of providers or payers under a PIP will remain public even after the completion of the PIP.
- Adds additional options for HPC to respond to an unsuccessful PIP, including requiring the entity to include specific action steps in an updated plan or conducting a CMIR of the entity.
- Increases penalties for failure to cooperate with HPC during the PIP process, including escalating civil penalties starting at $500,000 and ending at $1,000,000 for a third or subsequent violation, as well as barring the entity from seeking a DoN.

**Updated HPC & CHIA Operations Assessment**

- Expands categories of entities subject to the CHIA's operating assessment to "non-hospital provider organization", defined to include to a provider organization required to register under section 11 that is a (i) non-hospital-based physician practice with not less than $500,000,000 in annual gross patient service revenue, (ii) clinical laboratory, (iii) imaging facility, or (iv) network of affiliated urgent care centers
- Requires the assessment on non-hospital provider organization to be no less than 5% of the total assessment levied against hospitals, ambulatory surgical centers, and non-hospital provider organizations under this section.

**Establishing Division of Health Insurance**

- Establishes the following responsibilities of the Commissioner of Health Insurance: (i) protect the interests of consumers of health insurance; (ii) encourage fair treatment of health care providers by health insurers; (iii) enhance equity, access, quality and affordability in the health care system; (iv) guard the solvency of health insurers; (v) work cooperatively with the health policy commission and the center for health information and analysis to monitor health care spending; and (v) prioritize affordability of health insurance products during rate review.
    - Defines "Rate review", as any examination performed by the commissioner of health insurance of the aggregate rates of payment proposed in contracts submitted for review
- Directs the Commissioner of Health Insurance to develop affordability standards to consider when conducting rate reviews, and in accordance with solvency and actuarial soundness that is also required under existing applicable statues.
    - Affordability standards developed by the Commissioner shall consider the following:
        - (i) affordability for consumers, including the totality of costs paid by consumers of health insurance for covered benefits including, but not limited to, the enrollee's share of premium, out-of-pocket maximum amounts, deductibles, copays, coinsurance, and other forms of cost sharing for health insurance coverage;
        - (ii) affordability for purchasers, including the totality of costs paid by purchasers of health insurance, including, but not limited to, premium costs, actuarial value of coverage for covered benefits and the value delivered on health care spending in terms of improved quality and cost efficiency;
        - (iii) the impact of the proposed rates on the commonwealth's performance against the health care cost growth benchmark established by the HPC

    - In the examination of rates of payments submitted by state regulated health insurance plans for approval to determine whether a contract is not excessive, requires the Division of Health Insurance to consider affordability to consumers and affordability to purchasers of health insurance products.
- Requires the Commissioner of Health Insurance to review data and documents submitted to the division, including but not limited to, any materials submitted as part of rate reviews, to examine the cause of premium rate increases and excessive provider price variation.
- Establishes the following positions within the Division of Health Insurance: a first deputy, a general counsel, a chief health economist, a chief actuary, a chief research analyst, and a chief examiner. Authorizes the Commissioner of Health Insurance to employee additional staff.
- Establishes an assessment against the health insurance carriers to pay for the expenses of the division. The assessment shall be at a rate sufficient to produce $2,000,000 annually.

**HPC  Health Planning Council & State Health Plan**

- Transfers responsibility for the Health Planning Council from EOHHS to HPC; Health Planning Council charged with developing a State Health Plan include anticipated need for health care services, providers, programs and facilities; resources available to meet those needs and priorities for addressing those needs
- The Health Planning Council shall consist of the following 11 members:
    - 8 government officers or designees: Ex. Dir. of HPC [Chair]; Sec. of EOHHS; Comm. of DPH, Asst. Sec. for MassHealth; comm. of DMH; Comm. of DOHI; Sec, of Elder Affairs; Ex. Dir. of CHIA
    - 3 members appointed by the Gov.: 1 health economist; 1 health policy and planning expert; 1 experienced in health care market planning and service line analysis