AN ACT ENHANCING THE HEALTH CARE MARKET REVIEW PROCESS

SECTION 1. Section 16 of chapter 6A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 24 to 26, inclusive, the words ", the division of medical assistance and the Betsy Lehman center for patient safety and medical error reduction" and inserting in place thereof the following words:- and the division of medical assistance.

SECTION 2. Section 16D of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 22 to 24, inclusive, the words "department of public health established by section 217 of chapter 111" and inserting in place thereof the following words:- health policy commission established by section 16 of chapter 6D.

SECTION 3. Section 16N of said chapter 6A is hereby repealed.

SECTION 4. Section 16T of said chapter 6A is hereby repealed.

SECTION 5. Section 1 of chapter 6D of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Alternative payment methodologies or methods" the following definition:-

"Benchmark cycle", a period of 2 consecutive calendar years during which the projected annualized growth rate in total health care expenditures in the commonwealth is calculated pursuant to section 9 and monitored pursuant to section 10.

SECTION 6. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Fee-for-service" the following definition:-

"Financial interest", when a private equity firm or its corporate affiliate has a direct or indirect ownership share of, or controlling interest in, or is a holder of significant debt from a provider or provider organization or the provider or provider organization's corporate affiliates.

SECTION 7. Said section 1 of said chapter 6D, as so appearing, 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 annualized growth rate in total health care expenditures in the commonwealth during a benchmark cycle, as established in section 9.

SECTION 8. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Health care provider” the following definition:-

“Health care resource”, any resource, whether personal or institutional in nature and whether owned or operated by any person, the commonwealth or political subdivision thereof, the principal purpose of which is to provide, or facilitate the provision of, services for the prevention, detection, diagnosis or treatment of those physical and mental conditions experienced by humans which usually are the result of, or result in, disease, injury, deformity or pain; provided, that the term “treatment” shall include custodial and rehabilitative care incident to infirmity, developmental disability or old age.

SECTION 9. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Health care services” the following 2 definitions:-

“Health disparities”, preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

“Health equity”, the state in which a health system offers the infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities to provide every resident of the commonwealth with the opportunity and reasonable expectation to achieve optimal health and equal access to health care regardless of race,

ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among such communities or identities or socially determined circumstances.

SECTION 10. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Hospital service corporation" the following 2 definitions:-

"Management services organization", a corporation that provides management or administrative services to a provider or provider organization for compensation.

"Maximum adjusted debt to adjusted EBITDA ratio", the highest ratio of total adjusted debt to adjusted earnings before interest, taxes, depreciation and amortization the commission determines that a provider or provider organization is permitted to have without becoming financially unstable; provided, however, that the commission, in consultation with the center, shall establish a standard method of calculating and reporting total adjusted debt and adjusted earnings before interest, taxes, depreciation and amortization; and provided further, that the methodology and reporting shall include capitalized lease obligations.

SECTION 11. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 189, the words "not include excludes ERISA plans" and inserting in place thereof the following words:- include self-insured plans to the extent allowed under the federal Employee Retirement Income Security Act of 1974.

SECTION 12. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Performance penalty" the following 2 definitions:-

"Pharmaceutical manufacturing company", an entity engaged in the: (i) production, preparation, propagation, compounding, conversion or processing of prescription drugs, directly or indirectly, by extraction from substances of natural origin, independently by means of

chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that pharmaceutical manufacturing company shall not include a wholesale drug distributor licensed under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said chapter 112.

"Pharmacy benefit manager", a person, business or other entity, however organized, that directly or through a subsidiary provides pharmacy benefit management services for prescription drugs and devices on behalf of a health benefit plan sponsor including, but not limited to, a self-insurance plan, labor union or other third-party payer; provided, however, that pharmacy benefit management services shall include, but not be limited to: (i) the processing and payment of claims for prescription drugs; (ii) the performance of drug utilization review; (iii) the processing of drug prior authorization requests; (iv) pharmacy contracting; (v) the adjudication of appeals or grievances related to prescription drug coverage contracts; (vi) formulary administration; (vii) drug benefit design; (viii) mail and specialty drug pharmacy services; (ix) cost containment; (x) clinical, safety and adherence programs for pharmacy services; and (xi) management of the cost of covered prescription drugs; provided further, that pharmacy benefit manager shall include a health benefit plan sponsor that does not contract with a pharmacy benefit manager and manages its own prescription drug benefits unless specifically exempted by the commission.

SECTION 13. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Primary care provider" the following definition:-

"Private equity firm", a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and purchases, as a parent company or through another entity that it completely or partially owns or controls, a direct or indirect ownership share

of, or controlling interest in, or otherwise obtains a financial interest in, a provider, provider organization or management services organization; provided, however, that private equity firm shall not include venture capital firms exclusively funding startups or other early-stage business.

SECTION 14. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by striking out the definition of "Provider organization" and inserting the following 2 definitions:-

"Provider organization", a corporation, partnership, business trust, association or organized group of persons that is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers, third party administrators or public payers for the payments of health care services; provided, however, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, management services organizations, independent practice associations, provider networks, accountable care organizations, providers that are owned or controlled, fully or partially, by for-profit entities including, but not limited to, private equity firms, and any other organization that contracts with carriers, third party administrators or public payers for payment for health care services; and provided further, that "provider organization" shall not include any integrated care network that is owned and directed by long-term care.

SECTION 15. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Quality measure" the following definition:-

"Real estate investment trust", a real estate investment trust as defined in 26 U.S.C. 856.

SECTION 16. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Total health care expenditures" the following 2 definitions:-

"Total medical expenses", the total cost of care for the patient population associated with a provider organization based on allowed claims for all categories of medical expenses and all non-claims related payments to providers.

"Unsafe financial actor", a private equity firm, private equity firm affiliate or real estate investment trust that has a financial interest in a provider or provider organization closing, declaring bankruptcy, or otherwise discontinuing its operations, within 15 years of the private equity firm or real estate investment trust's financial interest in the provider or provider organization.

SECTION 17. Section 2 of said chapter 6D, as so appearing, is hereby amended by striking out subsections (b) and (c) and inserting in place thereof the following 2 subsections:-

(b)(1) There shall be a board, with duties and powers established by this chapter, which shall govern the commission. The board shall consist of the following members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; 7 members to be appointed by the governor pursuant to paragraph (2), 1 of whom shall serve as chair; and 4 members to be appointed by the attorney general. Each appointment after the initial term of appointment shall serve a term of 5 years; provided, however, that a person appointed to fill a vacancy shall serve for not more than the unexpired term. An appointed member of the board shall be eligible for reappointment; provided, however, that no appointed member shall concurrently hold full or part-time employment in the executive branch. The board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board shall be a resident

of the commonwealth. A member of the board serving ex officio may appoint a designee under section 6A of chapter 30; provided further, however, that designee members shall not serve as chair or vice-chair.

(2) The person appointed by the governor to serve as chair shall have demonstrated expertise in health care administration, finance and management at a senior level. The second person appointed by the governor shall be a registered nurse with expertise in the delivery of care and development and utilization of innovative treatments in the practice of patient care. The third person appointed by the governor shall have demonstrated expertise in health plan administration and finance. The fourth person appointed by the governor shall have demonstrated expertise in representing the health care workforce as a leader in a labor organization. The fifth person appointed by the governor shall have demonstrated expertise in development and pricing for pharmaceuticals, biotechnology or medical devices. The sixth person appointed by the governor shall be a primary care physician. The seventh person appointed by the governor shall have demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration. The first person appointed by the attorney general shall have demonstrated expertise in hospitals or hospital health systems administration, finance or management. The second person appointed by the attorney general shall have demonstrated expertise in health care consumer advocacy. The third person appointed by the attorney general shall have expertise in behavioral health, substance use disorder, mental health services and mental health reimbursement systems. The fourth person appointed by the attorney general shall be a health economist.

(c) Seven members of the board shall constitute a quorum, and the affirmative vote of 6 members of the board shall be necessary and sufficient for any action taken by the board. No

vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the commission. The appointed members of the board shall receive a stipend in an amount not more than 10 per cent of the salary of the secretary of administration and finance under section 4 of chapter 7; provided, however, that the chairperson shall receive a stipend in an amount not more than 12 per cent of the salary of the secretary; and provided further, that ex officio members and their designees shall not receive a stipend for their service as board members. Appointed members of the board shall be special state employees subject to chapter 268A. An appointed member of the board shall not be employed by, a consultant to, a member of the board of directors of or otherwise be a representative of a health care entity, pharmaceutical manufacturer or pharmacy benefit manager while serving on the board.

SECTION 18. Said chapter 6D is hereby further amended by inserting after section 3 the following section:-

Section 3A. (a) There shall be within the commission an office for pharmaceutical policy and analysis. The office shall: (i) issue reports including, but not limited to, an annual report pursuant to subsection (b) and analyses of: (A) pharmaceutical spending in the commonwealth; the affordability of and access to pharmaceutical drugs; (B) the potential innovation of high value drugs and orphan drugs; and (C) the impacts of these issues on racially and ethnically diverse populations and individuals with disabilities; (ii) analyze pharmaceutical data collected by agencies of the commonwealth including, but not limited to, pharmaceutical data collected by the center pursuant to sections 8 to 10, inclusive, of chapter 12C and pharmaceutical data available through public and proprietary sources; provided, however, that the commission may solicit additional data and information directly from manufacturers, pharmacy benefit managers and payers to the extent necessary to perform the duties set forth in this section, including, but

not limited to, conducting an annual survey of payers on pharmaceutical access and plan design; provided, however, that confidential data shall not be a public record and shall be exempt from disclosure pursuant to clause Twenty-sixth of section 7 of chapter 4 and section 10 of chapter 66; (iii) assess the value and pricing of pharmaceutical drugs used in the commonwealth including, but not limited to, reviewing disclosures submitted pursuant to section 8A; and (iv) advise other state agencies and entities including, but not limited to, the executive office of health and human services, the office of Medicaid, the division of insurance, the group insurance commission, the commonwealth health insurance connector authority, the department of corrections, the Massachusetts Life Sciences Center and the joint committee on health care financing on actions, including any proposed legislation, that may improve the value and pricing of pharmaceutical drugs in the commonwealth.

(b) The commission shall compile an annual report concerning trends and underlying factors for pharmaceutical drug spending including, but not limited to, analysis of: (i) prices and utilization; (ii) drugs or categories of drugs with the highest impact on spending; (iii) trends in patient out-of-pocket spending; and (iv) any recommendations for strategies to reduce pharmaceutical spending growth, promote affordability and enhance pharmaceutical access. The report shall be based on: (A) the commission’s analysis of information provided at the annual health care cost trends hearings by providers, provider organizations and insurers; (B) data collected by the center for health information and analysis under sections 8 to10, inclusive, of chapter 12C; and (C) any other information the commission considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the commission. Annually, not later than December 31, the commission shall submit the report 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 publish and make the report available to the public.

SECTION 19. Said chapter 6D is hereby further amended by striking out section 4, as appearing in the 2022 Official Edition, and inserting in place thereof the following section:-

Section 4. There shall be an advisory council to the commission. The council shall advise on the overall operation and policy of the commission. The commission shall convene the council quarterly or more frequently as requested by the commission. Members of the board of the health policy commission shall convene and consult with advisory council members on issues brought before the commission and shall present the views of advisory council members in board meetings. The council shall be appointed by the executive director and reflect a broad distribution of diverse perspectives on the health care system, including, but not limited to, health care professionals, educational institutions, consumer representatives, purchasers of health insurance representing business management or health benefits administration, medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers, providers, provider organizations, hospitals, community health centers, labor organizations and public and private payers.

SECTION 20. Section 5 of said chapter 6D, as so appearing, is hereby amended by inserting after the word “growth”, in line 3, the following words:- and affordability.

SECTION 21. Said section 5 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 10, the words “and (vii)” and inserting in place thereof the following words:- ; (vii) monitor pharmaceutical spending and pricing and patient access to pharmaceuticals; and (viii).

SECTION 22. The first paragraph of section 6 of said chapter 6D, as so appearing, is hereby amended by adding the following sentence:-

Each pharmaceutical manufacturing company and pharmacy benefit manager shall pay to the commonwealth an amount for the estimated expenses of the center and for the other purposes described in this chapter.

SECTION 23. Said section 6 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 5 and 36, the figure “33”, each time it appears, and inserting in place thereof, in each instance, the following figure:- 25.

SECTION 24. Said section 6 of said chapter 6D, as so appearing, is hereby further amended by adding the following 3 paragraphs:-

To the maximum extent permissible under federal law, provided that such assessment will not result in any reduction of federal financial participation in Medicaid, the assessed amount for pharmaceutical manufacturing companies shall be not less than 25 per cent of the amount appropriated by the general court for the expenses of the commission less amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission's publication or dissemination of reports and information; and (iii) federal matching revenues received for said expenses or received retroactively for expenses of predecessor agencies. Pharmaceutical manufacturing companies shall pay such assessed amount multiplied by the ratio of the pharmaceutical manufacturing company’s gross sales of outpatient prescription drugs dispensed in the commonwealth or similar measure determined by the commission consistent with applicable federal requirements.

To fund the operations of the commonwealth’s licensure of pharmacy benefit managers and to the maximum extent permissible under federal law; provided, however, that such

assessment will not result in any reduction of federal financial participation in Medicaid, the assessed amount for pharmacy benefit managers shall be not less than 25 per cent of the amount appropriated by the general court for the expenses of the commission less amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission's publication or dissemination of reports and information; and (iii) federal matching revenues received for said expenses or received retroactively for expenses of predecessor agencies. Pharmacy benefit managers shall pay such assessed amount multiplied by the ratio of the pharmacy benefit manager's gross revenue related to outpatient prescription drugs dispensed in the commonwealth or similar measure determined by the commission consistent with applicable federal requirements. In no event shall this assessment, when combined with an assessment of pharmacy benefit managers pursuant to section 7 of chapter 12C and a pharmacy benefit manager licensing fee pursuant to section 2 of chapter 176Y, exceed the commonwealth's estimated expense in operating the pharmacy benefit manager licensure program.

Each pharmaceutical manufacturing company and each pharmacy benefit manager shall make a preliminary payment to the commission annually on October 1 in an amount equal to 1/2 of the initial year's total assessment and, for subsequent years, in an amount equal to 1/2 of the previous year's total assessment. Thereafter, each pharmaceutical manufacturing company and each pharmacy benefit manager shall pay, within 30 days of receiving notice from the commission, the balance of the total assessment for the current year as determined by the commission.

SECTION 25. Section 7 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 35, the words "and (vi)" and inserting in place thereof the following words:- (vi) advance health equity; and (vii).

SECTION 26. Said chapter 6D is hereby further amended by striking out section 8, as so appearing, and inserting in place thereof the following section:-

Section 8. (a) Not later than October 1 of every year, the commission shall hold public hearings based on the report submitted by the center pursuant to section 16 of chapter 12C comparing: (i) the average of the annual growth in total health care expenditures during each year of the most recently concluded benchmark cycle to the health care cost growth benchmark for that benchmark cycle; and (ii) the growth in the affordability index pursuant to said section 16 of said chapter 12C to the affordability benchmark. At said hearings, the commission shall examine 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 private equity firms, real estate investment trusts and management services organizations on such 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 behavioral health expenditures.

(b) The attorney general may intervene in such hearings.

(c) Public notice of any hearing shall be provided not less than 60 days in advance.

(d) The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers, private equity firms, real estate investment trusts, management services organizations, pharmaceutical manufacturing companies, pharmacy benefit managers and others, including: (i) not less than 3 academic medical centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii) not less than 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of gross patient service revenue is attributable to Title XVIII and XIX of the Social Security Act or other

governmental payers; (iii) community hospitals from not less than l 3 separate regions of the commonwealth; (iv) freestanding ambulatory surgical centers from not less than 3 separate regions of the commonwealth; (v) community health centers from at not less than 3 separate regions of the commonwealth; (vi) the 5 commercial carriers with the highest enrollments in the commonwealth; (vii) any managed care organization that provides health benefits under Title XIX of the Social Security Act ; (viii) the group insurance commission; (ix) not less than 3 municipalities that have adopted chapter 32B; (x) not less than 4 provider organizations which shall be from diverse geographic regions of the commonwealth, not less than 2 of which shall be certified as accountable care organizations and 1 of which shall be certified as a model ACO; (xi) at least 1 private equity firms, real estate investment trust or management services organization associated with a provider or provider organization; (xii) the assistant secretary for MassHealth; (xiii) not less than 3 representatives of pharmaceutical manufacturing companies doing business in the commonwealth or trade groups thereof; (xiv) 1 pharmacy benefit manager or trade groups thereof; and (xv) any witness identified by the attorney general or the center.

(e) Witnesses shall provide testimony under oath and subject to examination and cross examination by the commission, the executive director of the center and the attorney general at the public hearing in a manner and form to be determined by the commission, including, but not limited to: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system,

efforts to reduce the inappropriate or duplicative use of technology and the impact of price transparency on prices; (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, efforts by the payer to reduce the use of fee-for-service payment mechanisms, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to promote the standardization of administrative practices, the impact of price transparency on prices and any other matters as determined by the commission; (iii) in the case of the assistant secretary for MassHealth, testimony concerning the structure, benefits, eligibility, caseload and financing of MassHealth and other Medicaid programs administered by the office of Medicaid or in partnership with other state and federal agencies and the agency’s activities to align or redesign said programs in order to encourage the development of more integrated and efficient health care delivery systems; (iv) in the case of private equity firms, real estate investment trusts or management services organization, testimony concerning changes to patient access to health care services or facilities, health outcomes, prices charged to insurers and patients, staffing levels, clinical workflow, financial stability and ownership structure as the result of an acquisition of a provider or provider organization, the amount of debt and equity leveraged in an acquisition of a provider or provider organization, additional debt taken on by a provider or provider organization after an acquisition, dividends paid out to investors, changes to real estate ownership and any leaseback agreements and management of clinical assets and any other matters as determined by the commission; and (v) in the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony concerning

factors underlying prescription drug costs and price changes including, but not limited to, the initial prices of drugs coming to market and subsequent price changes, changes in industry profit levels, marketing expenses, reverse payment patent settlements, impacts of manufacturer rebates, discounts and other price concessions on net pricing, availability of alternative drugs or treatments, corporate ownership organizational structure and any other matters as determined by the commission. The commission shall solicit testimony from a payer which has been identified by the center's annual report under subsection (a) of section 16 of chapter 12C as: (A) paying providers more than 10 per cent above or more than 10 per cent below the average relative price; or (B) entering into alternative payment contracts that vary by more than 10 per cent. A payer identified by the center's report shall explain the extent of price variation between the payer's participating providers and describe any efforts to reduce such price variation.

(f) If the center's annual report pursuant to subsection (a) of section 16 of chapter 12C finds that the average of the annual percentage changes in total health care expenditures during a benchmark cycle exceeded the health care cost growth benchmark for that benchmark cycle or the percentage change in the affordability index exceeded the affordability benchmark, the commission may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the commission, the executive director of the center and attorney general at the public hearing in a manner and form to be determined by the commission, including, but not limited to: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures and affordability, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures,

including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the cost of providing certain specialty services, including, but not limited to, the provision of health care to children, cancer-related health care and medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; (vii) testimony related to premiums by market segment and community, plan and benefit design and cost sharing, including deductibles and co-pays; and (viii) any other factors that may have led to excessive health care cost growth.

(g) The commission shall annually compile a report for the most recently concluded benchmark cycle concerning spending trends, including primary care and behavioral health expenditures, affordability and the underlying factors influencing said spending trends. The report shall be based on the commission's analysis of information provided at the hearings by witnesses, providers, provider organizations, payers, private equity firms, real estate investment trusts, management services organizations, pharmaceutical manufacturing companies and pharmacy benefit managers, 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 further defined in regulations promulgated by the commission. To the extent practicable, the report shall not contain any data that is likely to compromise the financial, competitive or proprietary nature of the information. The report 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 made available to the public annually, not later than December 31, of each year. The report shall include recommendations for strategies to increase the efficiency of the health care system and promote affordability for individuals and families and analysis of specific spending trends that may impede the commonwealth's ability to meet the health care cost growth benchmark, together with any drafts of legislation language necessary to implement said recommendations.

SECTION 27. Said chapter 6D is hereby further amended by striking out sections 9 and 10, as so appearing, and inserting in place thereof the following 3 sections:-

Section 9. (a) Not later than April 15 of every year, the board shall establish the health care cost growth benchmark for a benchmark cycle consisting of the 2 calendar years beginning after the year in which the April 15 date occurs.

(b) The health care cost growth benchmark shall be equal to the average of the growth rate of potential gross state product established under section 7H½ of chapter 29 for each of the 2 calendar years that comprise the benchmark cycle. The commission shall establish procedures to prominently publish the health care cost growth benchmark on the commission's website.

(c) For all benchmark cycles through the cycle containing the calendar years 2039 and 2040, if the commission determines that an adjustment in the health care cost growth benchmark is reasonably warranted, having first considered any testimony at a public hearing as required under subsection (d), the board of the commission may recommend a modification of the health care cost growth benchmark, in any amount as determined by the commission. The board shall submit notice of its recommendation for any modification to the joint committee on health care financing. Within 30 days of such filing, the joint committee may hold a public hearing on the board's proposed modification to the health care cost growth benchmark. Within 30 days of the

public hearing, the joint committee may report its findings and proposed legislation, including its recommendation on whether to affirm or reject the boards' recommendation, to the general court and provide a copy of its findings and proposed legislation to the board.

(d) Prior to making any recommended modification to the health care cost growth benchmark under subsection (c), the board shall hold a public hearing on any such recommended modification. The public hearing shall be based on the report submitted by the center pursuant to section 16 of chapter 12C comparing the average of the annual growth in total health care expenditures during each year of the most recently concluded benchmark cycle to the health care cost growth benchmark, any other data provided by the center and such other pertinent information or data as may be available to the board. The hearing shall examine the costs, prices and cost trends of health care provider, provider organization and private and public health care payer and any relevant impact of private equity firms, real estate investment trusts, management services organizations, pharmaceutical manufacturing companies and pharmacy benefit managers on such 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, a modification in the health care cost growth benchmark is appropriate. The commission shall provide public notice of such hearing not less than 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, private equity firms, real estate investment trusts, management services organizations, pharmaceutical manufacturing companies, pharmacy

benefit managers and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing.

(e) Any recommendation of the commission to modify the health care cost growth benchmark under subsection (c) of this section shall be approved by a two-thirds vote of the board.

Section 9A. Not later than April 15 of every year, the board shall establish a health care affordability benchmark for the following calendar year. The commission shall establish procedures to prominently publish the annual affordability benchmark on the commission's website.

Section 10. (a) For the purpose of this section, “Health care entity” shall mean any health care entity identified by the center pursuant to section 18 of chapter 12C.

(b) The commission shall provide notice to a health care entity that the commission may analyze the health care spending performance of such health care entity and that such health care entity shall perform certain actions as provided in subsection (c); provided, however, that at the discretion of the commission, the commission may publicly identify the identities and performance results of such health care entity.

(c) The commission may require a performance improvement plan to be filed with the commission for a health care entity that is identified by the center under section 18 of chapter 12C.

(d) In addition to the notice provided under subsection (b), the commission shall provide written notice to a health care entity that 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 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 spending, price and utilization trends of the health care entity over time, independently and as compared to similar entities, and any demonstrated improvement to reduce spending or total medical expenses;

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

(3) whether the factors that led to increased spending 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: (A) within 45 days of receipt of a notice under subsection (d); (B) 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 (C) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall identify the causes of the entity's excessive spending, and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve spending performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

(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 excessive spending 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 of not more than 30 calendar days, for resubmission.

(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. 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 assist the health care entity with the successful implementation of the performance improvement plan.

(l) Health care entities subject to a performance improvement plan shall, in good faith, work to implement such plan and 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 under subsection (c), including requiring specific elements for approval; or (iv) waive or delay the requirement to file any additional performance improvement plans.

(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 a recommendation for proposed legislation 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)(1) 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 or falsified information required by this section to the commission, the commission may: (A) 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; provided, however, that a civil penalty assessed pursuant to one of the above clauses shall be a first offense if a previously assessed penalty was assessed pursuant to a different clause; (B) stay consideration of any material change notice submitted under section 13 of this chapter by the health care entity or any affiliates until the commission determines that the health care entity is in compliance with this section; and (C) 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. A civil penalty assessed under this subsection shall be deposited into the Healthcare Payment Reform Fund established under section 100 of chapter 194 of the acts of 2011. Except as otherwise expressly authorized under this section, the commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(2) In lieu of requiring a performance improvement plan pursuant to this section, the commission may assess a civil penalty on a health care entity identified by the center pursuant to section 18 of chapter 12C if the commission determines that a performance improvement plan is not an appropriate remedial measure. The civil penalty may amount to not more than the amount of spending attributable to the health care entity that is in excess of the health care cost growth benchmark and shall be deposited into the Healthcare Payment Reform Fund established under section 100 of chapter 194 of the acts of 2011. Prior to assessing the civil penalty, the commission shall provide the health care entity with written notice of its intent to assess the penalty; provided, however, that the commission shall provide the health care entity not less than 10 days to respond to said written notice with a written request for a hearing; provided further, that, if the health care entity requests a hearing, the commission shall hold the hearing within 30 days of the commission's receipt of the request; and provided further, that if the health care entity does not request a hearing, the commission shall provide the health care entity with not less than 30 days to respond in writing to said written notice.

(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 state administration and regulatory oversight and the joint committee on health care financing not less than180 days before adoption.

SECTION 28. Section 11 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 3, the words "2 years" and inserting in place thereof the following words:- 1 year.

SECTION 29. Said section 11 of said chapter 6D, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) The commission shall require that all provider organizations report information detailed in section 9 of chapter 12C. The commission may specify additional data elements in a given reporting year to support the development of the state health plan or the focused assessments defined in section 22 of chapter 6D.

SECTION 30. Said section 11 of said chapter 6D, as so appearing, is hereby further amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) The commission may enter into interagency agreements with the center and other state agencies to effectuate the goals of this section.

SECTION 31. Said chapter 6D is hereby further amended by striking out sections 12 and 13, as so appearing, and inserting in place thereof the following 2 sections:-

Section 12. (a) The commission shall ensure the timely reporting of information required under section 11. The commission shall notify provider organizations of any applicable reporting deadlines; provided, that the commission shall notify, in writing, a provider organization that has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice may result in penalties. The commission may assess a penalty against a provider organization that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this subsection of up to $10,000 per week for each week of delay after the 2-week period following provider organization's receipt of the written notice; provided, however, that the maximum annual penalty against a provider organization under this section shall be $500,000 per registration cycle. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund established under section 100 of chapter 194 of the Acts of 2011.

(b) Notwithstanding any general or special law to the contrary, any material change notice submitted under section 13 and any determination of need application submitted under sections 25B to 25G, inclusive, of chapter 111 by a provider organization that has failed to provide required information pursuant to section 11 and section 9 of chapter 12C shall be incomplete until such time as the provider organization has provided such required information.

(c) Nothing in this chapter shall require a provider organization which represents providers who collectively receive, less than $25,000,000 in annual net patient service revenue to be registered if such provider or provider organization is not a risk-bearing provider organization or is not owned or controlled, whether fully or partially, directly or indirectly, by a private equity firm.

Section 13. (a)(1) Every provider or provider organization shall, before making any material change to its operations or governance structure, submit notice to the commission, the center and the attorney general of such change not less than 60 days before the date of the proposed change, provided, however, that material changes shall include, but not be limited to: (i) significant expansions in a provider or provider organization's capacity; (ii) a corporate merger, acquisition or affiliation of a provider or provider organization and a carrier; (iii) mergers or acquisitions of hospitals or hospital systems; (iv) acquisition of insolvent provider organizations; (v) significant new for-profit investment in, acquisitions of the assets of or ownership or direct or indirect control of a provider or provider organization by for-profit entities, including, but not limited to, private equity firms and management services organizations; (vi) substantial acquisition or sale of assets for an ownership share or for the purposes of a lease-back arrangement; (vii) conversion of a provider or provider organization from a non-profit entity to a for-profit entity; and (viii) mergers or acquisitions of provider

organizations which will result in a provider organization having a dominant market share in a given service or region.

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

(2) If the commission determines that a proposed material change is likely to have a significant negative impact on health care consumers in the commonwealth, including through significantly increased costs, significantly reduced quality, or significantly impaired access to health care services, including for at-risk, underserved and government payer patient populations, the commission may recommend modifications to the proposed material change to mitigate such impacts. Notwithstanding any general or special law to the contrary, failure to modify the proposed material change to substantially address such impacts identified by the commission shall constitute an unfair business practice under chapter 93A subject to challenge pursuant to section 4 of said chapter 93A but not pursuant to sections 9 or 11 of said chapter 93A. The commission shall notify the office of the attorney general of any provider or provider organization's failure to modify the proposed material change to substantially address such impacts.

(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 benchmark cycle report under section 16 of

chapter 12C, that the average of the annual percentage changes in total health care expenditures during each year of the benchmark cycle exceeded the health care cost growth benchmark for that benchmark cycle, the commission may conduct a cost and market impact review of any provider organization identified by the center under section 18 of said chapter 12C.

(c)(1) The commission shall initiate a cost and market impact review by sending the provider or provider organization notice of a cost and market impact review, which shall explain the basis for the review and the particular factors that the commission seeks to examine through the review. The provider or provider organization shall submit to the commission, within 21 days of the commission's notice, a written response to the notice, including, but not limited to, any information or documents sought by the commission that are described in the commission's notice. The commission may require that any provider, provider organization, payer, investor or other party associated with a given transaction submit documents and information in connection with a notice of material change or a cost and market impact review under this section. The commission may also require, for a period of 5 years following the completion of a material change, that any provider or provider organization submit data and information to assess the post-transaction impacts of a material change and compliance with any commitments or conditions agreed to by the parties. The commission shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the provider or payer that produced the information or documents, except in a preliminary report or final report under this section if the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential

information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

(2) For any material change involving significant new for-profit investment in, acquisitions of the assets of or ownership or direct or indirect control of a provider or provider organization by a for-profit entity, the for-profit entity, and the parent company or person or persons controlling the for-profit entity, if any, will be required to submit, at a minimum, the following information to complete the notice: (i) information regarding the capital structure, general financial condition, ownership and management of the for-profit entity and any person controlling the for-profit entity; (ii) the identity and relationship of every member of the for-profit entity; (iii) fully audited financial information for the preceding 5 fiscal years or for such lesser period as the for-profit entity and any predecessors thereof shall have been in existence; (iv) any plans or proposals to liquidate such provider or provider organization, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management; (v) fully audited financial information of all health care entities acquired by the for-profit entity, the parent company and person or persons controlling the for-profit entity, for the preceding 5 fiscal years or for such lesser period as the for-profit entity and any predecessors thereof shall have been in existence as well as other financial information the commission deems relevant, including, but not limited to, bankruptcy filings, sales of non-clinical assets and dividend recapitalizations; (vi) operational information regarding health care entities acquired by the acquiring party or person or persons controlling the acquiring party for the preceding 10 fiscal years or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, including, but not limited to, reduction or closure of health care services; and (vii) such additional information as the commission may

deem necessary or appropriate for the protection of essential health services or to evaluate the material change notice.

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

provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (xi) consumer concerns, including, but not limited to, complaints or other allegations that the provider or provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; (xii) the cumulative impact of mergers, acquisitions, affiliations or joint ventures on the health care market over a reasonable period of time, as defined by the commission; (xiii) alignment with the state health plan and any focused assessments conducted pursuant to section 22; and (xiv) any other factors that the commission determines to be in the public interest.

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

(f) Within 30 days after issuance of a preliminary report, the provider or provider organization may respond in writing to the findings in the report. The commission shall then issue its final report. The commission shall refer to the attorney general its report on any provider or provider organization that meets all 3 criteria under subsection (e). The commission shall issue its final report on the cost and market impact review within 185 days from the date that the

provider or provider organization has submitted a completed notice to the commission under the commission's regulations; provided, however, that the provider or provider organization has certified substantial compliance with the commission's requests for data and information pursuant to subsection (c) within 21 days of the commission's notice or by a later date set by mutual agreement of the provider or provider organization and the commission.

(g) Nothing in this section shall prohibit a proposed material change under subsection (a); provided, however, that any proposed material change shall not be completed: (i) until not later than 30 days after the commission has issued its final report; or (ii) if the attorney general brings an action as described in paragraph (2) of subsection (a) or subsection (h), while such action is pending and prior to a final judgment being issued by a court of competent jurisdiction, whichever is later.

(h) A provider or provider organization that meets the criteria in subsection (e) has engaged, or through a material change will engage, in an unfair method of competition or unfair and deceptive trade practice subject to challenge pursuant to section 4 of chapter 93A, but not sections 9 or 11 of said chapter 93A. The attorney general may take action under said chapter 93A or any other law to protect consumers in the health care market, including by bringing an action seeking to restrain such violation of said chapter 93A. The commission's final report may be evidence in any such action brought by the attorney general.

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

(j) The commission shall adopt regulations for conducting cost and market impact reviews and for administering this section. These regulations shall include definitions of material change and non-material change, primary service areas, dispersed service areas, dominant market

share, materially higher prices, materially higher health status adjusted total medical expenses and any other terms as necessary to provide market participants with appropriate notice. These regulations may identify filing thresholds in connection with this section; provided, however, that the commission shall determine that multiple mergers, acquisitions or affiliations over time may together meet such thresholds. All regulations promulgated by the commission shall comply with chapter 30A.

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

(l) Upon issuance of its final report pursuant to subsection (f), the commission shall provide a copy of said final report to the department of public health. The final report shall be included in the written record and considered by the department of public health during its review of an application for determination of need under section 25C of chapter 111 and considered where relevant in connection with licensure or other regulatory actions involving the provider or provider organization.

SECTION 32. Said chapter 6D is hereby further amended by adding the following 2 sections:-

Section 22. (a)(1) Not less than once every 5 years, the commission shall develop a state health plan in consultation with the executive office of health and human services, the department of public health, the office of Medicaid, the department of mental health, the division of insurance, the executive office of elder affairs, the center for health information and analysis and other state agencies as appropriate.

(2) The state health plan shall identify: (i) the current and anticipated needs of the commonwealth for health care services, providers, programs and facilities; (ii) the existing health care resources available to meet those needs; (iii) recommendations for the appropriate supply and distribution of resources, workforce, programs, capacities, technologies and services on a statewide and regional basis; (iv) major barriers preventing communities and residents from accessing needed health care; (v) priorities for addressing those barriers; and (vi) recommendations for any further legislative or other state action to assist the commonwealth in achieving the recommendations identified in the plan.

(3) The state health plan shall be based on data from all available sources, including data collected by the commission, the center for health information and analysis, the executive office of health and human services, the department of public health, the office of Medicaid, the department of mental health, the division of insurance, the executive office of elder affairs, the board of registration in medicine, the bureau of health professions licensure, the office of the attorney general and other state agencies as appropriate. All such agencies shall provide data and information necessary for the commission to create the plan.

(4) The state health plan shall include recommendations across a range of health care services, including, but not limited to: (i) acute care; (ii) non-acute care; (iii) specialty care, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post-operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; (iv) skilled nursing facilities; (v) assisted living facilities; (vi) long-term care facilities; (vii) ambulatory surgical centers; (viii) office-based surgical centers; (ix) urgent care centers; (x) home health; (xi) adult and pediatric behavioral health and mental health services and supports; (xii) substance use disorder treatment and recovery services; (xiii) emergency care;

(xiv) ambulatory care services; (xv) primary care resources; (xvi) pediatric care services; (xvii) pharmacy and pharmacological services; (xviii) family planning services; (xix) obstetrics and gynecology and maternal health services; (xx) allied health services, including, but not limited to, optometric care, chiropractic services, oral health care and midwifery services; (xxi) federally qualified health centers and free clinics; (xxii) technologies or equipment defined as innovative services or new technologies by the department of public health pursuant to section 25B of chapter 111; (xxiii) hospice and palliative care service; (xxiv) health screening and early intervention services; and (xxv) any other service or resource identified by the commission.

(5) The goal of the state health plan shall be to promote the appropriate and equitable distribution of health care resources across geographic regions of the commonwealth based on the needs of the population on a statewide basis and the needs of particular geographic and demographic groups. The state health plan shall seek to support the commonwealth's goals of: (i) maintaining and improving the quality of and access to health care services; (ii) ensuring a stable and adequate health care workforce; (iii) meeting the health care cost growth benchmark established pursuant to section 9; (iv) supporting innovative health care delivery and alternative payment models as identified by the commission; (v) reducing unnecessary duplication of health care resources; (vi) advancing health equity and addressing disparities in the health care system based on the needs of particular demographic factors, including, but not limited to, race, ethnicity, immigration status, sexual orientation, gender identity, geographic location, age, language spoken, ability and socioeconomic status; (vii) integrating oral health, mental health, behavioral and substance use disorder treatment services with overall medical care; (viii) aligning housing, health care and home care to improve overall health outcomes and reduce costs; (ix) tracking trends in utilization and promoting the best standards of care; and (x)

ensuring equitable access to health care resources across geographic regions of the commonwealth.

(6) The commission shall consult with the advisory council established pursuant to section 4 in the development of the state health plan.

(7) In developing the state health plan, the commission, in consultation with the department of public health, shall conduct at least 1 public hearing seeking input on the state health plan and shall give interested persons an opportunity to submit their views orally and in writing. In addition, the commission may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(8) The commission may require the submission of data and documents from providers, provider organizations and payers to support creation of the state health plan; provided, that the information is not already required to be reported to another state agency and accessible to the commission. Nonpublic clinical, financial, strategic or operational documents or information provided to the commission in connection with this section shall be subject to section 2A.

(b)(1) In addition to the state health plan, the commission shall conduct regular, focused assessments of provider supply and distribution in relation to projected need in at least 1 specific service line. Each assessment shall be conducted in consultation with other state agencies as appropriate, including, but not limited to, the executive office of health and human services, the department of public health, the department of mental health, the office of Medicaid, the division of insurance, the center for health information and analysis, the executive office of elder affairs, the board of registration in medicine, the bureau of health professions licensure and the office of the attorney general. All such agencies shall provide data and information necessary for the commission to conduct the assessment. The commission shall consider available state and

national data and academic research on health service supply and need and relevant community health needs assessments by non-profit hospitals and other organizations and other individual and community statements of need.

(2) Each focused assessment shall examine at least 1 specific service line and at least 1 relevant region and may examine other factors in the public interest, such as populations served, as appropriate. The service lines and regions shall be identified and prioritized for assessment by the commission in consultation with the above-referenced agencies, as consistent with available resources. In prioritizing service lines and regions, the commission may consider factors including, but not limited to: (i) services with limited alternatives or substitutions; (ii) services where supply has been shown to be misaligned with need nationally or in academic research; (iii) services or regions undergoing significant changes in ownership, supply, or distribution; (iv) services or regions with evidence of access challenges or barriers, particularly for vulnerable populations; (v) input from the advisory council established pursuant to section 4; and (vi) requests for analysis from the executive office of health and human services or other agencies; provided, that prioritized service lines under this paragraph shall include primary care and behavioral health.

(3) Each assessment may include findings that include, but are not limited to: (i) the extent to which supply of a given service line aligns with projected need at the statewide or regional level; (ii) health system factors driving any documented health disparities; (iii) services or providers, including in a specific geographic area, that are critical to the proper functioning of the health care system; (iv) estimates of where and how many additional units of service would be needed in the state or in a specific geographic area to meet projected need; (v) identification of barriers impacting accessibility of available supply by specific populations; and (vi) policy

recommendations to address the drivers of disparities, access barriers and areas of misalignment of need and supply.

(4) The commission shall consult with the advisory council established pursuant to section 4 in the development of such focused assessments.

(5) The commission, in consultation with the department of public health, shall conduct at least 1 public hearing seeking input on each focused assessment and shall give interested persons an opportunity to submit testimony orally and in writing.

(6) The commission may require the submission of data and documents from payers, providers or provider organizations that offer a service that is the subject of an assessment conducted under this section; provided, that the information is not already reported to another state agency and made accessible to the commission. Nonpublic clinical, financial, strategic or operational documents or information provided to the commission in connection with this section shall be subject to section 2A.

(c) The commission shall publish analyses, reports and interpretations of information collected pursuant to this section to promote awareness of the distribution and nature of health care resources in the commonwealth.

(d) Biennially, not later than January 1, the commission shall file a report with the joint committee on health care financing , which shall include, but not be limited to: (i) a summary of the current state health plan and a description of focused assessments conducted during the past 2 years; (ii) a summary of actions taken by the commission and progress made toward developing the state health plan and focused assessments during the past 2 years; and (iii) recommendations for further legislative action to assist the commission in its implementation of this section.

Section 23. (a) A provider or a provider organization in which a private equity firm has a financial interest shall not: (i) meet or exceed the maximum adjusted debt to adjusted EBITDA ratio; (ii) otherwise become highly leveraged, as determined by the commission; (iii) transact with an unsafe financial actor; (iv) for the period during which the private equity firm has a financial interest in the provider or provider organization, (A) provide capital distributions, including, but not limited, to cash dividends, stock dividends that are not strictly dilutive or any other similar distributions, (B) perform stock buybacks, stock redemptions or similar transactions or (C) pay to a private equity firm management fees or similar fees or costs; or (v) perform any other action or exceed any other metric the commission determines may cause a provider or provider organization to become financially distressed.

(b) Within 30 days of the commission receiving a referral from the center pursuant to paragraph (4) of subsection (e) of section 9 of chapter 12C or the commission becoming aware of a potential violation of subsection (a) pursuant to the filing of a completed notice of material change under section 13, the commission shall make a determination of whether there has been a violation. If the commission determines a violation has occurred, the commission shall require the provider to come into compliance with said subsection (a) and may set conditions that the provider or provider organization shall follow to come into compliance. The commission shall notify the provider or provider organization in writing of its determination, conditions, if any, and reasoning. The provider or provider organization shall have not less than 30 days to respond in writing and 10 days to request a hearing from the date of notification. If a hearing is requested, the hearing shall be held within 30 days of the commission’s receipt of the request. Within 10 days of receiving written comments or holding any requested hearing, whichever is later, the commission shall notify the provider or provider organization in writing that the provider or

provider organization is required to come into compliance with section (a) and which conditions, if any, shall go into effect. Upon providing notice, such requirements and conditions, if any, shall go into effect.

In making the determinations pursuant to subsection (a), the commission may consider all publicly available data and documents, including information submitted to the commission and the center under any authority. The commission may also solicit additional non-public information from providers to the extent necessary to achieve the purposes of this section. The commission shall keep confidential all nonpublic information and documents obtained under this section, and such information shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

(c)(1) Within 3 months, or a shorter reasonable time as determined by the commission, the commission shall determine whether the provider or provider organization has substantially complied with its conditions or if no conditions were set, whether the provider or provider organization has come into compliance with subsection (a). The commission shall notify the provider or provider organization of its determination and reasoning, and the provider or provider organization shall have not less than 30 days to respond in writing and 10 days to request a hearing from the date of notification. If a hearing is requested, the hearing shall be held within 30 days of the commission's receipt of the request. Within 10 days of receiving written comments and holding any requested hearing, whichever is later, the commission shall make a final determination and notify the provider or provider organization of the determination in writing.

(2) If the commission makes a final determination that the provider or provider organization has failed to substantially implement the commission's conditions, or, if no

conditions were set, to come in compliance with subsection (a), the department of public health may collect the bond deposited. The commission shall notify the department of public health of its determination and refer the provider or provider organization to the attorney general.

(3) Failure to substantially implement the commission's conditions, or, if no conditions are set, failure to come in compliance with subsection (a) shall constitute a violation of said chapter 93A. Only the attorney general, or an organization representing workers who: (i) worked for the provider or provider organization; (ii) worked in the provider or provider organization's facilities, if any; or (iii) contracted with the provider or provider organization, may bring an action under chapter 93A for such a violation. The commission's final determination may be used as prima facie evidence of a violation of said chapter 93A.

(d) A private equity firm shall deposit, upon submission of a notice of material change pursuant to section 13 of chapter 6D, a bond with the department of public health ensuring that the provisions of subsection (a) shall not be violated; provided, however, that the private equity firm shall not use any of the provider or provider organization's assets or property as security for the bond, pay for the bond by placing debt on the provider or provider organization or otherwise permit the provider or provider organization to pay the bond on the private equity firm's behalf or allow the provider or provider organization to be liable for the bond.

SECTION 33. Section 5A of chapter 12 of the General Laws, as so appearing, is hereby amended by striking out, in line 26, the words "or 'knowingly'" and inserting in place thereof the following words:- , "knowingly" or "knows".

SECTION 34. Said section 5A of said chapter 12, as so appearing, is hereby further amended by inserting after the definition of "Overpayment" the following definition:-

"Ownership or investment interest", any: (1) direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of an entity; (2) interest held by an investor or group of investors who engages in the raising or returning of capital and who invests, develops or disposes of specified assets; (3) interest held by a pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds; or (4) interest held by a real estate investment trust.

SECTION 35. Section 5B of said chapter 12, as so appearing, is hereby amended by striking out, in line 29, the word "or", the second time it appears.

SECTION 36. Said section 5B of said chapter 12, as so appearing, is hereby further amended by inserting after the word "applicable", in lines 38 and 39, the following words:- ; or (11) has an ownership or investment interest in any person who violates clauses (1) to (10), inclusive, knows about the violation, and fails to disclose the violation to the commonwealth or a political subdivision thereof within 60 days of identifying the violation.

SECTION 37. Section 11N of said chapter 12, as so appearing, is hereby amended by striking out, in line 7, the words "or provider organization" and inserting in place thereof the following words:- , provider organization, private equity firm, real estate investment trust, management services organization, pharmaceutical manufacturing company and pharmacy benefit manager.

SECTION 38. Said section 11N of said chapter 12, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) The attorney general may investigate any provider organization referred to the attorney general by the health policy commission under chapter 6D to determine whether the provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law, and, if appropriate, take action under said chapter 93A or any other law to protect consumers in the health care market, including, but not limited to, an action for injunctive relief.

SECTION 39. Section 1 of chapter 12C of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Ambulatory surgical center services" the following definition:-

"Benchmark cycle", a period of 2 consecutive calendar years during which the projected annualized growth rate 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 40. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Fee-for-service" the following definition:-

"Financial interest", when a private equity firm or its corporate affiliate has a direct or indirect ownership share of, or controlling interest in, or is a holder of significant debt from a provider or provider organization or the provider or provider organization's corporate affiliates

SECTION 41. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by striking out the definition of "Health care cost growth benchmark" and inserting in place thereof the following 2 definitions:-

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

"Health care entity", as defined in section 1 of chapter 6D.

SECTION 42. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Health care services" the following 2 definitions:-

"Health disparities", preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

"Health equity", the state in which a health system offers the infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities that will provide all people with the opportunity and reasonable expectation that they can reach their full health potential and well-being and are not disadvantaged in access to health care by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or their socially determined circumstances.

SECTION 43. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Major service category" the following 2 definitions:-

"Management services organization", a business that provides management or administrative services to a provider or provider organization for compensation. "Maximum adjusted debt to adjusted EBITDA ratio", the highest ratio of total adjusted debt to adjusted earnings before interest, taxes, depreciation and amortization the commission determines that a provider or provider organization can have without becoming financially unstable; provided further, that the commission, in consultation with the center, shall establish a standard method of calculating and reporting total adjusted debt and adjusted earnings before interest, taxes, depreciation and

amortization; and provided further, that the methodology and reporting shall include capitalized lease obligations.

SECTION 44. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Patient-centered medical home" the following 3 definitions:-

"Payer", any entity, other than an individual, that pays providers for the provision of health care services; provided, that "payer" shall include both governmental and private entities; provided further, that "payer" shall include self-insured plans to the extent allowed under the federal Employee Retirement Income Security Act of 1974.

"Pharmaceutical manufacturing company", an entity engaged in the: (i) production, preparation, propagation, compounding, conversion or processing of prescription drugs, directly or indirectly, by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis; or (ii) packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that "pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said chapter 112.

"Pharmacy benefit manager", a person, business or other entity, however organized, that, directly or through a subsidiary, provides pharmacy benefit management services for prescription drugs and devices on behalf of a health benefit plan sponsor, including, but not limited to, a self-insurance plan, labor union or other third-party payer; provided, however, that pharmacy benefit management services shall include, but not be limited to: (i) the processing and payment of claims for prescription drugs; (ii) the performance of drug utilization review; (iii) the processing

of drug prior authorization requests; (iv) pharmacy contracting; (v) the adjudication of appeals or grievances related to prescription drug coverage contracts; (vi) formulary administration; (vii) drug benefit design; (viii) mail and specialty drug pharmacy services; (ix) cost containment; (x) clinical, safety and adherence programs for pharmacy services; and (xi) managing the cost of covered prescription drugs; provided further, that "pharmacy benefit manager" shall include a health benefit plan sponsor that does not contract with a pharmacy benefit manager and manages its own prescription drug benefits unless specifically exempted by the commission.

SECTION 45. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Primary service area" the following definition:-

"Private equity firm", a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and purchases, as a parent company or through another entity that it completely or partially owns or controls, a direct or indirect ownership share of or controlling interest in, or otherwise obtains a financial interest in, a provider, provider organization or management services organization; provided, however, that "private equity firm" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

SECTION 46. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by striking out the definition of "Provider organization" and inserting in place thereof the following definition:-

"Provider organization", any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not, that represents at least 1 health care providers in contracting with carriers, third party administrators or public payers for the payments of health care services;

provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations, management services organizations, providers that are owned or controlled, fully or partially, by for-profit entities, including, but not limited to, private equity firms, and any other organization that contracts with carriers, third party administrators or public payers for payment for health care services; and provided, further that “provider organization” shall not include any integrated care network that is owned and directed by a long-term care providers.

SECTION 47. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of “Quality measures” the following definition:-

“Real estate investment trust”, a real estate investment trust as defined in 26 U.S.C. 856.

SECTION 48. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of “Total health care expenditures” the following 2 definitions:-

“Total medical expenses”, the total cost of care for the patient population associated with a provider organization based on allowed claims for all categories of medical expenses and all non-claims related payments to providers.

“Unsafe financial actor”, a private equity firm or real estate investment trust that had a financial interest in a provider or provider organization closing, declaring bankruptcy or otherwise discontinuing its operations within 15 years of the private equity firm or real estate investment trust’s financial interest in the provider or provider organization.

SECTION 49. Section 2A of said chapter 12C, as so appearing, is hereby amended by inserting after the word “cybersecurity”, in line 9, the following words:- and 1 of whom shall have experience in health equity advocacy.

SECTION 50. Section 3 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 11, the word “benchmark” and inserting in place thereof the following words:- and affordability benchmarks.

SECTION 51. Said section 3 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 12, the words “section 9” and inserting in place thereof the following words:- sections 9 and 9A.

SECTION 52. The first paragraph of section 7 of said chapter 12C, as so appearing, is hereby amended by adding the following sentence:-

Each pharmaceutical manufacturing company and pharmacy benefit manager shall pay to the commonwealth an amount for the estimated expenses of the center and for the other purposes described in this chapter.

SECTION 53. Said section 7 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 8 and 42, the figure “33” and inserting in place thereof, in each instance, the following figure:- “25”.

SECTION 54. Said section 7 of said chapter 12C, as so appearing, is hereby further amended by adding following 3 paragraphs:- To the maximum extent under federal law, provided that such assessment shall not result in any reduction of federal financial participation in Medicaid, the assessed amount for pharmaceutical manufacturing companies shall be not less than 25 per cent of the amount appropriated by the general court for the expenses of the center minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the center's

publication or dissemination of reports and information; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Pharmaceutical manufacturing companies shall pay such assessed amount multiplied by the ratio of the pharmaceutical manufacturing company's gross sales of outpatient prescription drugs dispensed in the commonwealth or similar measure determined by the center consistent with applicable federal requirements.

To fund the operations of the licensure of pharmacy benefit managers to the maximum extent allowed by federal law and to the extent that the assessment will not result in any reduction of federal financial participation in Medicaid, the assessed amount for pharmacy benefit managers shall be not less than 25 per cent of the amount appropriated by the general court for the expenses of the center minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the center's publication or dissemination of reports and information; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Pharmacy benefit managers shall pay such assessed amount multiplied by the ratio of the pharmacy benefit manager's gross revenue related to outpatient prescription drugs dispensed in the commonwealth or similar measure determined by the center consistent with applicable federal requirements. In no event may this assessment, when combined with the assessment of pharmacy benefit managers in section 6 of chapter 6D and the pharmacy benefit manager licensing fee in section 2 of chapter 176Y, exceed the commonwealth's estimated expense in operating the pharmacy benefit manager licensure program. Each pharmaceutical manufacturing company and each pharmacy benefit manager shall make a preliminary payment to the center on October 1 of each year in an amount equal to 1/2 of the initial year's and, subsequently, the previous year's total assessment. Thereafter, each pharmaceutical

manufacturing company and each pharmacy benefit manager shall pay, within 30 days' notice from the center, the balance of the total assessment for the current year as determined by the center.

SECTION 55. Section 8 of said chapter 12C, as so appearing, is hereby amended by inserting after the word "entities", in line 5, the following words:- , including, but not limited to, private equity firms, real estate investment trusts and management services organizations.

SECTION 56. Said section 8 of said chapter 12C, as so appearing, is hereby further amended by inserting after the word "statements", in line 23, the following words:- , including the audited financial statements of the parent organization's out-of-state operations, private equity firms, real estate investment trusts and management services organizations,.

SECTION 57. Said section 8 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 49, the words "and (6)" and inserting in place thereof the following words:- (6) investments; and (7) information on any relationships with private equity firms, real estate investment trusts and management services organizations; and (8).

SECTION 58. Said chapter 12C is hereby further amended by striking out section 9, as so appearing, and inserting in place thereof the following section:-

Section 9. (a) The center, in consultation with the commission, shall promulgate regulations to require that provider organizations registered under section 11 of chapter 6D annually report the data as the center considers necessary to better protect the public interest in monitoring the financial conditions, organizational structure, business practices, clinical services and market share of each registered provider organization. The center may assess administrative fees on provider organizations in an amount to help defray the center's costs in complying with

this section. The center may specify in regulations uniform reporting standards and reporting thresholds as it determines necessary.

(b) The center shall require registered provider organizations to report information necessary to achieve the goals described in subsection (a), which may include, but shall not be limited to: (i) organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations and community advisory boards; (ii) the number of affiliated health care professional full-time equivalents by license type, specialty, name and address of practice locations and whether the professional is employed by the organization; (iii) the name and address of licensed facilities by license number, license type and capacity in each major service category; (iv) the name, address and capacity of all other locations where the provider organization, or any of its affiliates, delivers health care services, including those services listed in paragraph (4) of subsection (a) of section 22 of chapter 6D; (v) counts and capacity estimates of health care equipment as defined by the center, including imaging equipment; (vi) a comprehensive financial statement, including information on parent entities, including their out-of-state operations, and corporate affiliates, including private equity firms, real estate investment trusts and management services organizations, as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves; (vii) information on stop-loss insurance and any non-fee-for-service payment arrangements; (viii) information on clinical quality, care coordination and patient referral practices; (ix) information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; (x) information regarding charitable care and community benefit programs; (xi) for any risk-bearing provider organization, a certificate from the division of

insurance under chapter 176U; (xii) 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 real estate investment trusts; and (xiii) such other information as the center considers appropriate as set forth in the center's regulations; provided, however, that the center shall coordinate with the commission and the division of insurance to obtain information directly from the commission; provided further, that the center shall consider the administrative burden of reporting when developing reporting requirements. The center may, in consultation with the division of insurance and the commission, merge similar reporting requirements where appropriate. The center, in its discretion, may specify additional data elements in a given reporting year to support the development of the state health plan or the focused assessments defined in said section 22 of said chapter 6D.

(c) Annual reporting shall be in a form provided by the center. The center shall promulgate regulations that define criteria for waivers from certain annual reporting requirements under this section. Criteria for waivers may include operational size of the provider organization, the provider organization's annual net patient service revenue, the degree of risk assumed by the provider organization and other criteria as the center considers appropriate.

(d) Notwithstanding the annual reporting requirements under this section, the center may require in writing, at any time, additional information that is reasonable and necessary to determine the financial condition, organizational structure, business practices, clinical services or market share of a registered provider organization.

(e) The center shall develop and maintain an inventory of health care resources on its website in a form usable by the public; provided, that the extracts must include information on

the geographic distribution of clinicians, facilities, equipment or any other health care resources. Such inventory shall be derived from all available data, including, but not limited to, data collected under this section and data collected by other state agencies. Agencies that license, register, regulate or otherwise collect cost, quality or other data concerning health care resources shall provide the center and the commission such data and information necessary to develop and maintain the inventory required by this this section.

(f) The center may enter into interagency agreements with the commission and other state agencies to effectuate the goals of this section.

(g)(1) The center shall also collect and analyze such data as it considers necessary to protect the public interest in monitoring financial conditions of registered provider organizations and compliance with subsection (a) of section 23 of chapter 6D by registered provider organizations with private equity investment. To effectuate this subsection, the center may: (i) modify uniform reporting requirements; (ii) require registered provider organizations with private equity investment to report required information quarterly; (iii) require relevant information from private equity firms and their affiliates; and (iv) communicate confidentially with registered provider organizations as the center deems necessary.

(2) The information shall be analyzed on an industry-wide and provider-specific basis and shall include, but not be limited to: (i) gross and net patient service revenues; (ii) sources of revenue; (iii) total payroll as a per cent of operating expenses and the salary and benefits of the top 10 highest compensated employees, identified by position description and specialty; and (iv) other relevant measures of financial health or distress.

(3) The center shall publish annual reports and establish a continuing program of investigation and study of financial trends among registered provider organizations, including an

analysis of systemic instabilities or inefficiencies that contribute to financial distress. The reports shall include an identification and examination of: (i) registered provider organizations that the center considers to be in financial distress, including any at risk of closing or discontinuing essential health services, as defined by the department of public health under section 51G of chapter 111, as a result of financial distress; and (ii) registered provider organizations with private equity investment that have violated subsection (a) of section 23 of chapter 6D. The center may provide this information in the report it produces pursuant to subsection (c) of section 8.

(4) The center shall refer to the commission any provider in which a private equity firm has a financial interest that has violated subsection (a) of section 23 of chapter 6D.

SECTION 59. Section 10 of said chapter 12C, as so appearing, is hereby amended by inserting after the word “of”, in line 21, the following words:- communities and purchaser.

SECTION 60. Subsection (b) of said section 10 of chapter 12C, as so appearing, is hereby further amended by striking out clause (8) and inserting in place thereof the following clause:-

(8) relative prices paid to every hospital or physician group in the payer’s network, by type of provider, with hospital inpatient and outpatient prices listed separately and product type, including health maintenance organization and preferred provider organization products.

SECTION 61. Said subsection (b) of said section 10 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 56 to 61, inclusive, the words “and (11) a comparison of relative prices for the payer’s participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage, and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above

and more than 10 per cent, 15 per cent and 20 per cent below the average relative price" and inserting in place thereof the following words:- (11) information about prescription drug utilization and spending for all covered drugs, including for generic drugs, brand-name drugs and specialty drugs provided in an inpatient or outpatient setting or sold in a retail setting, including, but not limited to, information sufficient to show the: (i) highest utilization drugs, (ii) drugs with the greatest increases in utilization, (iii) drugs that are most impactful on plan spending, net of rebates, (iv) drugs with the highest year-over-year price increases, net of rebates, and (v) drugs with the highest cost per prescription both gross and net of rebates; (12) information on clinical quality, care coordination and patient referral practices; and (13) a comparison of relative prices for the payer's participating health care providers by provider type, which shows the average relative price and the extent of variation in price and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price.

SECTION 62. Subsection (c) of said section 10 of said chapter 12C, as so appearing. is hereby amended by striking out clause (8) and inserting in place thereof the following clause:-

(8) relative prices paid to every hospital or physician group in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately and product type, including health maintenance organization and preferred provider organization products.

SECTION 63. Said subsection (c) of said section 10 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 99 to 104, inclusive, the words "and (11) a comparison of relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and

more than 10 per cent, 15 per cent and 20 per cent below the average relative price" and inserting in place thereof the following words:- (11) information about prescription drug utilization and spending for all covered drugs, including for generic drugs, brand-name drugs and specialty drugs provided in an inpatient or outpatient setting or sold in a retail setting, including, but not limited to, information sufficient to show the: (i) highest utilization drugs, (ii) drugs with the greatest increases in utilization, (iii) drugs that are most impactful on plan spending, net of rebates, (v) drugs with the highest year-over-year price increases, net of rebates, and (v) drugs with the highest cost per prescription, both gross and net of rebates; (12) information on clinical quality, care coordination and patient referral practices; and (13) a comparison of relative prices for the payer's participating health care providers by provider type, which shows the average relative price and the extent of variation in price and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price.

SECTION 64. Said chapter 12C is hereby amended by inserting after section 10 the following section:-

Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform annual reporting of information from pharmacy benefit managers certified under chapter 176Y, including, but not limited to, data from the most recent calendar year detailing: (i) all discounts, including the total dollar amount and percentage discount and rebates received from a manufacturer for each drug on the pharmacy benefit manager's formularies; (ii) the total dollar amount of all discounts and rebates that are retained by the pharmacy benefit manager for each drug on the pharmacy benefit manager's formularies; (iii) actual total reimbursement amounts for each drug the pharmacy benefit manager pays retail pharmacies after all direct and indirect

administrative and other fees that have been retrospectively charged to the pharmacies are applied; (iv) the negotiated price health plans pay the pharmacy benefit manager for each drug on the pharmacy benefit manager's formularies; (v) the amount, terms and conditions relating to copayments, reimbursement options and other payments or fees associated with a prescription drug benefit plan; and (vi) disclosure of any ownership interest the pharmacy benefit manager has in a pharmacy or health plan with which it conducts business or any corporate affiliation between the pharmacy benefit manager and the pharmacy or health plan with which it conducts business; provided, however, that the center may examine or audit the financial records of a pharmacy benefit manager for purposes of ensuring the information submitted pursuant to regulations promulgated under this section is accurate.

(b) The center shall analyze the information and data collected under subsection (a) and shall publish an annual report summarizing, at minimum, the information collected under said subsection (a) and comparing the information as it relates to pharmacy benefit managers certified under chapter 176Y with respect to drugs provided to residents of the commonwealth.

(c) Except as specifically provided otherwise by the center or under this chapter, pharmacy benefit manager data collected by the center under this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66. The center may confidentially provide pharmacy benefit manager data collected by the center under this section to the health policy commission.

SECTION 65. Said chapter 12C is hereby further amended by striking out section 11, as appearing in the 2022 Official Edition, and inserting in place thereof the following section:-

Section 11. The center shall ensure the timely reporting of information required under sections 8 to 10, inclusive. The center shall notify entities required to submit data under this

chapter of any applicable reporting deadlines. The center shall notify, in writing, an entity, other than a public payer required to submit data under this chapter, which has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice may result in penalties. The center may assess a penalty against an entity other than a public health care payer required to submit data under this chapter that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this paragraph, of not more than $25,000 per week for each week of delay after the 2-week period following the reporting entity's receipt of the written notice. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund, established under section 100 of 194 of the acts of 2011. The center shall notify the commission and the department of public health if a provider or provider organization fails to timely report in accordance with this section, or if the center has assessed a penalty under this section. Such notification shall be considered by the commission in a cost and market impact review under section 13 of chapter 6D, and by the department in determining licensure and suitability in accordance with section 51 of chapter 111 and for a determination of need under section 25C of said chapter 111.

SECTION 66. Section 12 of said chapter 12C, as so appearing, is hereby amended by adding the following subsection:-

(c) Notwithstanding any general or special law to the contrary, a provider, private health care payer, public health care payer, agency, department, division, commission, board, authority or other public or quasi-public entity in the commonwealth that collects patient information, including personal data as defined in section 1 of chapter 66A, shall, upon a request from the center, provide such data to the center for any purpose consistent with this chapter; provided, however, that the disclosure of such information shall be in compliance with federal law.

SECTION 67. Said chapter 12C is hereby further amended by striking out section 14, as so appearing, and inserting in place thereof the following section:-

Section 14. (a)(1) Not later than March 1 in each even-numbered year, the center, in consultation with the statewide advisory committee established pursuant to subsection (c), shall establish a standard set of measures of health care provider quality and health system performance, hereinafter referred to as the "standard quality measure set", for use in: (i) contracts between payers, including between the commonwealth and carriers and between health care providers, provider organizations and accountable care organizations, which incorporate quality measures into payment terms, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information; (iv) monitoring system-wide performance; and (v) reducing provider administrative burden related to quality measure reporting.

(2) The standard quality measure set shall designate: (i) core measures that shall be used in contracts that incorporate quality measures into payment terms between payers, including the commonwealth and carriers, and health care providers, including provider organizations and accountable care organizations, and shall meet the core criteria set by the statewide advisory committee pursuant to paragraph (3) of subsection (c); and (ii) a menu of non-core measures that may be used in such contracts. The standard quality measure set shall allow for innovation and the development of outcome measures for quality and safety. If the standard quality measure set established by the center differs from the recommendations of the statewide advisory committee, the center shall issue a written report detailing each area of disagreement and the rationale for the center's decision.

(b) The center shall develop uniform reporting requirements for the standard quality measure set for each health care provider facility, medical group or provider group in the commonwealth; provided, however, that the center shall prioritize the development of uniform reporting requirements for primary care and behavioral health providers; and provided further, that the uniform reporting requirements shall not increase provider administrative burden related to quality measure reporting.

(c)(1) The center shall convene a statewide advisory committee which shall make recommendations for the standard quality measure set to: (i) ensure consistency in the use of quality and safety measures in contracts between payers, including the commonwealth and carriers, and health care providers in the commonwealth; (ii) ensure consistency in methods for the assignment of tiers to providers in the design of any health plan; (iii) improve quality and safety of care; (iv) improve transparency for consumers and employers; (v) improve health system monitoring and oversight by relevant state agencies; and (vi) reduce administrative burdens.

(2) The statewide advisory committee shall consist of commissioner of insurance or a designee, who shall serve as co-chair; the executive director of the health policy commission, or their designee, who shall serve as co-chair; the executive director of the center; the executive director of the Betsy Lehman center for patient safety and medical error reduction; the executive director of the group insurance commission; the secretary of elder affairs; the assistant secretary for MassHealth; the commissioner of the department of public health; the commissioner of the department of mental health; and 11 members who shall be appointed by the governor, 1 of whom shall be a representative of Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.,

1 of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall be a registered nurse licensed to practice in the commonwealth who practices in a patient care setting, 1 of whom shall be a representative of a labor organization representing health care workers, 1 of whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider and 1 of whom shall be a representative of consumers. Members appointed to the statewide advisory committee shall have experience with and expertise in health care quality measurement.

(3) The statewide advisory committee shall meet quarterly to develop recommendations for the core measure and non-core measures to be adopted in the standard quality measure set for use in: (i) contracts between payers, including the commonwealth and carriers, and health care providers, provider organizations and accountable care organizations, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information; (iv) monitoring system-wide performance; and (v) reducing provider administrative burdens related to quality measure reporting.

(4) In developing its recommendations for the standard quality measure set, the statewide advisory committee shall incorporate recognized quality and safety measures including, but not limited to, measures used by the Centers for Medicare and Medicaid Services, the group insurance commission, carriers and providers and provider organizations in the commonwealth and other states, as well as other valid measures of health care provider performance and outcomes, including patient-reported outcomes and functional status, patient experience, health

disparities and population health. The statewide advisory committee shall consider measures applicable to primary care providers, specialists, hospitals, provider organizations, accountable care organizations, oral health providers and other types of providers and measures applicable to different patient populations.

(5) Not later than January 1 in each even-numbered year, the statewide advisory committee shall submit to the center its recommendations on the core measures and non-core measures to be adopted, changed or updated by the center in the standard quality measure set, along with a report in support of its recommendations.

SECTION 68. Section 15 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 4, the word “injury” and inserting in place thereof the following word:- harm.

SECTION 69. Said section 15 of said chapter 12C, as so appearing, is hereby further amended by striking out the definition of “Board” and inserting in place thereof the following 3 definitions:-

“Agency”, an agency of the executive branch of the commonwealth including, but not limited to, a constitutional or other office, executive office, department, division, bureau, board, commission or committee thereof, or any authority created by the general court to serve a public purpose, having either statewide or local jurisdiction.

“Board”, the patient safety and medical errors reduction board.

“Healthcare-associated infection”, an infection that a patient acquires during the course of receiving treatment for other conditions within a health care setting.

SECTION 70. Said section 15 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of “Patient safety” the following definition:-

“Patient safety information”, data and information related to patient safety, including adverse events, incidents, medical errors or health care-associated infections, that is collected or maintained by agencies.

SECTION 71. Said section 15 of said chapter 12C, as so appearing, is hereby further amended by striking out subsection (f) and inserting in place thereof the following 3 subsections:-

(f) Notwithstanding any general or special law to the contrary, the Lehman center and any agency, provider organization, department, division, commission, board, authority or other public or quasi-public entity in the commonwealth that collects or maintains patient safety information may transmit such information, including personal data as defined in section 1 of chapter 66A, to each other, and shall transmit such information to the Lehman center upon request from the Lehman center; provided, however, that transmission of such information shall be governed by an agreement, which may be an interagency service agreement, between the party transmitting the information and the Lehman center; provided further, that such agreement shall provide for any safeguards necessary to protect the privacy and security of the information; and provided further, that the transmission of such information shall be in compliance with federal law.

(g) The Lehman center may adopt rules and regulations necessary to carry out the purpose of this section. The Lehman center may contract with any federal, state or municipal entity or other public institution or with any private individual, partnership, firm, corporation, association or other entity to manage its affairs or carry out the purpose of this section.

(h) The Lehman center shall report annually to the joint committee on health care financing regarding the progress made in improving patient safety and medical error reduction.

The Lehman center may seek federal and foundation support to supplement state resources to carry out the Lehman center's patient safety and medical error reduction goals.

SECTION 72. Section 16 of said chapter 12C, as so appearing, is hereby amended by inserting after the word "publish", in line 1, the following words:- , for the most recently concluded benchmark cycle, .

SECTION 73. Said section 16 of said chapter 12C, as so appearing, is hereby further amended by inserting after the word "submitted", in line 2, the following words:- for that benchmark cycle .

SECTION 74. Said section 16 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 7, the word "benchmark" and inserting in place thereof the following words:- and affordability benchmarks.

SECTION 75. Said section 16 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 8, the words "section 9" and inserting in place thereof the following words:- sections 9 and 9A.

SECTION 76. Said section 16 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 43, the words "and (12)" and inserting in place thereof the following words:- (12) a standard set of measures of health care affordability in the commonwealth, including family health care expenditures and an annual index of how such health care costs compare to the health care affordability benchmark set under section 9A of chapter 6D; and (13).

SECTION 77. Said chapter 12C of the General Laws is hereby amended by striking out sections 17 and 18, as so appearing, and inserting in place thereof the following 2 sections:-

Section 17. The attorney general may review and analyze any information submitted to the center by a provider, provider organization, private equity firm, real estate investment trust, management services organization, pharmaceutical manufacturing company, pharmacy benefit manager or payer pursuant to sections 8, 9 and 10 of this chapter, and to the commission under section 8 of chapter 6D. The attorney general may require that such entities produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends, factors that contribute to cost growth within the commonwealth's health care system and the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the entity that produced the information or documents; provided, however, that the attorney general may disclose such information or documents during (i) the annual hearing conducted under section 8 of chapter 6D, (ii) a rate hearing before the health insurance bureau, or (iii) in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that the disclosure would be in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

Section 18. (a) 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 levels and growth, including but not limited to, spending levels and growth as measured by health-status adjusted total medical expense or 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

commission under section 9 of chapter 6D; provided further, that the center shall identify cohorts for similar health care entities and establish differential standards for excessive growth rates within the health care cost growth benchmark established by the commission under section 9 of chapter 6D, based on factors which may include, but are not limited to, a health care entity's spending, pricing levels and payer mix; or (2) data is not submitted to the center in a proper, timely or complete manner.

(b) The center shall confidentially provide a list of the health care entities to the 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 78. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby amended by striking out the last paragraph and inserting in place thereof the following paragraph:-

The board may: (i) adopt, amend and rescind such rules and regulations as it deems necessary to carry out this chapter subject to the approval of the commissioner of public health; (ii) make contracts and arrangements for the performance of administrative and similar services required or appropriate in the performance of the duties of the board; and (iii) adopt and make public rules of procedure and other regulations not inconsistent with other provisions of the General Laws. The commissioner of public health shall appoint an executive director and a legal counsel for the board.

SECTION 79. Said chapter 13 is hereby further amended by striking out section 10A, as so appearing, and inserting in place thereof the following section:-

Section 10A. The commissioner of public health shall review and approve any rule or regulation proposed by the board of registration in medicine pursuant to section 10. Such rule or regulation shall be deemed disapproved unless approved within 60 days of submission to the commissioner pursuant to said section 10.

SECTION 80. Chapter 26 of the General Laws is hereby amended by striking out section 7A, as so appearing, and inserting in place thereof the following section:-

Section 7A. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Bureau", health insurance bureau.

"Deputy commissioner", the deputy commissioner of the health insurance bureau.

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under chapter 176B; an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G, and a dental service plan offered by a dental service corporation under chapter 176E. Health benefit plans shall not include: (i) accident only, credit only, limited scope vision if offered separately; (ii) hospital indemnity insurance policies that provide a benefit to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, that are sold as a supplement and not as a substitute for a health benefit plan and that meet any requirements set by the commissioner by regulation; (iii) disability income insurance; (iv) coverage issued as a supplement to liability insurance; (v) specified disease insurance that is purchased as a supplement and not as a

substitute for a health plan and meets any requirements the commissioner by regulation may set; (vi) insurance arising out of a workers' compensation law or similar law; (vii) automobile medical payment insurance; (viii) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; (ix) long-term care if offered separately; (x) coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; (xi) travel insurance; or (xii) any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A; provided, however, that travel insurance for the purpose of this chapter is insurance coverage for personal risks incident to planned travel, including, but not limited to: (A) interruption or cancellation of trip or event; (B) loss of baggage or personal effects; (C) damages to accommodations or rental vehicles; or (D) sickness, accident, disability or death occurring during travel, provided, however, that the health benefits are not offered on a stand-alone basis and are incidental to other coverages; and provided further, that the term “travel insurance” shall not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including for example, those working overseas as ex-patriot or military personnel being deployed.

“Rate review”, any examination performed by the deputy commissioner of the aggregate rates of payment pursuant to sections 5, 6 and 10 of chapter 176A; section 4 of chapter 176B; section 16 of chapter 176G; section 6 of chapter 176J; and section 7 of chapter 176K.

(b) There shall be within the division of insurance a health insurance bureau overseen by a deputy commissioner, whose duties shall include, but not be limited to, rate review of premium rates for health benefit plans offered, issued or renewed in the commonwealth, administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers about health insurance coverage and access to affordable products. The deputy commissioner shall: (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 (vi) consider affordability of health insurance products during rate review.

(c) The deputy commissioner shall develop affordability standards to consider during rate review; provided, however, that the deputy commissioner’s review of a carrier’s rates shall adhere to principles of solvency and actuarial soundness. Such standards shall consider factors including, but not limited to: (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; and (iii) the impact of proposed rates on the commonwealth’s performance against the health care cost growth benchmark established

in section 9 of chapter 6D and the affordability benchmark established in section 9A of said chapter 6D.

(d) The deputy commissioner shall review data and documents submitted to the division, including, but not limited to, any materials submitted as part of rate reviews, to examine the causes of premium rate increases and excessive provider price variation.

(e) The commissioner shall appoint, at a minimum, the following employees to the bureau: a deputy commissioner, a general counsel, a chief health economist, a chief actuary, a chief research analyst and a chief examiner. The appointed employees shall devote their full time to the duties of their offices, shall be exempt from chapters 30 and 31 and shall serve at the pleasure of the commissioner. The commissioner may appoint and remove additional employees, including, but not limited to, a first deputy, economists, analysts, examiners, assistant actuaries, inspectors, clerks and other assistants as the work of the division may require. Such additional employees shall perform such duties as the commissioner may prescribe.

(f) The commissioner shall make and collect an assessment against the carriers licensed under chapters 175, 176A, 176B, 176E, 176F and 176G to pay for the expenses of the bureau. The assessment shall be at a rate sufficient to produce $1,000,000 annually. In addition to that amount, the assessment shall include an amount to be credited to the General Fund which shall be equal to the total amount of funds estimated by the secretary of administration and finance to be expended from the General Fund for indirect and fringe benefit costs attributable to the personnel costs of the bureau. The assessment shall be allocated on a fair and reasonable basis among all carriers licensed under said chapters. The funds produced by the assessments shall be expended by the bureau, in addition to any other funds which may be appropriated, to assist in defraying the general operating expenses of the division and may be used to compensate

consultants retained by the bureau. A carrier licensed under said chapters shall pay the amount assessed against it within 30 days after the date of the notice of assessment from the commissioner.

(g) Notwithstanding any general or special law to the contrary, carriers offering health benefit plans, including carriers licensed under chapter 175, 176A, 176B or 176G, shall annually file a summary of negotiated rate increases for their largest providers, by provider group to the bureau. The deputy commissioner shall confidentially provide such information to the health policy commission.

Rates of reimbursement or rate increases submitted for review by the bureau under this section shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66. The deputy commissioner shall adopt regulations to carry out this section.

SECTION 81. 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:- Annually, not later than January 15, 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 calendar year that will begin 2 years following the calendar year in which the January 15 date occurs, which shall be agreed to by the secretary and the committees.

SECTION 82. Section 9-609 of chapter 106 of the General Laws, as so appearing, is hereby amended by adding the following subsection:-

(d) Notwithstanding subsection (a), in the case of a debtor that is a hospital licensed by the department of public health under section 51 of chapter 111 and collateral that is a medical

device, a secured party shall send notice to the debtor and the department of public health not less than 90 days prior to taking possession of the collateral, rendering equipment unusable or disposing of the collateral on the debtor's premises pursuant to subsection (a). For the purposes of this subsection, "medical device" shall have the same meaning as that term is defined in section 1 of chapter 111N.

SECTION 83. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after the definition "Nuclear reactor" the following definition:-

"Party of record", during the pendency of an application for a determination of need, an applicant for a determination of need, the attorney general, the center for health information and analysis, the health policy commission, any government agency with relevant oversight or licensure authority over the proposed project or components therein or any 10 taxpayers of the commonwealth organized as a group.

SECTION 84. Section 25A of said chapter 111, as so appearing, is hereby amended by striking out the first 5 paragraphs.

SECTION 85. Section 25C of said chapter 111, as so appearing, is hereby amended by striking out subsections (g) to (j), inclusive, and inserting in place thereof the following 4 subsections:-

(g) The department, in making any determination of need, shall: (i) assess both the applicant and the proposed project; (ii) be guided by the state health plan and focused health assessments pursuant to section 22 of chapter 6D and the health care resources inventory pursuant to section 9 of chapter 12C; (iii) encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services so that adequate health care services will be made reasonably available to

every person within the commonwealth at the lowest reasonable aggregate cost; (iv) be guided by the commonwealth's cost containment and affordability goals; (v) assess the impacts on the applicant's patients and on other residents of the commonwealth, including, but not limited to, considerations of health equity and the workforce of surrounding health care providers; and (vi) take into account any comments and relevant data from the center for health information and analysis, the health policy commission, including, but not limited to, any cost and market impact review report pursuant to subsection (f) of section 13 of chapter 6D, and any other state agency or entity. The department may impose reasonable terms and conditions on the approval of a determination of need as the department determines are necessary to achieve the purposes and intent of this section, including, but not limited to, conditions intended to address health care disparities and better align a project with community needs. The department may recognize the special needs and circumstances of projects that: (i) are essential to the conduct of research in basic biomedical or health care delivery areas or to the training of health care personnel; (ii) are unlikely to result in any increase in the clinical bed capacity or outpatient load capacity of the facility; and (iii) are unlikely to cause an increase in the total patient care charges of the facility to the public for health care services, supplies and accommodations, as such charges shall be defined from time to time in accordance with section 5 of chapter 409 of the acts of 1976. The department may also recognize the special needs and circumstances of projects that may address a lack of supply for a specific region, population or service line that has been identified in the state health plan or focused assessments pursuant to section 22 of chapter 6D.

(h) Applications for such determination shall be filed with the department, together with other forms and information as shall be prescribed by, or acceptable to, the department. No provider or provider organization may apply for a notice of determination of need until a

material change notice, if required, has been submitted to the health policy commission under section 13 of chapter 6D. A duplicate copy of any application together with supporting documentation for such application, shall be a public record and kept on file in the department. The department may require a public hearing on any application at its discretion or at the request of the attorney general. The attorney general may intervene in any hearing under this section. A reasonable fee, established by the department, shall be paid upon the filing of such application; provided, however, that such fee shall not exceed 0.2 per cent of the capital expenditures, if any, proposed by the applicant. The department may adapt the information required and fees required for applications if it determines a project or class of projects may address a lack of supply for a specific region, population or service line that has been identified in the state health plan or focused assessments pursuant to section 22 of chapter 6D. The department may also require an independent cost analysis be conducted, at the expense of the applicant, by an entity selected and overseen by the department, including, but not limited to, another state agency, to demonstrate that the application is consistent with the commonwealth's efforts to meet the health care cost containment goals established by the commission. Such entity may request, and the applicant may not unreasonably withhold, confidential data and documents necessary to conduct an independent cost analysis pursuant to such section; provided, however, that any confidential data and documents so requested shall be provided to the entity conducting the independent cost analysis, the department, the health policy commission and the attorney general, but shall not be disclosed to any other person without the consent of the applicant, except in summary form, or when the department, health policy commission or attorney general determines that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations; and provided further, that any confidential data and

documents so provided shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

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

(j) The department shall so approve or disapprove, in whole or in part, each such application for a determination of need not more than 6 months after filing with the department; provided, however, that the department may, on not more than 1 occasion, delay the action for up to 2 months after the applicant has provided information which the department has reasonably requested during the 8-month period; provided further, that: (i) the period for review of an

application for which an independent cost analysis is conducted pursuant to subsection (h) shall be stayed until a completed independent cost analysis is received and accepted by the department: (ii) the period of review of an application for which the commission conducts a cost and market impact review shall be stayed until a final cost and market impact review has been issued: and (iii) the period of review of an application for which the applicant is subject to a performance improvement plan pursuant to section 10 of chapter 6D shall be stayed until the commission determines that the applicant is implementing or has implemented said performance improvement plan in good faith; and provided further, that the commission may rescind its determination that the applicant is implementing a performance improvement plan in good faith at any time prior to successful completion of the performance improvement plan. Applications remanded to the department by the health facilities appeals board under section 25E shall be acted upon by the department within the same time limits provided in this section for the department to approve or disapprove applications for a determination of need. If an application has not been acted upon by the department within such time limits, the applicant may, within a reasonable period of time, bring an action in the nature of mandamus in the superior court to require the department to act upon the application.

SECTION 86. Said section 25C of said chapter 111, as so appearing, is hereby further amended by adding the following 2 subsections:-

(o) Notwithstanding sections (a) through (d), the department may create a process under which persons or entities proposing a project that would normally require a determination of need may apply for a waiver of such requirement. Such waiver shall be granted only in cases in which the person or entity demonstrates the project will address a lack of supply for a specific region, population or service line that has been identified in the state health plan or focused

assessments pursuant to section 22 of chapter 6D. The department may require a waiver request be accompanied by forms and information as shall be prescribed by, or acceptable to, the department. A duplicate copy of any waiver request together with supporting documentation for such application shall be a public record and kept on file in the department.

(p) A party of record may review an application for determination of need and provide written comment or specific recommendations for consideration by the department. Whenever a party of record submits written materials concerning an application for determination of need, the department shall provide copies of such materials to all other parties of record.

SECTION 87. Section 25F of said chapter 111, as so appearing, is hereby amended by inserting after the word “care”, in line 7, the following word:- financing.

SECTION 88. Paragraph (4) of subsection (d) of section 51G of said chapter 111, as so appearing, is hereby further amended by inserting, after the third sentence, the following sentence:-

The department may seek an analysis of the impact of the closure from the health policy commission.

SECTION 89. Said subsection (d) of said section 51G of said chapter 111, as so appearing, is hereby further amended by adding the following 2 paragraphs:-

(7) No original license shall be granted or renewed, to establish or maintain an acute-care hospital unless: (i) all documents related to any lease, master lease, sublease, license or any other agreement for the use, occupancy or utilization of the premises occupied by the acute-care hospital are disclosed to the department upon application for licensure; and (ii) the department has reviewed such documentation and determined the applicant is suitable for licensure.

(8) No original license shall be granted, nor renewed, to establish or maintain an acute-care hospital, as defined in section 25B, unless the applicant is in compliance with the reporting requirements established in sections 8 to 10, inclusive, of chapter 12C.

SECTION 90. Section 51H of said chapter 111, as so appearing, is hereby amended by striking out the definition of "Facility" and inserting in place thereof the following definition:

"Facility", a hospital, institution for the care of unwed mothers, clinic providing ambulatory surgery as defined in section 25B, limited-service clinic licensed pursuant to section 51J, office-based surgical center licensed pursuant to section 51M or urgent care center licensed pursuant to section 51N.

SECTION 91. Said section 51H of said chapter 111, as so appearing, is hereby further amended by inserting after the definition of "Healthcare-associated infection" the following definition:-

"Operational impairment event", any action, or notice of impending action, including a notice of financial delinquency, concerning the repossession of medical equipment or supplies necessary for the provision of patient care.

SECTION 92. Subsection (b) of said section 51H of said chapter 111, as so appearing, is hereby amended by adding the following paragraph:-

An operational impairment event shall be reported by a facility to the department not later than 1 calendar day after it occurs. Notwithstanding any general or special law to the contrary, no contract between a facility and a lessor of medical equipment shall authorize the repossession of medical equipment or supplies unless the lessor provides a notice of financial delinquency to the department not less than 90 days prior to repossession of any medical equipment or supplies necessary for the provision of patient care. Any provision of any contract or other document

between a lessor of medical equipment and a facility which does not comply with this paragraph shall be void.

SECTION 93. Said chapter 111 is hereby further amended by inserting after section 51L the following 2 sections:-

Section 51M. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Deep sedation", a drug-induced depression of consciousness during which: (i) the patient cannot be easily awakened but responds purposefully following repeated painful stimulation; (ii) the patient's ability to maintain independent ventilatory function may be impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

"General anesthesia", a drug-induced depression of consciousness during which: (i) the patient is not able to be awakened, even by painful stimulation; (ii) the patient's ability to maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often requires assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function; and (iv) the patient's cardiovascular function may be impaired.

"Minimal sedation", a drug-induced state during which: (i) patients respond normally to verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory and cardiovascular functions are unaffected.

"Minor procedures", (i) procedures that can be performed safely with a minimum of discomfort where the likelihood of complications requiring hospitalization is minimal; (ii)

procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less than 500cc of fat under un-supplemented local anesthesia.

"Moderate sedation", a drug-induced depression of consciousness during which: (i) the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous ventilation is adequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

"Office-based surgical center", an office, group of offices, a facility or any portion thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice, however organized, whether conducted for profit or not for profit, which is advertised, announced, established or maintained for the purpose of providing office-based surgical services; provided, however, that "office-based surgical center" shall not include: (i) a hospital licensed under section 51 or by the federal government; (ii) an ambulatory surgical center as defined pursuant to section 25B and licensed under said section 51; or (iii) a surgical center performing services in accordance with section 12M of chapter 112.

"Office-based surgical services", an ambulatory surgical or other invasive procedure requiring: (i) general anesthesia; (ii) moderate sedation; or (iii) deep sedation and any liposuction procedure, excluding minor procedures and procedures requiring minimal sedation, where such surgical or other invasive procedure or liposuction is performed by a practitioner at an office-based surgical center.

(b) The department shall establish rules, regulations and practice standards for the licensing of office-based surgical centers. In determining rules, regulations and practice standards necessary for licensure as an office-based surgical center, the department may, at its

discretion, determine which regulations applicable to an ambulatory surgical center, as defined in section 25B, shall apply to an office-based surgical center. The department shall consult with the board of registration in medicine prior to promulgating regulations or establishing rules or practice standards pursuant to this section.

(c) The department shall issue for a term of 2 years and renew for a like term, a license to maintain an office-based surgical center to an entity or organization that demonstrates to the department that it is responsible and suitable to maintain such a center. An office-based surgical center license shall list the specific locations on the premises where surgical services are provided. In the case of the transfer of ownership of an office-based surgical center, the application of the new owner for a license, when filed with the department on the date of transfer of ownership, shall have the effect of a license for a period of 3 months.

(d) An office-based surgical center license shall be subject to suspension, revocation or refusal to issue or to renew for cause if, in its reasonable discretion, the department determines that the issuance of such license would be inconsistent with the best interests of the public health, welfare or safety. Nothing in this subsection shall limit the authority of the department to require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to renew a license issued pursuant to subsection (c).

(e) Initial application and renewal fees for the license shall be established pursuant to section 3B of chapter 7.

(f) The department may impose a fine of up to $10,000 on a person or entity that advertises, announces, establishes or maintains an office-based surgical center without a license granted by the department. The department may impose a fine of not more than $10,000 on a licensed office-based surgical center for violations of this section or any rule or regulation

promulgated pursuant to this section. Each day during which a violation continues shall constitute a separate offense. The department may conduct surveys and investigations to enforce compliance with this section.

(g) Notwithstanding any general or special law or rule to the contrary, the department may issue a 1-time provisional license to an applicant for an office-based surgical center licensed pursuant to this section if such office-based surgical center holds: (i) a current accreditation from the Accreditation Association for Ambulatory Health Care, American Association for Accreditation of Ambulatory Surgery Facilities, Inc., or the Joint Commission On Accreditation of Healthcare Organizations; or (ii) a current certification for participation in either Medicare or Medicaid. The department may approve such a provisional application upon a finding of responsibility and suitability and that the office-based surgical center meets all other licensure requirements as determined by the department. Such provisional license issued to an office-based surgical center shall not be extended or renewed.

Section 51N. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:-

"Emergency services", as defined in section 1 of chapter 6D.

"Urgent care center", a clinic owned or operated by an entity that is not corporately affiliated with a hospital licensed under section 51, however organized, whether conducted for profit or not for profit, that is advertised, announced, established or maintained for the purpose of providing urgent care services in an office or a group of offices, or any portion thereof, or an entity that is advertised, announced, established or maintained under a name that includes the words "urgent care" or that suggests that urgent care services are provided therein and is not corporately affiliated with a hospital licensed under 51; provided, however, that an urgent care

center shall not include: (i) a hospital licensed under said section 51 or operated by the federal government or by the commonwealth; (ii) a clinic licensed under said section 51; (iii) a limited service clinic licensed under section 51J; or (iv) a community health center receiving a grant under 42 U.S.C. 254b.

"Urgent care services", a model of episodic care for the diagnosis, treatment, management or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or injury that is immediate in nature but does not require emergency services; (ii) provided on a walk-in basis without a prior appointment; (iii) available to the general public during times of the day, weekends or holidays when primary care provider offices are not customarily open; and (iv) not intended, and should not be used for, preventative or routine services.

(b) The department shall establish rules, regulations and practice standards for the licensing of urgent care centers. In determining regulations and practice standards necessary for licensure as an urgent care center, the department may, at its discretion, determine which regulations applicable to a clinic licensed under section 51, shall apply to an urgent care center.

(c) The department shall issue for a term of 2 years and renew for a like term, a license to maintain an urgent care center to an entity or organization that demonstrates to the department that it is responsible and suitable to maintain such an urgent care center. In the case of the transfer of ownership of an urgent care center, the application of the new owner for a license, when filed with the department on the date of transfer of ownership, shall have the effect of a license for a period of 3 months.

(d) An urgent care center license shall be subject to suspension, revocation or refusal to issue or to renew for cause if, in its reasonable discretion, the department determines that the

issuance of such license would be inconsistent with or opposed to the best interests of the public health, welfare or safety. Nothing in this subsection shall limit the authority of the department to require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to renew a license issued pursuant to subsection (c).

(e) Initial application and renewal fees for the license shall be established pursuant to section 3B of chapter 7.

(f) The department may impose a fine of up to $10,000 on a person or entity that advertises, announces, establishes or maintains an urgent care center without a license granted by the department. The department may impose a fine of not more than $10,000 on a licensed urgent care center for violations of this section or any rule or regulation promulgated pursuant to this section. Each day during which a violation continues shall constitute a separate offense. The department may conduct surveys and investigations to enforce compliance with this section.

(g) Notwithstanding any general or special law or rule to the contrary, the department may issue a 1-time provisional license to an applicant for an urgent care center if such urgent care center holds: (i) a current accreditation from the Accreditation Association for Ambulatory Health Care, Urgent Care Association of America or the Joint Commission On Accreditation of Healthcare Organizations; or (ii) a current certification for participation in either Medicare or Medicaid. The department may approve such provisional application upon a finding of responsibility and suitability and that the urgent care center meets all other licensure requirements as determined by the department. Such provisional license issued to an urgent care center shall not be extended or renewed.

SECTION 94. Said section 218 of said chapter 111, as so appearing, is hereby further amended by striking out, in line 28, the words “Maintenance Organizations” and inserting in place thereof the following word:- Plans.

SECTION 95. Said chapter 111, as so appearing, is hereby further amended by inserting after section 244 the following section:-

Section 245. (a) Pursuant to section 23 of chapter 6D, a private equity firm shall deposit, upon submission of a notice of material change pursuant to section 13 of chapter 6D, a bond with the department of public health.

(b) Until such bond has been deposited, the department of public health shall not issue a license to such provider or provider organization under this chapter, the department of mental health shall not issue a license to such provider or provider organization under chapter 19, and any determination of need application submitted under sections 25B to 25G, inclusive, of said chapter 111 or material change notice submitted under section 13 of chapter 6D shall be deemed incomplete. Notwithstanding any general or special law to the contrary, if the bond has not been deposited, but the department of public health would otherwise be eligible to collect the bond, the department shall be permitted to collect from the private equity firm the amount it would have been able to collect had the bond been deposited.

(c) The health policy commission shall determine the amount of the bond, which shall equal 1 year of the provider or provider organization’s average or estimated operating expenses, plus the estimated cost of hiring an independent supervisor and reasonable staff to supervise and facilitate collecting and spending the bond. The private equity firm shall maintain the bond for as long as it has a financial interest in the provider or provider organization, and for 7 years thereafter.

(d) The department of public health may collect the bond if the health policy commission provides the department of public health with notification pursuant to subsection (c) of section 23 of chapter 6D, or if the provider or provider organization in which the private equity firm has or had a financial interest declares bankruptcy. The department of public health, in consultation with the health policy commission and the center for health information and analysis, shall use the bond proceeds to support the continued provision of health services to patients served by the provider or provider organization. Prior to spending the bond, the department of public health shall seek input from the public, including, but not limited to, providers, provider organizations and patients in the affected region, regarding how to spend the bond. The department of public health may, in consultation with the health policy commission and center for health information and analysis, select an independent supervisor and reasonable staff to supervise and facilitate collecting and spending the bond.

SECTION 96. Section 1 of chapter 112 of the General Laws, as so appearing, is hereby amended by inserting after the third paragraph the following paragraph:-

The commissioner of occupational licensure and the commissioner of public health shall by regulation define the words “good moral character”, establish a standardized assessment of “good moral character” for applicants for certification or licensure. Each of the boards of registration and examination under supervision of the commissioner of occupational licensure and the commissioner of public health shall apply said standard definition and assessment of “good moral character” for applicants of certification or licensure. The commissioners shall hold at least 1 public hearing seeking input on the standard definition and assessment of “good moral character” for applicants of certification or licensure. In developing the standard definition and assessment of “good moral character”, the commissioners shall consider factors including, but

not limited to: (i) the nature and gravity of any conduct that would cause concerns about an applicant's moral character, including whether the conduct demonstrates a disregard for the welfare, safety or rights of another or disregard for honesty, integrity or trustworthiness; (ii) the nature of the job; (iii) the length of time that has passed since the conduct; (iv) the circumstances surrounding the conduct, including the age of the offender and contributing social conditions and biases; (v) evidence of rehabilitation, including subsequent work history and character references; and (vi) racial, ethnic and other inequities in the criminal justice system.

SECTION 97. The sixth paragraph of section 2 of said chapter 112, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- The renewal application shall be accompanied by a fee determined under the aforementioned provision and shall include the physician's name, license number, home address, office address, specialties, the principal setting of their practice and whether they are an active or inactive practitioner.

SECTION 98. Said chapter 112 is hereby further amended by inserting after section 4 the following 2 sections:-

Section 4A. (a) For the purposes of this section and section 4B, the following words shall have the following meanings unless the context clearly requires otherwise:

"Clinician", a physician, nurse, physician assistant, psychologist or independent clinical social worker, who is licensed to provide health services and registered in the commonwealth pursuant to this chapter to provide such services, and any other individual who is licensed to provide health services and registered in the commonwealth pursuant to this chapter to provide such services.

"Clinician with independent practice authority", a physician registered to practice medicine in the commonwealth or a nurse practitioner, psychiatric nurse mental health clinical specialist or nurse anesthetist who is registered to practice nursing in the commonwealth and who has independent practice authority pursuant to sections 80E, 80H and 80J.

"Health care practice", a business, regardless of form, through which a clinician with independent practice authority licensed by the board of registration in medicine or the board of registration in nursing offers health services; provided, however, that "health care practice" shall not include any entity that holds a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111.

"Management services organization", a business that provides management or administrative services to a provider or provider organization for compensation.

"Nurse anesthetist", an advanced practice registered nurse who is authorized advanced nursing practice in the commonwealth pursuant to sections 80B and 80H.

"Nurse practitioner", an advanced practice registered nurse who is authorized in advanced nursing practice in the commonwealth pursuant to sections 80B and 80E.

"Physician", a doctor of medicine or doctor of osteopathy who is registered to practice medicine in the commonwealth pursuant to section 2.

"Provider", shall have the same definition as in section 1 of chapter 6D.

"Provider organization", shall have the same definition as in section 1 of chapter 6D; provided, however, that for the purposes of this section, "provider organization" shall not include a management services organization.

“Psychiatric nurse mental health clinical specialist”, an advanced practice registered nurse who is authorized in advanced nursing practice in the commonwealth pursuant to sections 80B, 80E and 80J.

(b) A clinician with independent practice authority may practice medicine or nursing at a health care practice that is: (i) wholly owned and controlled by 1 or more clinicians with independent practice authority who hold a certificate of registration that: (1) is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 and 80B of this chapter; and (2) has not been suspended or revoked; or (ii) conducted through a business organization, a majority share of which is owned by clinicians with independent practice authority or a provider or provider organization, and which is formed as: (1) a professional corporation pursuant to chapter 156A; (2) a nonprofit organization, a nonprofit hospital services corporation organized under chapter 176A or a nonprofit medical services corporation organized under chapter 176B; (3) a limited liability company organized under chapter 156C; provided, however, that there are no limited liability company’s provisions limiting or eliminating the licensee's liability for intentional tort or negligence; (4) a partnership organized under chapter 108A, including, but not limited to, a registered limited liability partnership; provided, however, that the partnership has no provisions limiting or eliminating the licensee's liability for intentional torts or negligence; or (5) an organization similar to those organizations described in clauses (i) to (iv), inclusive, and organized under a comparable law of any other jurisdiction within the United States; provided, however, that a majority share of the organization shall be owned by clinicians with independent practice authority or a provider organization.

(c) It shall constitute the unauthorized practice of medicine in violation of section 6 for any person or entity, on their own or in combination with another person or entity, to own a majority share in a health care practice other than provider or provider organization that is substantially engaged in delivering health care to patients in the commonwealth or a clinician with independent practice authority who: (i) holds a certificate of registration that is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 or 80B and has not been suspended or revoked; and (ii) is substantially engaged in delivering health care to patients in the commonwealth through the practice or managing of the health care practice. This section shall not apply to a health care facility or entity that holds a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111.

(d)(1) Nothing in this section shall prohibit a clinician with independent practice authority from practicing medicine or nursing as an employee of a health care facility or entity that holds a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111.

(2) Health care facilities or entities that hold a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111, providers and provider organizations shall not, themselves or through a management services organization that the provider organization fully or partially owns or controls, directly or indirectly interfere with, control or otherwise direct the professional judgment or clinical decisions of clinicians with independent practice authority who receive compensation, including, but not limited to, as employees or independent contractors, from the health care facility, provider, provider organization or an entity that the provider organization fully or partially owns or controls.

Conduct prohibited under this paragraph shall include, but not be limited to, controlling, either directly or indirectly, through discipline, punishment, threats, adverse employment actions, coercion, retaliation or excessive pressure, regarding: (i) the amount of time spent with patients, including the time permitted to triage patients in the emergency department or evaluate admitted patients; (ii) the time period within which a patient must be discharged; (iii) decisions involving the patient's clinical status, including, but not limited to, whether the patient should be kept in observation status, whether the patient should receive palliative care and where the patient should be placed upon discharge; (iv) the diagnosis, diagnostic terminology or codes that are entered into the medical record; or (v) any other conduct the department of public health determines by regulation would interfere with, control or otherwise direct the professional judgement or clinical decisions of clinicians with independent practice authority. Such health care facilities or entities shall not limit the range of clinical orders available to clinicians either directly or by configuring the medical record to prohibit or significantly limit the clinical order options available. Nondisclosure or non-disparagement agreements regarding subsections (i) through (v), inclusive, between clinicians with independent practice authority and health care facilities or entities that hold a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111, providers, provider organizations or their corporate affiliates shall be considered void and unenforceable. If a court of competent jurisdiction finds a policy, contract or contract provision void and unenforceable pursuant to this section, the court shall award the plaintiff reasonable attorney's fees and costs. Nothing in this section shall limit the ability of any person to bring any action relating to defamation, disclosure of confidential or proprietary information or trade secrets or similar torts.

(e) All health care practices shall provide written certification that the health care practice meets the requirements in this section to the board of registration in medicine or the board of registration in nursing at the time of formation and on a biennial basis thereafter. If a health care practice's owners consist of individuals registered solely with the board of registration in medicine or the board of registration in nursing, the health care practice shall provide the certification to the applicable board. If the practice's owners consist of individuals registered with both boards, the health care practice shall provide the certification to the board of registration in medicine, which shall transmit a copy to the board of registration in nursing. Health care practices shall, at the time that such clinicians with independent practice authority are hired or affiliated with the practice and within 30 days of providing certification to the applicable board pursuant to this section, provide a copy of the most recent certification to all clinicians with independent practice authority who: (i) engage in providing health services at the health center practice; and (ii) do not hold any ownership interest in the health center practice.

(f) Health care practices shall file with the applicable board a registration application containing such information as the board may reasonably require, including, but not limited to: (i) the identity of the applicant and of the clinicians with independent practice authority which constitute the practice; (ii) any management services organization under contract with the health care practice; (iii) a certified copy of the health care practice's certificate of organization, if any, as filed with the secretary of the commonwealth, or any applicable partnership agreement; (iv) the address of the health care practice; (v) the services provided by the health care practice; and (vi) any information the board, in consultation with the health policy commission and the center for health information and analysis, deems relevant for the state health plan and focused assessments pursuant to section 22 of chapter 6D and the health care resources inventory

pursuant to section 9 of chapter 12C. The application shall be accompanied by a fee in an amount to be determined pursuant to section 3B of chapter 7. All health care practices registered in the commonwealth shall renew their certificates of registration with the applicable board every 2 years. The board shall share information relevant to the state health plan and focused assessments pursuant to section 22 of chapter 6D with the commission and information relevant to the health care resources inventory pursuant to section 9 of section 12C with the center.

(g) All health care practices with more than 1 clinician with independent practice authority that constitutes the practice shall designate a clinician with independent practice authority at the practice to serve as health care director; provided, however, that the designated clinician shall hold a certificate of registration that: (i) is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 or 80B; and (ii) has not been suspended or revoked. The director shall be responsible for implementing policies and procedures to ensure compliance with local ordinances and state and federal laws and regulations governing the practice of medicine or the practice of nursing, including regulations promulgated and policies established by the applicable board. The board may impose discipline against the licenses of the director and clinicians with independent practice authority who own and control the health care practice for failure of the health care practice to comply with local ordinances and state and federal laws and regulations governing the practice of medicine or the practice of nursing, including regulations promulgated and policies established by the applicable board.

(h) The board of registration in medicine and board of registration in nursing may promulgate regulations to establish minimum requirements for the conduct of a health care practice, including, but not limited to: (i) compliance with section 4A; (ii) maintenance and

access to medical records; and (iii) in the event of a planned closure of the health care practice or an unplanned event that prevents the health care practice from continuing operations, the development of a continuity plan to: (1) ensure access to medical records, (2) provide notice to patients; and (3) assist patients with transitioning to a new provider. If a practice's owners consist of individuals registered solely with the board of registration in medicine or the board of registration in nursing, the practice shall comply with the applicable board's regulations. If the practice's owners consist of individuals registered with both boards, the practice shall comply with the regulations issued by the board of registration in medicine. Each board shall consult with the other when promulgating regulations.

Section 4B. (a) It shall be a violation of this section for a management services organization to exercise control over clinical decisions. A management services organization, or any other organization that is not a health care practice, that does any of the following shall be considered to have control over the clinical decisions of the health care practice: (i) managing, supervising, evaluating or recommending promotion or discipline of any owner of or clinician with independent practice authority associated with the health care practice; (ii) negotiating with third-party payers on behalf of a health care practice without first obtaining informed consent from the health care practice's owners; (iii) advertising or otherwise presenting as a health care practice or provider of health care services; or (iv) performing any other functions that the department of public health determines, by regulation, confers to a management services organization or any other entity that is not a health care practice the ability to control the clinical decisions of the health care practice or its clinicians with independent practice authority.

(b) A health care practice shall maintain ultimate decision-making authority over: (i) personnel decisions involving clinicians, including, but not limited to, employment status,

compensation, hours or working conditions; (ii) coding or billing decisions; (iii) the selection and use of property, including, but not limited to, real property, medical equipment or medical supplies; (iv) the number of patients seen in a given period of time or the amount of time spent with each patient; (v) the appropriate diagnostic test for medical conditions; (vi) the use of patient medical records; (vii) referral decisions; or (viii) any other function or decision that the department of public health determines, by regulation, confers to a management services organization or any other entity that is not a health care practice the ability to control the clinical decisions of a health care practice or its clinicians with independent practice authority.

(c) It shall be a violation of this section for a management services organization or any other entity that is not a health care practice to include in an agreement with any health care practice provisions that would: (i) restrict the ability of the health care practice or practice owner to exercise complete, unfettered control and discretion over the finances or capital of the health care practice, including, but not limited to, restricting the ability to create, buy or sell stock, issue dividends or sell the health care practice; (ii) restrict the ability of a person who owns stock in the health care practice to transfer, alienate or otherwise exercise unfettered discretion and control over their stock; (iii) restrict in any way the ability of the health care practice or clinicians with independent practice authority associated with the health care practice to provide health care services in any place, for any entity or in any form otherwise permitted by law; (iv) restrict the ability of the health care practice to contract with another management services organization for management or administrative services upon expiration of the current contract; (v) limit the ability of the health care practice or the practice’s owners, employees or agents to publicly discuss the business relationship between the health care practice and the management services organization; provided, however, that this provision shall not limit the ability of any

person to bring any action relating to defamation, disclosure of confidential or proprietary information or trade secrets or similar torts; (vi) limit access to, take control from or otherwise obscure from any clinicians providing services in connection with the health care practice, the price, rate or amount of the charges for their services; (vii) establish, supervise, manage or otherwise control the health care practice's officers or directors; or (viii) create any other situation the department of public health determines, by regulation, could create the possibility of allowing the management services organization to control the clinical decisions of the health care practice.

(d) No management services organization shall have any ownership interest in or direct or indirect control over health care practices for which the management services organization provides services. No health care practice shall have any ownership interest in or direct or indirect control over a management services organization unless the management services organization is fully owned, alone or in combination, by: (i) health care practices substantially engaged in delivering health care to patients in the commonwealth; (ii) clinicians with independent practice authority who both: (1) hold a certificate of registration that is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 and 80B and has not been suspended or revoked; and (2) are substantially engaged in delivering health care to patients in the commonwealth; or (iii) provider organizations. For the purposes of this subsection, a de minimis interest in a publicly traded company held in a mutual fund, index fund or similar financial instrument shall not be considered an ownership interest.

(e) No person may serve as a director, officer, employee or contractor for both a management services organization and a health care practice for which the management services

organization provides services; provided, however, that this subsection shall not apply when the management services organization is fully owned, alone or in combination, by: (i) health care practices substantially engaged in delivering health care to patients in the commonwealth; (ii) clinicians with independent practice authority who both: (1) hold a certificate of registration that is issued by the board of registration in medicine or the board of registration in nursing pursuant to the requirements of sections 2 and 80B and has not been suspended or revoked; and (2) are substantially engaged in delivering health care to patients in the commonwealth; or (iii) provider organizations.

(f) A violation of this section shall constitute the unauthorized practice of medicine in violation of section 6 or the unauthorized practice of nursing in violation of section 80E, 80H or 80J. Any provision of a contract or agreement that has the effect of violating this section shall be void and unenforceable. If a court of competent jurisdiction finds a policy, contract or contract provision void and unenforceable pursuant to this section, the court shall award the plaintiff reasonable attorney's fees and costs.

(g) The department of public health, in consultation with the health policy commission, shall promulgate regulations to effectuate the purposes of this section.

SECTION 99. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Foreign company" the following definition:-

"Health insurance company", a company that engages in the business of health insurance.

SECTION 100. Said section 1 of said chapter 175, as so appearing, is hereby further amended by inserting after the definition of "Net value of policies" the following definition:-

"Party of record", for the purpose of a review by the commissioner of a written agreement for a merger or consolidation of 2 or more health insurance companies, the health

policy commission, the center for health information and analysis, the attorney general, the center for health information and analysis and any government agency with relevant oversight or licensure authority over the proposed project or components therein.

SECTION 101. The fourth paragraph of section 5 of chapter 176A of the General Laws, as so appearing, is hereby amended by inserting after the fourth sentence the following sentence:- In determining whether rates of payment under this section are excessive, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's rates solely on the basis of the affordability standard.

SECTION 102. The second paragraph of section 6 of said chapter 176A, as so appearing, is hereby amended by adding the following sentence:- In determining whether the rates of payment under a contract are excessive under this section, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's rates solely on the basis of the affordability standard.

SECTION 103. The third paragraph of section 10 of said chapter 176A, as so appearing, is hereby amended by inserting after the first sentence the following sentence:- In determining whether the rates of payment under a contract are excessive under this section, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's rates solely on the basis of the affordability standard.

SECTION 104. The second paragraph of section 4 of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the second sentence the following

sentence:- In determining whether the rates of payment under an agreement are excessive under this section, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's rates solely on the basis of the affordability standard.

SECTION 105. The first paragraph of section 16 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the second sentence the following sentence:- In determining whether the rates of payment under a contract are excessive under this section, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's rates solely on the basis of the affordability standard.

SECTION 106. Subsection (c) of section 6 of chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after the second sentence the following sentence:- In determining whether the proposed changes to base rates of payment are excessive under this section, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's proposed changes to base rates solely on the basis of the affordability standard.

SECTION 107. The second paragraph of subsection (g) of section 7 of chapter 176K of the General Laws, as so appearing, is hereby amended by adding the following sentence:- In determining whether rates of payment are excessive under this section, the commissioner shall consider the affordability for consumers and purchasers of health insurance products; provided, however, that the commissioner shall not disapprove a carrier's rates solely on the basis of the affordability standard.

SECTION 108. Section 12 of chapter 176O of the General Laws, as so appearing, is amended by adding the following subsections:-

(g) For an insured member who is stable on a treatment, service or course of medication as determined by a health care provider and approved for coverage by a previous carrier or health benefit plan, a carrier or utilization review organization shall not restrict coverage of such treatment, service or course of medication for at least 90 days upon the insured member's enrollment unless the previously approved admission, procedure, treatment, service or course of medication is not a covered benefit under the insured member's new plan; provided, however, that a carrier may condition coverage of continued treatment by a provider under this subsection upon the provider's agreeing to accept reimbursement from the carrier at the average in-network rate and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing imposed if the provider were in network.

(h) Preauthorization approval issued by a carrier for a prescribed maintenance medication shall be valid for the length of the prescription, as written by the prescriber, up to 1 year. For the purposes of this section, "maintenance medication" shall mean a prescribed treatment services, or course of medication intended for chronic disease management.

SECTION 109. The General Laws are hereby amended by inserting after chapter 176X the following chapter:-

Chapter 176Y. LICENSING AND REGULATION OF PHARMACY BENEFIT MANAGERS.

Section 1. As used in this chapter, the following words shall have the following meanings unless the context clearly requires otherwise:

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical service corporation organized under chapter 176B, a health maintenance organization organized under chapter 176G or an organization entering into a preferred provider arrangement under chapter 176I; provided, however, that "carrier" shall not include an employer purchasing coverage or acting on behalf of its employees or the employees of a subsidiary or affiliated corporation of the employer; and provided further, that unless otherwise provided, "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

"Center", the center for health information and analysis established under chapter 12C.

"Commissioner", the commissioner of insurance.

"Division", the division of insurance.

"Health benefit plan", a contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided, however, that the commissioner may, by regulation, define other health coverage as a "health benefit plan" for the purposes of this chapter.

"Pharmacy", a physical or electronic facility under the direction or supervision of a registered pharmacist that is authorized to dispense prescription drugs and has entered into a network contract with a pharmacy benefit manager or a carrier.

"Pharmacy benefit manager", a person, business or other entity, however organized, that directly or through a subsidiary provides pharmacy benefit management services for prescription drugs and devices on behalf of a health benefit plan sponsor, including, but not limited to, a self-

insurance plan, labor union or other third-party payer; provided, however, that pharmacy benefit management services shall include, but not be limited to: (i) the processing and payment of claims for prescription drugs; (ii) the performance of drug utilization review; (iii) the processing of drug prior authorization requests; (iv) pharmacy contracting; (v) the adjudication of appeals or grievances related to prescription drug coverage contracts; (vi) formulary administration; (vii) drug benefit design; (viii) mail and specialty drug pharmacy services; (ix) cost containment; (x) clinical, safety and adherence programs for pharmacy services; and (xi) management of the cost of covered prescription drugs; and provided further, that "pharmacy benefit manager" shall not include a health benefit plan sponsor unless otherwise specified by the division.

Section 2. (a) No person, business or other entity shall establish or operate as a pharmacy benefit manager without obtaining a license from the division pursuant to this section. A license may be granted if the division is satisfied that the applicant possesses the necessary organization, background expertise and financial integrity to supply the services sought to be offered. A pharmacy benefit manager license shall be valid for a period of 3 years and shall be renewable for additional 3-year periods. The commissioner shall charge application and renewal fees in the amount of $25,000. In no event may these fees, when combined with the assessment of pharmacy benefit managers in section 6 of chapter 6D and section 7 of chapter 12C, exceed the commonwealth's estimated operating expenses of the pharmacy benefit manager licensure program.

(b) A license granted pursuant to this section and any rights or interests therein shall not be transferable.

(c) A person, business or other entity licensed as a pharmacy benefit manager shall submit data and reporting information to the center according to the standards and methods specified by the center pursuant to section 10A of chapter 12C.

(d) The division may issue or renew a license pursuant to this section, subject to restrictions in order to protect the interests of consumers. Such restrictions may include: (i) limiting the type of services that a license holder may provide; (ii) limiting the activities in which the license holder may be engaged; or (iii) addressing conflicts of interest between pharmacy benefit managers and health plan sponsors.

(e) The division shall develop an application for the licensure of pharmacy benefit managers that shall include, but not be limited to: (i) the name of the applicant or pharmacy benefit manage; (ii) the address and contact telephone number for the applicant; (iii) the name and address of the agent of the applicant or pharmacy benefit manager for service of process in the commonwealth; (iv) the name and address of any person with management or control over the applicant or pharmacy benefit manager; and (v) any audited financial statements specific to the applicant or pharmacy benefit manager. An applicant or pharmacy benefit manager shall inform the division any material change to the information contained in its application, certified by an officer of the applicant, within 30 days of such a change; provided, however, that, once licensed, a pharmacy benefit manager shall inform the division of any material change to the information contained in its application, certified by an officer of the pharmacy benefit manager.

(f) The division may suspend, revoke, refuse to issue or renew or place on probation an application or pharmacy benefit manager license for cause, which shall include, but not be limited to: (i) the applicant or pharmacy benefit manager engaging in fraudulent activity that is found by a court of law to be a violation of state or federal law; (ii) the division receiving

consumer complaints that justify an action under this chapter to protect the health, safety and interests of consumers; (iii) the applicant or pharmacy benefit manager failing to pay an application or renewal fee for a license; (iv) the applicant or pharmacy benefit manager failing to comply with reporting requirements of the center under section 10A of chapter 12C; or (v) the applicant or pharmacy benefit manager failing to comply with a requirement of this chapter.

The division shall provide written notice to the applicant or pharmacy benefit manager and advise in writing of the reason for any suspension, revocation, refusal to issue or renew or placement on probation of an application or pharmacy benefit manager license. A copy of the notice shall be forwarded to the center. The applicant or pharmacy benefit manager may make a written demand upon the division within 30 days of receipt of such notice for a hearing before the division to determine the reasonableness of the division's action. The hearing shall be held pursuant to chapter 30A.

The division shall not suspend or cancel a license unless the division has first afforded the pharmacy benefit manager an opportunity for a hearing pursuant to said chapter 30A.

(g) If a person, business or other entity performs the functions of a pharmacy benefit manager in violation of this chapter, the person, business or other entity shall be subject to a fine of $5,000 per day for each day that the person, business or other entity is found to be in violation.

(h) A pharmacy benefit manager licensed under this section shall notify a health carrier client in writing of any activity, policy, practice contract or arrangement of the pharmacy benefit manager that directly or indirectly presents any conflict of interest to the pharmacy benefit manager's relationship with or obligation to the health carrier client.

(i) The division shall promulgate regulations and adopt policies and procedures necessary to implement this section.

SECTION 110. There shall be a task force to: (i) study primary care access, delivery and payment in the commonwealth; (ii) develop and issue recommendations to stabilize and strengthen the primary care system and the primary care workforce; and (iii) increase the financial investment in and patient access to primary care across the commonwealth.

(b) The task force shall consist of: the secretary of health and human services or a designee, who shall serve as co-chair; the executive director of the health policy commission or a designee, who shall serve as co-chair; the assistant secretary for MassHealth or a designee; the executive director of the center for health information and analysis or a designee; the commissioner of insurance or a designee; the chairs of the joint committee on health care financing or their designees; 1 member from the Massachusetts Academy of Family Physicians, Inc.; 1 member from the Massachusetts Chapter of the American Academy of Pediatrics; 1 member from the Massachusetts Medical Society with expertise in primary care; 1 member from the Massachusetts Coalition of Nurse Practitioners, Inc. with expertise in primary care or in delivering care in a community health center; 1 member from the Massachusetts Association of Physician Assistants, Inc. with expertise in primary care; 1 member from the National Association of Social Workers, Inc. – Massachusetts Chapter with expertise in behavioral health in a primary care setting; 1 member from the Massachusetts League of Community Health Centers, Inc.; 1 member from the Massachusetts Health and Hospital Association, Inc.; 1 member from the Massachusetts Association of Health Plans, Inc.; 1 member from Blue Cross and Blue Shield of Massachusetts, Inc.; 1 member from the Association Industries of Massachusetts; 1 member from the Retailers Association of Massachusetts, Inc.; 1 member from Health Care For All, Inc.; 1 member from the Massachusetts Chapter of the American College of

Physicians; 1 member from the Massachusetts Primary Care Alliance for Patients; and 1 member from Massachusetts Health Quality Partners, Inc.

(c) The task force shall develop recommendations to: (i) define primary care services, codes and providers; (ii) develop a standardized set of data reporting requirements for private and public health care payers, providers and provider organizations to enable the commonwealth and private and public health care payers to track payments for primary care services, including, but not limited to, fee-for-service, prospective payments, value-based payments and grants to primary care providers, fees levied on a primary care provider by a provider organization or hospital system of which the primary care provider is affiliated and provider spending on primary care services; (iii) establish a primary care spending target for private and public health care payers that reflects the cost to deliver evidence-based, equitable and culturally competent primary care; (iv) propose payment models to increase private and public reimbursement for primary care services; (v) assess the impact of health plan design on health equity and patient access to primary care services; (vi) monitor and track the needs of and service delivery to residents of the commonwealth; and (vii) create a short-term and long-term workforce development plan to increase the supply and distribution of and improve working conditions of primary care clinicians and other primary care workers. The task force may make additional recommendations and propose legislation necessary to carry out its recommendations.

(d) The task force shall, in consultation with the center for health information and analysis, define the data required to satisfy the contents of this section. The center for health information and analysis shall adopt regulations to require providers and private and public health care payers to submit data or information necessary for the task force to fulfill its duties with this section. Any data collected shall be public and available through the Massachusetts

Primary Care Dashboard maintained by the center and Massachusetts Health Quality Partners, Inc.

(e) Not later than March 15, 2025, the task force shall issue its report of the findings and recommendations under clauses (i) and (ii) of subsection (c) with the clerks of the senate and the house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

(f) Not later than June 15, 2025, the task force shall issue its report of the findings and recommendations under clause (iii) of subsection (c) with the clerks of the senate and the house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

(g) Not later than September 15, 2025, the task force shall issue its report of the findings and recommendations under clauses (iv) and (v) of subsection (c) with the clerks of the senate and the house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

(h) Not later than December 15, 2025, the task force shall issue its report of the findings and recommendations under clauses (vi) and (vii) of subsection (c) with the clerks of the senate and the house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

SECTION 111. (a) There shall be a task force to study the use of prior authorization for health care services and its impact on overall costs in the health care system, and delivery of and access to high quality health care. The task force shall consist of 11 members: the executive director of the health policy commission or a designee, who shall serve as co-chair; the commissioner of insurance or a designee, who shall serve as co-chair; the assistant secretary for MassHealth; the executive director of the group insurance commission; 1 representative from the Massachusetts Association of Health Plans, Inc.; 1 representative from Blue Cross and Blue Shield of Massachusetts, Inc.; 1 representative from the Massachusetts Medical Society; 1 representative from the Massachusetts Health and Hospital Association, Inc.; 1 representative from the Massachusetts Academy of Family Physicians, Inc.; 1 representative from the Massachusetts League of Community Health Centers, Inc.; 1 representative from Massachusetts Taxpayers Foundation, Inc.; 1 representative from Associated Industries of Massachusetts; and 1 representative from Health Care For All, Inc.

(b) The task force shall analyze: (i) the services, treatments and medications that require prior authorization by payers in Massachusetts; (ii) the factors used by payers to determine whether a service, treatment or medication is appropriate for prior authorization, including considerations of potential for provider abrasion, adverse impacts on health outcomes, the availability, and comparative cost and effectiveness of alternative treatment options and risk of provider overuse of the treatment; (iii) the processes used by payers to obtain prior authorization for a service, treatment or medication; (iv) the potential for streamlining prior authorization processes using automation, electronic submissions, gold carding or other means; (v) actuarial analysis of the impact of prior authorization requirements on the commonwealth's efforts to meet the health care cost benchmark established under section 9 of chapter 6D; (vi) any state and

federal laws requiring or limiting prior authorization by public or private payers for a service, treatment or medication; (vii) the feasibility of an easily accessible, publicly available website with up-to-date information that provides information regarding utilization review requirements for treatments; (viii) the services that have no or low prior authorization denial rates across carriers; (ix) administrative barriers preventing active prior authorizations to continue for their approved duration in instances where an insured individual transitions to a new plan with the same carrier or to a new carrier; (x) expedited utilization review processes across carriers; and (xi) barriers to and solutions for providing uniformity in processes or requirements among different health care segments, including Medicaid, Medicare, fully-insured and self-insured commercial plans.

(c) The task force shall develop recommendations regarding: (i) simplifying and standardizing prior authorization for evidence-based treatments, services or courses of medication; (ii) improving access to medically necessary covered services for patients; (iii) reducing the response time from a carrier or utilization review organization for prior authorization approvals and denials; (iv) reducing administrative barriers and costs related to prior authorization on health care providers; (v) limiting the recoupment and denial of claims for medically necessary covered services; (vi) increasing transparency for covered benefits and prior authorization requirements; (vii) standardizing prior authorization processes, forms and requirements for use across health insurance carriers; (viii) eliminating prior authorization requirements for services, treatments, procedures and prescription drugs that have low variation in utilization across providers or low denial rates; (ix) eliminating prior authorization for or reducing the prior authorization review process to 24 hours for emergency treatments, services or courses of medication; (x) ensuring any physician or personnel under the supervision of a

physician that is reviewing a prior authorization request for a carrier has the clinical expertise to treat the medical condition or disease that is the subject of the request; and (xi) removing prior authorization for certain chronic disease management.

(d) The task force shall develop a report of its findings and recommendations, including any legislative or regulatory changes necessary to implement its recommendations. The task force shall file its report with the clerks of the senate and the house of representatives, the senate and house committees on ways and means and the joint committee on health care financing not later than July 31, 2025.

SECTION 112. Notwithstanding any general or special law to the contrary, the division of insurance shall consider the recommendations issued by the task force established in section 111 in developing and implementing rules, regulations, bulletins or other guidance to simplify health insurance prior authorization standards and processes.

SECTION 113. (a) Notwithstanding any general or special law to the contrary, the secretary of health and human services shall direct monthly payments to eligible hospitals in the form of enhanced Medicaid payments, supplemental payments or other appropriate mechanisms. Each payment made to an eligible hospital shall be allocated in direct proportion to each eligible hospital’s average monthly Medicaid payments, as determined by the secretary, for inpatient and outpatient acute hospital services for the preceding year or the most recent year for which data is available; provided, however, that such enhanced Medicaid payments shall not be used in subsequent years by the secretary to calculate an eligible hospital’s average monthly payment; and provided further, that such payments shall not offset existing Medicaid payments for which an eligible hospital may be qualified to receive. In any fiscal year, the total sum of all payments

made to eligible hospitals under this section shall not exceed $45,000,000. Eligible hospitals may consider expending said payments to strengthen behavioral health supports and services.

(b) The secretary may require as a condition of receiving payment any such reasonable condition of payment that the secretary determines necessary to ensure the availability, to the extent possible, of federal financial participation for the payments and the secretary may incur expenses and the comptroller may certify amounts for payment in anticipation of expected receipt of federal financial participation for the payments.

(c) The executive office of health and human services may promulgate regulations as necessary to carry out this section.

(d) For the purposes of this section "eligible hospital" shall mean an acute care hospital licensed under section 51 of chapter 111 of the General Laws that: (i) has a statewide relative price less than 0.99, as calculated by the center for health information and analysis according to data from the most recent available year; (ii) has a public payer mix greater than 63 per cent, as calculated by the center for health information and analysis according to data from the most recent available year; and (iii) is not owned by or financially consolidated or corporately affiliated with a provider organization, as defined by section 1 of chapter 6D of the General Laws and as reported by the center for health information and analysis in the fiscal year 2022 hospital cost report database: (1) owns or controls 4 or more acute care hospitals licensed under said section 51 of said chapter 111; or (2) through which the total net assets of all affiliated acute care hospitals within the provider organization is greater than $800,000,000.

(e) For the purposes of subsection (d), a clinical affiliation with a provider organization, absent ownership, financial consolidation or corporate affiliation, shall not disqualify an eligible hospital from payments authorized under this section.

SECTION 114. (a) Notwithstanding any general or special law to the contrary, for the purposes of monitoring and enforcing the health care cost growth benchmark for calendar years 2021 to 2025, inclusive, the center for health information and analysis shall apply sections 8, 9, 10, 16 and 18 of chapter 12C of the General Laws as those sections are in effect on December 1, 2024.

(b) Notwithstanding any general or special law to the contrary, for the purposes of monitoring and enforcing the health care cost growth benchmark for calendar years 2021 to 2025, inclusive, the health policy commission shall apply sections 9 and 10 of chapter 6D of the General Laws as those sections are in effect on December 1, 2024.

(c) Notwithstanding any general or special law to the contrary, the first benchmark cycle shall consist of the years 2025 and 2026. The health care cost growth benchmark for that benchmark cycle shall be the average of the 2025 health care cost growth benchmark that the health policy commission governing board established in 2024 and the growth rate of potential gross state product for 2026 established under section 7H½ of chapter 29 of the General Laws.

(d) Notwithstanding any general or special law to the contrary, not later than April 15, 2025, the board shall establish the health care cost growth benchmark pursuant to section 9 of chapter 6D of the general laws for: (i) the benchmark cycle consisting of the years 2025 and 2026; and (ii) the benchmark cycle consisting of the years 2026 and 2027.

(e) Notwithstanding any general or special law to the contrary, on or before January 15, 2025, the secretary and house and senate committees on ways and means shall jointly develop growth rates of potential gross state product pursuant to section 7H½ of chapter 29 of the General Laws for each of the calendar years of 2026 and 2027.

SECTION 115. Notwithstanding any general or special law, rule or regulation to the contrary, section 13 of chapter 6D of the General Laws, as amended by this act, shall apply only to material change notices submitted after the effective date of this act; provided, however, that said section 13 of said chapter 6D shall apply to material changes that meet all of the following criteria: (i) the health policy commission received a completed material change notice regarding the material change on or after March 1, 2024; (ii) the health policy commission has not yet determined whether to conduct a cost and market impact review in regard to the material change; and (iii) the health policy commission classifies the material change as involving a provider or provider organization's merger or affiliation resulting in an increase in net patient service revenue of $10,000,000 or more. For such material change notices, the health policy commission shall be permitted to require submission of a new or revised material change form, request additional documentation and information and take an additional 30 days to conduct its preliminary review.

SECTION 116. Notwithstanding any general or special law, rule or regulation to the contrary, the health policy commission shall submit the first state health plan to the governor and the general court, as required under section 22 of chapter 6D of the General Laws, on or before January 1, 2026.

SECTION 117. Notwithstanding any general or special law to the contrary, section 23 of said chapter 6D shall only apply to private equity firms that obtain a financial interest in a provider or provider organization and to financial actions taken by registered provider organizations with private equity investment after the effective date of this act.

SECTION 118. Notwithstanding any general or special law, rule or regulation to the contrary, section 4B of chapter 112 of the General Laws shall apply only to contracts or

agreements between medical practices and management services organizations entered into after the effective date of this act.

SECTION 119. Section 17 shall take effect on January 1, 2025.

SECTION 120. Section 67 shall take effect on August 1, 2025.

SECTION 121. All health care practices required to register pursuant to section 4A of chapter 112 of the General Laws shall register with the board of registration in medicine not later than January 1, 2026.

SECTION 122. The commissioner of occupational licensure and the commissioner of public health shall adopt the regulations required under section 96 not later than 6 months after the effective date of this act.

SECTION 123. The division of insurance shall adopt the rules and regulations required under section **Error! Reference source not found.**112 not later than 6 months after the task force established in section 111 issues its final report and recommendations.

SECTION 124. Section 113 is hereby repealed.

SECTION 125. Section 124 shall take effect 2 years from the effective date of this act.