Massachusetts Taxpayers Foundation

Order	Bill Section	MGL Chapter	MGL Section	Bill Section Summary
1	1	6A	16	Eliminates language including the Betsy Lehman Center within EOHHS.
2	2	6A	16D	Makes a technical change clarifying that the Office of Patient Protection is housed within the HPC.
3	3	6A	16N	Repeals requirement that the Commission study the feasibility of reducing or eliminating contributions to the Uncompensated Care Trust Fund.
4	4	6A	16T	Eliminates the Health Planning Council within EOHHS.
5	5 through 11	6D	1	Creates or amends 12 definitions within the HPC statute. New definitions are: • Health care real estate investment trust • Health care resource • Health disparities • Health equity • Management services organization • Pharmaceutical manufacturing company • Pharmacy benefit manager • Private equity company • Significant equity investor In addition, these sections amend the following definition: • Payer - eliminates exclusion of ERISA plans and allows inclusion to the extent allowed by ERISA
6	12	6D	2	Changes the makeup of the HPC. Under the changes: • HPC's board remains at 11 members • Eliminates membership of ANF secretary and adds the Commissioner of Insurance • Increases Governor appointments from 3 to 6 • Maintains AG's three appointments • Eliminates Auditor's 3 appointments • The Governor's appointments shall be: 1. a person with expertise in health care (HC) administration, finance, and management; 2. a person with expertise in representing hospitals or hospital systems; 3. a person with expertise in health plan administration & finance; 4. a registered nurse with expertise in the delivery of care and development and utilization of innovative treatments in the practice of patent care; 5. a person with expertise in HC workforce as a leader in a labor organization (nominated by the Senate President); 6. a person with expertise in health care innovation, including pharmaceuticals, biotech, or medical devices (nominated by the Speaker). • The AG's appointments shall be: 1. a health economist; 2. a health care consumer advocate; 3. a person with expertise in behavioral health. • Provides a stipend for all non ex-officio members equal to 10% of the ANF Secretary's salary (chair stipend equal to 12%)
7	13	6D	5	Adds to the HPC's role in monitoring the health care system by requiring the HPC to monitor the location and distribution of health care services and resources.

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8	14	6D	6	Adds non-hospital provider organizations (between 3 and 8 percent), pharmaceutical manufacturers (between 5 and 10 percent), and pharmacy benefit managers (between 5 and 10 percent) to the list of entities assessed to support the operations of the HPC. The assessment of PMs and PBMs is contingent on the assessment not resulting in any reduction in federal Medicaid reimbursement. Non-hospital provider organizations includes clinical labs, image facilities, and urgent care centers or non-hospital-based physician practices with at least $500M in annual gross patient service revenue. The assessment on acute hospitals, ambulatory surgical centers, and non-hospital provider organizations will be between 30 and 40 percent.
9	15	6D	7	Adds an eligibility criterion for receipt of funds from the HPC's Healthcare Payment Reform Fund. The new category is the advancement of health equity.
10	16 through 21	6D	8	Makes several changes to MGL 6D:8 (Health Care Cost Trends Hearing). The changes: • Add to the scope of health care entities under the purview of the hearings to include PMs, PBMs, and relevant impact of significant equity investors, HC REITs, and MSOs on cost, price, and cost trends • Add significant equity investors, HC REITS, and management services organizations to the list of required participants • Add 3 drug manufacturers (one publicly traded, one generic, one in business less than 10 years) and 2 PBMs to the list of required participators • Adds ED of the Health Connector and EOHHS Assistant Secretary for MassHealth to the list of required participants and directs HPC to ask CMS to participate • Defines the scope of testimony for the MassHealth director, significant equity investors, and pharmaceutical participants • Update language governing the cost trend report to reflect the expanded scope of the hearing • Require the HPC report to include recommendations to increase the efficiency and affordability of health care
11	22	6D	11	Requires that providers seeking registration or renewal provide information as to significant equity investors, health care real estate investment trusts, and management service organizations.
12	23	6D	12	Amends the registered provider reporting threshold to include any provider with $25M or more in annual net service revenue from all payers, including public payers, not just carriers and third party administrators.

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13	24	6D	13	Amends the HPC Material Change notification process. Under the new process, additional activities would be defined as material changes, including: • Significant expansions in capacity • Mergers or acquisitions (including those that result in a provider organization having a dominant market share in a given service or region) • Acquisition of insolvent provider organizations • Transactions involving significant equity investors which result in a change of ownership or control of a provider or provider organization • Significant acquisitions, sales or transfers of assets, including real estate lease-back arrangements • Conversion from a non-profit to a for-profit organization The new language also: • Lays out the type of information the HPC can request for material changes involving significant equity investors • Allows the HPC to require data submission related to a material change for 5 years following the completion of the change to assess impacts. • Allows the market impact review process to consider 15 factors including any data and reports from the Office of Health Resource Planning, the size and market share of corporate affiliates and significant equity investors, and the DPH inventor of health care resources • Directs the HPC to refer to the AG providers that are ID'd as meeting the following three criteria: 1. having or likely to have a dominant market share; 2. charge or will likely charge materially higher than median prices; 3. have or is likely to have, as a result of the change, a health status adjusted TME that is materially higher than the median TME for all other providers in the same market as a result of the change. • Allows the AG, upon referral, to conduct an investigation and, if appropriate, take action under 93A in which the HPC report may be evidence. • The final report of a market cost and impact review process shall be provided to DPH and considered relevant in its DON process.
14	25	6D	***22***	Directs the HPC to develop and maintain a state health resource plan, in consultation with EOHHS, its agencies, CHIA and DOI. The plan, to be developed at least every 5 years shall: • ID current and anticipated needs of the state for health care services, providers, programs, and facilities • ID existing resources and projected resources necessary to meet needs • Make recommendations for the appropriate supply and distribution of resources on a statewide and regional basis and recommendations for necessary action to accomplish those recommendations • Provide a forecast of demand, supply and distribution of 24 different health resources over each five-year period • Pursue a goal of the appropriate and equitable distribution of health care resources throughout the state, with 10 subgoals related to access, equity, cost and affordability, and system efficiency In addition to the health resource plan, HPC may also conduct "focused assessments" of resource supply and distribution related to need. The assessments can include policy recommendations to address disparities, barriers to access, and misalignment of supply and demand. • Provide direction to DPH to establish and maintain a health care resources inventory (which will be developed with the cooperation of relevant entities) • Require submission of information by relevant entities to conduct the focused assessments • Annually update the legislature on the progress of the plan and hold at least one annual public hearing
15	26	12	5A	Amends the AGO false claims statute definition of" 'knowing/knowingly" to also include "knows".

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16	27	12	5A	Adds a definition to the false claim statute for "Ownership or investment interest". Applies to direct ownership of 10% or more as well as two categories of investment involvement.
17	28 & 29	12	5B	Expands false claims liability to include those with an ownership or investment interest in a person who is subject to false claims liability and knows but fails to disclose the violation.
18	30	12	11N	Amends the scope of health care entities the AG can get information from to include significant equity investors, health care real estate investment trusts, and management services organizations.
19	31 through 36	12C	1	Adds or amends 18 definitions to the CHIA statute: • Health care real estate investment trust (new) • Health disparities (new) • Health equity (new) • Management services organization (new) • Payer (new) • Pharmaceutical manufacturing company (new) • Pharmacy benefit manager (new) • Private equity company (new) • Significant equity investor (new)
20	37	12C	2A	Adds a person with experience in health equity advocacy to the CHIA Oversight Council
21	38	12C	7	Updates the CHIA assessment to: • Require pharmaceutical manufacturing companies, PBMs, and non-hospital provider organizations to be assessed for CHIA costs • Changing the provider and carrier share of the CHIA assessment from not less than 33% to between 30 and 40% • Assessing non-hospital provider organizations between 3 and 8% of the CHIA assessment • Assessing pharmaceutical manufacturing companies and PBMs between 5 and 10% of each CHIA assessment, provided that it does not reduce the amount of FFP to MassHealth • Drug company payments shall be made based on MassHealth's spending on the company's drugs, and PBM payments shall be based on each PBM's share of total claims paid attributed to residents of the Commonwealth
22	39	12C	8	Adds significant equity investors, health care real estate investment trusts and management services organizations to the list of affiliated entities from whom CHIA can request information.
23	40	12C	8	Expands the scope of the audited financial statements that CHIA can request to include those of significant equity investors, health care real estate investment trusts and management services organizations.
24	41	12C	8	Directs CHIA to analyze health care data investments, and information on significant equity investors, health care real estate investment trusts and management services organizations.
25	42	12C	9	Strikes and replaces section governing CHIA data collections from providers. The new language: • Directs CHIA to consult with the HPC in determining data collection elements • Requires financial information to include information on out-of-state operations, information on private equity, REIT and MSO involvement • Requires information on other financial assets and liabilities that may affect the financial condition of the organization • Directs CHIA to consider administrative burden when considering data collection requirements

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26	43	12C	11	Increases the weekly fine for failing to meet CHIA reporting requirements from $1K to $25K and eliminates the $50K cap on fines. Expands the scope of CHIA's notification of reporting requirements to all entities subject to submission requirements (not just providers, provider organizations, and payers). . Requires CHIA to notify the HPC and DPH of failure to meet reporting requirements. Such failure shall be a consideration in material change analyses, licensure, and determination of need (DON) proceedings.
27	44	12C	14	Amends the CHIA Standard Quality Measure Set. Under the new process: • CHIA, in consultation with its Advisory Committee, will establish a standard set of health care provider quality and health system performance measures (the Standard Quality Measure Set) • The set is to be established by 3/1 on even-numbered years The set is to be used: • In contracts between payers • In assigning tiers to health care providers in plan design • In consumer transparency websites • Monitoring system-wide performance The set shall designate core measures to be used in provider/payer contracts that incorporate quality measures. The set must meet standards set by the Advisory Committee. CHIA must report on any differences between its set and the recommendations of the Advisory Committee. The Statewide Advisory Committee will consist of 19 members (8 ex officio) and be chaired by HPC and the Division of Health Insurance. The Committee will meet quarterly and make recommendations on the set. The recommendations must incorporate nationally recognized standards as well as recommendations by state entities. Recommendations from the group are due by January 1st of even-numbered years
28	45 through 48	12C	15	Amends the Lehman Center statute to: • Add or amend four definitions • Allow it to share information with other providers and agencies that collect patient safety information through an ISA (provided the agreement has necessary safeguards). It also explicitly allows the Lehman Center to adopt rules and regulations necessary for its operation and to contract with another entity to manage its affairs or carry out the purpose of the section.
29	49	12C	17	Expands the information reported to CHIA available to the AG to include information by significant equity investors, health care real estate investment trusts, and management service organizations. It also allows the AG to use the information provided during the HPC Annual Cost Trend Hearing and in cases brought by the AG.
30	50	13	10	Updates the Board of Registration in Medicine statute to allow the board to hire an ED, general counsel, and other staff as appropriate and to enter into contracts/arrangements necessary for the operation of the board
31	51	13	10A	Establishes that any proposed rule or regulation not approved by DPH within 30 days will be deemed disapproved.
32	52	106	9-609	Amends the Uniform Commercial Code related to secured transactions to require 60 days notice to DPH in any case where a secured party is looking to possess collateral in the form of a medical device
33	53 through 55	111	25A	Amends the DPH health care resources inventory statute to reflect a proposal to put the Office of Health Resource Planning under HPC
34	56	111	25B	Creates a definition for "Party of Record" for the DPH Determination of Need Process

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35	57	111	25C (g)	Amends the DPH Determination of Need (DON) Process. Under the proposed process: • DPH would consider several factors in making a DON: the state health plan, cost containment goals, impact on the applicant's patients, impact on the workforce of surrounding providers, impact on residents of the Commonwealth, any relevant HPC cost and market impact review, other data as relevant •DPH may impose reasonable terms on the DON as necessary to accomplish enumerated goals DPH may also consider special circumstances as they relate to workforce, research, capacity, and cost.
36	58	111	25C (h)	Changes the independent cost analysis provision to allow DPH to choose the entity from a list of three provided by the applicant
37	59	111	25C (i)	Amends the process for comment for DON by allowing the state to submit the required information and to allow other parties of record to request a public hearing.
38	60	111	25C (j)	Amends the timeline for DPH action on DON. The period review of an application with an independent cost review would be put on hold until the analysis is received and accepted by the department. The amended language would also prevent a DON from going into effect for at least 30 days after an HPC market cost and impact review is completed (if one is ongoing at the time of the DON). Similarly, a DON would not go into effect until 30 days after a determination by the HPC that the applicant is implementing or has implemented a PIP (when applicable). HPC can rescind such a determination at any time.
39	61	111	25C (o)	Adds a new paragraph to MGL 111:25C allowing a party of record to review a DON application and provide comments and recommendations. DPH is required to share written comments with all parties of record.
40	62	111	25F	Updates the DON legislative reporting requirement section to reflect the Joint Committee on Health Care Financing.
41	63	111	51G (4)	Amends the process for DPH notification of closure of an essential health service by authorizing DPH to seek an analysis from the HPC of the impact of the proposed closure.
42	64	111	51G (7(a))	Prohibits an original hospital license from being granted if the main campus is leased from a health care real estate investment trust. Any acute hospital leasing its main campus from such an entity as of 4/1/2024 will be exempt from this section and that exempt status will be maintained for any subsequent transfer. Prohibits any original license from being granted to establish or maintain an acute-care hospital unless all documents related to the lease/license for use are disclosed. Prohibits any original license from being granted to establish or maintain an acute-care hospital unless the applicant is in compliance with all CHIA reporting requirements.
43	65 through 67	111	51H	Amends DPH reporting requirements related to serious medical events to add a provision for an "operational impairment event." An operational impairment event pertains to financial delinquency including related potential repossession of medical equipment. Under the language, hospitals would be required to report relevant events within 1 day of their occurrence. The language also prohibits any medical equipment contracts from allowing for repossession in fewer than 60 days from notice to DPH.
44	68	111	***51N***	Creates a DPH licensing process for office-based surgical centers. Licenses will be granted/renewed for 2 years. The section defines the conditions under which a facility would be subject to regulation under the section.

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45	68	111	***51O***	Creates a DPH licensing process for urgent care centers. Licenses will be granted/renewed for 2 years. The section defines the conditions under which a facility would be subject to regulation under the section.
46	69	111	218	Updates DPH statute to replace MAHMO with MAHP.
47	70	111D	7	Allows "clinical laboratory directors" to serve for a maximum of 5 months (current maximum is 3 months).
48	71	112	2	Removes reference to "his or her" specialties in the information required upon licensure.
49	72	118E	9C	Updates MassHealth statute to reflect the correct name of the Joint Committee on Health Care Financing
50	73	176A	5	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
51	74	176A	6	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
52	75	176A	10	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
53	76	176B	4	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
54	77	176G	16	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
55	78	176J	6	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
56	79	176K	7	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that any review of rates must adhere to principles of solvency and actuarial soundness.
57	80	NWS		Creates a task force to study and make recommendations to improve primary care access, delivery and financial stability. The Task Force: • Is made up of 25 members and chaired by EOHHS and HPC • All members are named in the section • The task force's recommendations will include: definitions of service, create standardized data reporting, establishing a primary care spending target for public and private payers, assessing impacts on health equity, and devising ways to increase the workforce supply and improve employment conditions • The state will publish relevant data on a Primary Care Dashboard maintained by CHIA and Massachusetts Health Quality Partners • Recommendations related to definitions and standardized data collection and reporting are due by 9/15/2025 • Recommendations related to the spending target are due by 12/15/2025 • Recommendations related to payment models and plan design are due on 3/15/2026 • Recommendations on service delivery are due on 5/15/2026
58	81	NWS		Makes changes to the assessment method for HPC and CHIA administrative budgets effective for the FY 2026 budget
59	82	NWS		Requires the Office of Health Resource Planning to submit a state health resource plan not later than 1/1/2027.
60	83	NWS		Requires DPH, in consultation with the Board of Registration in Medicine, to promulgate regulations related to office-based surgical centers by 10/1/2025.
61	84	NWS		Requires DPH, in consultation with the Board of Registration in Medicine, to promulgate regulations related to urgent care centers by 10/1/2025.

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62	85	NWS		Allows DPH to issue a 1-time provisional waiver for up to 1 year to an office-based surgical center which is not in full compliance with applicable requirements but demonstrates potential for achieving full compliance within the provisional period.
63	86	NWS		Allows DPH to issue a 1-time provisional waiver for up to 1 year to an urgent care center that is not in full compliance with applicable requirements but demonstrates the potential for achieving full compliance within the provisional period.
64	87	NWS		Establishes that current members of the HPC board shall continue to serve until the expiration of their term or 6/30/2025, whichever comes first, and establishes a process and terms for new appointments as required by the bill.
65	88	NWS		Makes changes to the HPC board effective 7/1/2025.