Massachusetts Taxpayers Foundation

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
1	6A	16	Eliminates language including the Betsy Lehman Center within EOHHS.		
2	6A	16D	Makes a technical change clarifying that the Office of Patient Protection is housed within the HPC.		
3	6A	16N	Repeals requirement that the Commission study the feasibility of reducing or eliminating contributions to the Uncompensated Care Trust Fund.		
4	6A	16T	Eliminates the Health Planning Council within EOHHS.		
5 through 16	6D	1	Creates or amends 11 definitions within HPC statute. New definitions are: • Benchmark cycle - a 2 year calendar period during which the projected annualized growth in total health care expenditures is calculated as set forth in MGL 6D:10 • Financial Interest • Health care resource • Health disparities • Health equity • Management services organization • Maximum adjusted debt to adjusted EBITDA ratio • Pharmaceutical manufacturing company • Pharmacy benefit manager • Private equity firm • Real estate investment trust • Total medical expenses • Unsafe financial sector In addition, these sections amend the following definitions • Health care cost growth benchmark • Payer - eliminates exclusion of ERISA plans and allows inclusion to the extent allowed by ERISA • Provider organization	Health Equity	

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
17	6D	2	Changes the makeup of the HPC. Under the changes: • Increases total membership from 11 to 13 • Increases gubernatorial appointments from 3 to 7 • Increases AG appointments from 3 to 4 • 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 registered nurse with experience in delivery of care & innovative patient treatments; 3. a person with expertise in health plan administration & finance; 4. a person with expertise in HC workforce; 5. a person with expertise in life sciences; 6. a primary care physician; 7. a person with expertise as a purchaser of health insurance. • The AG's appointments shall be: 1. a person with expertise representing hospitals/health systems administration and finance; 2. a health care consumer advocate; 3. a person with expertise in behavioral health; 4. a health economist. • Provides a stipend for all non ex-officio members equal to 10% of the ANF Secretary's salary (chair stipend equal to 12%)		
18	6D	3A	Creates an office of Pharmaceutical Policy and Analysis within the HPC. The office is charged with issuing reports relating to key issues of pharmaceutical spending, innovation in high value drugs, and the impact of these issues on racially and ethnically diverse populations and those with disabilities. The office is empowered to solicit data directly from manufacturers, PBMs and payers necessary to develop their reports. The Office will produce an annual report on trends and underlying factors affecting drug spending.	Health Equity	Administrative Costs
19	6D	4	Amends the HPC Advisory Council to: • Require that the Council meet at least quarterly • Require the HPC to present the views of the Council at Board meetings • Add community health centers & purchasers of health insurance representing business management or benefits administration to the perspectives to be reflected in the Council		
20 & 21	6D	5	Adds to the HPC's role in monitoring the health care system by requiring health care cost growth and affordability goals (currently just cost) and adding a charge to monitor pharmaceutical spending, pricing and patient access.		
22 through 24	6D	6	Changes the assessment for HPC costs to: • Require pharmaceutical manufacturers and PBMs to the list of assessed industries • Change the provider assessment from 33 to 25 percent of the HPC appropriation • Allow the assessment to include costs for other HPC programs including the Community Hospital Reinvestment Trust Fund • Assess pharmaceutical manufacturing companies and PBMs for 25 percent of HPC and related costs, provided that such assessments do not reduce the state's FFP. The PBM assessment will cover the cost of licensure for the industry. • Pharmaceutical manufacturers and PBMs will pay the assessment on the shares of sales or drugs dispensed in the Commonwealth • Total PBM fees cannot exceed the estimated expense of operating a PBM in the Commonwealth.		

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Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
25	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.	Health Equity	
26	6D	8	Strikes and replaces MGL 6D:8 (HPC Annual Cost Trend Hearing). The changes: • Reflect the proposed 2 year cost growth benchmark • Require analysis of costs compared to the proposed Affordability Index • Add to the scope of health care entities under the purview of the hearings to include private equity, REITs, management services organizations, drug manufacturers and PBMs • Add private equity/REIT/management services organizations associated with a provider to the list of required participators • Add drug manufacturers and PBMs to the list of required participators • Define scope of testimony for the MassHealth director, private equity and pharmaceutical participants • Require that witnesses from providers be from geographically diverse regions of the Commonwealth • Add testimony related to health insurance premium and cost sharing to the list of topics for testimony in instances when the benchmark is exceeded • Update language governing the cost trend report to reflect the expanded scope of the hearing • Require the HPC report to include recommendations to increase efficiency and affordability of health care		
27	6D	9	Strikes and replaces MGL 6D:9, which defines the HC Cost Growth Benchmark. The Senate proposal: • Extends the time frame of the benchmark to two years • Defines the benchmark as the average growth rate of potential GSP for the two years that comprise the cycle • Up to and including the 2039-2040 benchmark cycle, the HPC may adjust the benchmark if reasonably warranted, provided they hold a hearing first. The scope of the hearing is expanded to include issues related to private equity/investment in HC and drug cost.		
27	6D	9A	Requires the HPC to establish a health care affordability benchmark for each calendar year.		
27	6D	10	Amends the process for HC entities identified by the HPC as exceeding the cost growth benchmark. Under the Senate language: • The HPC is empowered to identify the identities and performance results of "referred entities" • Makes the definition of health care entity consistent with CHIA definition • Changes language relating to information the HPC is to consider if an entity requests a waiver or delay in a PIP. Price, labor costs and comparative analysis are now included. • The word 'cost' is replaced by 'spending' • In lieu of a PIP, the HPC can assess a fine on an entity equal to spending in excess of the benchmark. Any fines would be deposited into the Payment Reform Fund. HPC would need to provide prior notice and the entity could request a hearing or respond in writing to the notice to assess a fine. • Eliminates prohibition on the HPC considering separate elements of PIPs separately and removes the physician practice PIP exemption. • For entities that do not comply or fail to act in good faith, the Senate proposes increasing financial penalties, allowing the HPC to pause any of the entity's active material change notices, and notifying DPH for consideration as part of the DON process		Potential Administrative Costs

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
28	6D	11	Reduces the length of an HPC provider licensure from two years to one year to align reporting between the HPC and CHIA.		
29	6D	11	Amends information by the HPC for provider licensure to be consistent with MGL 12C:9. HPC retains the ability to request other information as it deems necessary.		
30	6D	11	Eliminates language requiring the HPC to support DOI in review of MGL 176U organizations and instead allows HPC to enter into interagency agreements with CHIA and other states agencies as appropriate.		
31	6D	12	Amends HPCs powers to monitor and enforce MGL 6D:11 (registration of provider organizations). Under the new language, providers who fail to provide required information can be fined up to $10K per week (with a cap of $500K). Any revenue to be deposited into the Payment Reform Fund. The section also deems incomplete material change or DON applications from providers that have not provided information required by section 11.		

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
31	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 • Transactions involving new for-profit investment in acquisition of assets, ownership and control by for-profit entities (including private equity) • Substantial acquisition or sale of assets for an ownership share or for the purposes of a leaseback arrangement • Conversion from a non-profit to a for-profit organization The new language also: • Allows the HPC to recommend modifications in instances in which it believes the change would result in a significant negative impact on health care consumers in the commonwealth. If modifications are not made based on the recommendations, it would constitute a 93A violation subject to challenge under section 4 of that chapter. • Updates how the cost growth benchmark will interact with cost and market impact reviews. • Expands the scope of consideration for market cost and impact reviews. The Senate includes language allowing HPC to require data submission related to a material change for 5 years following the completion of the change to assess impacts and follow-through on any commitments made. • Allows the review to consider what is likely to result from the proposed change, including the cumulative impact mergers, acquisitions and joint ventures undertaken over a reasonable time period. • Defines providers that are ID'd as having or likely to have a dominant market share or charge materially higher than median prices as a result of the change to be presumed to be engaging in unfair/deceptive business practices and subject to AG powers under 93A (but powers of the AG are limited in certain cases). • Allows HPC to define thresholds for when a change meets certain standards (i.e. is a non-material change or when dominant market share is involved) and in establishing those thresholds, HPC shall weigh whether multiple mergers, etc. over time trigger the identified threshold. • Allows HPC to review the changes alignment with the State Health Plan • The final report of a market cost and impact review process shall be provided to DPH and considered as relevant in its DON process.	Health Equity	Potential Administrative Costs

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
32	6D	***22***	Directs the HPC to develop and maintain a state health 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, barriers and make recommendations as necessary to reduce barriers and appropriately supply services • Include recommendations related to provision of 24 different types of HC services • Pursue of a goal of the appropriate and equitable distribution of health care resources throughout the state, with 9 subgoals related to access, equity, cost and affordability and system efficiency • Require submission of information by relevant entities • Include regular "focused assessments" of provider supply and distribution related to need in specific service lines in one or more relevant regions. The language sets forth a rubric for identifying and prioritizing service lines. The assessments can include policy recommendations to address disparities, barriers to access and misalignment of supply and demand • Every 2 years the HPC will publish a summary of the current state plan, a description of focused assessments undertaken in the last two years, and legislative recommendations.	Health Equity	Potential Administrative Costs
32	6D	***23***	Establishes limits on private equity investment in health care providers and creates mechanisms for enforcing those standards and implementing penalties when standards are not met. Under the proposal: • Providers with private equity investment cannot exceed a maximum adjusted debt to EBITDA ratio, become highly leveraged, transact with unsafe financial actors or engage in a number of types of financial transactions as long as the private equity firm has a stake in the provider • Private equity firms as required to deposit a bond with DPH ensuring that requirements of private equity investment in providers are not violated. Provider assets cannot be used as security for the bond and the bond shall not be paid for by placing debt on the provider. • Compliance shall be determined by HPC based on data provided by CHIA • HPC can require the entity to come into compliance with the section within 3 months or a shorter reasonable time • If an entity does not remain in compliance, DPH can collect the bond required of all providers with qualifying private equity investment. The bond is equal to 1 year of the provider's annual operating expenses plus staff necessary to oversee and facilitate spending of the bond • If an entity is not in compliance or if an entity fails to comply with HPC conditions, it constitutes a 93A violation (only the AG, affected workers or an organization with a contract with the provider can bring a 93A action)	Health Equity	
33	12	5A	Amends the AGO false claims statute definition of 'knowing/knowingly' to also include 'knows'.		
34	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.		
35 & 36	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.		
37	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, management services organizations, drug manufacturers and PBMs.		

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
38	12	11N	Amends the provision governing what the AG can do in cases of referral from the HPC under MGL 6D:13 to include injunctive relief.		
39 through 48	12C	1	Adds or amends 18 definitions to the CHIA statute: • Benchmark cycle (new) • Financial interest (new) • Health care cost growth benchmark (amended) • Health care entity (new) • Health disparities (new) • Health equity (new) • Management services organization (new) • Maximum adjusted debt to adjusted EBITDA ratio (new) • Payer (new) • Pharmaceutical manufacturing company (new) • Pharmacy benefit manager (new) • Private equity firm (new) • Provider organization (amended) • Real estate investment trust (new) • Total medical expenses (new) • Unsafe financial actor (new)	Health Equity	
49	12C	2A	Adds a person with experience with health equity advocacy to the CHIA Oversight Council	Health Equity	
50	12C	3	Updates reference to cost and affordability benchmark		
51	12C	3	Updates CHIA statute to reflect roll in data for HPC affordability benchmark		
52 through 54	12C	7	Updates the CHIA assessment to: • Require pharmaceutical manufacturing companies and PBMs to be assessed for CHIA costs • Changing the provider and carrier share of the CHIA assessment from 33% to 25% • Assessing pharmaceutical manufacturing companies and PBMs not less than 25% of the CHIA assessment, provided that it does not reduce the amount of FFP to MassHealth • Drug company and PBM payments shall be made based on their share of drug sales/drugs dispensed in the Commonwealth • Prohibits combined total of PBM assessments from exceeding the cost of the state's PBM licensure program		
55	12C	8	Adds private equity firms, health care real estate investment trusts and management services organizations to the list of affiliated entities from whom CHIA can request information.		
56	12C	8	Expands the scope of the audited financial statements that CHIA can request to include those of private equity firms, health care real estate investment trusts and management services organizations.		

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
57	12C	8	Directs CHIA to analyze health care data investments, and information on private equity firms, health care real estate investment trusts and management services organizations.		
58	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 collections elements • Adds requirement for data on the location and capacity of all locations where a provider operates including information on health care equipment (including imaging equipment) • 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 • Allows CHIA to request additional information in a given year to support the state health plan • Moves the health care resources inventory from DPH to CHIA and requires CHIA to develop and maintain an inventory of HC resources on its website • Empowers CHIA to collect data it deems necessary in protecting the public interest in monitoring the fiscal health of providers; this includes potential quarterly reporting for entities with private equity involvement • Financial information will be reported on an industry-wide and provider specific basis and include detail on revenue and highly compensated employees • Directs CHIA to consider administrative burden when considering data collections requirements • Directs CHIA to annually publish reports on the financial health of the system including the identification of providers considered to be in fiscal distress, and to ID providers in which a private equity firm has a financial interest. Any relevant providers shall be referred to the HPC.		Potential Administrative Costs
59	12C	10	Amends CHIA data requirements for payers to submit data for a representative range of Massachusetts communities, as well as group sizes.		
60 through 63	12C	10	Amends statute related to CHIA data submission requirements of insurance companies and MassHealth. The changes: • Limit the requirement for relative price submissions to every hospital and physician group in the payer's network • Add a requirement for information related to drug spending and utilization, including information on drugs with the biggest increases in utilization, and with the biggest impact on costs • Add a requirement for information on clinical quality, care coordination and referral practices • Enables CHIA to use non-payer data sources to collect data for non hospital and non-physician group providers. • Enhances pharmaceutical data collection through CHIA. • Adds quality data reporting requirements for private and public health care payers.		
64	12C	10A	Adds a new section to the CHIA statute which requires uniform annual reporting of PBMs. PBMs would be required to submit a range of information on their discounts, reimbursements, prices, and ownership interest or corporate affiliation in pharmacies or health plans. CHIA will publish an annual report on the information		

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65	12C	11	Increases the weekly fine for failing to meet CHIA reporting requirements from $1K to $25K and eliminates $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), but exempts public payers from penalties. 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.		Yes
66	12C	12	Requires any provider, payer or public agency that collects patient information to provide that information, when requested, by CHIA (consistent with this chapter and federal law)		
67	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). There will be uniform reporting requirements for the set, with a priority for primary care and behavioral health providers. The reporting will be designed so as to not add to administrative burden. • 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 • Reducing provider administrative burden related to quality measure reporting 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 the 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.	Health Equity	Potential Administrative Costs
68 through 71	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.		

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72 through 76	12C	16	Specifies that CHIA's annual report will cover the most recently completed benchmark cycle, updates references to the affordability benchmark, updates cross references to newly proposed HPC sections, and adds requirement that CHIA report on a standard set of measures of health care affordability and an index of how costs compare to the affordability index		
77	12C	17	Expands the information reported to CHIA available to the AG to include information by private equity firms, health care real estate investment trusts, management service organizations, drug manufacturers and PBMs. It also allows the AG to use information provided during the HPC Annual Cost Trend Hearing and in cases brought by the AG.		
77	12C	18	Amends the requirements for CHIA analysis of data submitted by health care entities. CHIA would continue to ID insurance carriers and providers contributing to health care cost growth (as measured by TME or total medical expense), but CHIA is directed to establish different standards for excessive growth based on cohorts of similar health care entities, an entity's baseline spending, pricing levels and payer mix. The CHIA report would also include entities that have not submitted information in a timely manner. CHIA is directed to confidentially provide the HPC with a list of entities that the HPC may want to review for PIP purposes given these criteria.		
78	13	10	Updates the Board of Registration in Medicine statute to allow the board to hire an ED and legal counsel. Any rule and regulation changes would still be subject to approval of DPH.		Potential Administrative Costs
79	13	10A	Establishes that any proposed rule or regulation not approved by DPH within 60 days will be deemed disapproved.		
80	26	7A	Changes the name of the Health Care Access Bureau within DOI to the Health Insurance Bureau (HIB) and significantly expands the section in MGL 26 governing its role. Under the new section: • The HIB is tasked with rate review of premium rates for health benefit plans, and retains prior language giving it authority for execution of the HIB's statutory and regulatory authority of the small and individual markets, oversight of affordable plans, and dissemination of information to consumers • The Deputy Commissioner of HIB has 6 defined cases: protecting the interests of consumers, encouraging fair treatment of providers, enhancing access, equity, quality and affordability, guarding solvency of insurers, working cooperatively with HPC and CHIA to monitor HC spending, and to consider affordability of products during rate review • The HIB is directed to develop affordability standards to consider during rate review • The HIB is directed to review documents submitted during rate review to examine causes of premium rate increase and provider price variation • The payer assessment for the division is increased from $600K to $1M • Payers are required to submit to the HIB annually a summary of negotiated rate increases for their largest providers, by provider group. This information will be provided to the HPC. • Rates of reimbursement or increase submitted to the HIB shall be deemed confidential and exempt from public records.	Health Equity	Potential Administrative Costs

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81	29	7H 1/2	Amends the statute governing the annual establishment of potential gross state product to reflect the proposed two year benchmark cycle.		
82	106	9-609	Amends the Uniform Commercial Code related to secured transactions to require 90 days notice to DPH in any case where a secured party is looking to possess collateral in the form of a medical device.		
83	111	1	Adds a definition for "Party of Record" related to a DON within the DPH statute.		
84	111	25A	Eliminates language from the DPH statute requiring the department to develop and publish a health resources inventory.		
85	111	25C (g)	Amends the DPH Determination of Need (DON) Process. Under the proposed process: • DPH would be guided by 6 principles in making the decision: 1. the project; 2. the state's health plan; 3. appropriate allocation of public and private health resources; 4. cost containment and affordability goals; 5. the impact on patients and on health equity goals; and 6. relevant comments from CHIA and HPC. •DPH may impose reasonable terms on the DON as necessary to accomplish enumerated goals including conditions intended to address health care disparities and better align with community need. DPH may also consider special circumstances as they relate to workforce, research, capacity, and cost. Special needs and circumstances may also relate to a lack of supply for a region, population or service line as identified in the state health plan or focused assessments.	Health Equity	Potential Administrative Costs
85	111	25C (h)	Strikes and replaces language governing DON applications. Under the new language: • DONs cannot be submitted unless the provider has submitted any material change notices required by HPC • Allows DPH to amend information or fees required in cases where the project addresses a lack of supply as identified in the state health plan or focused assessments • Specifies that the independent cost analysis will be conducted by an entity selected and overseen by the department • Empowers the independent entity to get from the application confidential information necessary to conduct its analysis. The information would also be provided to the HPC, DPH and the AG. The information could be disclosed by those agencies if it is in the public interest (after taking into account all relevant factors). Information provided would not be a public record.		
85	111	25C (i)	Amends the process for comment for DON by allowing the state to submit required information and to allow other parties of record (established in 111:25 1/4) to request a public hearing.		
85	111	25C (j)	Amends the timeline for DPH action on DON. Under the proposed process: • DPH would need to rule on a DON not more than 6 months after filing, however DPH can extend that process for a further 2 months • The period for review is stayed until the independent cost analysis is completed • The period is also stayed until a final cost and market impact review is completed (when required) • The period is stayed for any entity undergoing a PIP until HPC determines the PIP has been or is being appropriately implemented • HPC can rescind its determination of good faith implementation of the PIP at any time		

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86	111	25C (o) & (p)	Adds two new paragraphs to MGL 111:25C. • Paragraph (o) allows the department to create a DON waiver process. The process would exist in cases where the project addresses a specific need for a region, population or service line ID'd in the health plan or focused analyses. • Paragraph (p) allows a party of record to review a DON application and provide comment and requires DPH to share written comments with all parties of record.	Health Equity	
87	111	25F	Updates the DON legislative reporting requirement section to reflect the Joint Committee on Health Care Financing.		
88	111	51G	Allows DPH to seek analysis on the impacts of a closure of an essential health service from HPC.		
89	111	51G	Prohibits an original hospital license from being granted or renewed unless all documents related to leases, master lease, license for use and other related documents are disclosed to DPH upon licensure and the Department, after reviewing the documents, determines the applicant is suitable for use. 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.		
90 through 92	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.		
93	111	51M	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.		Potential Administrative Costs
93	111	51N	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.		Potential Administrative Costs
94	111	218	Updates DPH statute to replace MAHMO with MAHP.		
95	111	245	Creates a new section in DPH statute governing requirements for bonds required by private equity firms invested in providers upon submission of a material change notice. Under the section: • Until a bond has been submitted, DPH and DMH shall not issue a license and any DON or material change notice will be considered incomplete • The amount of the bond will be determined by the HPC and will be equal to 1 year of the provider's operating expenses plus administrative costs of collecting and spending the bond • The bond can be collected if HPC notifies DPH that the related provider organization has declared bankruptcy • Directs DPH to seek public input on how to spend the bond		Yes

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
96	112	1	Directs Occupational Licensure and DPH to define by regulation "Good Moral Character" and establish a standard assessment for applicants that would also be required of applicants for all boards of registration and examination under their purview. The section enumerates 6 factors for consideration in developing the definition of "Good Moral Character".		
97	112	2	Removes reference to "his or her" specialties in the information required upon licensure.		
98	112	4A	Defines the structure and regulatory framework governing health care practices, including those operated by physicians with independent practice authority. The section: • Defines the standards a health care practice operated by a clinician with independent practice authority must meet; • Prohibits a medical practice from being owned by a non-clinician under conditions laid out in the section • Prohibits health care facilities that employ clinicians from indirectly or directly interfering with the clinicians professional judgment or clinical decisions and defines what this interference entails • Defines the process for health care practices to be registered with the appropriate boards biennially • Requires practices with more than 1 physician to designate one physician to serve as health care director • Directs the relevant boards to promulgate regulations for conduct/licensure of medical practices		
98	112	4B	Prohibits management services organizations or other organizations that are not health care practices from exercising control over clinical decisions at health care practices and defines what control over clinical decisions entails. It also prohibits MSOs inclusion in agreements with health care practices a number of restrictive provisions including those that would restrict the ability of the practice to exercise financial or medical control over the organization, or contract with other MSOs. The section also prohibits MSOs from having ownership or direct or indirect control over an HC practice for whom it provides services. Prohibits someone from being employed by both and MSO and a health care practice. Requires that health care practices maintain ultimate control over decision making authority relating personnel, medical coding, use of property, number of patients, appropriate testing, and other care related responsibilities.		
99 & 100	175	1	Adds definitions of "Health Insurance Company" & "Party of Record" to MGL 175		
101	176A	5	Directs DOI to consider affordability for consumers and purchasers when approving rates under this section, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		
102	176A	6	Directs DOI to consider affordability for consumers and purchasers when determining whether rates are excessive under this section, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		
103	176A	10	Directs DOI to consider affordability for consumers and purchasers when considering whether rates of payments in a contract are excessive, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		
104	176B	4	Directs DOI to consider affordability for consumers and purchasers when determining whether rates are excessive under this section, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		
105	176G	16	Directs DOI to consider affordability for consumers and purchasers when determining whether rates are excessive under this section, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
106	176J	6	Directs DOI to consider affordability for consumers and purchasers when determining whether rates are excessive under this section, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		
107	176K	7	Directs DOI to consider affordability for consumers and purchasers when determining whether rates are excessive under this section, but states that DOI cannot disapprove rates solely on the basis of the affordability standard		
108	176O	12	Adds 2 new paragraphs to the section which : • Requires that a new insurer continue to approve a successful course of treatment for at least 90 days after a member has moved to a new insurer, unless the new treatment is not covered by the carrier. The section allows the carrier to negotiate with the provider to accept an in-network rate for continuation of the treatment • Makes preauthorization for a prescribed maintenance medication valid for the length of the prescription up to 1 year.		
109	176Y	NEW	Creates a new chapter providing for the licensure and oversight of PBMs. • Only licensed PBMs are authorized to operate in the state • Licenses are given by DOI for a term of 3 years • There is a $25K application fee • PBMs are required to submit all data required by CHIA • DOI is empowered to develop a licensing application and to issue new or renewed limited licenses • DOI is empowered to suspend, revoke, or not issue licenses for cause • PBMs are required to notify a health carrier client of any direct or indirect conflicts of interest • DOI is to develop regulations to implement the section.		Yes
110	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 23 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, establish a primary care spending target for public and private payers, assess impacts on health equity, and devise 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 collections and reporting are due by 5/15/2025 • Recommendations related to the spending target is due by 6/15/2025 • Recommendations related to payment models and plan design are due on 9/15/2025 • Recommendations on service delivery are due on 12/15/2025	Health Equity	

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
111	NWS		Creates a task force to study the impact of prior authorization and health care cost, delivery of care, and access. The task force: • Is made up of 11 members and will be chaired by HPC and DOI • All members are named • The task force will analyze 10 aspects of prior authorization, including: instances in which it is used; actuarial impact of its use on cost; processes to receive prior authorization; possible ways to improve use of prior authorization and create uniformity in its use. • The task force will come up with recommendations within 11 categories related to improvements in efficiency, information, clinical appropriateness and removal of prior authorization in certain circumstances. • The report is due to the Joint Committee on Health Care Financing and House and Senate Ways and Means on 7/31/2025		
112	NWS		Directs DOI to consider the recommendations of the prior authorization task force when developing and implementing rules related to prior authorization.		
113	NWS		Directs EOHHS to make $45M in annual supplemental payments to hospitals with a relative price of .99 or less, with a public payer mix of 63% or more, provided that the hospital is not owned or affiliated with a provider organization that owns 2 or more acute care hospitals and has total net assets in excess of $800M		Yes
114	NWS		Directs CHIA and HPC to calculate the health care cost benchmark between 2021 and 2025 as under the MGLs in effect on 12/1/2024. The benchmark in years 2025 and 2026 will be the average of the benchmark in 2025 and the growth rate of potential gross state product for 2026. Not later than 4/15/2025 the HPC Board will establish the growth benchmark for the 2025/2026 and the 2026/2027 cycles. ANF and House and Senate Ways and Means will develop the growth rates of potential gross state product for 2026 and 2027 by 1/15/2025.		
115	NWS		States that only material change applications submitted after the effective date of the act will be subject to the amended language set forth in the bill, except for material change applications • Received by HPC after 3/1/2024 • The HPC has not yet made a decision whether or not to conduct a review • The HPC estimates the impact of the change as impacting net patient service revenue by $10M or more In this case, HPC can ask for a resubmission, request additional information and take an additional 30 days to conduct an initial review.		
116	NWS		Requires the HPC to submit a State Health Plan by 1/1/2026.		
117	NWS		States that the provisions of MGL 6D:23 shall only apply to private equity firms obtaining a financial interest in a provider organization and to financial actions taken after the effective date of the act.		
118	NWS		States that the requirements of MGL 112:4B as established by this bill shall only apply to agreements between medical practices and management services organizations entered into after the effective date of the act.		

Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Category	State Fiscal Impact?
119	NWS		Makes section 17 (HPC Board changes) effective 1/1/2025.		
120	NWS		Makes the standard health care measure set effective 8/1/2025.		
121	NWS		Requires health care practices to register with the Board of Registration in Medicine no later than 1/1/2026.		
122	NWS		Requires "Good Moral Character" regulations to be adopted within 6 months of the effective date of the act.		
123	NWS		Requires DOI to adopt rules and regulations informed by the Prior Authoriztation task within 6 months of the task force's recommendations.		
124 & 125	NWS		Repeals enhanced Medicaid payments to eligible hospitals (proposed in section 113) 2 years after the effective date of the act.		