HOUSE . . . . . No. 5159

The Commonwealth of Massachusetts

The committee of conference on the disagreeing votes of the two branches with reference to the Senate amendments (striking out all after the enacting clause and inserting in place thereof the text contained in Senate document numbered 2881; and by striking out the title and inserting in place thereof the following title: "An Act enhancing the health care market review process.") of the House Bill enhancing the market review process (House, No. 4653), reports recommending passage of the accompanying bill (House, No. 5159). December 27, 2024.

John J. Lawn, Jr.	Cindy F. Friedman
Frank A. Moran	John J. Cronin
Hannah Kane	

FILED ON: 12/27/2024

HOUSE . . . . . No. 5159

The Commonwealth of Massachusetts

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

An Act enhancing the market review process.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

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 23, inclusive, the words "in the department of public health established by section 217 of chapter 111" and inserting in place thereof the following words:- within the health policy commission established by section 16 of chapter 6D.

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 Section 16N of said chapter 6A of the General Laws is hereby repealed.

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 Section 16T of said chapter 6A of the General Laws is hereby repealed.

SECTION 5. Section 1 of chapter 6D of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after the definition of "Health care provider" the following 2 definitions:-

"Health care real estate investment trust", a real estate investment trust, as defined by 26 U.S.C section 856, whose assets consist of real property held in connection with the use or operations of a provider or provider organization.

"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, which usually are the result of, or result in, disease, injury, deformity or pain; provided, however, that the term "treatment", as used in this definition, shall include custodial and rehabilitative care incident to infirmity, developmental disability or old age.

SECTION 6. 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 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 7. 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 definition:-

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

SECTION 8. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by striking out the definition of "Payer" and inserting in place thereof the following definition:-

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

SECTION 9. 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 hospital licensed under section 51 of chapter 111, 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", as defined in section 1 of chapter 176Y.

SECTION 10. 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 company", any company that collects capital investments from individuals or entities and purchases, as a parent company or through another entity that the company completely or partially owns or controls, a direct or indirect ownership share of a provider, provider organization or management services organization; provided, however, that "private equity company" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

SECTION 11. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Shared decision-making" the following definition:-

"Significant equity investor", (i) any private equity company with a financial interest in a provider, provider organization or management services organization; or (ii) an investor, group of investors or other entity with a direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of a provider, provider organization or management services organization; provided, however, that "significant equity investor" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

SECTION 12. 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 11 members: 1 of whom shall be the secretary of health and human services, or a designee; 1 of whom shall be the commissioner of insurance, or a designee; 6 of whom shall be appointed by the governor, 1 of whom shall serve as chairperson, 1 of whom shall be selected from a list of 3 nominees submitted by the president of the senate and 1 of whom shall be selected from a list of 3 nominees submitted by the speaker of the house or representatives; and 3 of whom shall be appointed by the attorney general. All appointed members shall serve for a term of 5 years, but a person appointed to fill a vacancy shall serve only for the remainder of the unexpired term. An appointed member of the board shall be eligible for reappointment; provided, however, that no appointed member shall hold full or part-time employment in the executive branch of state government. 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.

(2) The person appointed by the governor to serve as chairperson shall have demonstrated expertise in health care administration, finance and management at a senior level. The second person appointed by the governor, shall have demonstrated expertise in representing hospitals or hospital health systems. 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 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 fifth person appointed by the governor, from the list of nominees submitted by the president of the senate, shall have

demonstrated expertise in representing the health care workforce as a leader in a labor organization. The sixth person appointed by the governor, from the list of nominees submitted by the speaker of the house of representatives, shall have demonstrated expertise in health care innovation, including pharmaceuticals, biotechnology or medical devices. The first person appointed by the attorney general shall be a health economist. 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.

(c) Six 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 of administration and finance under said section 4 of said chapter 7. The secretary of health and human services and the commissioner of insurance, or their designees, shall not receive a stipend for their service as board members. A member of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, have a financial stake in or otherwise be a representative of a health care entity while serving on the board.

SECTION 13. Section 5 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 10, the words “and (vii)” and inserting in place thereof the following words:-

; (vii) monitor the location and distribution of health care services and health care resources; and (viii).

SECTION 14. Said chapter 6D is hereby further amended by striking out section 6, most recently amended by section 5 of chapter 140 of the acts of 2024, and inserting in place thereof the following section:-

Section 6. (a) For the purposes of this section, "non-hospital provider organization" shall mean a provider organization required to register under section 11 that is: (i) a non-hospital-based physician practice with not less than $500,000,000 in annual gross patient service revenue; (ii) a clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated urgent care centers.

(b) Each acute hospital, ambulatory surgical center, non-hospital provider organization, pharmaceutical manufacturing company and pharmacy benefit manager shall pay to the commonwealth an amount for the estimated expenses of the commission.

(c) The assessed amount for acute hospitals, ambulatory surgical centers and non-hospital provider organizations shall be not less than 30 per cent nor more than 40 per cent of the amount appropriated by the general court for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies; provided, however, that, to the maximum extent permissible under federal law, non-hospital provider organizations shall be assessed not less than 3 per cent nor more than 8 per cent of the total assessed amount for acute hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute hospital, ambulatory surgical center and non-hospital

provider organization shall pay such assessed amount multiplied by the ratio of the acute hospital's, ambulatory surgical center's or non-hospital provider organization's gross patient service revenues to the total gross patient service revenues of all such hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute hospital, ambulatory surgical center and non-hospital provider organization shall make a preliminary payment to the commission on October 1 of each year in an amount equal to 1/2 of the previous year's total assessment. Thereafter, each acute hospital, ambulatory surgical center and non-hospital provider organization shall pay, within 30 days' notice from the commission, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The commission shall subsequently adjust the assessment for any variation in actual and estimated expenses of the commission and for changes in acute hospital, ambulatory surgical center and non-hospital provider organization gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such acute hospital, ambulatory surgical center or non-hospital provider organization, the treasurer shall advance the amount of due and unpaid funds to the commission prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such assessments and the commission shall reimburse the treasurer for such advances upon receipt of such revenues. This section shall not apply to any state institution or to any acute hospital which is operated by a city or town.

(d) To the maximum extent permissible under federal law, and 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 5 per cent

nor more than 10 per cent of the amount appropriated by the general court for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each pharmaceutical manufacturing company shall pay such assessed amount multiplied by the ratio of MassHealth's net spending for the manufacturer's prescription drugs used in the MassHealth rebate program to MassHealth's total pharmacy spending.

(e) To the maximum extent permissible under federal law, and provided 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 5 per cent nor more than 10 per cent of the amount appropriated by the general court for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each pharmacy benefit manager shall pay such assessed amount multiplied by the ratio of the claims paid by the pharmacy benefit manager attributed to residents of the commonwealth for whom it manages pharmaceutical benefits on behalf of carriers to the total of all such claims paid by all pharmacy benefit managers attributed to residents of the commonwealth for whom they manage pharmaceutical benefits on behalf of carriers.

(f) 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 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 15. Section 7 of said chapter 6D, as appearing in the 2022 Official Edition, 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 16. Subsection (a) of section 8 of said chapter 6D, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following sentence:- The hearings 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 significant equity investors, health care real estate investment trusts, 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 primary care and behavioral health expenditures.

SECTION 17. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “payers” in line 16, the following words:- , significant equity investors, health care real estate investment trusts, management services organizations, pharmaceutical manufacturing companies, pharmacy benefit managers.

SECTION 18. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 29 through 34, inclusive, the words “(x) at least 4 provider organizations, at least 2 of which shall be certified as accountable care organizations, 1 of which has been certified as a model ACO, which shall be from diverse geographic regions of the

commonwealth; and (xi) any witness identified by the attorney general or the center" and inserting in place thereof the following words:- (x) at least 4 provider organizations which shall be from diverse geographic regions of the commonwealth, at least 2 of which shall be certified as accountable care organizations and 1 of which shall be certified as a model ACO; (xi) any significant equity investor, health care real estate investment trust or management services organization associated with a provider or provider organization; (xii) a representative from the division of insurance; (xiii) the executive director of the commonwealth health insurance connector authority; (xiv) the assistant secretary for MassHealth; (xv) not less than 2 representatives of the pharmacy benefit management industry; (xvi) not less than 3 representatives of pharmaceutical manufacturing companies, 1 of whom shall be a representative of a publicly traded company that manufactures specialty drugs, 1 of whom shall be a representative of a company that manufacturers generic drugs and 1 of whom shall be a representative of a company that has been in existence for fewer than 10 years; and (xvii) any witness identified by the attorney general or the center. The commission shall also request testimony from officials representing the federal Centers for Medicare and Medicaid Services.

SECTION 19. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 49, the first time it appears, the word "and".

SECTION 20. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word "commission", in line 60, the first time it appears, the following words:- ; (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 those programs in order to

encourage the development of more integrated and efficient health care delivery systems; (iv) in the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony concerning factors underlying prescription drug costs and price increases, the impact of aggregate manufacturer rebates, discounts and other price concessions on net pricing; provided, however, that such testimony shall be suitable for public release and not likely to compromise the financial, competitive or proprietary nature of any information or data; and (v) in the case of significant equity investors, health care real estate investment trusts or management services organization associated with a provider or provider organization, testimony concerning health outcomes, prices charged to insurers and patients, staffing levels, clinical workflow, financial stability and ownership structure of an associated provider or provider organization, dividends paid out to investors, compensation including, but not limited to, base salaries, incentives, bonuses, stock options, deferred compensations, benefits and contingent payments to officers, managers and directors of provider organizations in the commonwealth acquired, owned or managed, in whole or in part, by said significant equity investors, health care real estate investment trusts or management services organizations.

SECTION 21. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The commission shall compile an annual report concerning spending trends, including primary care and behavioral health expenditures, 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 and payers, 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 defined in regulations promulgated by the commission. The report shall be submitted to the house and senate committees on ways and means and the joint committee on health care financing and shall be published and available to the public 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, recommendations on the specific spending trends that impede the commonwealth's ability to meet the health care cost growth benchmark and draft legislation necessary to implement said recommendations.

SECTION 22. Section 11 of chapter 6D, as so appearing, is hereby amended by inserting after the word "affiliates", in line 17, the following words:- , significant equity investors, health care real estate investment trusts, management services organizations.

SECTION 23. Section 12 of said chapter 6D, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words "carriers or third party administrators" and inserting in place thereof the following word:- payers.

SECTION 24. Said chapter 6D is hereby further amended by striking out section 13, as so appearing, and inserting in place thereof the following section:-

Section 13. (a) 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 fewer than 60 days before the date of the proposed change. 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) transactions involving a significant equity investor which result in a change of ownership or control of a provider or provider organization; (vi) significant acquisitions, sales or transfers of assets including, but not limited to, real estate sale lease-back arrangements; (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.

(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 annual report under section 16 of chapter 12C, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, 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, significant equity investor, or other party involved in 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 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 a significant equity investor, the commission may specify certain information required to be submitted as part of the notice, including, but not limited to, information regarding the significant equity investor's capital structure, general financial condition, ownership and management structure and audited financial statements.

(3) 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 necessary for the commission to assess the post-transaction impacts of a material change.

(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 to 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 those 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 size and market share of any corporate affiliates or significant equity investors of the provider or provider organization; (xiii) the inventory of health care resources maintained by the department of public health, pursuant to section 25A of chapter 111; (xiv) any related data or reports from the office of health resource planning, established in section 22; and (xv) 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 criteria: (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 comparable 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 market.

(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; provided,

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 at least 30 days after the commission has issued its final report; or (ii) if the attorney general brings an action under chapter 93A or any other law related to the material change, while such action is pending and prior to a final judgment being issued by a court of competent jurisdiction, whichever is later.

(h) When the commission, under subsection (f), refers a report on a provider or provider organization to the attorney general, the attorney general may: (i) conduct an investigation to determine whether the provider or provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law; (ii) report to the commission in writing the findings of the investigation and a conclusion as to whether the provider or provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law; and (iii) if appropriate, take action under chapter 93A or any other law to protect consumers in the health care market. The commission's final report may be evidence in any such action.

(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 and 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 any financial threshold identified by the commission shall be adjusted annually based on any inflation index established by the United States Department of Health and Human Services or similarly reliable national index, as set forth by the commission. 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 and considered where relevant in connection with licensure or other regulatory actions involving the provider or provider organization.

SECTION 25. Said chapter 6D is hereby further amended by adding the following section:-

Section 22. (a)(1) There shall be within the commission an office for health resource planning. The office shall develop a state health resource plan to identify: (i) the anticipated

needs of the commonwealth for health care services, providers, programs and facilities; (ii) the existing health care resources, providers, programs and facilities available to meet those needs; (iii) the projected resources, including the health care workforce, necessary to meet those anticipated needs; (iv) recommendations for the appropriate supply and distribution of resources, workforce, programs, capacities, technologies and services on a statewide and regional basis; (v) the priorities for addressing those needs; and (vi) recommendations for any further legislative, regulatory or other state action to assist the commonwealth in achieving the recommendations identified in the plan.

(2) The state health resource plan developed by the office shall be a forecast of anticipated demand, production, supply and distribution of health care resources on a state-wide and regional basis during a 5-year planning period, and shall include the location, distribution and nature of all health care resources in the commonwealth, including: (i) acute care units; (ii) non-acute care units; (iii) specialty care units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post-operative recovery care, pulmonary care, rare diseases 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) numbers of technologies or equipment defined as innovative services or new technologies by the department of public health pursuant to section 25C 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 office.

(3) The goal of the state health resource 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 recommendations shall support, at a minimum, 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) avoiding unnecessary duplication of health care resources; (vi) advancing health equity and addressing health disparities; (vii) integrating oral health, mental health, behavioral health 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.

(b)(1) In addition to the state health resource plan, the office may conduct focused assessments of health care resource supply, distribution and capacity in relation to projected need. Each assessment shall be conducted in consultation with the board, the advisory council established pursuant to section 4 and other state agencies as appropriate, including, but not limited to, the executive office, the executive office of economic development, the board of

higher education, 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 Massachusetts Life Sciences Center, the executive office of elder affairs, the board of registration in medicine, the bureau of health professions licensure and the office of health equity established under section 16AA of chapter 6A. All such agencies shall provide data and information necessary for the office to conduct the assessment. The office 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 may present findings that include, but are not limited to: (i) the extent to which supply, distribution and capacity of a given health care resource 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) an analysis of health care workforce needs; (vi) identification of barriers impacting accessibility of available health care resources by specific populations; and (vii) legislative, regulatory or other policy recommendations to address the drivers of health disparities, access barriers and areas of misalignment of need and supply, distribution and capacity.

(c) The office shall provide direction to the department of public health to establish and maintain on a current basis an inventory of all such health care resources together with all other reasonably pertinent information concerning such resources. Agencies of the commonwealth that

license, register, regulate or otherwise collect cost, quality or other data concerning health care resources shall cooperate with the office and the department of public health in coordinating such data and information collected pursuant to this section and section 25A of chapter 111. The inventory compiled pursuant to this section and said section 25A of said chapter 111 and all related information shall be maintained in a form usable by the general public and shall constitute a public record; provided, however, that any item of information which is confidential or privileged in nature under any other law shall not be regarded as a public record pursuant to this section.

(d) In developing the state health resource plan, the office shall conduct no fewer than 1 annual public hearing seeking input on the development of the plan and any focused assessment under development, and shall give interested persons an opportunity to submit their views orally and in writing. In addition, the office may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(e) The office 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.

(f) Annually, not later than January 1, the office shall file a report with the joint committee on health care financing concerning the activities of the office in general and, in particular, describing the progress to date in developing the state health resource plan and any focused assessment produced to date or under development, and recommending such further legislative action as it considers appropriate.

(g) Nothing in this section shall be construed to impose caps on health care resources in the commonwealth or a particular region in the commonwealth.

SECTION 26. Section 5A of chapter 12 of the General Laws, as appearing in the 2022 Official Edition, 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 27. 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; or (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.

SECTION 28. 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 29. 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) through (10), 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 30. 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, significant equity investor, health care real estate investment trust or management services organization.

SECTION 31. Section 1 of chapter 12C of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Health care cost growth benchmark”, the following definition:-

“Health care real estate investment trust”, a real estate investment trust, as defined by 26 U.S.C section 856, whose assets consist of real property held in connection with the use or operations of a provider or provider organization.

SECTION 32. 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 33. 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 definition:-

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

SECTION 34. 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, however, that “payer” shall include both governmental and private entities; and provided further, that “payer” shall include self-insured plans to the extent allowed under the 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 hospital licensed under section 51 of chapter 111, 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”, as defined in section 1 of chapter 176Y.

SECTION 35. 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 company", any company that collects capital investments from individuals or entities and purchases, as a parent company or through another entity that the company completely or partially owns or controls, a direct or indirect ownership share of a provider, provider organization or management services organization; provided, however, that "private equity company" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

SECTION 36. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Self-insured group" the following definition:-

"Significant equity investor", (i) any private equity company with a financial interest in a provider, provider organization or management services organization; or (ii) an investor, group of investors or other entity with a direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of a provider, provider organization or management services organization; provided, however, that "significant equity investor" shall not include venture capital firms exclusively funding startups or other early-stage businesses.

SECTION 37. Section 2A of said chapter 12C, as so appearing, is hereby further 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 38. Said chapter 12C is hereby further amended by striking out section 7, as amended by section 18 of chapter 140 of the acts of 2024, and inserting in place thereof the following section:-

Section 7. (a) For the purposes of this section, “non-hospital provider organization” shall mean a provider organization required to register under section 11 under chapter 6D that is: (i) a non-hospital-based physician practice with not less than $500,000,000 in annual gross patient service revenue; (ii) a clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated urgent care centers.

(b) Each acute hospital, ambulatory surgical center, non-hospital provider organization, 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 which shall include any transfer made to the Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29.

(c) The assessed amount for acute hospitals, ambulatory surgical centers and non-hospital provider organizations shall be not less than 30 per cent nor more than 40 per cent of the amount appropriated by the general court for the expenses of the center and for the other purposes described in this chapter which shall include any transfer made to the Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29 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; provided, however, that, to the maximum extent permissible under federal law, non-hospital provider organizations shall be assessed not less than 3 per cent nor more than 8 per cent of the total assessed amount for acute hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute hospital, ambulatory surgical center and non-hospital provider organization shall pay such assessed amount multiplied by the ratio of the acute hospital’s, ambulatory surgical center’s or

non-hospital provider organization's gross patient service revenues to the total gross patient services revenues of all such hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute hospital, ambulatory surgical center and non-hospital provider organization shall make a preliminary payment to the center on October 1 of each year in an amount equal to 1/2 of the previous year's total assessment. Thereafter, each acute hospital, ambulatory surgical center and non-hospital provider organization shall pay, within 30 days' notice from the center, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The center shall subsequently adjust the assessment for any variation in actual and estimated expenses of the center and for changes in acute hospital, ambulatory surgical center and non-hospital provider organization gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such acute hospital, ambulatory surgical center or non-hospital provider organization, the treasurer shall advance the amount of due and unpaid funds to the center prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such assessments and the center shall reimburse the treasurer for such advances upon receipt of such revenues. This section shall not apply to any state institution or to any acute hospital which is operated by a city or town.

(d) To the maximum extent permissible under federal law, and 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 5 per cent nor more than 10 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. Each pharmaceutical manufacturing company shall pay such assessed amount multiplied by the ratio of MassHealth's net spending for the manufacturer's prescription drugs used in the MassHealth rebate program to MassHealth's total pharmacy spending.

(e) To the maximum extent permissible under federal law, and provided 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 5 per cent nor more than 10 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. Each pharmacy benefit manager shall pay such assessed amount multiplied by the ratio of the claims paid by the pharmacy benefit manager attributed to residents of the commonwealth for whom it manages pharmaceutical benefits on behalf of carriers to the total of all such claims paid by all pharmacy benefit managers attributed to residents of the commonwealth for whom they manage pharmaceutical benefits on behalf of carriers.

(f) Each pharmaceutical manufacturing company and each pharmacy benefit manager shall make a preliminary payment to the center annually on October 1 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' notice from the center, the balance of the total assessment for the current year as determined by the center.

SECTION 39. Section 8 of said chapter 12C, as appearing in the 2022 Official Edition, is hereby amended by inserting after the word “entities”, in line 5, the following words:- including significant equity investors, health care real estate investment trusts and management services organizations.

SECTION 40. 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, significant equity investors, health care real estate investment trusts and management services organizations,.

SECTION 41 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) margins, including margins by payer type; (7) investments; (8) information on any relationships with significant equity investors, health care real estate investment trusts and management service organizations; and (9).

SECTION 42. 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 shall 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, by regulation, uniform reporting standards and reporting thresholds as it determines necessary.

(b) The center shall require registered provider organizations to annually report information necessary to achieve the goals described in subsection (a) which shall 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 subsection (a) of section 22 of chapter 6D; (v) a comprehensive financial statement, including information on parent entities, including their out-of-state operations, and corporate affiliates, including significant equity investors, health care real estate investment trusts and management services organizations as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves; (vi) information on stop-loss insurance and any non-fee-for-service payment arrangements; (vii) information on clinical quality, care coordination and patient referral practices; (viii) information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; (ix) information regarding charitable care and community benefit programs; (x) for any risk-bearing provider organization, a certificate from the division of insurance under chapter 176U; (xi) information regarding other assets and liabilities that may

affect the financial condition of the provider organization or the provider organization’s facilities including, but not limited to, real estate sale-leaseback arrangements with health care real estate investment trusts; and (xii) 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 or division; and 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.

(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, such additional information as it deems reasonable and necessary to determine the organizational structure, business practices, clinical services, market share or financial condition of a registered provider organization, including information related to its total adjusted debt and total adjusted earnings. The center may: (i) modify uniform reporting requirements; (ii) require registered provider organizations with private equity investment to report required information quarterly; or (iii) require the disclosure of relevant information from any significant equity investor associated with a registered provider organization.

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

SECTION 43. Section 11 of said chapter 12C, as so appearing, is hereby amended by striking out the second to fifth sentences, inclusive, and inserting in place thereof the following 6 sentences:-

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 required to submit data under this chapter that has failed to meet a reporting deadline and shall notify such entity 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 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 in section 100 of chapter 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 chapter 111.

SECTION 44. 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) The center, in consultation with the statewide advisory committee established pursuant to subsection (c), shall, not later than March 1 in each even-numbered year, 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 the commonwealth and carriers, and 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; and (iv) monitoring systemwide performance.

(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.

(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 burden.

(2) The statewide advisory committee shall consist of commissioner of insurance and the executive director of the health policy commission, or their designees, who shall serve as co-chairs, and shall include the following members or their designees: 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 public health; the commissioner of mental health; and 11 members to be appointed by the governor, 1 of whom shall be a representative of the 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 the 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 for 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; and (iv) monitoring systemwide performance.

(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) The statewide advisory committee shall, not later than January 1 in each even-numbered year, 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 45. 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 46. 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”, any agency of the executive branch of the commonwealth, including, but not limited to, any 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 47. 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 48. 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, 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 consistent 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 shall seek federal and foundation support to supplement state resources to carry out the Lehman center’s patient safety and medical error reduction goals.

SECTION 49. Said chapter 12C is hereby further amended by striking out section 17, as so appearing, and inserting in place thereof the following section:-

Section 17. The attorney general may review and analyze any information submitted to the center by a provider, provider organization, significant equity investor, health care real estate investment trust, management services organization or payer pursuant to sections 8, 9 and 10 and to the health policy 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 division of insurance; 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 and section 10 of chapter 66.

SECTION 50. 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 shall adopt, and may amend or rescind, such rules and regulations as it deems necessary to carry out this chapter; provided, however, that prior to adoption, amendment or rescission, any rule or regulation shall be submitted to the commissioner of public health for approval. The board may, subject to the approval of the commissioner of public health, appoint appropriate staff, including an executive director, legal counsel and any such other assistants as the board may require. The board may also make contracts and arrangements for the performance of administrative and similar services required, or appropriate, in the performance of the duties of the board.

SECTION 51. 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 30 days after submission to the commissioner pursuant to said section 10.

SECTION 52. 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 60 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 53. The first paragraph of section 25A of chapter 111 of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- Under the direction of the office of health resource planning established in section 22 of chapter 6D, the department shall establish and maintain, on a current basis, an inventory of all health care resources and all other reasonably pertinent information concerning such resources, in order to identify the location, distribution and nature of all such resources in the commonwealth.

SECTION 54. Said section 25A of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 16 and 17, the words “in a designated office of the department” and inserting in place thereof the following words:- as determined by the office of health resource planning established in section 22 of chapter 6D.

SECTION 55. Said section 25A of said chapter 111, as so appearing, is hereby further amended by striking out the fourth paragraph.

SECTION 56. Section 25B of said chapter 111, as so appearing, is hereby amended by inserting after the definition of “Outpatient services” the following definition:-

“Party of record”, during the pendency of an application for a determination of need: (i) an applicant for a determination of need; (ii) the attorney general; (iii) the center for health information and analysis; (iv) the health policy commission; any government agency with relevant oversight or licensure authority over the proposed project or components therein; or (v) any 10 taxpayers of the commonwealth organized as a group.

SECTION 57. Section 25C of said chapter 111, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The department, in making any determination of need, shall 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. The department, in making any determination of need, shall consider: (i) the state health resource plan developed pursuant to section 22 of chapter 6D; (ii) the commonwealth's cost containment goals; (iii) the impacts on the applicant's patients, including considerations of health equity, the workforce of surrounding health care providers and on other residents of the commonwealth; and (iv) 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 submitted pursuant to subsection (l) of section 13 of chapter 6D and any other state agency. 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. The department may also 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.

SECTION 58. Said section 25C of said chapter 111, as so appearing, is hereby further amended by inserting after the word “applicant”, in line 129, the following words:- by an entity selected by the department from a list of 3 entities submitted by the applicant.

SECTION 59. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out subsection (i) and inserting in place thereof the following subsection:-

(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 at least 30 days; (ii) the center for health information and analysis, the health policy commission, 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 developmental disabilities, the department of mental health and the department of 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 and 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.

SECTION 60. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out subsection (j) and inserting in place thereof the following subsection:-

(j) The department shall approve or disapprove, in whole or in part, each such application for a determination of need within 4 months after filing with the department; provided, however, that the department may, on 1 occasion only, delay the action for up to 2 months after the applicant has provided information which the department has reasonably requested; and provided further, that the period for review of an application for which an independent cost-analysis is required pursuant to subsection (h) shall be stayed until a completed independent cost-analysis is received and accepted by the department. Any determination of need issued to a holder that is subject to a cost and market impact review under section 13 of chapter 6D shall not go into effect until a minimum of 30 days after the issuance of a final report under subsection (f) of said section 13 of said chapter 6D. Any determination of need issued to a holder that is subject to a performance improvement plan pursuant to section 10 of said chapter 6D shall not go into effect until 30 days after a determination by the health policy commission that the holder is implementing or has implemented said performance improvement plan; provided, however, that the health policy commission may rescind its determination that the holder is implementing a performance improvement plan 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 61. Said section 25C of said chapter 111, as so appearing, is hereby further amended by adding the following subsection:-

(o) A party of record may review an application for determination of need for which it is appropriately registered and provide written comment or specific recommendations for consideration by the department, including written comment by a party of record as it relates to any independent cost-analyses made pursuant to subsection (h). 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 62. 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 63. Section 51G of said chapter 111, as so appearing, is hereby further amended by striking out paragraph (4) and inserting in place thereof the following paragraph:-

(4) Any hospital shall inform the department 90 days prior to the closing of the hospital or the discontinuance of any essential health service provided therein. The department shall by regulation define the words “essential health service” for the purposes of this section. The department shall, in the event that a hospital proposes to discontinue an essential health service or services, conduct a public hearing on the closure of said essential services or of the hospital, and the department may seek an analysis of the impact of the closure from the health policy commission. The department shall determine whether any such discontinued services are necessary for preserving access and health status in the hospital’s service area and shall require hospitals to submit a plan for assuring access to such necessary services following the hospital’s closure of the service and assure continuing access to such services in the event that the

department determines that their closure will significantly reduce access to necessary services. The department shall conduct a public hearing prior to a determination on the closure of said essential services or of the hospital. No original license shall be granted to establish or maintain an acute-care hospital, as defined in section 25B, unless the applicant submits a plan, to be approved by the department, for the provision of community benefits, including the identification and provision of essential health services. In approving the plan, the department may take into account the applicant's existing commitment to primary and preventive health care services and community contributions as well as the primary and preventive health care services and community contributions of the predecessor hospital. The department may waive this requirement, in whole or in part, at the request of the applicant that has provided or at the time the application is filed, is providing, substantial primary and preventive health care services and community contributions in its service area.

SECTION 64. Said section 51G of said chapter 111, as so appearing, is hereby further amended by adding the following 2 paragraphs:-

(7)(a) No original license shall be granted, or renewed, to establish or maintain an acute-care hospital, as defined in section 25B, if the main campus of the acute-care hospital is leased from a health care real estate investment trust, as defined in section 1 of chapter 6D; provided, however, that any acute-care hospital that, as of April 1, 2024, is leasing its main campus from a health care real estate investment trust shall be exempt from the requirements of this subsection. An exempt acute-care hospital under this subsection shall maintain its exempt status after a transfer to any transferee and subsequent transferees. A transferee or subsequent transferee of an acute-care hospital that is exempt from the requirements of this subparagraph shall be issued a license if the transferee otherwise satisfies all other requirements for licensure under this chapter.

For the purposes of this subsection, “main campus” shall mean the licensed premises within which the majority of inpatient beds are located.

(b) No original license shall be granted, or renewed, to establish or maintain an acute-care hospital unless 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.

(8) No original license shall be granted, or 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, 9 and 10 of chapter 12C.

SECTION 65. 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 51N or urgent care center licensed pursuant to section 51O.

SECTION 66. 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 67. 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 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 60 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 as against the public policy of the commonwealth.

SECTION 68. Said chapter 111 is hereby further amended by inserting after section 51M the following 2 sections:-

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

"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, 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 51O. (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; 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) is 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; 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 69. Section 218 of said chapter 111, as appearing in the 2022 Official Edition, is hereby amended by striking out, in line 28, the words “Maintenance Organizations” and inserting in place thereof the following word:- Plans.

SECTION 70. Section 7 of chapter 111D of the General Laws, as so appearing, is hereby amended by striking out, in line 51, the word “three” and inserting in place thereof the following figure:- 5.

SECTION 71. The sixth paragraph of section 2 of chapter 112 of the General Laws, 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 72. Section 9C of chapter 118E of the General Laws, as so appearing, is hereby amended by striking out, in line 161, the words “committee on health care” and inserting in place thereof the following words:- joint committee on health care financing.

SECTION 73. 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:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 74. The second paragraph of section 6 of said chapter 176A, as so appearing, is hereby amended by adding the following sentence:- For the purposes of the review of rates of payment under this section, whether a contract is not excessive shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 75. 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:- For the purposes of the review of rates of payment under this section, whether a contract is not excessive shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 76. 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:- For the purposes of the review of rates of payment under this section, whether an agreement is not excessive shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 77. 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:- For the purposes of the review of rates of payment under this section, whether a contract is not excessive shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 78. 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:- For the purposes of the review of rates of payment under this section, whether the proposed changes to base rates are excessive shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 79. 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:- For the purposes of the review of rates of payment under this section, whether rates are excessive shall include considerations of affordability for consumers and purchasers of health insurance products; provided, however, that such review shall adhere to principles of solvency and actuarial soundness.

SECTION 80. 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 increase of recruitment and retention in 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 American Academy of Family Physicians Mass Chapter, Inc.; 1 member from the Massachusetts chapter of the American Academy of Pediatrics; 1 member from a rural health care practice with expertise in primary care; 1 member from Community Care Cooperative, Inc.; 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 Associates, Inc. with expertise in primary care; 1 member from the Massachusetts chapter of the National Association of Social Workers, Inc. 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 Associated Industries of Massachusetts, Inc.; 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 short-term and long-term workforce development plans 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 under 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 September 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 house of representatives and the senate, the house and senate 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 December 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 house of representatives and the senate, the house and senate 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 March 15, 2026, 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 house of representatives and the senate, the house and senate 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 May 15, 2026, 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 house of representatives and the senate, the house and senate 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 81. The assessments in section 6 of chapter 6D of the General Laws, as amended by section 14, and in section 7 of chapter 12C of the General Laws, as amended by section 38, shall apply to the budgets for the health policy commission and the center for health information and analysis, respectively, beginning in fiscal year 2026; provided, however, that each pharmaceutical manufacturing company and each pharmacy benefit manager shall make a preliminary payment to the commission on October 1, 2025 in an amount equal to 1/2 of the initial year's total assessment, as determined by the commission and center, respectively, and thereafter shall pay, within 30 days of receiving notice, the balance of the total assessment for the initial year.

SECTION 82. Notwithstanding any general or special law to the contrary, the office of health resource planning established in section 22 of chapter 6D of the General Laws shall submit a state health resource plan to the governor and the general court as required by said section 22 of said chapter 6D not later than January 1, 2027.

SECTION 83. The department of public health, in consultation with the board of registration in medicine, shall promulgate regulations establishing the requirements for licensure as an office-based surgical center pursuant to section 51N of chapter 111 of the General Laws not later than October 1, 2025.

SECTION 84. The department of public health, in consultation with the board of registration in medicine, shall promulgate regulations establishing the requirements for licensure

as an urgent care center pursuant to section 51O of chapter 111 of the General Laws not later than October 1, 2025.

SECTION 85. Notwithstanding any general or special law to the contrary, the department of public health may issue a 1-time provisional license for a period of not more than 1 year to an applicant for an initial office-based surgical center license pursuant to section 51N of chapter 111 of the General Laws, which is not in full compliance with applicable requirements but the department finds it is in substantial compliance with such requirements and demonstrates potential for achieving full compliance within the provisional licensure period. A provisional license issued to an office-based surgical center shall not be extended or renewed.

SECTION 86. Notwithstanding any general or special law to the contrary, the department of public health may issue a 1-time provisional license for a period of not more than 1 year to an applicant for an initial an urgent care center license pursuant to section 51O of chapter 111 of the General Laws, which is not in full compliance with applicable requirements but the department finds it is in substantial compliance with such requirements and demonstrates potential for achieving full compliance within the provisional licensure period. A provisional license issued to an urgent care center shall not be extended or renewed.

SECTION 87. (a) Notwithstanding any general or special law to the contrary, members of the board of the health policy commission appointed pursuant to section 2 of chapter 6D of the General Laws and serving as of the effective date of this act, shall continue to serve until the expiration of the terms for which they were appointed or until June 30, 2025, whichever first occurs.

(b) Any vacancy on the board that results from the resignation, removal or expiration of a board member's term shall be filled in accordance with subsection (b) of section 2 of chapter 6D of the General Laws.

(c) In making the original appointments to the health policy commission established in section 2 of chapter 6D of the General Laws, the governor shall appoint 2 members for a term of 2 years, 2 members for a term of 3 years and 2 members for a term of 4 years. As each member's term expires thereafter, their successor shall be appointed for a term of 5 years. The governor shall make all appointments not later than July 1, 2025.

(d) In making the original appointments to the health policy commission established in section 2 of chapter 6D of the General Laws, the attorney general shall appoint 1 member for a term of 2 years, 1 member for a term of 3 years and 1 member for a term of 4 years. As each member's term expires thereafter, their successor shall be appointed for a term of 5 years. The attorney general shall make all appointments not later than July 1, 2025.

(e) The health policy commission may issue guidance to ensure the orderly transition of the board in accordance with this act.

SECTION 88. Section 12 shall take effect on July 1, 2025.