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HOUSE . . . . No. 4653

House bill No. 4643, as amended and passed to be engrossed by the House. May 16, 2024.

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:

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

6 SECTION 2. Section 16D of said chapter 6A, as so appearing, is hereby amended by
7 striking out, in lines 4 and 5, the words "commissioner of insurance" and inserting in place
8 thereof the following words:- commissioner of health insurance.

9 SECTION 3. Said section 16D of said chapter 6A, as so appearing, is hereby further
10 amended by striking out, in lines 22 to 24, inclusive, the words "department of public health
11 established by section 217 of chapter 111, and the managed care bureau in the division of
12 insurance" and inserting in place thereof the following words:- health policy commission

13 established by section 16 of chapter 6D, and the managed care bureau in the division of health
14 insurance.

15 SECTION 4. Section 16G of said chapter 6A, as amended by section 16 of chapter 7 of
16 the acts of 2023, is hereby further amended by striking out subsection (b) and inserting in place
17 thereof the following subsection:-

18 (b) The following divisions and agencies shall be within the department of consumer
19 affairs and business regulation: the division of banks, the division of insurance, the division of
20 health insurance, the division of standards, the division of occupational licensure and the
21 department of telecommunications and cable.

22 SECTION 5. Section 16N of said chapter 6A of the General Laws is hereby repealed.

23 SECTION 6. Section 16Q of said chapter 6A of the General Laws, as appearing in the
24 2022 Official Edition, is hereby amended by striking out, in line 13, the word "insurance" and
25 inserting in place thereof the following words:- health insurance.

26 SECTION 7. Section 16T of chapter 6A of the General Laws is hereby repealed.

27 SECTION 8. Section 16Z of said chapter 6A, as appearing in the 2022 Official Edition, is
28 hereby amended by striking out, in line 7, the word "insurance" and inserting in place thereof the
29 following words:- health insurance.

30 SECTION 9. Section 1 of chapter 6D of the General Laws, as so appearing, is hereby
31 amended by inserting after the definition of "Alternative payment methodologies or methods"
32 the following definition:-

33 “Benchmark cycle”, a fixed, predetermined period of 3 consecutive calendar years during
34 which the projected average annual percentage change in total health care expenditures in the
35 commonwealth is calculated pursuant to section 9 and monitored pursuant to section 10.

36 SECTION 10. Said section 1 of said chapter 6D, as so appearing, is hereby further
37 amended by striking out the definition of “Health care cost growth benchmark” and inserting in
38 place thereof the following definition:-

39 “Health care cost growth benchmark”, the projected average annual percentage change in
40 total health care expenditures in the commonwealth during a benchmark cycle, as established in
41 section 9.

42 SECTION 11. Said section 1 of said chapter 6D, as so appearing, is hereby further
43 amended by inserting after the definition of “Health care provider” the following 2 definitions:-

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

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

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

56 "Health disparities", preventable differences in the opportunities to achieve optimal
57 health experienced by socially disadvantaged racial, ethnic and other population groups and
58 communities, including, but not limited to, preventable differences between groups in health
59 insurance coverage, affordability and access to quality health care services.

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

67 SECTION 13. Said section 1 of said chapter 6D, as so appearing, is hereby further
68 amended by inserting after the definition of "Hospital service corporation" the following
69 definition:-

70 "Management services organization", any organization that is contracted by a provider or
71 provider organization to perform management or administrative services relating to, supporting
72 or facilitating the provision of patient care.

73 SECTION 14. Said section 1 of said chapter 6D, as so appearing, is hereby further
74 amended by striking out, in lines 168 and 169, the word "insurance" and inserting in place
75 thereof the following words:- health insurance.

76 SECTION 15. Said section 1 of said chapter 6D, as so appearing, is hereby further
77 amended by striking out, in line 189, the word "excludes".

78 SECTION 16. Said section 1 of said chapter 6D, as so appearing, is hereby further
79 amended by inserting after the definition of "Primary care provider" the following definition:-

80 "Private equity company", any company that collects capital investments from
81 individuals or entities and purchases a direct or indirect ownership share of a provider or
82 provider organization.

83 SECTION 17. Said section 1 of said chapter 6D, as so appearing, is hereby further
84 amended by inserting after the definition of "Shared decision-making" the following definition:-

85 "Significant equity investor", (i) any private equity company with a financial interest in a
86 provider or provider organization, or (ii) an investor, group of investors or other entity with a
87 direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per
88 cent of a provider or provider organization.

89 SECTION 18. Said section 1 of said chapter 6D, as so appearing, is hereby further
90 amended by inserting after the definition of "Surcharge payor" the following definition:-

91 "Technical advisory committee", the technical advisory committee of the health policy
92 commission established by section 4A.

93 SECTION 19. Section 2 of said chapter 6D, as so appearing, is hereby amended by
94 striking out subsections (b) and (c) and inserting in place thereof the following subsections:-

95 (b)(1) There shall be a board, with duties and powers established by this chapter, which
96 shall govern the commission. The board shall consist of 9 members: 1 of whom shall be the

97 secretary of health and human services, or a designee; 1 of whom shall be the commissioner of
98 health insurance, or a designee; 5 of whom shall be appointed by the governor, 1 of whom shall
99 serve as chairperson, 1 of whom shall be selected from a list of 3 nominees submitted by the
100 president of the senate, and 1 of whom shall be selected from a list of 3 nominees submitted by
101 the speaker of the house or representatives; and 2 of whom shall be appointed by the attorney
102 general. All appointed members shall serve for a term of 5 years, but a person appointed to fill a
103 vacancy shall serve only for the unexpired term. An appointed member of the board shall be
104 eligible for reappointment; provided, however, no appointed member shall hold full or part-time
105 employment in the executive branch of state government. The board shall annually elect 1 of its
106 members to serve as vice-chairperson. Each member of the board shall be a resident of the
107 commonwealth.

108 (2) The person appointed by the governor to serve as chairperson shall have demonstrated
109 expertise in health care administration, finance and management at a senior level. The second
110 person appointed by the governor, shall have demonstrated expertise in representing hospitals or
111 hospital health systems. The third person appointed by the governor shall have demonstrated
112 expertise in health plan administration, benefits management or health insurance brokerage. The
113 fourth person appointed by the governor, from the list of nominees submitted by the president of
114 the senate, shall have demonstrated expertise in representing the health care workforce as a
115 leader in a labor organization. The fifth person appointed by the governor, from the list of
116 nominees submitted by the speaker of the house of representatives, shall have demonstrated
117 expertise in health care innovation, including pharmaceuticals, biotechnology or medical
118 devices. The first person appointed by the attorney general shall be a health economist. The

119 second person appointed by the attorney general shall have demonstrated expertise in health care
120 consumer advocacy.

121 (c) Five members of the board shall constitute a quorum, and the affirmative vote of 5
122 members of the board shall be necessary and sufficient for any action taken by the board. No
123 vacancy in the membership of the board shall impair the right of a quorum to exercise all the
124 rights and duties of the commission. The appointed members of the board shall receive a stipend
125 in an amount not greater than 10 per cent of the salary of the secretary of administration and
126 finance under section 4 of chapter 7; provided, however, that the chairperson shall receive a
127 stipend in an amount not greater than 12 per cent of the salary of the secretary. The secretary of
128 health and human services and the commissioner of health insurance shall not receive a stipend
129 for their service as board members. Appointed members of the board shall be special state
130 employees subject to chapter 268A. An appointed member of the board shall disclose any
131 employment by, affiliation with, or financial interest in a health care entity, and the governor and
132 attorney general shall consider, in light of the requirements of said chapter 268A, any such
133 employment, affiliation or financial interest prior to appointing a member of the board.

134 SECTION 20. Said chapter 6D is hereby further amended by inserting after section 4 the
135 following section:-

136 Section 4A. (a) There is hereby established a technical advisory committee consisting of
137 appointed members with demonstrated experience in a broad range of provider sectors and
138 public and private health care payers. The technical advisory committee shall: (i) establish the
139 adjustment factor as part of the health care cost growth benchmark setting process pursuant to
140 subsection (c) of section 9; (ii) provide technical advice to the commission upon request; (iii)

141 provide the commission with operational, policy, regulatory or legislative recommendations for
142 the commission's consideration; and (iv) produce an annual report and other reports pursuant to
143 subsection (c).

144 (b) The technical advisory committee shall consist of the following 16 members: the
145 executive director of the commission, who shall serve as non-voting chairperson; the assistant
146 secretary for MassHealth, or a designee; the executive director of the commonwealth health
147 insurance connector authority, or a designee; the executive director of the group insurance
148 commission, or a designee; and 12 members appointed by the executive director of the
149 commission for their technical experience in specific health care sectors, 1 of whom shall be
150 selected from a list of 3 nominees submitted by the Massachusetts Hospital Association, Inc., 1
151 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Senior Care
152 Association, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the
153 Massachusetts Medical Society, 1 of whom shall be selected from a list of 3 nominees submitted
154 by the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be selected
155 from a list of 3 nominees submitted by the Massachusetts Biotechnology Council, Inc., 1 of
156 whom shall be selected from a list of 3 nominees submitted by the Massachusetts Association of
157 Health Plans, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by Blue
158 Cross Blue Shield of Massachusetts, Inc., and 5 of whom shall be selected by the executive
159 director from applications submitted by candidates with demonstrated experience in health care
160 delivery, health equity advocacy, health care economics, health care data analysis, clinical
161 research and innovation in health care delivery, health care benefits management or expertise in
162 behavioral health, substance use disorder, mental health services and mental health
163 reimbursement systems. In selecting members, the executive director shall ensure that the

164 composition of the committee reflects a diversity of expertise in health care providers,
165 purchasers, and consumer advocacy groups. Each member of the committee shall serve without
166 compensation for a term of 3 years, or until a successor is appointed; provided, that no member
167 shall serve more than 2 consecutive terms. Members of the committee shall be special state
168 employees subject to chapter 268A. The technical advisory committee shall meet at least
169 quarterly or at other times as specified by the commission and shall annually elect 1 of its
170 members to serve as vice-chairperson.

171 (c) The technical advisory committee shall report a summary of its activities to the
172 commission at least annually, and shall submit additional reports with technical
173 recommendations, as requested by the commission. In developing any reports or
174 recommendations to the commission, the technical advisory committee shall consider the
175 availability, timeliness, quality and usefulness of existing data, including the data collected by
176 the center under chapter 12C, and assess the need for additional investments in data collection,
177 data validation or data analysis capacity to support the committee in performing its duties.

178 SECTION 21. Section 5 of said chapter 6D, as so appearing, is hereby amended by
179 striking out, in line 10, the words "and (vii)" and inserting in place thereof the following words:-
180 ; (vii) monitor the location and distribution of health care services and health care resources; and
181 (viii).

182 SECTION 22. Section 6 of said chapter 6D, as so appearing, is hereby amended by
183 striking out the first and second paragraphs and inserting in place thereof the following
184 paragraphs:-

185 Each acute hospital, ambulatory surgical center, non-hospital provider organization and
186 surcharge payor shall pay to the commonwealth an amount for the estimated expenses of the
187 commission. For the purposes of this section, "non-hospital provider organization" shall mean a
188 provider organization required to register under section 11 that is: (i) a non-hospital-based
189 physician practice with not less than $500,000,000 in annual gross patient service revenue; (ii) a
190 clinical laboratory; (iii) an imaging facility; or (iv) a network of affiliated urgent care centers.

191 The assessed amount for hospitals, ambulatory surgical centers and non-hospital provider
192 organizations shall be not less than 33 per cent of the amount appropriated by the general court
193 for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and
194 charges generated by the commission; and (iii) federal matching revenues received for these
195 expenses or received retroactively for expenses of predecessor agencies; provided, that non-
196 hospital provider organizations shall be assessed not less than 5 per cent of the assessed amount
197 for hospitals, ambulatory surgical centers and non-hospital provider organizations. Each acute
198 hospital, ambulatory surgical center, and non-hospital provider organization shall pay such
199 assessed amount multiplied by the ratio of the hospital's, ambulatory surgical center's or non-
200 hospital provider organization's gross patient service revenues to the total gross patient service
201 revenues of all such hospitals, ambulatory surgical centers, and non-hospital provider
202 organizations. Each acute hospital, ambulatory surgical center and non-hospital provider
203 organization shall make a preliminary payment to the commission on October 1 of each year in
204 an amount equal to 1/2 of the previous year's total assessment. Thereafter, each hospital,
205 ambulatory surgical center and non-hospital provider organization shall pay, within 30 days'
206 notice from the commission, the balance of the total assessment for the current year based upon
207 its most current projected gross patient service revenue. The commission shall subsequently

208 adjust the assessment for any variation in actual and estimated expenses of the commission and
209 for changes in hospital, ambulatory surgical center and non-hospital provider organization gross
210 patient service revenue. Such estimated and actual expenses shall include an amount equal to the
211 cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D
212 of chapter 29. In the event of late payment by any such hospital, ambulatory surgical center or
213 non-hospital provider organization, the treasurer shall advance the amount of due and unpaid
214 funds to the commission prior to the receipt of such monies in anticipation of such revenues up
215 to the amount authorized in the then current budget attributable to such assessments and the
216 commission shall reimburse the treasurer for such advances upon receipt of such revenues. This
217 section shall not apply to any state institution or to any acute hospital which is operated by a city
218 or town.

219 SECTION 23. Section 7 of said chapter 6D, as so appearing, is hereby amended by
220 striking out, in line 35, the words "and (vi)" and inserting in place thereof the following words:-
221 (vi) advance health equity; and (vii).

222 SECTION 24. Section 8 of said chapter 6D, as so appearing, is hereby further amended
223 by striking out the words "for the previous calendar year", in lines 5 and 6, and inserting in place
224 thereof the following words:- established under section 9.

225 SECTION 25. Said section 8 of said chapter 6D, as so appearing, is hereby further
226 amended by striking out, in lines 33 and 34, the words "and (xi) any witness identified by the
227 attorney general or the center" and inserting in place thereof the following words:- (xi) any
228 significant equity investor, health care real estate investment trust or management services
229 organization associated with a provider or provider organization; (xii) a representative from the

230 division of health insurance; (xiii) the executive director of the commonwealth health insurance
231 connector authority; (xiv) the assistant secretary for MassHealth; and (xv) any witness identified
232 by the attorney general or the center. The commission shall also request testimony from officials
233 representing the federal Centers for Medicare and Medicaid Services.

234 SECTION 26. Said section 8 of said chapter 6D, as so appearing, is hereby further
235 amended by striking out, in line 49, the first time it appears, the word "and".

236 SECTION 27. Said section 8 of said chapter 6D, as so appearing, is hereby further
237 amended by inserting after the word "commission", in line 60, the first time it appears, the
238 following words:- ; and (iii) in the case of the assistant secretary for MassHealth, testimony
239 concerning the structure, benefits, eligibility, caseload and financing of MassHealth and other
240 Medicaid programs administered by the office of Medicaid or in partnership with other state and
241 federal agencies and the agency's activities to align or redesign those programs in order to
242 encourage the development of more integrated and efficient health care delivery systems.

243 SECTION 28. Said section 8 of said chapter 6D, as so appearing, is hereby amended, in
244 lines 71 and 72, by striking out the words "exceeded the health care cost benchmark in the
245 previous calendar year" and inserting in place thereof the following words:- in the previous
246 calendar year exceeded the average annual growth established in the health care cost growth
247 benchmark.

248 SECTION 29. Said section 8 of said chapter 6D, as so appearing, is hereby amended by
249 striking out subsection (g) and inserting in place thereof the following subsection:-

250 (g) The commission shall compile an annual health care cost growth progress report
251 concerning spending trends, including primary care and behavioral health expenditures, and the

252 underlying factors influencing said spending trends. The commission shall issue a final
253 benchmark cycle report after the third year of a benchmark cycle which shall analyze spending
254 trends for the entire benchmark cycle. The reports shall be based on the commission's analysis of
255 information provided at the hearings by witnesses, providers, provider organizations and payers,
256 registration data collected pursuant to section 11, data collected or analyzed by the center
257 pursuant to sections 8, 9 and 10 of chapter 12C and any other available information that the
258 commission considers necessary to fulfill its duties under this section, as defined in regulations
259 promulgated by the commission. The reports shall be submitted to the chairs of the house and
260 senate committees on ways and means and the chairs of the joint committee on health care
261 financing and shall be published and available to the public not later than December 31 of each
262 year. The reports shall include recommendations for strategies to increase the efficiency of the
263 health care system and, in the case of annual progress reports, recommendations on the specific
264 spending trends that threaten the commonwealth's ability to meet the health care cost growth
265 benchmark, along with legislative language necessary to implement said recommendations.

266 SECTION 30. Said chapter 6D is hereby further amended by striking out sections 9 and
267 10, as so appearing, and inserting in place thereof the following 3 sections:-

268 Section 9. (a) The board shall establish a health care cost growth benchmark for the
269 average annual growth in total health care expenditures in the commonwealth during a period of
270 3 consecutive calendar years. The commission shall establish the health care cost growth
271 benchmark not later than April 15 of the year immediately preceding the first calendar year of a
272 benchmark cycle.

273 (b) The health care cost growth benchmark shall be equal to the growth rate of potential
274 gross state product established under section 7H½ of chapter 29, plus the adjustment factor
275 adopted by the commission upon the recommendation of the technical advisory committee
276 pursuant to subsections (c) and (d). The commission shall establish procedures to prominently
277 publish the health care cost growth benchmark on the commission's website.

278 (c) The technical advisory committee shall recommend an adjustment factor to the
279 commission not later than February 15 of the year immediately preceding the first calendar year
280 of the benchmark cycle; provided, that the adjustment factor shall not be greater than 1 per cent
281 or less than minus 1 per cent. The adjustment factor shall be based on economic and market
282 factors specific to the health care industry including, but not limited to, the following factors: (i)
283 medical inflation as measured by the medical care index within the consumer price index
284 calculated by the United States Bureau of Labor Statistics; (ii) labor and workforce development
285 costs; (iii) the introduction of new pharmaceuticals, medical devices and other health
286 technologies; (iv) historical growth rate in the commonwealth's gross state product; and (v) any
287 other factors as determined by the technical advisory committee. The recommended adjustment
288 factor shall be approved by a majority vote of the technical advisory committee; provided,
289 however, that should the technical advisory committee fail to approve a recommended
290 adjustment factor, the adjustment factor shall be 0 per cent. The technical advisory committee
291 shall submit its recommendation to the commission in a public report that shall include an
292 analysis supporting the technical advisory committee's recommended adjustment factor.

293 (d) The commission shall hold a public hearing prior to accepting or rejecting the
294 technical advisory committee's recommended adjustment factor. The public hearing shall be
295 based on the report submitted by the technical advisory committee pursuant to subsection (c), the

296 report submitted by the center pursuant to section 16 of chapter 12C, any other data provided by
297 the technical advisory committee and the center, and such other pertinent information or data as
298 may be available to the commission. The commission shall provide public notice of such hearing
299 at least 45 days prior to the date of the hearing, including notice to the joint committee on health
300 care financing. The joint committee on health care financing may participate in the hearing. The
301 commission shall identify as witnesses for the public hearing a representative sample of
302 providers, provider organizations, payers and such other interested parties as the commission
303 may determine. Any other interested parties may testify at the hearing. The hearing shall
304 examine health care provider, provider organization and private and public health care payer
305 costs, prices and cost trends, with particular attention to factors that contribute to cost growth
306 within the commonwealth's health care system, and whether, based on the testimony,
307 information and data presented at the hearing, it is appropriate to accept the recommended
308 adjustment factor.

309 (e) The commission shall approve the recommended adjustment factor by a majority vote
310 of the board.

311 Section 9A. (a) For the purposes of this section, "low historic relative price hospital"
312 shall mean an acute hospital (i) with an average statewide relative price across all carriers during
313 a 5-year period of less than 0.85, and (ii) that is either corporately independent or is corporately
314 affiliated with 2 or more acute hospitals but negotiates carrier contracts separately and on its own
315 behalf. The commission, in consultation with the center, shall annually publish a list of acute
316 hospitals that qualify as low historic relative price hospitals under this section.

317 (b) The commission shall establish a rate equity target to advance the equitable
318 reimbursement of low historic relative price hospitals:

319 (1) For the benchmark cycle of calendar years 2026 to 2029, inclusive, a carrier shall not
320 pay any in-network low historic relative price hospital a payment rate that is less than 15 per cent
321 below the average relative price of all acute hospitals in the carrier's network;

322 (2) For the benchmark cycle of calendar years 2029 to 2032, inclusive, the average
323 annual reimbursement rate increase from a carrier to a low historic relative price hospital shall be
324 not less than 2 per cent above the health care cost growth benchmark;

325 (3) For the benchmark cycle of calendar years 2032 to 2035, inclusive, the average
326 annual reimbursement rate increase from a carrier to a low historic relative price hospital shall be
327 not less than 1 per cent above the health care cost growth benchmark; and

328 (4) Beginning in the benchmark cycle of calendar years 2035 to 2038, inclusive, and
329 beyond, the average annual reimbursement rate increase from a carrier to a low historic relative
330 price hospital shall be not less than the health care cost growth benchmark.

331 Section 10. (a) As used in this section the following words shall, unless the context
332 clearly requires otherwise, have the following meanings:

333 "Health care entity", a clinic, hospital, ambulatory surgical center, physician
334 organization, carrier or accountable care organization required to register under section 11.

335 (b) The commission shall provide notice to all health care entities that have been
336 identified by the center under section 18 of chapter 12C. Such notice shall state that the
337 commission may analyze the cost growth and the health care spending performance of the

338 individual health care entity and that the commission may require certain actions, as established
339 in this section, from health care entities so identified.

340 (c)(1) If the commission finds, based on the center's benchmark cycle report issued under
341 subsection (d) of section 16, that the percentage change in total health care expenditures during
342 the benchmark period exceeded the health care cost growth benchmark, the commission may
343 require certain health care entities to file and implement a performance improvement plan,
344 subject to the factors in subsection (f).

345 (2) The commission may require a carrier to file and implement a performance
346 improvement plan if the commission determines that the carrier has both: (i) exceeded the health
347 care cost growth benchmark; and (ii) failed to meet the rate equity target established by section
348 9A.

349 (d) In addition to the notice provided under subsection (b), the commission shall provide
350 written notice to any health care entity it determines must file a performance improvement plan.
351 Within 45 days of receipt of such written notice, the health care entity shall either:

352 (1) file a performance improvement plan with the commission; or

353 (2) file an application with the commission to waive or extend the requirement to file a
354 performance improvement plan.

355 (e) The health care entity may file any documentation or supporting evidence with the
356 commission to support the health care entity's application to waive or extend the requirement to
357 file a performance improvement plan. The commission shall require the health care entity to
358 submit any other relevant information it deems necessary in considering the waiver or extension

359 application; provided, however, that such information shall be made public at the discretion of
360 the commission.

361 (f) The commission may waive or delay the requirement for a health care entity to file a
362 performance improvement plan in response to a waiver or extension request filed under
363 subsection (d) in light of all information received from the health care entity, based on a
364 consideration of the following factors:

365 (1) the baseline spending and trends relative to cost, price, utilization and payer mix of
366 the health care entity over time, independently and as compared to similar entities, and any
367 demonstrated improvement to reduce health status adjusted total medical expenses;

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

370 (3) whether the factors that led to increased costs for the health care entity can reasonably
371 be considered to be unanticipated and outside of the control of the entity. Such factors may
372 include, but shall not be limited to, age and other health status adjusted factors and other cost
373 inputs such as pharmaceutical expenses, medical device expenses and labor costs;

374 (4) the overall financial condition of the health care entity;

375 (5) a significant difference between the growth rate of potential gross state product and
376 the growth rate of actual gross state product, as determined under section 7H½ of chapter 29; and

377 (6) any other factors the commission considers relevant.

378 (g) If the commission declines to waive or extend the requirement for the health care
379 entity to file a performance improvement plan, the commission shall provide written notice to the

380 health care entity that its application for a waiver or extension was denied and the health care
381 entity shall file a performance improvement plan.

382 (h) A health care entity shall file a performance improvement plan: (1) within 45 days of
383 receipt of a notice under subsection (d); (2) if the health care entity has requested a waiver or
384 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
385 (3) if the health care entity is granted an extension, on the date given on such extension. The
386 performance improvement plan shall be generated by the health care entity and shall identify the
387 causes of the entity's cost growth and, in the case of carriers, the causes for the carrier’s failure to
388 meet the rate equity target under section 9A, and shall include, but not be limited to, specific
389 strategies, adjustments and action steps the entity proposes to implement to improve cost
390 performance and performance against the rate equity target. The proposed performance
391 improvement plan shall include specific identifiable and measurable expected outcomes and a
392 timetable for implementation. The timetable for a performance improvement plan shall not
393 exceed 3 years.

394 (i) The commission shall approve any performance improvement plan that it determines
395 is reasonably likely to address the underlying cause of the health care entity’s cost growth and
396 has a reasonable expectation for successful implementation.

397 (j) If the board determines that the performance improvement plan is unacceptable or
398 incomplete, the commission may provide consultation on the criteria that have not been met and
399 may allow an additional time period, up to 30 calendar days, for resubmission; provided,
400 however, that all aspects of the performance improvement plan shall be proposed by the health
401 care entity and the commission shall not require specific elements for approval.

402 (k) Upon approval of the proposed performance improvement plan, the commission shall
403 notify the health care entity to begin implementation of the performance improvement plan.
404 Public notice shall be provided by the commission on its website, identifying that the health care
405 entity is implementing a performance improvement plan. All health care entities implementing
406 an approved performance improvement plan shall be subject to additional reporting requirements
407 and compliance monitoring, as determined by the commission. The commission shall provide
408 assistance to the health care entity in the successful implementation of the performance
409 improvement plan.

410 (l) All health care entities shall, in good faith, work to implement the performance
411 improvement plan. A health care entity may file amendments to the performance improvement
412 plan at any point during the implementation of the performance improvement plan, subject to
413 approval of the commission.

414 (m) At the conclusion of the timetable established in the performance improvement plan,
415 the health care entity shall report to the commission regarding the outcome of the performance
416 improvement plan. If the commission finds that the performance improvement plan was
417 unsuccessful, the commission shall either: (i) extend the implementation timetable of the existing
418 performance improvement plan; (ii) approve amendments to the performance improvement plan
419 as proposed by the health care entity; (iii) require the health care entity to submit a new
420 performance improvement plan, including requiring specific elements for approval,
421 notwithstanding the limitation in subsection (j) on the commission's authority during its review
422 of an initial plan proposal; (iv) waive or delay the requirement to file any additional performance
423 improvement plans; or (v) conduct a cost and market impact review of the health care entity
424 under section 13.

425 (n) Upon the successful completion of the performance improvement plan, the identity of
426 the health care entity shall be removed from the list of entities currently implementing a
427 performance improvement plan on the commission's website.

428 (o) The commission may submit a recommendation for proposed legislation to the joint
429 committee on health care financing if the commission determines that further legislative
430 authority is needed to achieve the commonwealth's health care quality and spending
431 sustainability objectives, assist health care entities with the implementation of performance
432 improvement plans or otherwise ensure compliance with the provisions of this section.

433 (p) If the commission determines that a health care entity has: (i) willfully neglected to
434 file a performance improvement plan with the commission within 45 days as required under
435 subsection (d); (ii) failed to file an acceptable performance improvement plan in good faith with
436 the commission; (iii) failed to implement the performance improvement plan in good faith; or
437 (iv) knowingly failed to provide information required by this section to the commission or
438 knowingly falsified the same, the commission may: (i) assess a civil penalty to the health care
439 entity of not more than $500,000 for a first violation, not more than $750,000 for a second
440 violation and not more than $1,000,000 for a third or subsequent violation; (ii) stay consideration
441 of any material change notice submitted under section 13 by the health care entity until the
442 commission determines that the health care entity is in compliance with this section; and (iii)
443 notify the department of public health that the health care entity, if applying for a notice of
444 determination of need, is not in compliance with this section. The commission shall seek to
445 promote compliance with this section and shall only impose a civil penalty as a last resort.

446 (q) The commission shall promulgate regulations necessary to implement this section;
447 provided, however, that notice of any proposed regulations shall be filed with the joint
448 committee on health care financing at least 180 days before adoption.

449 SECTION 31. Section 11 of said chapter 6D of the General Laws, as appearing in the
450 2022 Official Edition, is hereby amended by striking out, in lines 5, 34 and 40 the words
451 "division of insurance" and inserting in place thereof, in each instance, the following words:-
452 division of health insurance.

453 SECTION 32. Said section 11 of chapter 6D, as so appearing, is hereby amended by
454 inserting after the word "affiliates", in line 17, the following words:- , significant equity
455 investors, health care real estate investment trusts, management services organizations.

456 SECTION 33. Section 12 of said chapter 6D, as so appearing, is hereby amended by
457 striking out, in lines 8 and 9, the words "carriers or third party administrators" and inserting in
458 place thereof the following word:- payers.

459 SECTION 34. Chapter 6D of the General Laws is hereby further amended by striking out
460 section 13, as so appearing, and inserting in place thereof the following section:-

461 Section 13. (a) Every provider or provider organization shall, before making any material
462 change to its operations or governance structure, submit notice to the commission, the center and
463 the attorney general of such change, not fewer than 60 days before the date of the proposed
464 change. Material changes shall include, but not be limited to: (i) significant expansions in a
465 provider or provider organization's capacity; (ii) a corporate merger, acquisition or affiliation of
466 a provider or provider organization and a carrier; (iii) mergers or acquisitions of hospitals or
467 hospital systems; (iv) acquisition of insolvent provider organizations; (v) transactions involving a

468 significant equity investor which result in a change of ownership or control of a provider,
469 provider organization or a carrier; (vi) significant transfers of assets including, but not limited to,
470 real estate sale lease-back arrangements; (vii) conversion of a provider or provider organization
471 from a non-profit entity to a for-profit entity; and (viii) mergers or acquisitions of provider
472 organizations which will result in a provider organization having a dominant market share in a
473 given service or region.

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

481 (b) In addition to the grounds for a cost and market impact review set forth in subsection
482 (a), if the commission finds, based on the center's final benchmark cycle report under subsection
483 (d) of section 16 of chapter 12C, that the percentage change in total health care expenditures
484 during the benchmark cycle exceeded the health care cost growth benchmark, the commission
485 may conduct a cost and market impact review of any provider organization identified by the
486 center under section 18 of chapter 12C.

487 (c) The commission shall initiate a cost and market impact review by sending the
488 provider or provider organization notice of a cost and market impact review, which shall explain
489 the basis for the review and the particular factors that the commission seeks to examine through

490 the review. The provider or provider organization shall submit to the commission, within 21 days
491 of the commission's notice, a written response to the notice, including, but not limited to, any
492 information or documents sought by the commission that are described in the commission's
493 notice. The commission may require that any provider or provider organization submit
494 documents and information in connection with a notice of material change or a cost and market
495 impact review under this section. The commission shall keep confidential all nonpublic
496 information and documents obtained under this section and shall not disclose the information or
497 documents to any person without the consent of the provider or payer that produced the
498 information or documents, except in a preliminary report or final report under this section if the
499 commission believes that such disclosure should be made in the public interest after taking into
500 account any privacy, trade secret or anti-competitive considerations. The confidential
501 information and documents shall not be public records and shall be exempt from disclosure
502 under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

503 (d) A cost and market impact review may examine factors relating to the provider or
504 provider organization's business and its relative market position, including, but not limited to: (i)
505 the provider or provider organization's size and market share within its primary service areas by
506 major service category, and within its dispersed service areas; (ii) the provider or provider
507 organization's prices for services, including its relative price compared to other providers for the
508 same services in the same market; (iii) the provider or provider organization's health status
509 adjusted total medical expense, including its health status adjusted total medical expense
510 compared to similar providers; (iv) the quality of the services provided by the provider or
511 provider organization, including patient experience; (v) provider cost and cost trends in
512 comparison to total health care expenditures statewide; (vi) the availability and accessibility of

513 services similar to those provided, or proposed to be provided, through the provider or provider
514 organization within its primary service areas and dispersed service areas; (vii) the provider or
515 provider organization's impact on competing options for the delivery of health care services
516 within its primary service areas and dispersed service areas including, if applicable, the impact
517 on existing service providers of a provider or provider organization's expansion, affiliation,
518 merger or acquisition, to enter a primary or dispersed service area in which it did not previously
519 operate; (viii) the methods used by the provider or provider organization to attract patient volume
520 and to recruit or acquire health care professionals or facilities; (ix) the role of the provider or
521 provider organization in serving at-risk, underserved and government payer patient populations,
522 including those with behavioral, substance use disorder and mental health conditions, within its
523 primary service areas and dispersed service areas; (x) the role of the provider or provider
524 organization in providing low margin or negative margin services within its primary service
525 areas and dispersed service areas; (xi) consumer concerns, including but not limited to,
526 complaints or other allegations that the provider or provider organization has engaged in any
527 unfair method of competition or any unfair or deceptive act or practice; (xii) the size and market
528 share of any corporate affiliates or significant equity investors of the provider or provider
529 organization; (xiii) the inventory of health care resources maintained by the department of public
530 health, pursuant to section 25A of chapter 111, and any related data or reports from the health
531 resource planning council, established in section 22; and (xiv) any other factors that the
532 commission determines to be in the public interest.

533 (e) The commission shall make factual findings and issue a preliminary report on the cost
534 and market impact review. In the report, the commission shall identify any provider or provider
535 organization that meets all of the following criteria: (i) the provider or provider organization has,

536 or likely will have as a result of the proposed material change, a dominant market share for the
537 services it provides; (ii) the provider or provider organization charges, or likely will charge as a
538 result of the proposed material change, prices for services that are materially higher than the
539 median prices charged by all other providers for the same services in the same market; and (iii)
540 the provider or provider organization has, or likely will have as a result of the proposed material
541 change, a health status adjusted total medical expense that is materially higher than the median
542 total medical expense for all other providers for the same service in the same market.

543 (f) Within 30 days after issuance of a preliminary report, the provider or provider
544 organization may respond in writing to the findings in the report. The commission shall then
545 issue its final report. The commission shall refer to the attorney general its report on any provider
546 or provider organization that meets all 3 criteria under subsection (e). The commission shall
547 issue its final report on the cost and market impact review within 185 days from the date that the
548 provider or provider organization has submitted notice to the commission; provided, that the
549 provider or provider organization has certified substantial compliance with the commission's
550 requests for data and information pursuant to subsection (c) within 21 days of the commission's
551 notice, or by a later date set by mutual agreement of the provider or provider organization and
552 the commission.

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

558 (h) A provider or provider organization that meets the criteria in subsection (e) has
559 engaged, or through a material change will engage, in an unfair method of competition or unfair
560 and deceptive trade practice subject to challenge pursuant to section 4, but not sections 9 or 11,
561 of chapter 93A. When the commission, under subsection (f), refers a report on a provider or
562 provider organization to the attorney general, the report shall create a presumption that the
563 provider or provider organization has met or through the material change addressed in the report
564 will meet the 3 criteria in subsection (e) and therefore has engaged, or through a material change
565 will engage, in an unfair method of competition or unfair and deceptive trade practice in
566 violation of chapter 93A. The attorney general may take action under chapter 93A or any other
567 law to protect consumers in the health care market, including by bringing an action seeking to
568 restrain such violation of chapter 93A. The commission's final report may be evidence in any
569 such action brought by the attorney general.

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

572 (j) The commission shall adopt regulations for conducting cost and market impact
573 reviews and for administering this section. These regulations shall include definitions of material
574 change and non-material change, primary service areas, dispersed service areas, dominant market
575 share, materially higher prices and materially higher health status adjusted total medical
576 expenses, and any other terms as necessary. All regulations promulgated by the commission shall
577 comply with chapter 30A.

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

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

586 SECTION 35. Section 15 of said chapter 6D, as so appearing, is hereby amended by
587 striking out, in line 38, the words "division of insurance" and inserting in place thereof the
588 following words:- division of health insurance.

589 SECTION 36. Paragraph (15) of subsection (c) of said section 15 of said chapter 6D, as
590 so appearing, is hereby amended by striking out, in line 168, the word "and".

591 NO SECTION 37.

592 SECTION 38. Section 16 of said chapter 6D, as so appearing, is hereby amended by
593 striking out, in lines 9, 12 and 67, each time they appear, the words "division of insurance" and
594 inserting in place thereof, in each instance, the following words:- division of health insurance.

595 SECTION 39. Said section 16 of said chapter 6D, as so appearing, is hereby further
596 amended by striking out, in lines 43 and 44, the words "commissioner of insurance" and
597 inserting in place thereof the following words:- commissioner of health insurance.

598 SECTION 40. Said chapter 6D is hereby further amended by adding the following
599 section:-

600 Section 22. (a) There is hereby established within the commission a health resource
601 planning council, consisting of the executive director of the health policy commission, who shall
602 serve as co-chair; the secretary of health and human services or a designee, who shall serve as
603 co-chair; the commissioner of public health or a designee; the director of the office of Medicaid
604 or a designee; the commissioner of mental health or a designee; the commissioner of health
605 insurance or a designee; the secretary of elder affairs or a designee; the executive director of the
606 center for health information and analysis or a designee; and 3 members appointed by the
607 governor, 1 of whom shall be a health economist, 1 of whom shall have experience in health care
608 market planning and service line analysis, including an analysis of health care workforce needs
609 and 1 of whom shall have experience in health care administration and delivery.

610 (b)(1) The council shall develop a state health plan to identify: (i) the anticipated needs of
611 the commonwealth for health care services and facilities; (ii) the existing health care resources
612 available to meet those needs; (iii) the projected resources, including the health care workforce,
613 necessary to meet those anticipated needs; and (iv) the priorities for addressing those needs.

614 (2) The state health plan developed by the council shall be a forecast of anticipated
615 demand, supply and distribution of health care resources during a 5-year planning period, and
616 shall include the location, distribution and nature of all health care resources in the
617 commonwealth, including: (i) acute care units; (ii) non-acute care units; (iii) specialty care units,
618 including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and
619 post-operative recovery care, pulmonary care, rare diseases care, renal dialysis and surgical,

620 including trauma and intensive care units; (iv) skilled nursing facilities; (v) assisted living
621 facilities; (vi) long-term care facilities; (vii) ambulatory surgical centers; (viii) office-based
622 surgical centers; (ix) urgent care centers; (x) home health; (xi) adult and pediatric behavioral
623 health and mental health services and supports; (xii) substance use disorder treatment and
624 recovery services; (xiii) emergency care; (xiv) ambulatory care services; (xv) primary care
625 resources; (xvi) pediatric care services; (xvii) family planning services; (xviii) obstetrics and
626 gynecology and maternal health services; (xix) allied health services including, but not limited
627 to, optometric care, chiropractic services, oral health care and midwifery services; (xx) federally
628 qualified health centers and free clinics; (xxi) numbers of technologies or equipment defined as
629 innovative services or new technologies by the department of public health pursuant to section
630 25C of chapter 111; (xxii) hospice and palliative care service; (xxiii) health screening and early
631 intervention services; and (xxiv) any other service or resource identified by the council.

632 (3) The state health plan shall also make recommendations for the supply and distribution
633 of health care resources on a state-wide or regional basis based on an assessment of need during
634 the 5-year plan and options for implementing such recommendations. The recommendations
635 shall reflect, at a minimum, the following goals: (i) to maintain or improve the quality of and
636 access to health care services; (ii) to ensure a stable and adequate health care workforce; (iii) to
637 support the commonwealth's efforts to meet the health care cost growth benchmark established
638 pursuant to section 9; (iv) to support innovative health care delivery and alternative payment
639 models as identified by the commission; (v) to reduce unnecessary duplication of health care
640 resources; (vi) to advance health equity and to address health disparities based on the needs of
641 particular demographic factors, including, but not limited to, race, ethnicity, immigration status,
642 sexual orientation, gender identity, geographic location, age, language spoken, ability and

643 socioeconomic status; (vii) to support efforts to integrate oral health, mental health, behavioral
644 and substance use disorder treatment services with overall medical care; (viii) to support efforts
645 to align housing, health care and home care to improve overall health outcomes and reduce costs;
646 (ix) to reflect the latest trends in utilization and support the best standards of care; and (x) to
647 ensure equitable access to health care resources across geographic regions of the commonwealth.

648 (c) The council shall provide direction to the department of public health to establish and
649 maintain on a current basis an inventory of all such health care resources together with all other
650 reasonably pertinent information concerning such resources. Agencies of the commonwealth that
651 license, register, regulate or otherwise collect cost, quality or other data concerning health care
652 resources shall cooperate with the council and the department of public health in coordinating
653 such data and information collected pursuant to this section and section 25A of chapter 111. The
654 inventory compiled pursuant to this section and said section 25A of said chapter 111 and all
655 related information shall be maintained in a form usable by the general public and shall
656 constitute a public record; provided, however, that any item of information which is confidential
657 or privileged in nature under any other law shall not be regarded as a public record pursuant to
658 this section.

659 (d) The council shall establish an advisory committee of not more than 15 members who
660 shall reflect a broad distribution of diverse perspectives on the health care system, including
661 health care providers and provider organizations, public and private third-party payers, consumer
662 representatives, health equity advocates and labor organizations representing health care
663 workers. Not fewer than 2 members of the advisory committee shall have expertise in rural
664 health matters and rural health needs in the commonwealth. The advisory committee shall review

665 drafts and provide recommendations to the council during the development of the state health
666 plan described in subsection (b).

667 (e) The council shall conduct at least 5 public hearings, in geographically diverse areas
668 throughout the commonwealth, during the development of the state health plan and shall give
669 interested persons an opportunity to submit their views orally and in writing. In addition, the
670 council may create and maintain a website to allow members of the public to submit comments
671 electronically and review comments submitted by others.

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

675 (g) The council shall file a report annually by January 1 with the joint committee on
676 health care financing concerning the activities of the council in general and, in particular,
677 describing the progress to date in developing the state health plan and recommending such
678 further legislative action as it considers appropriate.

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

681 SECTION 41. Section 5A of chapter 12 of the General Laws, as appearing in the 2022
682 Official Edition, is hereby amended by striking out the words "or "knowingly"", in line 26, and
683 inserting in place thereof the following words:- , "knowingly" or "knows".

684 SECTION 42. Said section 5A of said chapter 12, as so appearing, is hereby further
685 amended by inserting after the definition of "Overpayment" the following definition:-

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

693 SECTION 43. Said section 5B of said chapter 12, as so appearing, is hereby further
694 amended by striking out, in line 29, the word “or”, the second time it appears.

695 SECTION 44. Said section 5B of said chapter 12, as so appearing, is hereby further
696 amended by inserting after the word “applicable” in lines 38 and 39, the following words:- ; or
697 (11) has an ownership or investment interest in any person who violates clauses (1) through (10),
698 knows about the violation, and fails to disclose the violation to the commonwealth or a political
699 subdivision thereof within 60 days of identifying the violation.

700 SECTION 45. Section 11F of said chapter 12, as so appearing, is hereby amended by
701 striking out, in lines 6 and 7, the words “division of insurance within the department of banking
702 and insurance” and inserting in place thereof the following words:- division of insurance or the
703 division of health insurance within the department of banking, insurance and health insurance.

704 SECTION 46. Section 11N of said chapter 12, as so appearing, is hereby amended by
705 striking out the words “or provider organization”, in line 7, and inserting in place thereof the
706 following words:- , provider organization, significant equity investor, health care real estate
707 investment trust or management services organization.

708 SECTION 47. Said section 11N of said chapter 12, as so appearing, is hereby further
709 amended by striking out subsection (b) and inserting in place thereof the following subsection:-

710 (b) The attorney general may investigate any provider organization referred to the
711 attorney general by the health policy commission under section 13 of chapter 6D to determine
712 whether the provider organization engaged in unfair methods of competition or anti-competitive
713 behavior in violation of chapter 93A or any other law, and, if appropriate, take action under
714 chapter 93A or any other law to protect consumers in the health care market including, but not
715 limited to, an action for injunctive relief.

716 SECTION 48. Section 1 of chapter 12C of the General Laws, as appearing in the 2022
717 Official Edition, is hereby amended by inserting after the definition of "Ambulatory surgical
718 center services", the following definition:-

719 "Benchmark cycle", a fixed, predetermined period of 3 consecutive calendar years during
720 which the projected average annual percentage change in total health care expenditures in the
721 commonwealth is calculated pursuant to section 9 of chapter 6D and monitored pursuant to
722 section 10 of said chapter 6D.

723 SECTION 49. Said section 1 of said chapter 12C, as so appearing, is hereby further
724 amended by striking out the definitions of "Health care professional" and "Health care cost
725 growth benchmark" and inserting in place thereof the following 3 definitions:-

726 "Health care cost growth benchmark", the projected average annual percentage change in
727 total health care expenditures in the commonwealth during a benchmark cycle, as established in
728 section 9 of chapter 6D.

729 "Health care professional", a physician or other health care practitioner licensed,
730 accredited, or certified to perform specified health services consistent with law.

731 "Health care real estate investment trust", a real estate investment trust, as defined by 28
732 U.S.C section 856, whose assets consist of real property held in connection with the use or
733 operations of a provider or provider organization.

734 SECTION 50. Said section 1 of said chapter 12C, as so appearing, is hereby further
735 amended by inserting after the definition of "Health care services" the following 2 definitions:-

736 "Health disparities", preventable differences in the opportunities to achieve optimal
737 health experienced by socially disadvantaged racial, ethnic and other population groups and
738 communities, including, but not limited to, preventable differences between groups in health
739 insurance coverage, affordability and access to quality health care services.

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

747 SECTION 51. Said section 1 of said chapter 12C, as so appearing, is hereby further
748 amended by inserting after the definition of "Major service category" the following definition:-

749 “Management services organization”, any organization that is contracted by a provider or
750 provider organization to perform management or administrative services relating to, supporting
751 or facilitating the provision of patient care.

752 SECTION 52. Said section 1 of said chapter 12C, as so appearing, is hereby amended by
753 striking out, in lines 189 and 190, the words “division of insurance” and inserting in place
754 thereof the following words:- division of health insurance.

755 SECTION 53. Said section 1 of said chapter 12C, as so appearing, is hereby further
756 amended by inserting after the definition of “Patient-centered medical home” the following
757 definition:-

758 “Payer”, any entity, other than an individual, that pays providers for the provision of
759 health care services; provided, that “payer” shall include both governmental and private entities;
760 provided further, that “payer” shall not include ERISA plans.

761 SECTION 54. Said section 1 of said chapter 12C, as so appearing, is hereby further
762 amended by inserting after the definition of “Primary service area” the following definition:-

763 “Private equity company”, a publicly traded or non-publicly traded company that collects
764 capital investments from individuals or entities and purchases a direct or indirect ownership
765 share of a provider or provider organization.

766 SECTION 55. Said section 1 of said chapter 12C, as so appearing, is hereby further
767 amended by inserting after the definition of “Self-insured group” the following definition:-

768 “Significant equity investor”, (i) any private equity company with a financial interest in a
769 provider or provider organization, or (ii) an investor, group of investors or other entity with a

770 direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per
771 cent of a provider or provider organization.

772 SECTION 56. Section 2A of said chapter 12C, as so appearing, is hereby amended by
773 striking out, in lines 6 and 7, the words "commissioner of insurance" and inserting in place
774 thereof the following words:- commissioner of health insurance.

775 SECTION 56A. Said section 2A of said chapter 12C, as so appearing, is hereby further
776 amended by inserting after the word "cybersecurity", in line 9, the following words:- and 1 of
777 whom shall have experience in health equity advocacy.

778 SECTION 57. Section 3 of said chapter 12C, as so appearing, is hereby amended by
779 striking out, in lines 19 and 20, the words "division of insurance" and inserting in place thereof
780 the following words:- division of health insurance.

781 SECTION 58. Section 7 of said chapter 12C, as so appearing, is hereby amended by
782 striking out the first two paragraphs and inserting in place thereof the following paragraphs:-

783 Each acute hospital, ambulatory surgical center, non-hospital provider organization and
784 surcharge payor shall pay to the commonwealth an amount for the estimated expenses of the
785 center and for the other purposes described in this chapter which shall include any transfer made
786 to the Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter
787 29. For the purposes of this section, "non-hospital provider organization" shall mean a provider
788 organization required to register under section 11 that is: (i) a non-hospital-based physician
789 practice with not less than $500,000,000 in annual gross patient service revenue; (ii) a clinical
790 laboratory; (iii) an imaging facility; or (iv) a network of affiliated urgent care centers.

791 The assessed amount for hospitals, ambulatory surgical centers and non-hospital provider
792 organizations shall be not less than 33 per cent of the amount appropriated by the general court
793 for the expenses of the center and for the other purposes described in this chapter which shall
794 include any transfer made to the Community Hospital Reinvestment Trust Fund established in
795 section 2TTTT of chapter 29 minus amounts collected from (i) filing fees; (ii) fees and charges
796 generated by the center's publication or dissemination of reports and information; and (iii)
797 federal matching revenues received for these expenses or received retroactively for expenses of
798 predecessor agencies; provided, that non-hospital provider organizations shall be assessed not
799 less than 5 per cent of the assessed amount for hospitals, ambulatory surgical centers and non-
800 hospital provider organizations. Each acute hospital, ambulatory surgical center and non-hospital
801 provider organization shall pay such assessed amount multiplied by the ratio of the hospital's,
802 ambulatory surgical center's or non-hospital provider organization's gross patient service
803 revenues to the total gross patient services revenues of all such hospitals, ambulatory surgical
804 centers and non-hospital provider organizations. Each acute hospital, ambulatory surgical center
805 and non-hospital provider organization shall make a preliminary payment to the center on
806 October 1 of each year in an amount equal to 1/2 of the previous year's total assessment.
807 Thereafter, each hospital, ambulatory surgical center and non-hospital provider organization
808 shall pay, within 30 days' notice from the center, the balance of the total assessment for the
809 current year based upon its most current projected gross patient service revenue. The center shall
810 subsequently adjust the assessment for any variation in actual and estimated expenses of the
811 center and for changes in hospital, ambulatory surgical center and non-hospital provider
812 organization gross patient service revenue. Such estimated and actual expenses shall include an
813 amount equal to the cost of fringe benefits and indirect expenses, as established by the

814 comptroller under section 5D of chapter 29. In the event of late payment by any such hospital,
815 ambulatory surgical center or non-hospital provider organization, the treasurer shall advance the
816 amount of due and unpaid funds to the center prior to the receipt of such monies in anticipation
817 of such revenues up to the amount authorized in the then current budget attributable to such
818 assessments and the center shall reimburse the treasurer for such advances upon receipt of such
819 revenues. This section shall not apply to any state institution or to any acute hospital which is
820 operated by a city or town.

821 SECTION 59. Section 8 of chapter 12C, as so appearing, is hereby amended by inserting
822 after the word "entities", in line 5, the following words:- including significant equity investors,
823 health care real estate investment trusts and management services organizations.

824 SECTION 60. Said section 8 of said chapter 12C, as so appearing, is hereby further
825 amended by inserting after the word "statements", in line 23, the following words:- , including
826 the audited financial statements of the parent organization's out-of-state operations, significant
827 equity investors, health care real estate investment trusts and management services
828 organizations,.

829 SECTION 61. Said section 8 of said chapter 12C, as so appearing, is hereby further
830 amended by striking out, in line 49, the words "and (6)" and inserting in place thereof the
831 following words:- (6) margins, including margins by payer type; (7) investments; (8) information
832 on any relationships with significant equity investors, health care real estate investment trusts
833 and management service organizations; and (9).

834 SECTION 62. Section 9 of said chapter 12C, as so appearing, is hereby amended by
835 striking out the words "entities and corporate affiliates", in line 21, and inserting in place thereof

836 the following words:- entities, including their out-of-state operations, and corporate affiliates,
837 including significant equity investors, health care real estate investment trusts and management
838 services organizations,.

839 SECTION 63. Said section 9 of said chapter 12C, as so appearing, is hereby further
840 amended by striking out, in lines 31, 34 and 35, and 36, each time they appear, the words
841 "division of insurance" and inserting in place thereof, in each instance, the following words:-
842 division of health insurance.

843 SECTION 64. Said section 9 of said chapter 12C, as so appearing, is hereby further
844 amended by striking out, in line 32, the words "and (10)" and inserting in place thereof the
845 following words:- (10) information regarding other assets and liabilities that may affect the
846 financial condition of the provider organization or the provider organization's facilities,
847 including, but not limited to, real estate sale-leaseback arrangements with health care real estate
848 investment trusts; and (11).

849 SECTION 65. Section 10 of said chapter 12C, as so appearing, is hereby amended by
850 striking out, in lines 24 and 25, the words "division of insurance" and inserting in place thereof
851 the following words:- division of health insurance.

852 SECTION 66. Said section 10 of said chapter 12C, as so appearing, is hereby further
853 amended by striking out, in lines 96 and 97, the words "commissioner of insurance" and
854 inserting in place thereof the following words:- commissioner of health insurance.

855 SECTION 67. Section 11 of said chapter 12C, as so appearing, is hereby further amended
856 by striking out, in line 11, the figure "$1,000" and inserting in place thereof the following
857 figure:- $25,000.

858 SECTION 68. Said section 11 of said chapter 12C, as so appearing, is hereby further
859 amended by striking out, in lines 13 to 16, inclusive, the words “notice; provided, however, that
860 the maximum annual penalty against a private payer, provider or provider organization under this
861 section shall be $50,000” and inserting in place thereof the following word:- notice.

862 SECTION 69. Said section 11 of said chapter 12C, as so appearing, is hereby further
863 amended by adding the following 2 sentences:- The center shall notify the commission and the
864 department of public health if a provider or provider organization fails to timely report in
865 accordance with this section, or if the center has assessed a penalty under this section. Such
866 notification shall be considered by the commission in a cost and market impact review under
867 section 13 of chapter 6D, and by the department in determining licensure and suitability in
868 accordance with section 51 of chapter 111 and for a determination of need under section 25C of
869 chapter 111.

870 SECTION 70. Said chapter 12C of the General Laws is hereby further amended by
871 striking out section 14, as so appearing, and inserting in place thereof the following section:-

872 Section 14. (a)(1) The center, in consultation with the statewide advisory committee
873 established pursuant to subsection (c), shall, not later than March 1 in each even-numbered year,
874 establish a standard set of measures of health care provider quality and health system
875 performance, hereinafter referred to as the “standard quality measure set”, for use in: (i) contracts
876 between payers, including the commonwealth and carriers, and health care providers, provider
877 organizations and accountable care organizations, which incorporate quality measures into
878 payment terms, including the designation of a set of core measures and a set of non-core
879 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)

880 consumer transparency websites and other methods of providing consumer information; and (iv)
881 monitoring system-wide performance.

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

892 (b) The center shall develop uniform reporting requirements for the standard quality
893 measure set for each health care provider facility, medical group or provider group in the
894 commonwealth.

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

902 (2) The statewide advisory committee shall consist of commissioner of health insurance
903 and the executive director of the health policy commission, or their designees, who shall serve as
904 co-chairs, and shall include the following members or their designees: the executive director of
905 the center; the executive director of the Betsy Lehman center for patient safety and medical error
906 reduction; the executive director of the group insurance commission; the secretary of elder
907 affairs; the assistant secretary for MassHealth; the commissioner of the department of public
908 health; the commissioner of the department of mental health; and 11 members who shall be
909 appointed by the governor, 1 of whom shall be a representative of the Massachusetts Health and
910 Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of
911 Community Health Centers, Inc., 1 of whom shall be a representative the Massachusetts Medical
912 Society, 1 of whom shall be a registered nurse licensed to practice in Massachusetts who
913 practices in a patient care setting, 1 of whom shall be a representative of a labor organization
914 representing health care workers, 1 of whom shall be a behavioral health provider, 1 of whom
915 shall be a long-term supports and services provider, 1 of whom shall be a representative of Blue
916 Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the
917 Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of a
918 specialty pediatric provider, and 1 of whom shall be a representative for consumers. Members
919 appointed to the statewide advisory committee shall have experience with and expertise in health
920 care quality measurement.

921 (3) The statewide advisory committee shall meet quarterly to develop recommendations
922 for the core measure and non-core measures to be adopted in the standard quality measure set for
923 use in: (i) contracts between payers, including the commonwealth and carriers, and health care
924 providers, provider organizations and accountable care organizations, including the designation

925 of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care
926 providers in the design of any health plan; (iii) consumer transparency websites and other
927 methods of providing consumer information; and (iv) monitoring system-wide performance.

928 (4) In developing its recommendations for the standard quality measure set, the statewide
929 advisory committee shall incorporate recognized quality measures including, but not limited to,
930 measures used by the Centers for Medicare and Medicaid Services, the group insurance
931 commission, carriers and providers and provider organizations in the commonwealth and other
932 states, as well as other valid measures of health care provider performance and outcomes,
933 including patient-reported outcomes and functional status, patient experience, health disparities
934 and population health. The statewide advisory committee shall consider measures applicable to
935 primary care providers, specialists, hospitals, provider organizations, accountable care
936 organizations, oral health providers and other types of providers and measures applicable to
937 different patient populations.

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

942 SECTION 71. Section 15 of said chapter 12C is hereby amended by striking out, in line
943 4, the word “injury” and inserting in place thereof the following word:- harm.

944 SECTION 72. Said section 15 of said chapter 12C is hereby further amended by striking
945 out the definition of “Board” and inserting in place thereof the following 3 definitions:-

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

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

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

953 SECTION 73. Said section 15 of said chapter 12C, as so appearing, is hereby further
954 amended by inserting after the definition of “Patient safety” the following definition:-

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

958 SECTION 74. Said section 15 of said chapter 12C, as so appearing, is hereby further
959 amended by striking out subsection (f) and inserting in place thereof the following 3
960 subsections:-

961 (f) Notwithstanding any general or special law to the contrary, the Lehman center and
962 any agency that collects or maintains patient safety information may transmit such information,
963 including personal data as defined in section 1 of chapter 66A, to each other through an
964 agreement, which may be an interagency service agreement, that provides for any safeguards
965 necessary to protect the privacy and security of the information; provided, that the transmission
966 of such information shall be consistent with federal law.

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

971 (h) The Lehman center shall report annually to the joint committee on health care
972 financing regarding the progress made in improving patient safety and medical error reduction.
973 The Lehman center shall seek federal and foundation support to supplement state resources to
974 carry out the Lehman center's patient safety and medical error reduction goals.

975 SECTION 75. Section 16 of said chapter 12C, as so appearing, is hereby amended by
976 inserting after subsection (c) the following subsection:-

977 (d) The center's report on the third year of a benchmark cycle shall be a final benchmark
978 cycle report and shall compare the costs and cost trends for the entire benchmark cycle with the
979 health care cost growth benchmark established by the health policy commission under section 9
980 of chapter 6D.

981 SECTION 76. Chapter 12C of the General Laws is hereby amended by striking out
982 section 17, as so appearing, and inserting in place thereof the following section:-

983 Section 17. The attorney general may review and analyze any information submitted to
984 the center by a provider, provider organization, significant equity investor, health care real estate
985 investment trust, management services organization or payer pursuant to sections 8, 9 and 10,
986 and to the health policy commission under section 8 of chapter 6D. The attorney general may
987 require that such entities produce documents, answer interrogatories and provide testimony under
988 oath related to health care costs and cost trends, factors that contribute to cost growth within the

989 commonwealth's health care system and the relationship between provider costs and payer
990 premium rates. The attorney general shall keep confidential all nonpublic information and
991 documents obtained under this section and shall not disclose the information or documents to any
992 person without the consent of the entity that produced the information or documents; provided,
993 however that the attorney general may disclose such information or documents during (i) the
994 annual hearing conducted under section 8 of chapter 6D, (ii) a rate hearing before the division of
995 health insurance, or (iii) in a case brought by the attorney general, if the attorney general believes
996 that such disclosure will promote the health care cost containment goals of the commonwealth
997 and that the disclosure would be in the public interest after taking into account any privacy, trade
998 secret or anti-competitive considerations. The confidential information and documents shall not
999 be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of
1000 chapter 4 or section 10 of chapter 66.

1001 SECTION 77. Said chapter 12C is hereby further amended by striking out section 18 and
1002 inserting in place thereof the following section:-

1003 Section 18. (a) For the purposes of this section, "health care entity" shall mean a clinic,
1004 hospital, ambulatory surgical center, physician organization, carrier or an accountable care
1005 organization required to register under section 11.

1006 (b) The center shall perform ongoing analysis of data it receives under this chapter to
1007 identify any health care entity whose:

1008 (1) contribution to health care spending growth, including but not limited to, spending
1009 levels and growth as measured by health status adjusted total medical expense, is considered
1010 excessive and who threaten the ability of the state to meet the health care cost growth benchmark

1011 established by the health policy commission under section 9 of chapter 6D; provided, that the
1012 center shall identify cohorts for similar health care entities and establish differential standards for
1013 excessive growth rates, based on a health care entity's baseline spending, pricing levels and
1014 payer mix; or

1015 (2) data is not submitted to the center in a proper, timely or complete manner.

1016 (c) The center shall confidentially provide a list of the health care entities to the health
1017 policy commission such that the commission may pursue further action under section 10 of
1018 chapter 6D. Confidential referrals under this section shall not preclude the center from using its
1019 authority to assess penalties for noncompliance under section 11.

1020 SECTION 78. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby
1021 amended by striking out the last paragraph and inserting in place thereof the following
1022 paragraph:-

1023 The board shall adopt, amend and rescind such rules and regulations as it deems
1024 necessary to carry out this chapter; provided, however, that prior to adoption, amendment or
1025 rescission, any rule or regulation shall be submitted to the commissioner of public health for
1026 approval. The board may, subject to the approval of the commissioner of public health, appoint
1027 appropriate staff, including an executive director, legal counsel and any such other assistants as
1028 the board may require. The board may also make contracts and arrangements for the
1029 performance of administrative and similar services required, or appropriate, in the performance
1030 of the duties of the board.

1031 SECTION 79. Said chapter 13 is hereby further amended by striking out section 10A, as
1032 so appearing, and inserting in place thereof the following section:-

1033 Section 10A. The commissioner of public health shall review and approve any rule or
1034 regulation proposed by the board of registration in medicine pursuant to section 10. Such rule or
1035 regulation shall be deemed disapproved unless approved within 30 days of submission to the
1036 commissioner pursuant to said section 10.

1037 SECTION 80. Section 1 of chapter 24A of the General Laws is hereby further amended
1038 by striking out, in lines 18 and 19, as so appearing, the words “department of banking and
1039 insurance” and inserting in place thereof the following words:- department of banking, insurance
1040 and health insurance.

1041 SECTION 81. Chapter 26 of the General Laws is hereby amended by striking out the title
1042 and inserting in place thereof the following title:- DEPARTMENT OF BANKING,
1043 INSURANCE AND HEALTH INSURANCE

1044 SECTION 82. Chapter 26 of the General Laws is hereby further amended by striking out
1045 section 1, as appearing in the 2022 Official Edition, and inserting in place thereof the following
1046 section:-

1047 Section 1. (a) There shall be a department of banking, insurance and health insurance
1048 consisting of a division of banks and loan agencies, a division of insurance and a division of
1049 health insurance.

1050 (b)(1) The division of health insurance shall have authority to oversee the health
1051 insurance market in the commonwealth and regulate companies organized to transact business
1052 and offering policies of accident and sickness insurance under chapter 175; nonprofit hospital
1053 service corporations under chapter 176A; nonprofit medical service corporations under chapter
1054 176B; nonprofit medical service plans under chapter 176C; dental service corporations under

1055 chapter 176E; optometric service corporations under chapter 176F; health maintenance
1056 organizations under chapter 176G; preferred provider arrangements under chapter 176I; health
1057 benefit plans under chapter 176J; Medicare supplemental insurance or Medicare select insurance
1058 contracts authorized under chapter 176K; nongroup health plans under chapter 176M; risk-
1059 bearing provider organizations under chapter 176T; long-term care insurance policies under
1060 chapter 176U; and dental benefit insurance plans under chapter 176X.

1061 (2) The division of insurance shall have authority for oversight over all other insurance
1062 markets not included in paragraph 1.

1063 (c) Each division shall have a commissioner who shall be known, respectively, as the
1064 commissioner of banks, the commissioner of insurance and the commissioner of health
1065 insurance. The commissioners shall act as a board in all matters concerning the department as a
1066 whole.

1067 SECTION 83. Said chapter 26 is hereby further amended by striking out section 7A, as
1068 so appearing, and inserting in place thereof the following section:-

1069 Section 7A. (a) As used in this section, the following words shall, unless the context
1070 clearly requires otherwise, have the following meanings:-

1071 "Commissioner", the commissioner of the division of health insurance.

1072 "Division", the division of health insurance.

1073 "Rate review", any examination performed by the commissioner of the aggregate rates of
1074 payment pursuant to sections 5, 6 and 10 of chapter 176A; section 4 of chapter 176B; section 16
1075 of chapter 176G; section 6 of chapter 176J; and section 7 of chapter 176K.

1076 (b) There shall be a commissioner within the division of health insurance who shall be
1077 the executive and administrative head of the division, with the authority to oversee the health
1078 insurance market in the commonwealth. The commissioner shall: (i) protect the interests of
1079 consumers of health insurance; (ii) encourage fair treatment of health care providers by health
1080 insurers; (iii) enhance equity, access, quality and affordability in the health care system; (iv)
1081 guard the solvency of health insurers; (v) work cooperatively with the health policy commission
1082 and the center for health information and analysis to monitor health care spending; and (vi)
1083 prioritize affordability of health insurance products during rate review.

1084 (c) The commissioner shall develop affordability standards to consider during rate
1085 review; provided, however, that the commissioner's review of a carrier's rates shall adhere to
1086 principles of solvency and actuarial soundness. Such standards shall consider the following:

1087 (i) affordability for consumers, including the totality of costs paid by consumers of health
1088 insurance for covered benefits including, but not limited to, the enrollee's share of premium, out-
1089 of-pocket maximum amounts, deductibles, copays, coinsurance and other forms of cost sharing
1090 for health insurance coverage;

1091 (ii) affordability for purchasers, including the totality of costs paid by purchasers of
1092 health insurance including, but not limited to, premium costs, actuarial value of coverage for
1093 covered benefits and the value delivered on health care spending in terms of improved quality
1094 and cost efficiency; and

1095 (iii) the impact of proposed rates on the commonwealth's performance against the health
1096 care cost growth benchmark established in section 9 of chapter 6D.

1097 (d) The commissioner shall review data and documents submitted to the division
1098 including, but not limited to, any materials submitted as part of rate reviews, to examine the
1099 causes of premium rate increases and excessive provider price variation.

1100 (e) The commissioner shall be appointed by the governor to serve for a term coterminous
1101 with that of the governor and shall devote their full time during business hours to the duties of
1102 the office. The position of commissioner shall be classified in accordance with section 45 of
1103 chapter 30 and the salary shall be determined in accordance with section 46C of said chapter 30.
1104 The commissioner shall appoint, at a minimum, the following employees: a first deputy, a
1105 general counsel, a chief health economist, a chief actuary, a chief research analyst, and a chief
1106 examiner. The appointed employees shall devote their full time to the duties of their offices, shall
1107 be exempt from chapters 30 and 31 and shall serve at the pleasure of the commissioner. In case
1108 of a vacancy in the office of commissioner, and during their absence or disability, the first deputy
1109 shall perform the duties of the office, or in case of the absence or disability of such first deputy,
1110 the general counsel. The commissioner may appoint and remove additional employees, including
1111 deputies, economists, analysts, examiners, assistant actuaries, inspectors, clerks and other
1112 assistants as the work of the division may require. Such additional employees shall perform such
1113 duties as the commissioner may prescribe.

1114 (f) The commissioner shall make and collect an assessment against the carriers licensed
1115 under chapters 175, 176A, 176B, 176E, 176F and 176G to pay for the expenses of the division.
1116 The assessment shall be at a rate sufficient to produce $2,000,000 annually. In addition to that
1117 amount, the assessment shall include an amount to be credited to the General Fund which shall
1118 be equal to the total amount of funds estimated by the secretary of administration and finance to
1119 be expended from the General Fund for indirect and fringe benefit costs attributable to the

1120 personnel costs of the division. The assessment shall be allocated on a fair and reasonable basis
1121 among all carriers licensed under said chapters. The funds produced by the assessments shall be
1122 expended by the division, in addition to any other funds which may be appropriated, to assist in
1123 defraying the general operating expenses of the division, and may be used to compensate
1124 consultants retained by the division. A carrier licensed under said chapters shall pay the amount
1125 assessed against it within 30 days after the date of the notice of assessment from the
1126 commissioner.

1127 SECTION 84. Section 7B of said chapter 26, as so appearing, is hereby amended by
1128 inserting after the word "commissioner", in line 2, the following words:- of health insurance.

1129 SECTION 85. Said section 7B of said chapter 26, as so appearing, is hereby further
1130 amended by striking out, in line 9, the word "bureau" and inserting in place thereof the following
1131 words:- division of health insurance.

1132 SECTION 86. Section 8H of said chapter 26, as so appearing, is hereby amended by
1133 striking out the first and second paragraphs.

1134 SECTION 87. Said section 8H of said chapter 26, as so appearing, is hereby further
1135 amended by striking out, in lines 48, 55 and 73 and 74, the words "division of insurance" and
1136 inserting in place thereof, in each instance, the following words:- division of health insurance.

1137 SECTION 88. Said section 8H of said chapter 26, as so appearing, is hereby further
1138 amended by striking out, in line 90, the words "commissioner of insurance" and inserting in
1139 place thereof the following words:- commissioner of health insurance.

1140 SECTION 89. Section 8K of said chapter 26, as so appearing, is hereby amended by
1141 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the
1142 following words:- commissioner of health insurance.

1143 SECTION 90. Said section 8K of said chapter 26, as so appearing, is hereby further
1144 amended by striking out, in line 28, the words “division of insurance” and inserting in place
1145 thereof the following words:- division of health insurance.

1146 SECTION 91. Section 8M of said chapter 26, as so appearing, is hereby amended by
1147 striking out, in lines 6 and 74 and 75, the words “commissioner of insurance” and inserting in
1148 place thereof, in each instance, the following words:- commissioner of health insurance.

1149 SECTION 92. Said section 8M of said chapter 26, as so appearing, is hereby further
1150 amended by striking out, in lines 128 and 129, the words “division of insurance” and inserting in
1151 place thereof the following words:- division of health insurance.

1152 SECTION 93. Subsection (b) of section 7H½ of chapter 29 of the General Laws, as so
1153 appearing, is hereby amended by striking out the first sentence and inserting in place thereof the
1154 following sentence:- On or before January 15 in the year immediately preceding the start of a
1155 benchmark cycle, as defined in section 1 of chapter 6D, the secretary of administration and
1156 finance shall meet with the house and senate committees on ways and means and shall jointly
1157 develop a growth rate of potential gross state product for the ensuing benchmark cycle which
1158 shall be agreed to by the secretary and the committees.

1159 SECTION 94. Section 3 of chapter 32A of the General Laws, as so appearing, is hereby
1160 amended by striking out, in line 5, the words “commissioner of insurance” and inserting in place
1161 thereof the following words:- commissioner of health insurance.

1162 SECTION 95. Section 17Q of said chapter 32A, as so appearing, is hereby amended by
1163 striking out, in lines 5 and 6 and 7, the words "division of insurance" and inserting in place
1164 thereof, in each instance, the following words:- division of health insurance.

1165 SECTION 96. Section 22B of said chapter 32A, as so appearing, is hereby amended by
1166 striking out, in lines 7 and 101 and 102, the words "commissioner of insurance" and inserting in
1167 place thereof, in each instance, the following words:- commissioner of health insurance.

1168 SECTION 97. Section 25 of said chapter 32A, as so appearing, is hereby amended by
1169 striking out, in lines 78 and 79 and 94, the words "commissioner of insurance" and inserting in
1170 place thereof, in each instance, the following words:- commissioner of health insurance.

1171 SECTION 98. Subsection (c) of section 8B of chapter 62C of the General Laws, as so
1172 appearing, is hereby amended by striking out the third and fourth sentences and inserting in place
1173 thereof the following 2 sentences:- The commissioner of revenue, in consultation with the
1174 commissioner of health insurance, may specify the content and format of the statements and
1175 reports. The commissioner of revenue may disclose the information in the statements and reports
1176 to the division of health insurance, the center for health information and analysis and the
1177 commonwealth health insurance connector.

1178 SECTION 99. Said section 8B of said chapter 62C, as so appearing, is hereby further
1179 amended by striking out, in lines 35 and 36, the words "commissioner of insurance" and
1180 inserting in place thereof the following words:- commissioner of health insurance.

1181 SECTION 100. Section 21 of said chapter 62C is hereby amended by inserting after the
1182 word "insurance", in line 146, as so appearing, the following words:- , the division of health
1183 insurance.

1184 SECTION 101. Section 12 of chapter 62E of the General Laws, as so appearing, is
1185 hereby amended by inserting after the word "insurance", in lines 19 and 20, the following
1186 words:- , the division of health insurance.

1187 SECTION 102. Section 26 of chapter 63 of the General Laws, as so appearing, is hereby
1188 amended by striking out, in lines 3 and 4, the words "and the commissioner of insurance" and
1189 inserting in place thereof the following words:- , the commissioner of insurance and the
1190 commissioner of health insurance.

1191 SECTION 103. Section 9-609 of chapter 106 of the General Laws, as so appearing, is
1192 hereby amended by adding the following subsection:-

1193 (d) Notwithstanding subsection (a), in the case of a debtor that is a hospital licensed by
1194 the department of public health under section 51 of chapter 111, and collateral that is a medical
1195 device, a secured party shall send notice to the debtor and the department of public health 60
1196 days prior to taking possession of the collateral, rendering equipment unusable or disposing of
1197 the collateral on the debtor's premises pursuant to subsection (a). For the purposes of this
1198 subsection, "medical device" shall have the same meaning as that term is defined in section 1 of
1199 chapter 111N.

1200 SECTION 104. Chapter 110C of the General Laws is hereby amended by striking out
1201 section 11, as so appearing, and inserting in place thereof the following section:-

1202 Section 11. If the offeror or a target company is an insurance company subject to
1203 regulation under chapter 175 to chapter 175C, inclusive, the commissioner of insurance
1204 appointed pursuant to section 6 of chapter 26 or their designee, or the commissioner of health
1205 insurance appointed pursuant to section 7A of chapter 26, or their designee, as appropriate, shall

1206 for all purposes of this section be substituted for the secretary. This section shall not be construed
1207 to limit or modify in any way any responsibility, authority, power or jurisdiction of the secretary,
1208 the commissioner of insurance or the commissioner of health insurance pursuant to any other
1209 provisions of law.

1210 SECTION 105. Section 24N of chapter 111 of the General Laws, as so appearing, is
1211 hereby amended by striking out, in line 71, the words "commissioner of insurance" and inserting
1212 in place thereof the following words:- commissioner of health insurance.

1213 SECTION 106. The first paragraph of section 25A of said chapter 111, as so appearing, is
1214 hereby amended by striking out the first sentence and inserting in place thereof the following
1215 sentence:- Under the direction of the health resource planning council established in section 22
1216 of chapter 6D, the department shall establish and maintain, on a current basis, an inventory of all
1217 health care resources together with all other reasonably pertinent information concerning such
1218 resources, in order to identify the location, distribution and nature of all such resources in the
1219 commonwealth.

1220 SECTION 107. Said section 25A of said chapter 111, as so appearing, is hereby further
1221 amended by striking out, in lines 16 and 17, the words "in a designated office of the department"
1222 and inserting in place thereof the following words:- as determined by the health resource
1223 planning council established in section 22 of chapter 6D.

1224 SECTION 108. Said section 25A of said chapter 111, as so appearing, is hereby further
1225 amended by striking out the fourth paragraph.

1226 SECTION 109. Section 25C of said chapter 111, as so appearing, is hereby amended by
1227 striking out subsection (g) and inserting in place thereof the following subsection:-

1228 (g) The department, in making any determination of need, shall encourage appropriate
1229 allocation of private and public health care resources and the development of alternative or
1230 substitute methods of delivering health care services so that adequate health care services will be
1231 made reasonably available to every person within the commonwealth at the lowest reasonable
1232 aggregate cost. The department, in making any determination of need, shall consider: (i) the state
1233 health plan developed pursuant to section 22 of chapter 6D; (ii) the commonwealth's cost
1234 containment goals; (iii) the impacts on the applicant's patients, including considerations of health
1235 equity, the workforce of surrounding health care providers and on other residents of the
1236 commonwealth; and (iv) any comments and relevant data from the center for health information
1237 and analysis, the health policy commission including, but not limited to, any cost and market
1238 impact review report pursuant to subsection (l) of section 13 of chapter 6D and any other state
1239 agency. The department may impose reasonable terms and conditions on the approval of a
1240 determination of need as the department determines are necessary to achieve the purposes and
1241 intent of this section. The department may also recognize the special needs and circumstances of
1242 projects that: (1) are essential to the conduct of research in basic biomedical or health care
1243 delivery areas or to the training of health care personnel; (2) are unlikely to result in any increase
1244 in the clinical bed capacity or outpatient load capacity of the facility; and (3) are unlikely to
1245 cause an increase in the total patient care charges of the facility to the public for health care
1246 services, supplies and accommodations, as such charges shall be defined from time to time in
1247 accordance with section 5 of chapter 409 of the acts of 1976.

1248 SECTION 110. Said section 25C of said chapter 111, as so appearing, is hereby further
1249 amended by inserting after the word "applicant", in line 129, the following words:- by an entity
1250 selected by the department from a list of 3 entities submitted by the applicant.

1251 SECTION 111. Said section 25C of said chapter 111, as so appearing, is hereby further
1252 amended by striking out subsection (i) and inserting in place thereof the following subsection:-

1253 (i) Except in the case of an emergency situation determined by the department as
1254 requiring immediate action to prevent further damage to the public health or to a health care
1255 facility, the department shall not act upon an application for such determination unless: (i) the
1256 application has been on file with the department for at least 30 days; (ii) the center for health
1257 information and analysis, the health policy commission, the state and appropriate regional
1258 comprehensive health planning agencies and, in the case of long-term care facilities only, the
1259 department of elder affairs, or in the case of any facility providing inpatient services for
1260 individuals with intellectual or developmentally disabilities, the departments of mental health or
1261 developmental services, respectively, have been provided copies of such application and
1262 supporting documents and given reasonable opportunity to supply required information and
1263 comment on such application; and (iii) a public hearing has been held on such application when
1264 requested by the applicant, the state or appropriate regional comprehensive health planning
1265 agency, any 10 taxpayers of the commonwealth and any other party of record as defined in
1266 section 25C¼. If, in any filing period, an individual application is filed that would implicitly
1267 decide any other application filed during such period, the department shall not act only upon an
1268 individual.

1269 SECTION 112. Said section 25C of said chapter 111, as so appearing, is hereby further
1270 amended by striking out subsection (j) and inserting in place thereof the following subsection:-

1271 (j) The department shall so approve or disapprove, in whole or in part, each such
1272 application for a determination of need within 4 months after filing with the department;

1273 provided, however, that the department may, on 1 occasion only, delay the action for up to 2
1274 months after the applicant has provided information which the department has reasonably
1275 requested; and provided further, that the period for review of an application for which an
1276 independent cost-analysis is required pursuant to subsection (h) shall be stayed until a completed
1277 independent cost-analysis is received and accepted by the department. Any determination of
1278 need issued to a holder that is subject to a cost and market impact review under section 13 of
1279 chapter 6D shall not go into effect until a minimum of 30 days after the issuance of a final report
1280 under subsection (f) of said section 13 of said chapter 6D. Any determination of need issued to a
1281 holder that is subject to a performance improvement plan pursuant to section 10 of said chapter
1282 6D shall not go into effect until 30 days after a determination by the health policy commission
1283 that the holder is implementing or has implemented said performance improvement plan;
1284 provided, however, that the health policy commission may rescind its determination that the
1285 holder is implementing a performance improvement plan at any time prior to successful
1286 completion of the performance improvement plan. Applications remanded to the department by
1287 the health facilities appeals board under section 25E shall be acted upon by the department
1288 within the same time limits provided in this section for the department to approve or disapprove
1289 applications for a determination of need. If an application has not been acted upon by the
1290 department within such time limits, the applicant may, within a reasonable period of time, bring
1291 an action in the nature of mandamus in the superior court to require the department to act upon
1292 the application.

1293 SECTION 112A. Said section 25C of said chapter 111, as so appearing, is hereby further
1294 amended by adding the following subsection:-

1295 (o) For a critical access hospital affiliated with a federally designated sole community
1296 hospital, with respect to any substantial capital expenditure or substantial change in services not
1297 otherwise exempt from determination of need requirements, the department may promulgate
1298 regulations to modify its review of such applications as follows: (i) the department may review
1299 and process such applications in an expedited manner to the maximum extent possible; (ii) the
1300 department may elect to use the delegated review process; and (iii) the department may, in its
1301 discretion, exempt or grant waivers to such critical access hospitals from other requirements in
1302 this section or in requirements promulgated by regulations pursuant to this section.

1303 SECTION 113. Said chapter 111 is hereby further amended by inserting after section 25C
1304 the following section:-

1305 Section 25C¼. (a) As used in this section, the following words shall, unless the context
1306 clearly requires otherwise, have the following meanings:-

1307 "Independent community hospital", any hospital that has been: (i) designated by the
1308 health policy commission as an independent community hospital for the year in which an
1309 application for a determination of need is filed; or (ii) qualified in the year 2021 as an eligible
1310 hospital as defined in subsection (d) of section 63 of chapter 260 of the acts of 2020.

1311 "Party of record", an applicant for a determination of need; the attorney general; the
1312 center for health information and analysis; the health policy commission; any government
1313 agency with relevant oversight or licensure authority over the proposed project or components
1314 therein; any 10 taxpayers of the commonwealth; or an independent community hospital whose
1315 primary service area overlaps with the primary service area of the applicant's proposed project.

1316 A party of record may review an application for determination of need as well as provide written
1317 comment for consideration by the department.

1318 “Primary service area”, the contiguous geographic area from which a health care facility
1319 draws 75 per cent of its commercial discharges, as measured by the zip codes closest to the
1320 facility by drive time, and for which the facility represents a minimum proportion of the total
1321 discharges in a zip code, as determined by the department in consultation with the health policy
1322 commission and based on the best available data using a methodology determined by the
1323 department in consultation with the health policy commission.

1324 “Proposed project”, a project for the construction of a freestanding ambulatory surgery
1325 center for which a notice of determination of need is a prerequisite of licensure.

1326 (b) For any application for a determination of need for which the primary service area of
1327 the proposed project overlaps with the primary service area of an existing independent
1328 community hospital, the applicant shall obtain and include in such application a letter of support
1329 from the independent community hospital’s chief executive officer and board chair; provided,
1330 however, that a proposed project that constitutes a joint venture between the applicant and the
1331 independent community hospital shall be exempt from this subsection. The department shall
1332 conduct a preliminary review of each application to determine compliance with this subsection.
1333 If the department determines that an application is not in compliance, the department shall
1334 identify to the applicant any independent community hospital whose support is required by this
1335 subsection and dismiss said application without prejudice. If the department fails to conduct a
1336 preliminary review of an application or fails to dismiss an application that does not satisfy the
1337 requirements of this subsection, the independent community hospital whose primary service area

1338 overlaps with the primary service area of the proposed project may, within a reasonable period of
1339 time, bring a civil action in the nature of mandamus in the superior court to require the
1340 department to act in accordance with this subsection.

1341 SECTION 114. Section 25F of said chapter 111, as appearing in the 2022 Official
1342 Edition, is hereby amended by inserting after the word "care", in line 7, the following word:-
1343 financing.

1344 SECTION 115. Section 25G of said chapter 111, as so appearing, is hereby amended by
1345 inserting after the word "agency", in line 3, the following words:- , an independent community
1346 hospital, as defined by section 25C¼, whose primary service area overlaps with the primary
1347 service area of a proposed project under said section 25C¼.

1348 SECTION 116. Section 51G of said chapter 111, as so appearing, is hereby further
1349 amended by striking out paragraph (4) and inserting in place thereof the following paragraph:-

1350 (4) Any hospital shall inform the department 90 days prior to the closing of the hospital
1351 or the discontinuance of any essential health service provided therein. The department shall by
1352 regulation define the words "essential health service" for the purposes of this section. The
1353 department shall, in the event that a hospital proposes to discontinue an essential health service
1354 or services, conduct a public hearing on the closure of said essential services or of the hospital,
1355 and the department may seek an analysis of the impact of the closure from the health policy
1356 commission. The department shall determine whether any such discontinued services are
1357 necessary for preserving access and health status in the hospital's service area and shall require
1358 hospitals to submit a plan for assuring access to such necessary services following the hospital's
1359 closure of the service and assure continuing access to such services in the event that the

1360 department determines that their closure will significantly reduce access to necessary services.
1361 The department shall conduct a public hearing prior to a determination on the closure of said
1362 essential services or of the hospital. No original license shall be granted to establish or maintain
1363 an acute-care hospital, as defined in section 25B, unless the applicant submits a plan, to be
1364 approved by the department, for the provision of community benefits, including the identification
1365 and provision of essential health services. In approving the plan, the department may take into
1366 account the applicant's existing commitment to primary and preventive health care services and
1367 community contributions as well as the primary and preventive health care services and
1368 community contributions of the predecessor hospital. The department may waive this
1369 requirement, in whole or in part, at the request of the applicant that has provided or at the time
1370 the application is filed, is providing, substantial primary and preventive health care services and
1371 community contributions in its service area.

1372 SECTION 117. Said section 51G of said chapter 111, as so appearing, is hereby
1373 further amended by adding the following 2 paragraphs:-

1374 (7)(a) No original license shall be granted, nor renewed, to establish or maintain an acute-
1375 care hospital, as defined in section 25B, if the main campus of the acute-care hospital is leased
1376 from a health care real estate investment trust, as defined in section 1 of chapter 6D; provided,
1377 however, that any acute-care hospital that, as of April 1, 2024, is leasing its main campus from a
1378 health care real estate investment trust shall be exempt from the requirements of this subsection.
1379 An exempt acute-care hospital under this subsection shall maintain its exempt status after a
1380 transfer to any transferee and subsequent transferees. A transferee or subsequent transferee of an
1381 acute-care hospital that is exempt from the requirements of this subsection shall be issued a
1382 license if the transferee otherwise satisfies all other requirements for licensure under this chapter.

1383 For the purposes of this subsection, “main campus” shall mean the licensed premises within
1384 which the majority of inpatient beds are located.

1385 (b) No original license shall be granted, nor renewed, to establish or maintain an acute-
1386 care hospital unless all documents related to any lease, master lease, sublease, license or any
1387 other agreement for the use, occupancy or utilization of the premises occupied by the acute-care
1388 hospital are disclosed to the department upon application for licensure.

1389 (8) No original license shall be granted, nor renewed, to establish or maintain an acute-
1390 care hospital, as defined in section 25B, unless the applicant is in compliance with the reporting
1391 requirements established in sections 8, 9 and 10 of chapter 12C.

1392 SECTION 118. Section 51H of said chapter 111, as so appearing, is hereby amended by
1393 striking out the definition of “Facility” and inserting in place thereof the following definition:-

1394 “Facility”, a hospital, institution for the care of unwed mothers, clinic providing
1395 ambulatory surgery as defined in section 25B, limited service clinic licensed pursuant to section
1396 51J, office-based surgical center licensed pursuant to section 51M or urgent care center licensed
1397 pursuant to section 51N.

1398 SECTION 119. Said section 51H of said chapter 111, as so appearing, is hereby further
1399 amended by inserting after the definition of “Healthcare-associated infection” the following
1400 definition:-

1401 “Operational impairment event”, any action, or notice of impending action, including a
1402 notice of financial delinquency, concerning the repossession of medical equipment or supplies
1403 necessary for the provision of patient care.

1404 SECTION 120. Subsection (b) of said section 51H of said chapter 111, as so appearing, is
1405 hereby amended by adding the following paragraph:-

1406 An operational impairment event shall be reported by a facility not later than 1 calendar
1407 day after it occurs. Notwithstanding any general or special law to the contrary, no contract
1408 between a facility and a lessor of medical equipment shall authorize the repossession of medical
1409 equipment or supplies unless the lessor provides a notice of financial delinquency to the
1410 department not less than 60 days prior to repossession of any medical equipment or supplies
1411 necessary for the provision of patient care. Any provision of any contract or other document
1412 between a lessor of medical equipment and a facility which does not comply with this paragraph
1413 shall be void as against public policy of the commonwealth.

1414 SECTION 121. Said chapter 111 is hereby further amended by inserting after section 51L
1415 the following 2 sections:-

1416 Section 51M. (a) As used in this section, the following words shall, unless the context
1417 clearly requires otherwise, have the following meanings:-

1418 "Deep sedation", a drug-induced depression of consciousness during which: (i) the
1419 patient cannot be easily awakened but responds purposefully following repeated painful
1420 stimulation; (ii) the patient's ability to maintain independent ventilatory function may be
1421 impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous
1422 ventilation may be inadequate; and (iv) the patient's cardiovascular function is usually
1423 maintained without assistance.

1424 "General anesthesia", a drug-induced depression of consciousness during which: (i) the
1425 patient is not able to be awakened, even by painful stimulation; (ii) the patient's ability to

1426 maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often
1427 requires assistance in maintaining a patent airway and positive pressure ventilation may be
1428 required because of depressed spontaneous ventilation or drug-induced depression of
1429 neuromuscular function; and (iv) the patient's cardiovascular function may be impaired.

1430 "Minimal sedation", a drug-induced state during which: (i) patients respond normally to
1431 verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory
1432 and cardiovascular functions are unaffected.

1433 "Minor procedures", (i) procedures that can be performed safely with a minimum of
1434 discomfort where the likelihood of complications requiring hospitalization is minimal; (ii)
1435 procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less
1436 than 500cc of fat under un-supplemented local anesthesia.

1437 "Moderate sedation", a drug-induced depression of consciousness during which: (i) the
1438 patient responds purposefully to verbal commands, either alone or accompanied by light tactile
1439 stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous
1440 ventilation is adequate; and (iv) the patient's cardiovascular function is usually maintained
1441 without assistance.

1442 "Office-based surgical center", an office, group of offices, a facility or any portion
1443 thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice,
1444 however organized, whether conducted for profit or not for profit, which is advertised,
1445 announced, established or maintained for the purpose of providing office-based surgical services;
1446 provided, however, that "office-based surgical center" shall not include: (i) a hospital licensed
1447 under section 51 or by the federal government; (ii) an ambulatory surgical center as defined

1448 pursuant to section 25B and licensed under said section 51; or (iii) a surgical center performing
1449 services in accordance with section 12M of chapter 112.

1450 "Office-based surgical services", any ambulatory surgical or other invasive procedure
1451 requiring: (i) general anesthesia; (ii) moderate sedation; or (iii) deep sedation and any liposuction
1452 procedure, excluding minor procedures and procedures requiring minimal sedation, where such
1453 surgical or other invasive procedure or liposuction is performed by a practitioner at an office-
1454 based surgical center.

1455 (b) The department shall establish rules, regulations and practice standards for the
1456 licensing of office-based surgical centers. In determining rules, regulations and practice
1457 standards necessary for licensure as an office-based surgical center, the department may, at its
1458 discretion, determine which regulations applicable to an ambulatory surgical center, as defined in
1459 section 25B, shall apply to an office-based surgical center. The department shall consult with the
1460 board of registration in medicine prior to promulgating regulations or establishing rules or
1461 practice standards pursuant to this section.

1462 (c) The department shall issue for a term of 2 years and renew for a like term, a license to
1463 maintain an office-based surgical center to an entity or organization that demonstrates to the
1464 department that it is responsible and suitable to maintain such a center. An office-based surgical
1465 center license shall list the specific locations on the premises where surgical services are
1466 provided. In the case of the transfer of ownership of an office-based surgical center, the
1467 application of the new owner for a license, when filed with the department on the date of transfer
1468 of ownership, shall have the effect of a license for a period of 3 months.

1469 (d) An office-based surgical center license shall be subject to suspension, revocation or
1470 refusal to issue or to renew for cause if, in its reasonable discretion, the department determines
1471 that the issuance of such license would be inconsistent with the best interests of the public health,
1472 welfare or safety. Nothing in this subsection shall limit the authority of the department to require
1473 a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to renew
1474 a license issued pursuant to subsection (c).

1475 (e) Initial application and renewal fees for the license shall be established pursuant to
1476 section 3B of chapter 7.

1477 (f) The department may impose a fine of up to $10,000 on a person or entity that
1478 advertises, announces, establishes or maintains an office-based surgical center without a license
1479 granted by the department. The department may impose a fine of not more than $10,000 on a
1480 licensed office-based surgical center for violations of this section or any rule or regulation
1481 promulgated pursuant to this section. Each day during which a violation continues shall
1482 constitute a separate offense. The department may conduct surveys and investigations to enforce
1483 compliance with this section.

1484 (g) Notwithstanding any general or special law or rule to the contrary, the department
1485 may issue a 1-time provisional license to an applicant for an office-based surgical center licensed
1486 pursuant to this section if such office-based surgical center holds: (i) a current accreditation from
1487 the Accreditation Association for Ambulatory Health Care, American Association for
1488 Accreditation of Ambulatory Surgery Facilities, Inc., or the Joint Commission, or (ii) a current
1489 certification for participation in either Medicare or Medicaid. The department may approve such
1490 a provisional application upon a finding of responsibility and suitability and that the office-based

1491 surgical center meets all other licensure requirements as determined by the department. Such
1492 provisional license issued to an office-based surgical center shall not be extended or renewed.

1493 Section 51N. (a) As used in this section, the following words shall, unless the context
1494 clearly requires otherwise, have the following meanings:-

1495 "Emergency services", as defined in section 1 of chapter 6D.

1496 "Urgent care center", a clinic owned or operated by an entity that is not corporately
1497 affiliated with a hospital licensed under section 51, however organized, whether conducted for
1498 profit or not for profit, that is advertised, announced, established or maintained for the purpose of
1499 providing urgent care services in an office or a group of offices, or any portion thereof, or an
1500 entity that is advertised, announced, established or maintained under a name that includes the
1501 words "urgent care" or that suggests that urgent care services are provided therein; provided,
1502 however, that an urgent care center shall not include: (i) a hospital licensed under said section 51
1503 or operated by the federal government or by the commonwealth; (ii) a clinic licensed under said
1504 section 51; (iii) a limited service clinic licensed under section 51J; or (iv) a community health
1505 center receiving a grant under 42 U.S.C. 254b.

1506 "Urgent care services", a model of episodic care for the diagnosis, treatment,
1507 management or monitoring of acute and chronic disease or injury that is: (i) for the treatment of
1508 illness or injury that is immediate in nature but does not require emergency services; (ii)
1509 provided on a walk-in basis without a prior appointment; (iii) available to the general public
1510 during times of the day, weekends or holidays when primary care provider offices are not
1511 customarily open; and (iv) is not intended, and should not be used for, preventative or routine
1512 services.

1513 (b) The department shall establish rules, regulations, and practice standards for the
1514 licensing of urgent care centers. In determining regulations and practice standards necessary for
1515 licensure as an urgent care center, the department may, at its discretion determine which
1516 regulations applicable to a clinic licensed under section 51, shall apply to an urgent care center.

1517 (c) The department shall issue for a term of 2 years and renew for a like term, a license to
1518 maintain an urgent care center to an entity or organization that demonstrates to the department
1519 that it is responsible and suitable to maintain such an urgent care center. In the case of the
1520 transfer of ownership of an urgent care center, the application of the new owner for a license,
1521 when filed with the department on the date of transfer of ownership, shall have the effect of a
1522 license for a period of 3 months.

1523 (d) An urgent care center license shall be subject to suspension, revocation or refusal to
1524 issue or to renew for cause if, in its reasonable discretion, the department determines that the
1525 issuance of such license would be inconsistent with or opposed to the best interests of the public
1526 health, welfare or safety. Nothing in this subsection shall limit the authority of the department to
1527 require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to
1528 renew a license issued pursuant to subsection (c).

1529 (e) Initial application and renewal fees for the license shall be established pursuant to
1530 section 3B of chapter 7.

1531 (f) The department may impose a fine of up to $10,000 on a person or entity that
1532 advertises, announces, establishes or maintains an urgent care center without a license granted by
1533 the department. The department may impose a fine of not more than $10,000 on a licensed
1534 urgent care center for violations of this section or any rule or regulation promulgated pursuant to

1535 this section. Each day during which a violation continues shall constitute a separate offense. The
1536 department may conduct surveys and investigations to enforce compliance with this section.

1537 (g) Notwithstanding any general or special law or rule to the contrary, the department
1538 may issue a 1-time provisional license to an applicant for an urgent care center if such urgent
1539 care center holds: (i) a current accreditation from the Accreditation Association for Ambulatory
1540 Health Care, Urgent Care Association of America, or the Joint Commission or (ii) a current
1541 certification for participation in either Medicare or Medicaid. The department may approve such
1542 provisional application upon a finding of responsibility and suitability and that the urgent care
1543 center meets all other licensure requirements as determined by the department. Such provisional
1544 license issued to an urgent care center shall not be extended or renewed.

1545 SECTION 122. Said chapter 111 is hereby further amended by inserting after section
1546 53H the following section:-

1547 Section 53I. (a) A clinic or physician practice registered under section 4A of chapter 112,
1548 hereinafter referred to as registered physician practice, shall notify the department not less than
1549 180 days prior to any sale, relocation or closure. The department may conduct a public hearing
1550 on the proposed sale, relocation or closure not less than 90 days prior to the proposed date of
1551 such event. The hearing shall consider the potential impacts of the proposed transaction,
1552 including, but not limited to:

1553 (i) the potential loss or change in access to services for the population served by the clinic
1554 or registered physician practice in the 24 months immediately preceding the notice to sell,
1555 relocate or close;

1556 (ii) alternative providers and locations where the population served by the clinic or
1557 registered physician practice will be able to obtain the health care services that were provided by
1558 the clinic or registered physician practice during the 24 months following the sale, relocation or
1559 closure; and

1560 (iii) options available to the department to mitigate the impact of the sale, relocation or
1561 closure on patients.

1562 (b) Any clinic or registered physician practice that intends to sell, relocate or close shall
1563 notify their patients in writing not less than 90 days prior to the date of such sale, relocation or
1564 closure. The written notice shall be sent in a manner prescribed by the department and shall
1565 notify the patient that the clinic or registered physician practice shall continue to provide services
1566 to the patient for 90 days. Such notice shall also offer the patient resources to assist in finding a
1567 substitute health care provider and include the name and contact information for the entity
1568 assuming responsibility for the management of the patient's medical records.

1569 SECTION 123. Section 206A of said chapter 111, as appearing in the 2022 Official
1570 Editions, is hereby amended by striking out, in lines 1 and 2, the words "division of insurance"
1571 and inserting in place thereof the following words:- division of health insurance.

1572 SECTION 124. Section 218 of said chapter 111, as so appearing, is hereby amended by
1573 striking out, in line 2, the words "commissioner of insurance" and inserting in place thereof the
1574 following words:- commissioner of health insurance.

1575 SECTION 125. Said section 218 of said chapter 111, as so appearing, is hereby further
1576 amended by striking out, in line 28, the words "Maintenance Organizations" and inserting in
1577 place thereof the following word:- Plans.

1578 SECTION 126. Section 2 of chapter 111K of the General Laws, as so appearing, is
1579 hereby amended by striking out, in lines 4 and 5, the words "commissioner of insurance" and
1580 inserting in place thereof the following words:- commissioner of health insurance.

1581 SECTION 127. Section 1 of chapter 111M of the General Laws, as so appearing, is
1582 hereby amended by striking out, in lines 34 and 35, the words "commissioner of insurance" and
1583 inserting in place thereof the following words:- commissioner of health insurance.

1584 SECTION 128. Section 2 of chapter 112 of the General Laws, as so appearing, is hereby
1585 amended by striking out the last sentence of the sixth paragraph and inserting in place thereof the
1586 following sentence:- The renewal application shall be accompanied by a fee determined under
1587 the aforementioned provision and shall include the physician's name, license number, home
1588 address, office address, specialties, the principal setting of their practice, and whether they are an
1589 active or inactive practitioner.

1590 SECTION 129. Said chapter 112 is hereby further amended by inserting after section 4
1591 the following section:-

1592 Section 4A. (a) The board shall establish and maintain a registry of all physician practices
1593 of greater than 10 physicians engaged in a wholly-owned and controlled group practice;
1594 provided, however, that a provider organization registered pursuant to section 11 of chapter 6D
1595 shall not be required to register under this section. Any person seeking to maintain a physician
1596 practice shall file with the board a registration application containing such information as the
1597 board may reasonably require including, but not limited to: (i) the identity of the applicant and of
1598 the physicians which constitute the practice; (ii) the identity of any substantial equity investor, as
1599 defined in section 1 of said chapter 6D, of the practice; (iii) any management services

1600 organization, as defined in said section 1 of said chapter 6D, under contract with the practice;
1601 and (iv) a certified copy of the physician practice's certificate of organization, if any, as filed
1602 with the secretary of the commonwealth, or any applicable partnership agreement. The
1603 application shall be accompanied by a fee in an amount to be determined pursuant to section 3B
1604 of chapter 7. All physician practices registered in the commonwealth shall renew their
1605 certificates of registration with the board every 2 years.

1606 SECTION 130. Said chapter 112 is hereby further amended by inserting after section 5O
1607 the following section:-

1608 Section 5P. (a) Any physician licensed by the board who intends to terminate a bona fide
1609 physician-patient relationship where the physician has a role in the ongoing care and treatment of
1610 the patient, shall notify the patient in writing not less than 90 days prior to the date of such
1611 termination in a manner prescribed through guidance established by the board. The requirements
1612 of this section may be satisfied through notice otherwise consistent with the requirements of this
1613 section delivered by the physician's employing entity, including, but not limited to, a physician
1614 practice registered pursuant to section 4A.

1615 (b) The notice required under this section shall also offer the patient resources to assist in
1616 finding a substitute health care provider and include the name and contact information for the
1617 entity assuming responsibility for the management of the patient's medical records. Any
1618 physician who terminates a physician-patient relationship without providing notice to a patient as
1619 provided for in this section shall be subject to discipline by the board of registration in medicine.

1620 SECTION 131. Section 9C of chapter 118E of the General Laws, as appearing in the
1621 2022 Official Edition, is hereby amended by striking out, in lines 43 and 44 and lines 147 and

1622 148, the words "commissioner of insurance" and inserting in place thereof, in each instance, the
1623 following words:- commissioner of health insurance.

1624 SECTION 132. Said section 9C of said chapter 118E, as so appearing, is hereby further
1625 amended by striking out, in line 161, the words "committee on health care" and inserting in place
1626 thereof the following words:- joint committee on health care financing.

1627 SECTION 133. Section 9D of said chapter 118E, as so appearing, is hereby amended by
1628 striking out, in line 183, the words "division of insurance" and inserting in place thereof the
1629 following words:- division of health insurance.

1630 SECTION 134. Section 13D of said chapter 118E, as so appearing, is hereby amended by
1631 striking out, in line 17, each time they appear, the words "division of insurance" and inserting in
1632 place thereof, in each instance, the following words:- division of health insurance.

1633 SECTION 135. Section 69 of said chapter 118E, as so appearing, is hereby amended by
1634 striking out, in line 58, the words "division of insurance" and inserting in place thereof the
1635 following words:- division of health insurance.

1636 SECTION 136. Section 189 of chapter 149 of the General Laws, as so appearing, is
1637 hereby amended by striking out, in lines 68 and 69, the words "and (iv) the commissioner of
1638 insurance or a designee" and inserting in place thereof the following words:- (iv) the
1639 commissioner of insurance or a designee; and (v) the commissioner of health insurance or a
1640 designee.

1641 SECTION 137. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
1642 amended by striking out the definition of "Commissioner" and inserting in place thereof the
1643 following definition:-

1644 "Commissioner", (i) the commissioner of insurance appointed pursuant to section 6 of
1645 chapter 26, or their designee, or, as appropriate, (ii) the commissioner of health insurance
1646 appointed pursuant to section 7A of said chapter 26, or their designee, to the extent that this
1647 chapter applies to companies that are regulated by the division of health insurance pursuant to
1648 section 1 of said chapter 26.

1649 SECTION 138. Said section 1 of said chapter 175, as so appearing, is hereby further
1650 amended by inserting after the definition of "Contract on a Variable Basis" the following
1651 definition:-

1652 "Division", the division of insurance or the division of health insurance, as appropriate.

1653 SECTION 139. Section 4 of said chapter 175, as so appearing, is hereby amended by
1654 striking out, in line 9, the words "of insurance".

1655 SECTION 140. Section 24D of said chapter 175, as so appearing, is hereby amended, in
1656 lines 19, 32 and 33, 59 and 99, by inserting after the words "commissioner of insurance", the
1657 following words, in each instance:- and the commissioner of health insurance.

1658 SECTION 141. Section 24E of said chapter 175, as so appearing, is hereby amended by
1659 inserting after the word "insurance", in line 70, the following words:- and the commissioner of
1660 health insurance.

1661 SECTION 142. Said section 24E of said chapter 175, as so appearing, is hereby further
1662 amended by inserting after the word "insurance", in line 102, the following words:- or the
1663 commissioner of health insurance.

1664 SECTION 143. Section 24F of said chapter 175, as so appearing, is hereby amended, in
1665 lines 17, 29 and 30, 65 and 83, by inserting after the words "commissioner of insurance", the
1666 following words, in each instance:- and the commissioner of health insurance.

1667 SECTION 144. Said section 24F of said chapter 175, as so appearing, is hereby further
1668 amended by inserting after the word "insurance", in line 100, the following words:- or the
1669 commissioner of health insurance.

1670 SECTION 145. Section 47B of said chapter 175, as so appearing, is hereby amended by
1671 striking out, in line 142, the words "division of insurance" and inserting in place thereof the
1672 following words:- division of health insurance.

1673 SECTION 146. Section 47J of said chapter 175, as so appearing, is hereby amended by
1674 striking out, in line 1, the words "commissioner of insurance" and inserting in place thereof the
1675 following words:- commissioner of health insurance.

1676 SECTION 147. Section 47W of said chapter 175, as so appearing, is hereby amended by
1677 striking out, in line 117, the words "commissioner of insurance" and inserting in place thereof
1678 the following words:- commissioner of health insurance.

1679 SECTION 148. Section 47AA of said chapter 175, as so appearing, is hereby amended by
1680 striking out, in lines 83 and 84 and line 99, the words "commissioner of insurance" and inserting
1681 in place thereof, in each instance, the following words:- commissioner of health insurance.

1682 SECTION 149. Section 47KK of said chapter 175, as so appearing, is hereby amended by
1683 striking out, in lines 7 and 8 and line 10, the words “division of insurance” and inserting in place
1684 thereof, in each instance, the following words:- division of health insurance.

1685 SECTION 150. Section 47TT of said chapter 175, as so appearing, is hereby amended by
1686 striking out, in line 51, the words “division of insurance” and inserting in place thereof the
1687 following words:- division of health insurance.

1688 SECTION 151. Section 108 of said chapter 175, as so appearing, is hereby amended by
1689 striking out, in lines 681 and 682, the words “commissioner of insurance” and inserting in place
1690 thereof the following words:- commissioner of health insurance.

1691 SECTION 152. Section 108I of said chapter 175, as so appearing, is hereby amended by
1692 striking out, in line 58, the words “of insurance”.

1693 SECTION 153. Section 108M of said chapter 175, as so appearing, is hereby amended by
1694 striking out, in line 10, the words “of insurance”.

1695 SECTION 154. Section 110I of said chapter 175, as so appearing, is hereby amended by
1696 striking out, in line 23, the words “of insurance”.

1697 SECTION 155. Section 110J of said chapter 175, as so appearing, is hereby amended by
1698 striking out, in line 22, the words “of insurance”.

1699 SECTION 156. Section 206 of said chapter 175, as so appearing, is hereby amended by
1700 striking out the definition of “Commissioner” and inserting in place thereof the following
1701 definition:-

1702 “Commissioner”, (i) the commissioner of insurance appointed pursuant to section 6 of
1703 chapter 26, or their designee, or, as appropriate, (ii) the commissioner of health insurance
1704 appointed pursuant to section 7A of said chapter 26, or their designee, to the extent that this
1705 chapter applies to companies that are regulated by the division of health insurance pursuant to
1706 section 1 of said chapter 26.

1707 SECTION 157. Said section 206 of said chapter 175, as so appearing, is hereby further
1708 amended by striking out the definition of “Division” and inserting in place thereof the following
1709 definition:-

1710 “Division”, the division of insurance or the division of health insurance, as appropriate.

1711 SECTION 158. Section 206C of said chapter 175, as so appearing, is hereby amended by
1712 striking out, in lines 647 and 648, the words “division of insurance’s” and inserting in place
1713 thereof the following words:- division’s.

1714 SECTION 159. Chapter 175B of the General Laws is hereby amended by inserting after
1715 section 1 the following section:-

1716 Section 1A. For the purposes of this chapter, the term “commissioner” shall mean: (i) the
1717 commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as
1718 appropriate, (ii) the commissioner of health insurance appointed pursuant to section 7A of said
1719 chapter 26, or their designee, to the extent that this chapter applies to companies that are
1720 regulated by the division of health insurance pursuant to section 1 of said chapter 26.

1721 SECTION 160. Section 2 of said chapter 175B, as appearing in the 2022 Official Edition,
1722 is hereby amended by striking out, in lines 9, 18, and 20 and 21, each time they appear, the
1723 words "of insurance".

1724 SECTION 161. Section 3A of said chapter 175B, as so appearing, is hereby amended by
1725 striking out, in line 7, the words "of insurance".

1726 SECTION 162. Section 1 of chapter 175D of the General Laws, as so appearing, is
1727 hereby amended by striking out paragraph (1) and inserting in place thereof the following
1728 paragraph:-

1729 (1) "Commissioner", (i) the commissioner of insurance appointed pursuant to section 6 of
1730 chapter 26, or their designee, or, as appropriate, (ii) the commissioner of health insurance
1731 appointed pursuant to section 7A of said chapter 26, or their designee, to the extent that this
1732 chapter applies to companies that are regulated by the division of health insurance pursuant to
1733 section 1 of said chapter 26.

1734 SECTION 163. Section 2 of chapter 175I of the General Laws, as so appearing, is hereby
1735 amended by striking out the definition of "Commissioner" and inserting in place thereof the
1736 following definition:-

1737 "Commissioner", (i) the commissioner of insurance appointed pursuant to section 6 of
1738 chapter 26, or their designee, or, as appropriate, (ii) the commissioner of health insurance
1739 appointed pursuant to section 7A of said chapter 26, or their designee, to the extent that this
1740 chapter applies to companies that are regulated by the division of health insurance pursuant to
1741 section 1 of said chapter 26.

1742 SECTION 164. Section 9 of said chapter 175I, as so appearing, is hereby amended by
1743 striking out, in lines 21 and 22, the words "of insurance".

1744 SECTION 165. Section 2 of chapter 176A of the General Laws, as so appearing, is
1745 hereby amended by striking out, in lines 11 and 12, and lines 13 and 14, the words
1746 "commissioner of insurance" and inserting in place thereof, in each instance, the following
1747 words:- commissioner of health insurance.

1748 SECTION 166. Section 3 of said chapter 176A, as so appearing, is hereby amended by
1749 striking out, in lines 3 and 4, the words "commissioner of insurance" and inserting in place
1750 thereof the following words:- commissioner of health insurance.

1751 SECTION 167. Section 5 of said chapter 176A, as so appearing, is hereby amended by
1752 inserting after the word "corporation.", in line 44, the following sentence:- For the purposes of
1753 the review of rates of payment under this section, "not excessive" shall include considerations of
1754 affordability for consumers and purchasers of health insurance products.

1755 SECTION 168. Said section 5 of said chapter 176A, as so appearing, is hereby further
1756 amended by striking out, in lines 205 and 206, the words "commissioner of insurance shall on
1757 December thirty-first, nineteen hundred and seventy and annually thereafter require" and
1758 inserting in place thereof the following words:- commissioner of health insurance shall require
1759 annually, on December 31,.

1760 SECTION 169. The second paragraph of section 6 of said chapter 176A, as so appearing,
1761 is hereby amended by adding the following sentence:- For the purposes of the review of rates of
1762 payment under this section, whether a contract is not excessive shall include considerations of
1763 affordability for consumers and purchasers of health insurance products.

1764 SECTION 170. Section 7 of said chapter 176A, as so appearing, is hereby amended by
1765 striking out, in lines 1 and 11, the words "commissioner of insurance" and inserting in place
1766 thereof, in each instance, the following words:- commissioner of health insurance.

1767 SECTION 171. Section 8 of said chapter 176A, as so appearing, is hereby amended by
1768 striking out, in line 27, the words "commissioner of insurance" and inserting in place thereof the
1769 following words:- commissioner of health insurance.

1770 SECTION 172. Section 8A of said chapter 176A, as so appearing, is hereby amended by
1771 striking out, in line 142, the words "division of insurance" and inserting in place thereof the
1772 following words:- division of health insurance.

1773 SECTION 173. Section 8F of said chapter 176A, as so appearing, is hereby amended by
1774 striking out, in line 19, the words "commissioner of insurance" and inserting in place thereof the
1775 following words:- commissioner of health insurance.

1776 SECTION 174. Section 8M of said chapter 176A, as so appearing, is hereby amended by
1777 striking out, in line 1, the words "commissioner of insurance" and inserting in place thereof the
1778 following words:- commissioner of health insurance.

1779 SECTION 175. Section 8W of said chapter 176A, as so appearing, is hereby amended by
1780 striking out, in line 114, the words "commissioner of insurance" and inserting in place thereof
1781 the following words:- commissioner of health insurance.

1782 SECTION 176. Section 8DD of said chapter 176A, as so appearing, is hereby amended
1783 by striking out, in lines 81 and 82 and line 97, the words "commissioner of insurance" and

1784 inserting in place thereof, in each instance, the following words:- commissioner of health
1785 insurance.

1786 SECTION 177. Section 8MM of said chapter 176A, as so appearing, is hereby amended
1787 by striking out, in lines 7 and 9, the words "division of insurance" and inserting in place thereof,
1788 in each instance, the following words:- division of health insurance.

1789 SECTION 178. Section 8UU of said chapter 176A, as so appearing, is hereby amended
1790 by striking out, in line 41, the words "division of insurance" and inserting in place thereof the
1791 following words:- division of health insurance.

1792 SECTION 179. Section 10 of said chapter 176A, as so appearing, is hereby amended by
1793 striking out, in line 25, the words "commissioner of insurance" and inserting in place thereof the
1794 following words:- commissioner of health insurance.

1795 SECTION 180. The third paragraph of said section 10 of said chapter 176A, as so
1796 appearing, is hereby further amended by inserting after the first sentence the following sentence:-
1797 For the purposes of the review of rates of payment under this section, whether a contract is not
1798 excessive shall include considerations of affordability for consumers and purchasers of health
1799 insurance products.

1800 SECTION 181. Section 11 of said chapter 176A, as so appearing, is hereby amended by
1801 striking out, in line 13, the words "commissioner of insurance" and inserting in place thereof the
1802 following words:- commissioner of health insurance.

1803 SECTION 182. Section 15 of said chapter 176A, as so appearing, is hereby amended by
1804 striking out, in line 3, the words "commissioner of insurance" and inserting in place thereof the
1805 following words:- commissioner of health insurance.

1806 SECTION 183. Section 16 of said chapter 176A, as so appearing, is hereby amended by
1807 striking out, in line 1, the words "commissioner of insurance" and inserting in place thereof the
1808 words:- commissioner of health insurance.

1809 SECTION 184. Section 17 of said chapter 176A, as so appearing, is hereby amended, in
1810 lines 9 and 11, by inserting after the words "commissioner of insurance", each time they appear,
1811 the following words, in each instance:- and the commissioner of health insurance.

1812 SECTION 185. Section 18 of said chapter 176A, as so appearing, is hereby amended by
1813 striking out, in line 3, the words "commissioner of insurance" and inserting in place thereof the
1814 following words:- commissioner of health insurance.

1815 SECTION 186. Section 20 of said chapter 176A, as so appearing, is hereby amended by
1816 striking out, in line 3, the words "commissioner of insurance" and inserting in place thereof the
1817 following words:- commissioner of health insurance.

1818 SECTION 187. Section 21 of said chapter 176A, as so appearing, is hereby amended by
1819 striking out, in line 1, the words "commissioner of insurance" and inserting in place thereof the
1820 following words:- commissioner of health insurance.

1821 SECTION 188. Section 22 of said chapter 176A, as so appearing, is hereby amended by
1822 striking out, in line 3, the words "commissioner of insurance" and inserting in place thereof the
1823 following words:- commissioner of health insurance.

1824 SECTION 189. Section 23 of said chapter 176A, as so appearing, is hereby amended by
1825 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the
1826 following words:- commissioner of health insurance.

1827 SECTION 190. Section 24 of said chapter 176A, as so appearing, is hereby amended by
1828 striking out, in line 19, the words “commissioner of insurance” and inserting in place thereof the
1829 following words:- commissioner of health insurance.

1830 SECTION 191. Section 25 of said chapter 176A, as so appearing, is hereby amended by
1831 striking out, in line 4, the words “commissioner of insurance” and inserting in place thereof the
1832 following words:- commissioner of health insurance.

1833 SECTION 192. Section 31 of said chapter 176A, as so appearing, is hereby amended by
1834 striking out, in line 5, the words “commissioner of insurance” and inserting in place thereof the
1835 following words:- commissioner of health insurance.

1836 SECTION 193. Section 37 of said chapter 176A, as so appearing, is hereby amended by
1837 striking out, in line 10, the words “division of insurance” and inserting in place thereof the
1838 following words:- division of health insurance.

1839 SECTION 194. Section 1 of chapter 176B of the General Laws, as so appearing, is
1840 hereby amended by striking out the definition of “Commissioner” and inserting in place thereof
1841 the following definition:-

1842 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A
1843 of chapter 26, or their designee.

1844 SECTION 195. Said section 1 of said chapter 176B, as so appearing, is hereby further
1845 amended by inserting after the definition of "Dependent" the following definition:-

1846 "Division", the division of health insurance.

1847 SECTION 196. The second paragraph of section 4 of said chapter 176B, as so appearing,
1848 is hereby amended by inserting after the second sentence, the following sentence:- For the
1849 purposes of the review of rates of payment under this section, whether an agreement is not
1850 excessive shall include considerations of affordability for consumers and purchasers of health
1851 insurance products.

1852 SECTION 197. Said section 4 of said chapter 176B, as so appearing, is hereby further
1853 amended by striking out, in line 48, the words "commissioner of insurance" and inserting in
1854 place thereof the following words:- commissioner of health insurance.

1855 SECTION 198. Section 4A of said chapter 176B, as so appearing, is hereby amended by
1856 striking out, in line 137, the words "division of insurance" and inserting in place thereof the
1857 following words:- division of health insurance.

1858 SECTION 199. Section 4M of said chapter 176B, as so appearing, is hereby amended by
1859 striking out, in line 1, the words "commissioner of insurance" and inserting in place thereof the
1860 following words:- commissioner of health insurance.

1861 SECTION 200. Section 4DD of said chapter 176B, as so appearing, is hereby amended
1862 by striking out, in lines 80 and 81 and line 96, the words "commissioner of insurance" and
1863 inserting in place thereof, in each instance, the following words:- commissioner of health
1864 insurance.

1865 SECTION 201. Section 4MM of said chapter 176B, as so appearing, is hereby amended
1866 by striking out, in lines 7 and 9, the words "division of insurance" and inserting in place thereof,
1867 in each instance, the following words:- division of health insurance.

1868 SECTION 202. Section 4UU of said chapter 176B, as so appearing, is hereby amended
1869 by striking out, in line 40, the words "division of insurance" and inserting in place thereof the
1870 following words:- division of health insurance.

1871 SECTION 203. Section 6 of said chapter 176B, as so appearing, is hereby amended by
1872 striking out, in line 16, the words "commissioner of insurance" and inserting in place thereof the
1873 following words:- commissioner of health insurance.

1874 SECTION 204. Section 6B of said chapter 176B, as so appearing, is hereby amended by
1875 striking out, in lines 18 and 19, the words "commissioner of insurance" and inserting in place
1876 thereof the following words:- commissioner of health insurance.

1877 SECTION 205. Section 10 of said chapter 176B, as so appearing, is hereby amended by
1878 striking out, in line 34, the words "commissioner of insurance" and inserting in place thereof the
1879 following words:- commissioner of health insurance.

1880 SECTION 206. Section 12 of said chapter 176B, as so appearing, is hereby amended by
1881 striking out, in lines 8 and 9, the words "division of insurance" and inserting in place thereof the
1882 following words:- division of health insurance.

1883 SECTION 207. Section 24 of said chapter 176B, as so appearing, is hereby amended by
1884 striking out, in line 10, the words "division of insurance" and inserting in place thereof the
1885 following words:- division of health insurance.

1886 SECTION 208. Section 9 of chapter 176C of the General Laws, as so appearing, is
1887 hereby amended by striking out, in lines 2 and 3 and lines 6 and 7, the words "commissioner of
1888 insurance" and inserting in place thereof, in each instance, the following words:- commissioner
1889 of health insurance.

1890 SECTION 209. Section 10 of said chapter 176C, as so appearing, is hereby amended by
1891 striking out, in lines 1, 9 and 13, the words "commissioner of insurance" and inserting in place
1892 thereof, in each instance, the following words:- commissioner of health insurance.

1893 SECTION 210. Section 17 of said chapter 176C, as so appearing, is hereby amended by
1894 striking out, in line 6, the words "commissioner of insurance" and inserting in place thereof the
1895 following words:- commissioner of health insurance.

1896 SECTION 211. Section 1 of chapter 176D of the General Laws, as so appearing, is
1897 hereby amended by striking out paragraph (b) and inserting in place thereof the following
1898 paragraph:-

1899 (b) "Commissioner", the commissioner of health insurance appointed pursuant to section
1900 7A of chapter 26, or their designee.

1901 SECTION 212. Section 3B of said chapter 176D, as so appearing, is hereby amended by
1902 striking out, in line 120, the words "commissioner of the division of insurance" and inserting in
1903 place thereof the following words:- commissioner of health insurance.

1904 SECTION 213. Section 1 of chapter 176E of the General Laws, as so appearing, is
1905 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
1906 the following definition:-

1907 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A
1908 of chapter 26, or their designee.

1909 SECTION 214. Section 6 of said chapter 176E, as so appearing, is hereby amended by
1910 striking out, in line 22, the words “commissioner of insurance” and inserting in place thereof the
1911 following words:- commissioner of health insurance.

1912 SECTION 215. Section 12 of said chapter 176E, as so appearing, is hereby amended by
1913 striking out, in lines 6 and 7, the words “division of insurance” and inserting in place thereof the
1914 following words:- division of health insurance.

1915 SECTION 216. Section 1 of chapter 176F of the General Laws, as so appearing, is hereby
1916 amended by striking out the definition of “Commissioner” and inserting in place thereof the
1917 following definition:-

1918 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A
1919 of chapter 26, or their designee.

1920 SECTION 217. Section 12 of said chapter 176F, as so appearing, is hereby amended by
1921 striking out, in line 7, the words “division of insurance” and inserting in place thereof the
1922 following words:- division of health insurance.

1923 SECTION 218. Section 1 of chapter 176G of the General Laws, as so appearing, is
1924 hereby amended by striking out the definition of “Commissioner” and inserting in place thereof
1925 the following definition:-

1926 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A
1927 of chapter 26, or their designee.

1928 SECTION 219. Section 4M of said chapter 176G, as so appearing, is hereby amended by
1929 striking out, in line 134, the words "division of insurance" and inserting in place thereof the
1930 following words:- division of health insurance.

1931 SECTION 220. Section 4V of said chapter 176G, as so appearing, is hereby amended by
1932 striking out, in lines 80 and 81 and line 96, the words "commissioner of insurance" and inserting
1933 in place thereof, in each instance, the following words:- commissioner of health insurance.

1934 SECTION 221. Section 4EE of said chapter 176G, as so appearing, is hereby amended by
1935 striking out, in lines 6 and 8, each time they appear, the words "division of insurance" and
1936 inserting in place thereof the following words:- division of health insurance.

1937 SECTION 222. Section 4MM of said chapter 176G, as so appearing, is hereby amended
1938 by striking out, in line 40, the words "division of insurance" and inserting in place thereof the
1939 following words:- division of health insurance.

1940 SECTION 223. Section 5A of said chapter 176G, as so appearing, is hereby amended by
1941 striking out, in lines 18 and 19, the words "commissioner of insurance" and inserting in place
1942 thereof the following words:- commissioner of health insurance.

1943 SECTION 224. Section 8 of said chapter 176G, as so appearing, is hereby amended by
1944 striking out, in line 7, the words "division of insurance" and inserting in place thereof the
1945 following words:- division of health insurance.

1946 SECTION 225. The first paragraph of section 16 of said chapter 176G, as so appearing, is
1947 hereby amended by inserting after the second sentence the following sentence:- For the purposes
1948 of the review of rates of payment under this section, whether a contract is not excessive shall

1949 include considerations of affordability for consumers and purchasers of health insurance
1950 products.

1951 SECTION 226. Section 17 of said chapter 176G, as so appearing, is hereby amended by
1952 striking out, in line 8, the words "commissioner of insurance" and inserting in place thereof the
1953 following words:- commissioner of health insurance.

1954 SECTION 227. Section 32 of said chapter 176G, as so appearing, is hereby amended by
1955 striking out, in line 10, the words "division of insurance" and inserting in place thereof the
1956 following words:- division of health insurance.

1957 SECTION 228. Section 1 of chapter 176I of the General Laws, as so appearing, is hereby
1958 amended by striking out the definition of "Commissioner" and inserting in place thereof the
1959 following definition:-

1960 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
1961 of chapter 26, or their designee.

1962 SECTION 229. Section 8 of said chapter 176I, as so appearing, is hereby amended by
1963 striking out, in line 16, the words "commissioner of insurance" and inserting in place thereof the
1964 following words:- commissioner of health insurance.

1965 SECTION 230. Section 1 of chapter 176J of the General Laws, as so appearing, is hereby
1966 amended by striking out the definition of "Commissioner" and inserting in place thereof the
1967 following definition:-

1968 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
1969 of chapter 26, or their designee.

1970 SECTION 231. Section 4 of said section 176J, as so appearing, is hereby amended by
1971 striking out, in lines 75 and 80, the words "commissioner of insurance" and inserting in place
1972 thereof, in each instance, the following words:- commissioner of health insurance.

1973 SECTION 232. Section 6 of said section 176J, as so appearing, is hereby amended by
1974 striking out, in lines 3, 110 and 111, and 125, each time they appear, the words "division of
1975 insurance" and inserting in place thereof, in each instance, the following words:- division of
1976 health insurance.

1977 SECTION 233. Subsection (c) of said section 6 of said chapter 176J, as so appearing, is
1978 hereby amended by inserting after the second sentence the following sentence:- For the purposes
1979 of the review of rates of payment under this section, whether the proposed changes to base rates
1980 are excessive shall include considerations of affordability for consumers and purchasers of health
1981 insurance products.

1982 SECTION 234. Section 10 of said section 176J, as so appearing, is hereby amended by
1983 striking out, in lines 1 and 11, the words "division of insurance" and inserting in place thereof, in
1984 each instance, the following words:- division of health insurance.

1985 SECTION 235. Section 11 of said section 176J, as so appearing, is hereby amended by
1986 striking out, in lines 16 and 69 and 70, the words "commissioner of insurance" and inserting in
1987 place thereof, in each instance, the following words:- commissioner of health insurance.

1988 SECTION 236. Said section 11 of said section 176J, as so appearing, is hereby further
1989 amended by striking out, in lines 35, 93, 95 and 107, the words "division of insurance" and
1990 inserting in place thereof, in each instance, the following words:- division of health insurance.

1991 SECTION 237. Said section 11A of said chapter 176J, as so appearing, is hereby further
1992 amended by striking out, in lines 31 and 32, the words "division of health care finance and
1993 policy" and inserting in place thereof the following words:- center for health information and
1994 analysis.

1995 SECTION 238. Section 17 of said chapter 176J, as so appearing, is hereby amended by
1996 striking out, in line 10, the words "division of insurance" and inserting in place thereof the
1997 following words:- division of health insurance.

1998 SECTION 239. Section 1 of chapter 176K of the General Laws, as so appearing, is
1999 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2000 the following definition:-

2001 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2002 of chapter 26, or their designee.

2003 SECTION 240. The second paragraph of subsection (g) of section 7 of said chapter
2004 176K, as so appearing, is hereby amended by adding the following sentence:- For the purposes
2005 of the review of rates of payment under this section, whether rates are excessive shall include
2006 considerations of affordability for consumers and purchasers of health insurance products.

2007 SECTION 241. Section 1 of chapter 176M of the General Laws, as so appearing, is
2008 hereby amended by striking out, in lines 21 and 22, the words "commissioner of insurance" and
2009 inserting in place thereof the following words:- commissioner of health insurance.

2010 SECTION 242. Said section 1 of said chapter 176M, as so appearing, is hereby further
2011 amended by striking out the definition of "Commissioner" and inserting in place thereof the
2012 following definition:-

2013 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2014 of chapter 26, or their designee.

2015 SECTION 243. Section 2 of said chapter 176M, as so appearing, is hereby amended by
2016 striking out, in line 156, the words "commissioner of insurance" and inserting in place thereof
2017 the following words:- commissioner of health insurance.

2018 SECTION 244. Section 3 said chapter 176M, as so appearing, is hereby amended by
2019 striking out, in line 107, the words "commissioner of insurance" and inserting in place thereof
2020 the following words:- commissioner of health insurance.

2021 SECTION 245. Section 1 of chapter 176N of the General Laws, as so appearing, is
2022 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2023 the following definition:-

2024 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2025 of chapter 26, or their designee.

2026 SECTION 246. Section 1 of chapter 176O of the General Laws, as so appearing, is
2027 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2028 the following definition:-

2029 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2030 of chapter 26, or their designee.

2031 SECTION 247. Said section 1 of said chapter 176O, as so appearing, is hereby further
2032 amended by striking out the definition of "Division" and inserting in place thereof the following
2033 definition:-

2034 "Division", the division of health insurance.

2035 SECTION 248. Section 2 of said chapter 176O, as so appearing, is hereby amended by
2036 striking out, in lines 79, 83 and 90, the words "commissioner of insurance" and inserting in place
2037 thereof, in each instance, the following words:- commissioner of health insurance.

2038 SECTION 249. Section 5B of said chapter 176O, as so appearing, is hereby amended by
2039 striking out, in lines 3 and 4, the words "division of insurance" and inserting in place thereof the
2040 following words:- division of health insurance.

2041 SECTION 250. Section 12B said chapter 176O, as so appearing, is hereby amended by
2042 striking out, in line 3, the words "commissioner of insurance" and inserting in place thereof the
2043 following words:- commissioner of health insurance.

2044 SECTION 251. Section 14 said chapter 176O is hereby amended by striking out, in lines
2045 14 and 15, as so appearing, the words "commissioner of insurance" and inserting in place thereof
2046 the following words:- commissioner of health insurance.

2047 SECTION 252. Said section 14 said chapter 176O is hereby further amended by striking
2048 out, in lines 93 and 94 and 108 and 109, as so appearing, the words "division of insurance", each
2049 time they appear, and inserting in place thereof, in each instance, the following words:- division
2050 of health insurance.

2051 SECTION 253. Section 1 of chapter 176Q of the General Laws, as so appearing, is
2052 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2053 the following definition:-

2054 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2055 of chapter 26, or their designee.

2056 SECTION 254. Section 2 of said chapter 176Q, as so appearing, is hereby amended by
2057 striking out, in lines 18 and 19, the words "commissioner of insurance" and inserting in place
2058 thereof the following words:- commissioner of health insurance.

2059 SECTION 255. Section 3 of said chapter 176Q, as so appearing, is hereby amended by
2060 striking out, in line 86, the words "division of insurance" and inserting in place thereof the
2061 following words:- division of health insurance.

2062 SECTION 256. Section 1 of chapter 176R of the General Laws, as so appearing, is
2063 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2064 the following definition:-

2065 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2066 of chapter 26, or their designee.

2067 SECTION 257. Section 1 of chapter 176S of the General Laws, as so appearing, is hereby
2068 amended by striking out the definition of "Commissioner" and inserting in place thereof the
2069 following definition:-

2070 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2071 of chapter 26, or their designee.

2072 SECTION 258. Section 1 of chapter 176T of the General Laws, as so appearing, is
2073 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2074 the following definition:-

2075 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2076 of chapter 26, or their designee.

2077 SECTION 259. Section 1 of chapter 176U of the General Laws, as so appearing, is
2078 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2079 the following definition:-

2080 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2081 of chapter 26, or their designee.

2082 SECTION 260. Section 6 of said chapter 176U, as so appearing, is hereby amended by
2083 striking out, in lines 42 and 43, the words "division of insurance" and inserting in place thereof
2084 the following words:- division of health insurance.

2085 SECTION 261. Section 7 of said chapter 176U, as so appearing, is hereby amended by
2086 striking out, in line 26, the words "division of insurance" and inserting in place thereof the
2087 following words:- division of health insurance.

2088 SECTION 262. Section 1 of chapter 176V of the General Laws, as so appearing, is
2089 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2090 the following definition:-

2091 "Commissioner", (i) the commissioner of insurance appointed pursuant to section 6 of
2092 chapter 26, or their designee, or, as appropriate, (ii) the commissioner of health insurance

2093 appointed pursuant to section 7A of said chapter 26, or their designee, to the extent that this
2094 chapter applies to companies that are regulated by the division of health insurance pursuant to
2095 section 1 of said chapter 26.

2096 SECTION 263. Section 1 of chapter 176W of the General Laws, as so appearing, is
2097 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2098 the following definition:-

2099 "Commissioner", (i) the commissioner of insurance appointed pursuant to section 6 of
2100 chapter 26, or their designee, or, as appropriate, (ii) the commissioner of health insurance
2101 appointed pursuant to section 7A of said chapter 26, or their designee, to the extent that this
2102 chapter applies to companies that are regulated by the division of health insurance pursuant to
2103 section 1 of said chapter 26.

2104 SECTION 264. Said section 1 of said chapter 176W, as so appearing, is hereby further
2105 amended by striking out the definition of "Division" and inserting in place thereof the following
2106 definition:-

2107 "Division", the division of insurance or the division of health insurance, as appropriate.

2108 SECTION 265. Section 1 of chapter 176X of the General Laws, as so appearing, is
2109 hereby amended by striking out the definition of "Commissioner" and inserting in place thereof
2110 the following definition:-

2111 "Commissioner", the commissioner of health insurance appointed pursuant to section 7A
2112 of chapter 26, or their designee.

2113 SECTION 266. Section 2 of said chapter 176X, as so appearing, is hereby amended by
2114 striking out, in lines 3, 75 and 76, and 90, the words "division of insurance" and inserting in
2115 place thereof the following words:- division of health insurance.

2116 SECTION 266A. (a) The health policy commission, in collaboration with the center for
2117 health information and analysis and the division of health insurance, shall conduct an analysis
2118 and report on the use of prior authorization for health care services and its impact on cost, quality
2119 and access.

2120 (b) The report shall include, but not be limited to: (i) an assessment and inventory of
2121 admissions, items, services, treatments, procedures and medications that require prior
2122 authorization and that have a high rate of approval or denial for standard and expedited requests,
2123 including after appeal; (ii) the timeline for review and adjudication, including the time to
2124 adjudicate an appeal, for standard and expedited requests for admissions, items, services,
2125 treatments, procedures and medications that require prior authorization; (iii) total health care
2126 expenditures associated with the submission and processing, including appeals, of prior
2127 authorization determinations; (iv) an analysis of the impact of prior authorization requirements
2128 on patient access to and cost of care by patient demographics, geographic region and type of
2129 service; (v) identification of admissions, items, services, treatments, procedures and medications
2130 subject to prior authorization that have low variation in utilization across providers and carriers,
2131 or low denial rates across carriers; (vi) identification of admissions, items, services, treatments,
2132 procedures and medications subject to prior authorization for certain chronic disease services that
2133 negatively impact chronic disease management; (vii) review and analysis of the integration of
2134 standardized electronic prior authorization attachments, standardized forms, requirements and
2135 decision support into electronic health records and other practice management software to

2136 promote transparency and efficiency; (viii) review and analysis of a waiver of prior authorization
2137 based on a carrier's standards or policies, or "gold-carding status," so called, and whether such
2138 status is available to all providers in a carrier's network; and (ix) recommendations regarding the
2139 simplification of health insurance prior authorization standards and processes to improve health
2140 care access and reduce the burden on health care providers.

2141 (c) The report shall be informed by data and information submitted by carriers to the
2142 division of health insurance and shall include, but not be limited to the following:

2143 (1) a list of all admissions, items, services, treatments, procedures and medications that
2144 require prior authorization;

2145 (2) the number and percentage of standard prior authorization requests that were
2146 approved, individualized for each admission, item, service, treatment, procedure and medication;

2147 (3) the number and percentage of standard prior authorization requests that were denied,
2148 individualized for each admission, item, service, treatment, procedure and medication;

2149 (4) the number and percentage of standard prior authorization requests that were initially
2150 denied and approved after appeal, individualized for each admission, item, service, treatment,
2151 procedure and medication;

2152 (5) the number and percentage of prior authorization requests for which the timeframe for
2153 review was extended, and the request was approved, individualized for each admission, item,
2154 service, treatment, procedure and medication;

2155 (6) the number and percentage of expedited prior authorization requests that were
2156 approved, individualized for each admission, item, service, treatment, procedure and medication;

2157 (7) the number and percentage of expedited prior authorization requests that were denied,

2158 individualized for each admission, item, service, treatment, procedure and medication;

2159 (8) the average mean and median time that elapsed between the submission of a request

2160 and a determination by the carrier for standard prior authorizations, individualized for each

2161 admission, item, service, treatment, procedure and medication;

2162 (9) the average and median time that elapsed between the submission of a request and a

2163 decision by the carrier for expedited prior authorizations, individualized for each admission,

2164 item, service, treatment, procedure and medication;

2165 (10) the average and median time that elapsed to process an appeal submitted by a health

2166 care provider initially denied by the carrier for standard prior authorizations, individualized for

2167 each admission, item, service, treatment, procedure and medication; and

2168 (11) the average and median time that elapsed to process an appeal submitted by a health

2169 care provider initially denied by the carrier for expedited prior authorizations, individualized for

2170 each admission, item, service, treatment, procedure and medication.

2171 (d) The report and any legislative recommendations shall be submitted to the chairs of the

2172 joint committee on health care financing, the house and senate committees on ways and means

2173 not later than 1 year from the effective date of this act.

2174 SECTION 266B. (a) Notwithstanding any general or special law to the contrary, the

2175 secretary of health and human services shall direct monthly payments to eligible hospitals in the

2176 form of enhanced Medicaid payments, supplemental payments or other appropriate mechanisms.

2177 Each payment made to an eligible hospital shall equal 5 per cent of the eligible hospital's

2178 average monthly Medicaid payments, as determined by the secretary, for inpatient and outpatient
2179 acute hospital services for the preceding year or the most recent year for which data is available;
2180 provided, however, that such enhanced Medicaid payments shall not be used in subsequent years
2181 by the secretary to calculate an eligible hospital's average monthly payment; and provided
2182 further, that such payments shall not offset existing Medicaid payments for which an eligible
2183 hospital may be qualified to receive. In any fiscal year, the total sum of all payments made to
2184 eligible hospitals under this section shall not exceed $35,000,000.

2185 (b) The secretary may require as a condition of receiving payment any such reasonable
2186 condition of payment that the secretary determines necessary to ensure the availability, to the
2187 extent possible, of federal financial participation for the payments, and the secretary may incur
2188 expenses and the comptroller may certify amounts for payment in anticipation of expected
2189 receipt of federal financial participation for the payments.

2190 (c) The executive office of health and human services may promulgate regulations as
2191 necessary to carry out this section.

2192 (d) For the purposes of this section "eligible hospital" shall mean an acute care hospital
2193 licensed under section 51 of chapter 111 of the General Laws that: (i) has a statewide relative
2194 price equal to or less than 0.90, as calculated by the center for health information and analysis
2195 according to data from the most recent available year; (ii) has a public payer mix equal to or
2196 greater than 60 per cent, as calculated by the center for health information and analysis according
2197 to data from the most recent available year; and (iii) is not owned by or financially consolidated
2198 or corporately affiliated with a provider organization, as defined by section 1 of chapter 6D of
2199 the Genera Laws, that: (A) owns or controls 2 or more acute care hospitals licensed under said

2200 section 51 of said chapter 111; and (B) the total net assets of all affiliated acute care hospitals

2201 within the provider organization is greater than $800,000,000, as calculated by the center for

2202 health information and analysis according to data from the most recent available year.

2203 (e) For the purposes of subsection (d), a hospital's mere clinical affiliation with a

2204 provider organization, absent ownership, financial consolidation or corporate affiliation, shall not

2205 disqualify an eligible hospital from payments authorized under this section.

2206 SECTION 267. (a) Notwithstanding any general or special law to the contrary, for the

2207 purposes of monitoring and enforcing the health care cost growth benchmark for calendar years

2208 2021 to 2025, inclusive, the center for health information and analysis shall apply sections 8, 9,

2209 10, 16 and 18 of chapter 12C of the General Laws as in effect on May 1, 2024.

2210 (b) Notwithstanding any general or special law to the contrary, for the purposes of

2211 monitoring and enforcing the health care cost growth benchmark for calendar years 2021 to

2212 2025, inclusive, the health policy commission shall apply sections 9 and 10 of chapter 6D of the

2213 General Laws as in effect on May 1, 2024; provided, however, that the commission shall not

2214 require a health care entity to file and implement a performance improvement plan unless a

2215 health care entity's average annual growth in health status adjusted total medical expense during

2216 any 3-year period, the final year of which occurring in calendar year 2021 to 2025, inclusive, is

2217 greater than 4 per cent.

2218 SECTION 268. Notwithstanding any general or special law, rule or regulation to the

2219 contrary, the health resource planning council established in section 22 of chapter 6D of the

2220 General Laws shall submit a state health plan to the governor and the general court, as required

2221 by said section 22 of said chapter 6D, on or before January 1, 2026.

2222 SECTION 269. Section 19 shall take effect January 1, 2025.

2223 SECTION 270. All physician practices required to register pursuant to section 4A of
2224 chapter 112 of the General Laws, as inserted by section 129, shall register with the board of
2225 registration in medicine not later than January 1, 2026.

2226 SECTION 271. Section 184B of chapter 111 of the General Laws, as appearing in the
2227 2020 Official Edition, is hereby amended by inserting after the words "federal hospitals," the
2228 following:— not-for-profit organizations registered as a blood establishment with the federal
2229 Food and Drug Administration,.

2230 SECTION 272. Section 266B is hereby repealed.

2231 SECTION 273. Section 272 shall take effect 2 years from the effective date of this act.