Office of Senator Cindy F. Friedman
Chair, Joint Committee on Health Care Financing
Fourth Middlesex District

July 17, 2024

S.2871
AN ACT ENHANCING THE HEALTH CARE MARKET REVIEW PROCESS

WHAT DOES THIS BILL DO

- Nuts and bolts bill focusing on healthcare market oversight
- Modifies Commonwealth's role to reflect 2024 and onward
- Realigns system to bring patient and those who provide direct care back to the central focus

ONGOING HEALTH CARE ISSUES

- Health care costs for patients and the state continue to rise, as well as the cost of delivering care.
- For-profit entities, such as private equity firms, extract critical dollars from the health care system.
- There are in oversight and transparency in many health care sectors, such as pharmaceuticals and pharmacy benefit managers (PBMs).
- Primary care is in crisis.
- We have lost the patient as the primary focus of the health care system.

S.2871 BUILDS ON PAST HEALTH CARE REFORM TO ADDRESS ONGOING ISSUES

- Strengthens health care market oversight and transparency to reflect how health care is organized and delivered today.
- Imposes strong guardrails on private equity investments in provider and provider organizations and protects clinical decision-making in health care practices.
- Significantly enhances transparency tools to understand all sectors of the market, including carriers, providers, PBMs, pharma, and for-profit investments and the role they play in the health care system.
- Takes steps to address the crisis in primary care and the administrative burden placed on providers driving many out of the practice of medicine.
- Protects patients and providers from the overuse of prior authorization and the practice of insurers inserting themselves into medical decisions.

HEALTH CARE MARKET TRANSPARENCY & OVERSIGHT

Steward Health Care's financial issues could spell catastrophe for the state

How a private equity firm made a killing on Steward Health Care

Cerberus Capital Management grabbed its $800 million profit before the hospital chain's financial problems became critical

Medical Properties Trust: A place where failure seems to pay

Steward's medical devices were repossessed. Weeks later, a new mother died.

STEWARD HEALTH CARE TIMELINE

2010: Cerberus acquires Caritas Christi for $895M, most of it debt, and creates Steward, which is liable for the debt

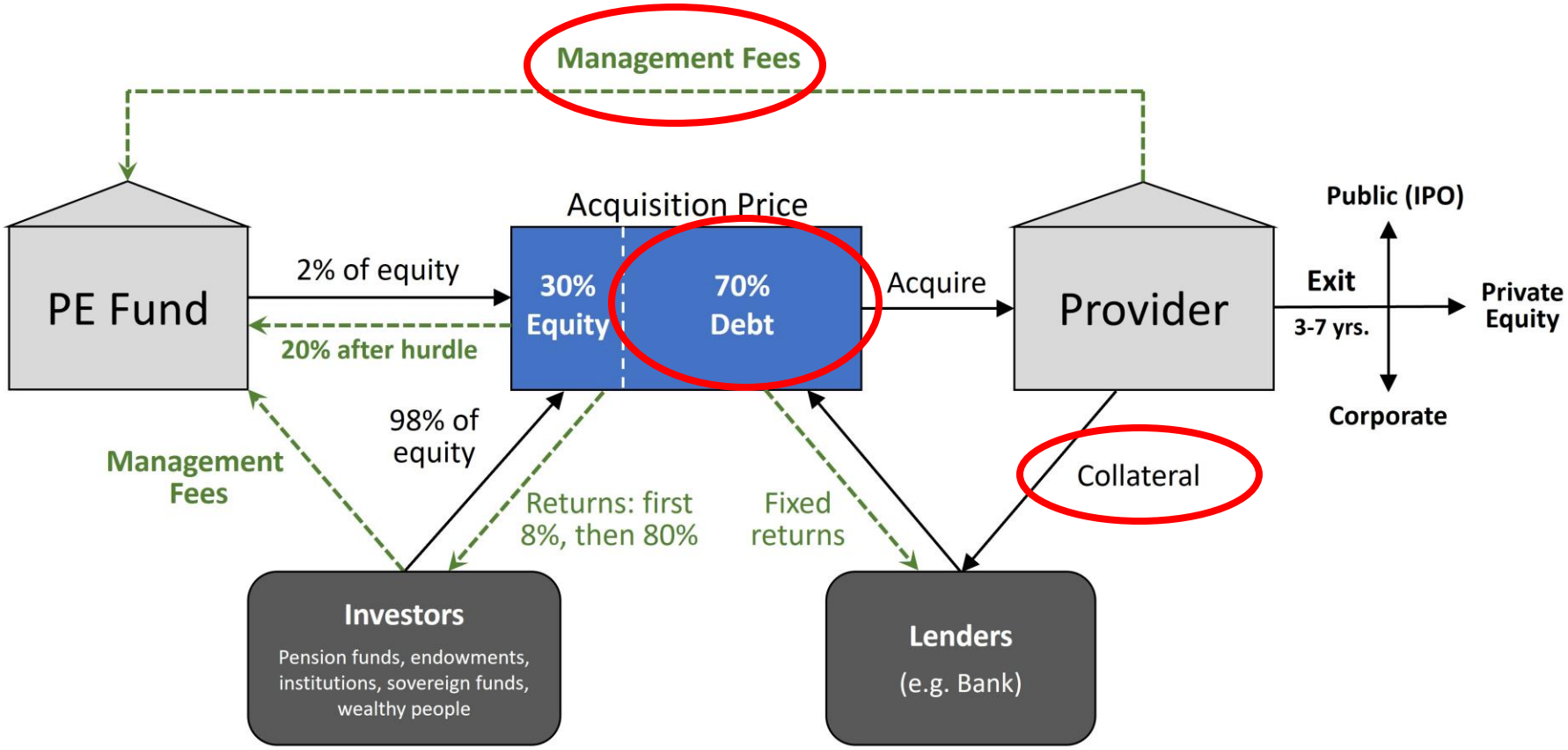
2014: Steward closes Quincy Medical Center, violating an agreement with the Attorney General

2016: Steward sells its MA properties to Medical Properties Trust (MPT) for $1.25B and leases back the properties

2020: Cerberus sells its stake with Steward doctors financed by MPT and exits with $800 million profit

2024: MPT announces plan to sell Steward's MA hospitals to cover unpaid rent; Steward declares Chapter 11 bankruptcy

PRIVATE EQUITY BUSINESS MODEL



Source: Zirui Song, MD, PhD

PROTECTING PROVIDER FINANCIAL STABILITY & PATIENT SAFETY

- Limits the amount of debt that a provider or provider organization in which a private equity firm has a financial interest can take on to reduce financial risk; non-compliance shall be considered a Chapter 93A violation.
- Requires private equity firms to post bond with the Department of Public Health (DPH) upon filing a MCN with HPC.
- Authorizes DPH to collect the bond upon failure to address violations or upon the provider or provider organization filing bankruptcy to ensure continued provision of health care services to patients.
- Requires not less than 90 days notice to DPH in any case where a party is seeking to possess collateral from a provider or provider organization in the form of a medical device.

EXPANDING HEALTH CARE MARKET REVIEW

- Adds significant for-profit investment in, acquisitions of assets of, or ownership or control of a provider or provider organization by for-profit entities to the Health Policy Commission's (HPC) Material Change Notice (MCN) process.
- Adds sale of assets for the purposes of a lease-back arrangement to the MCN process.
- Requires for-profit companies to submit additional information on corporate structure, financials, and portfolio companies to HPC as part of the MCN.
- Directs HPC to consider the cumulative impact of transactions over time when conducting a Cost and Market Impact Review (CMIR).
- Authorizes HPC to determine that multiple transactions over time may together meet the $25M net patient service revenue filing threshold.

INCREASING TRANSPARENCY & STRENGTHENING ENFORCEMENT

- Authorizes the Center for Health Information and Analysis (CHIA) to collect financial statements and other information from private equity (PE) firms, real estate investment trusts (REITs), and management services organizations (MSOs) and levy fines for non-compliance.
- Adds PE firms, REITs, and MSOs to the list of entities that the Attorney General can obtain information from.
- Adds PE firms, REITs, and MSOs to the Annual Cost Trends Hearing.
- Directs CHIA to analyze data on provider financial relationships with PE firms, REITs, and MSOs.
- Expands liability under the False Claims Act to hold private equity firms and other owners accountable for violations.

PROTECTING PATIENT ACCESS & CLINICIAN AUTONOMY

- Directs the Board of Registration in Medicine (BORIM) and Board of Registration in Nursing (BORIN) to establish minimum standards for health care practices to provide notice to patients and assist patients with transitioning to a new provider if the practice closes.
- Limits ownership of a health care practice to clinicians with independent practice authority and DPH-licensed health care facilities and entities.
- Prohibits MSOs, which can be affiliated with PE firms, from exercising control over the clinical decisions of the health care practice.

STRENGTHENING HEALTH INSURANCE OVERSIGHT

- Establishes the Health Insurance Bureau under the Division of Insurance (DOI), overseen by the Deputy Commissioner of Health Insurance, with the authority to review health insurance premium rates, establish affordability standards, and consider affordability during the rate review process.
- Establishes a task force to study and develop recommendations to standardize and limit the use of prior authorization.
- Directs DOI to adopt regulations on prior authorization and consider recommendations from the task force.
- Requires insurers to ensure continuity of coverage for patients on stable treatment for at least 90 days upon enrollment and requires prior authorization to be valid for the duration of treatment or at least 1 year.
- Authorizes HPC, CHIA, AGO, and other relevant state agencies to comment on mergers and consolidation between health insurance companies.

ESTABLISHING PHARMACEUTICAL COMPANY AND PHARMACY BENEFIT MANAGER OVERSIGHT

- Establishes the Office of Pharmaceutical Policy and Analysis under HPC.
- Enhances pharmaceutical data collection and monitoring through CHIA and HPC.
- Adds pharmaceutical companies and pharmacy benefit managers (PBMs) to the Annual Cost Trends Hearing.
- Assesses pharma and PBMs for the operations of HPC and CHIA.
- Authorizes DOI to license and regulate PBMs operating in Massachusetts and sets the licensing fee at $25,000 for a 3-year license.

HEALTH CARE MARKET REVIEW, REGISTRATION & LICENSURE

ADDRESSING GAPS IN MARKET REVIEW AUTHORITY

- Directs DPH consider the Commonwealth's cost containment goals, the impacts on the applicant's patients and on other residents, and the CMIR produced by HPC pursuant to the MCN process when making decisions on Determination of Need (DoN) applications.
- Clarifies that DPH should not act on a DoN application until HPC, CHIA, the AG, or other relevant state agencies have been given reasonable opportunity to supply required information.
- Tolls the DoN timeline for an independent cost analysis, CMIR and performance improvement plan that is not being implemented in good faith.
- Prohibits providers or provider organizations from applying for a DoN until an MCN has been submitted to HPC, if required.
- Permits DPH to remove administrative barriers for expansion of needed services, such as by streamlining the DoN process and reducing DoN fees.
- Authorizes HPC to recommend modifications on proposed material changes and establishes that failure by applicants to modify the proposed material change constitutes an unfair business practice under Chapter 93A.

ADDRESSING GAPS IN REGISTRATION & LICENSURE

- Creates a DPH licensing process for office-based surgical centers and urgent care centers.
- Requires provider organizations with $25M in net patient service revenue (NPSR) from all payers, not just commercial payers, to register with HPC.
- Requires provider organizations owned by private equity firms to register with HPC, regardless of NPSR.
- Requires health care practices owned by physicians or nurses to register with BORIM or BORIN.
- Authorizes DOI to license and regulate PBMs operating in the Commonwealth.
- Directs the Commissioner of Occupational Licensure and the Commissioner of Public Health to promulgate regulations defining "good moral character" and establishing a standardized assessment of "good moral character" for applicants for certification or licensure, which shall be adopted by boards of registration.

HEALTH CARE SPENDING & AFFORDABILITY

HEALTH CARE COST GROWTH BENCHMARK

The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

HPC

1-5 years

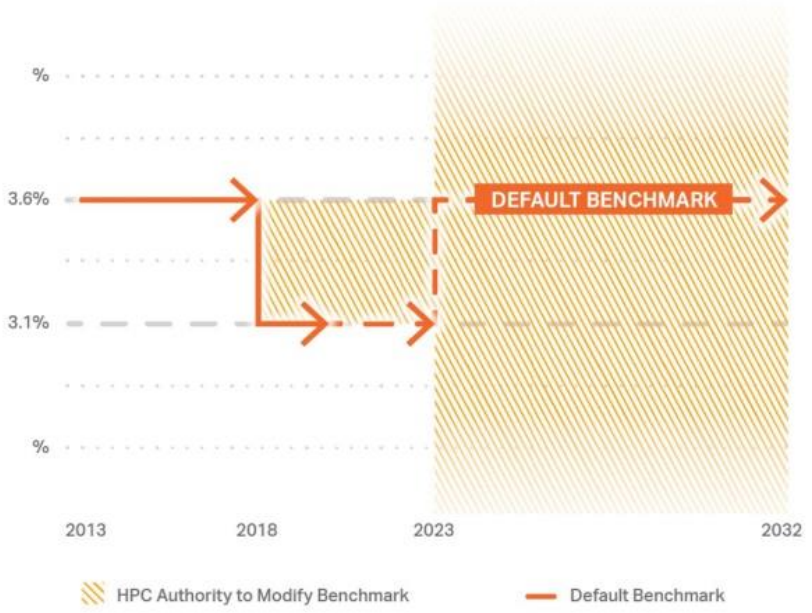
Benchmark established by law at PGSP (3.6%)

6-10 years

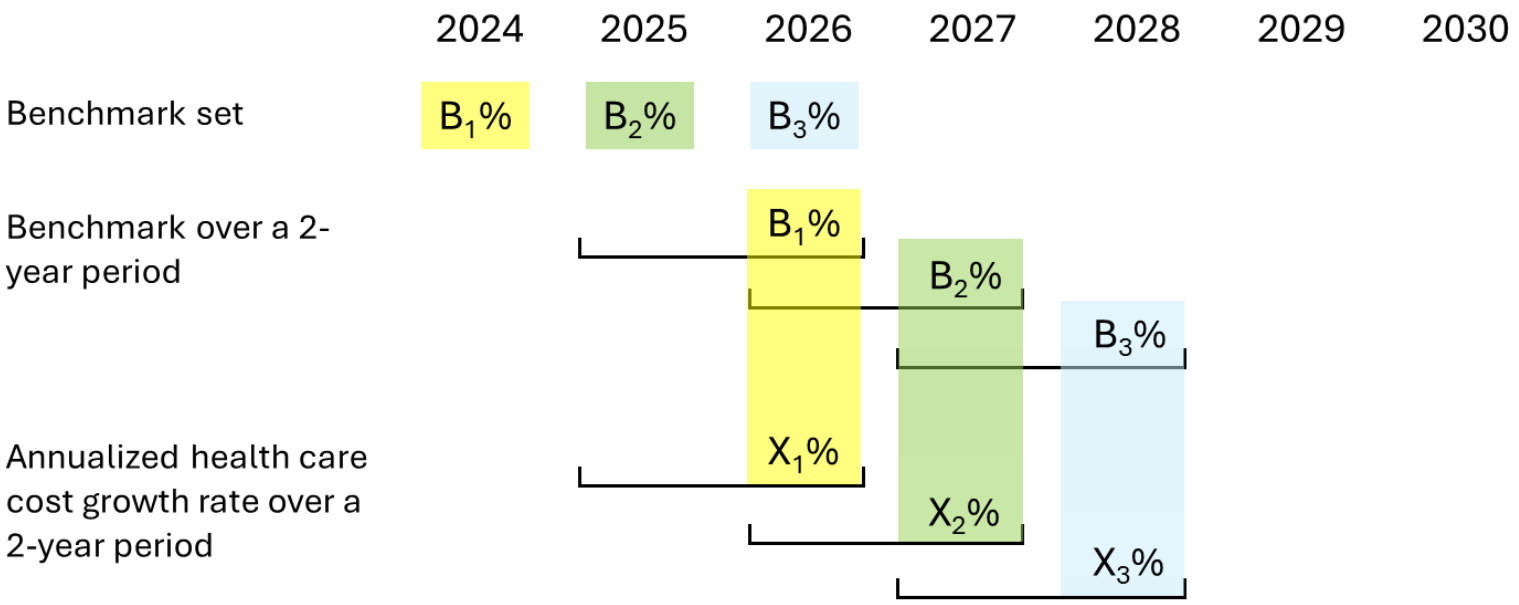
Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.

10-20 years

Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



AMENDING THE BENCHMARK TO A ROLLING 2-YEAR CYCLE



Key

B%: Health care cost growth benchmark, a statewide target for the rate of growth of total health care expenditures based on the growth rate of potential gross state product

X%: Annualized health care cost growth rate

CURRENT PERFORMANCE IMPROVEMENT PLAN PROCESS

- HPC and CHIA are charged with monitoring health care spending in Massachusetts and measuring performance against the health care cost growth benchmark.
- CHIA identifies and refers health care entities with excessive health care spending to HPC, which can elect to require the health care entity to file a performance improvement plan (PIP) to reduce spending.
- Currently, CHIA referral to HPC does not include health care entities such as specialty hospitals and all health care entities are held to the same benchmark.

HOLDING HEALTH CARE ENTITIES ACCOUNTABLE FOR EXCESSIVE SPENDING

- Directs CHIA to establish differential standards for excessive growth rates for cohorts of similar health care entities.
- Allows HPC to make public the identities and performance results of referred entities at its discretion.
- Authorizes HPC to assess a civil penalty in lieu of a PIP, provided that HPC gives written notice and opportunity for a hearing.
- Authorizes HPC to stay consideration of an MCN if a health care entity does not comply with the PIP process.
- Authorizes HPC to notify DPH if a health care entity does not comply with the PIP process.
- Adds labor costs to factors that HPC may consider to waive or extend a PIP.

IMPROVING AFFORDABILITY FOR HEALTH CARE CONSUMERS

- Directs HPC to set health care affordability goals for the Commonwealth.
- Directs HPC to establish a health care affordability benchmark.
- Directs CHIA to measure health care affordability goals for the Commonwealth.
- Directs the Health Insurance Bureau to establish affordability standards to be considered during the health insurance premium rate review process.

HEALTH PLANNING, HEALTH EQUITY, DATA COLLECTION & REPORTING

STATE HEALTH PLANNING AND HEALTH CARE RESOURCES INVENTORY

- Directs HPC to develop a state health plan, which shall identify current and anticipated health care needs in the Commonwealth and existing health care resources to meet those needs, identify major barriers to accessing health care, and make recommendations for the appropriate supply and distribution of resources, workforce, and services.
- Authorizes HPC to conduct focused assessments of supply and distribution of health care services in priority service lines, including primary care.
- Directs CHIA to develop a health care resources inventory that includes the geographic distribution of health care resources in the Commonwealth.
- Permits DPH to waive the requirement for a DoN application, and all associated fees, for projects that align with the state health plan and HPC's focused assessments.

ADVANCING HEALTH EQUITY

- Requires the state health plan to support goals of advancing health equity and addressing disparities in the health care system.
- Directs DPH to consider health equity during the DoN process.
- Directs the Health Insurance Bureau to enhance equity, access, quality, and affordability in the health care system.
- Adds health equity advocacy experience to the CHIA Oversight Council.

ENHANCING DATA COLLECTION & REPORTING

- Authorizes CHIA to levy weekly fines of $25,000 for non-compliance with reporting requirements and to notify HPC and DPH of failure to meet reporting requirements.
- Enables CHIA to collect data from non-hospital and non-physician group providers, such as nursing homes, and patient safety data from other state agencies and provider organizations.
- Expands CHIA's data collection to support the development of the state health plan and HPC's focused assessment.
- Requires reporting entities to provide CHIA with information on other assets and liabilities that may affect the financial condition of the organization including private equity investment and real estate sale leaseback arrangements.

BOARDS, TASK FORCES, & COMMITTEES

EXPANDING THE HPC BOARD TO REFLECT NEW HPC AUTHORITY

- Expands HPC Board from 11 members to 13 members by adding a member with expertise in development and pricing for pharmaceuticals, biotechnology, or medical devices and a member with expertise in hospital or hospital health system administration, finance and management.
- Moves 2 appointments by the Auditor to the Governor and 1 appointment by the Auditor to the AG.
- Provides stipends to certain Board members.
- Amends conflict of interest language for Board members by removing "financial stake".

ESTABLISHING A QUALITY MEASURE ALIGNMENT ADVISORY COMMITTEE TO CHIA

- Establishes an advisory committee, co-chaired by HPC and DOI, to make recommendations to CHIA on the standard quality measure set.
- Directs the committee to consider quality measures used by the Centers for Medicare and Medicaid Services, carriers, and providers in the Commonwealth and other states.
- Directs the committee to consider other valid measures of provider performance, such as patient experience and patient-reported health outcomes.

ESTABLISHING A PRIMARY CARE TASK FORCE

- Establishes a task force to study primary care access, delivery, and payment in the Commonwealth and make recommendations to stabilize the primary care system and the primary care workforce, increase financial investment in primary care, and improve patient access to primary care.
- Directs CHIA to adopt regulations to require providers and private and public health care payers to submit data or information necessary for the task force to fulfill its duties.

ESTABLISHING A PRIOR AUTHORIZATION TASK FORCE

- Establishes a task force, co-chaired by HPC and DOI, to study the use and impact of prior authorization, including factors carriers use to determine when prior authorization is appropriate and administrative burden on providers.
- Directs the task force to develop recommendations to simplify and standardize prior authorization, improve access to medically necessary covered services for patients, reduce response time, reduce administrative burden, ensure peer-to-peer physician review, and limit the use of prior authorization for certain services, treatments, or medication.
- Requires the task force to submit its report and recommendations within 1 year.