SENATE DOCKET, NO. 2233 FILED ON: 1/20/2023

SENATE . . . . No. 750

The Commonwealth of Massachusetts

PRESENTED BY:

Cindy F. Friedman

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to primary care for you.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Cindy F. Friedman	*Fourth Middlesex*	
John J. Cronin	*Worcester and Middlesex*	*4/13/2023*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*11/20/2023*
Mike Connolly	*26th Middlesex*	*1/4/2024*
Adam Scanlon	*14th Bristol*	*1/17/2024*
James K. Hawkins	*2nd Bristol*	*1/17/2024*
Kip A. Diggs	*2nd Barnstable*	*2/13/2024*

SENATE DOCKET, NO. 2233 FILED ON: 1/20/2023

SENATE . . . . No. 750

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 750) of Cindy F. Friedman for legislation relative to primary care for you. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *770* OF 2021-2022.]

The Commonwealth of Massachusetts

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

An Act relative to primary care for you.

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 1 of chapter 6D of the General Laws, as appearing in the 2020
2 Official Edition, is hereby amended by inserting after the definition of “After-hours care” the
3 following definitions:-

4 “Aggregate primary care baseline expenditures”, the sum of all primary care
5 expenditures, as defined by the center, in the commonwealth in the calendar year preceding the
6 year in which the aggregate primary care expenditure target applies.

7 “Aggregate primary care expenditure target”, the targeted sum, set by the commission in
8 section 9A, of all primary care expenditures, as defined by the center, in the commonwealth in
9 the calendar year in which the aggregate primary care expenditure target applies.

10 SECTION 2. Said section 1 of said chapter 6D, as so appearing, is hereby further
11 amended by inserting after the definition of "Physician" the following definitions:-

12 "Primary care baseline expenditures", the sum of all primary care expenditures, as
13 defined by the center, by or attributed to an individual health care entity in the calendar year
14 preceding the year in which the primary care expenditure target applies.

15 "Primary care expenditure target", the targeted sum, set by the commission in section 9A,
16 of all primary care expenditures, as defined by the center, by or attributed to an individual health
17 care entity in the calendar year in which the entity's primary care expenditure target applies.

18 SECTION 3. Section 8 of said chapter 6D, as so appearing, is hereby amended by
19 striking out subsection (a) and inserting in place thereof the following subsection:-

20 (a) Not later than October 1 of every year, the commission shall hold public hearings
21 based on the report submitted by the center under section 16 of chapter 12C comparing the
22 growth in total health care expenditures to the health care cost growth benchmark for the
23 previous calendar year and comparing the growth in actual aggregate primary care expenditures
24 for the previous calendar year to the aggregate primary care expenditure target. The hearings
25 shall examine health care provider, provider organization and private and public health care
26 payer costs, prices and cost trends, with particular attention to factors that contribute to cost
27 growth within the commonwealth's health care system and challenge the ability of the
28 commonwealth's health care system to meet the benchmark established under section 9 or the
29 aggregate primary care expenditure target established under section 9A.

30 SECTION 4. Said section 8 of said chapter 6D, as so appearing, is hereby further
31 amended by striking out, in line 94, the word “and” and inserting in place thereof the following
32 words:- , including primary care expenditures, and.

33 SECTION 5. Said chapter 6D is hereby further amended by inserting after section 9 the
34 following sections:-

35 Section 9A. (a) The commission- shall establish an aggregate primary care expenditure
36 target for the commonwealth, which the commission shall prominently publish on its website.

37 (b) The commission shall establish the aggregate primary care expenditure target and the
38 primary care expenditure target as follows:

39 (1) For the calendar year 2026, the aggregate primary care expenditure target and the
40 primary care expenditure target shall be equal to 8 per cent of total health care expenditures in
41 the commonwealth;

42 (2) For the calendar year 2027, the aggregate primary care expenditure target and the
43 primary care expenditure target shall be equal to 10 per cent of total health care expenditures in
44 the commonwealth;

45 (3) For the calendar year 2028, the aggregate primary care expenditure target and the
46 primary care expenditure target shall be equal to 12 per cent of total health care expenditures in
47 the commonwealth; and

48 (4) For calendar years 2029 and beyond, if the commission determines that an adjustment
49 in the aggregate primary care expenditure target and the primary care expenditure target is
50 reasonably warranted, the commission may recommend modification to such targets, provided,

51 that such targets shall not be lower than 12 per cent of total health care expenditures in the
52 commonwealth or higher than 15 per cent of total health care expenditures in the commonwealth.

53 (c) Prior to establishing the aggregate primary care expenditure target and the primary
54 care expenditure target, the commission shall hold a public hearing. The public hearing shall be
55 based on the report submitted by the center under section 16 of chapter 12C, comparing the
56 actual aggregate expenditures on primary care services to the aggregate primary care expenditure
57 target, any other data submitted by the center and such other pertinent information or data as may
58 be available to the commission. The hearings shall examine the performance of health care
59 entities in meeting the primary care expenditure target and the commonwealth's health care
60 system in meeting the aggregate primary care expenditure target. The commission shall provide
61 public notice of the hearing at least 45 days prior to the date of the hearing, including notice to
62 the joint committee on health care financing. The joint committee on health care financing may
63 participate in the hearing. The commission shall identify as witnesses for the public hearing a
64 representative sample of providers, provider organizations, payers and such other interested
65 parties as the commission may determine. Any other interested parties may testify at the hearing.

66 (d) Any recommendation of the commission to modify the aggregate primary care
67 expenditure target and the primary care expenditure target under paragraph (4) of subsection (b)
68 shall be approved by a two thirds vote of the board.

69 Section 9B. (a) As used in this section, the following words shall have the following
70 meanings, unless the context clearly requires otherwise:

71 "Primary care provider", a health care professional qualified to provide general medical
72 care for common health care problems, who supervises, coordinates, prescribes or otherwise

73 provides or proposes health care services, initiates referrals for specialist care and maintains
74 continuity of care within the scope of practice; provided, that a “primary care provider” shall
75 include a provider organization that provides primary care services in the commonwealth.

76 “Primary care service”, a service provided by a primary care provider.

77 (b) There shall be within the commission a primary care board, which shall consist of 19
78 members: the executive director of the commission or a designee, who shall serve as chair; the
79 secretary of the executive office of health and human services or a designee; the senate chair of
80 the joint committee on health care financing or a designee; the house chair of the joint committee
81 on health care financing or a designee; 2 members to be appointed by the governor, 1 of whom
82 shall be a primary care patient in the commonwealth and 1 of whom shall be the parent of a
83 pediatric primary care patient in the commonwealth; the commissioner of insurance or a
84 designee; 1 member from the Massachusetts Primary Care Alliance for Patients; 1 member from
85 the Massachusetts Academy of Family Physicians; 1 member from the Massachusetts Chapter of
86 the American Academy of Pediatrics; 1 member from the Massachusetts Chapter of the
87 American College of Physicians; 1 member from the Massachusetts League of Community
88 Health Centers; 1 member from Health Care For All Massachusetts; 1 member from the
89 Massachusetts Medical Society; 1 member from the Association for Behavioral Healthcare; 1
90 member from the Massachusetts Association of Physician Assistants; 1 member from the
91 Massachusetts Coalition of Nurse Practitioners; 1 member from the Massachusetts Association
92 of Health Plans; and 1 member from Blue Cross Blue Shield of Massachusetts.

93 All appointments shall serve a term of 3 years, but a person appointed to fill a vacancy
94 shall serve only for the unexpired term. An appointed member of the board shall be eligible for
95 reappointment. The members shall be appointed not later than 60 days after a vacancy.

96 (c) The board shall develop and recommend a primary care prospective payment model,
97 to be implemented by the commission, that allows a primary care provider in the commonwealth
98 to opt in to receiving a monthly lump sum payment for all primary care services delivered. Any
99 recommendation of the board to establish a primary care prospective payment model shall be
100 approved by a two thirds vote of the commission's board established in section 2; provided, that
101 the recommended payment model shall comply with the requirements of this section.

102 (d) The primary care prospective payment model shall include a baseline monthly per
103 patient payment, which shall be based on the historical monthly primary care spending per
104 patient at the primary care provider or provider organization level, the historical monthly primary
105 care spending per patient statewide, the primary care expenditure data published in the center's
106 annual report under section 16 of chapter 12C, and any other factors deemed relevant by the
107 board. The baseline monthly per patient payment shall be adjusted based on:

108 (1) a primary care provider's adoption of the primary care transformers established in
109 subsection (e);

110 (2) the quality of patient care delivered by a primary care provider, as described in
111 subsection (f); and

112 (3) the clinical and social risk of the primary care provider's patient panel, as described in
113 subsection (g).

114 (e) The primary care prospective payment model shall include a list of primary care
115 transformers, created by the board, that, if adopted by a primary care provider, shall increase a
116 primary care provider's baseline monthly per patient payment, as determined by the board. A
117 primary care transformer shall be an evidence-informed or evidence-based primary care service
118 that improves primary care quality, increases primary care access, enhances a patient's primary
119 care experience, or promotes health equity in primary care. A primary care transformer shall
120 include, but not be limited to: (i) employing community health workers or health coaches as part
121 of the primary care team; (ii) investing in social determinants of health; (iii) collaborating with
122 primary care-based clinical pharmacists; (iv) integrating behavioral health care with primary
123 care; (v) offering substance use disorder treatment, including medication-assisted treatment,
124 telehealth services, including telehealth consultations with specialists, medical interpreter
125 services, home care, patient advisory groups, and group visits; (vi) using clinician optimization
126 programs to reduce documentation burden, including, but not limited to, medical scribes and
127 ambient voice technology; (vii) investing in care management, including employing social
128 workers to help manage the care for patients with complicated health needs; (viii) establishing
129 systems to facilitate end of life care planning and palliative care; (ix) developing systems to
130 evaluate patient population health to help determine which preventative medicine interventions
131 require patient outreach; (x) offering walk-in or same-day care appointments or extended hours
132 of availability; and (xi) any other primary care service deemed relevant by the board.

133 The board shall assign a value to each primary care transformer based on the strength of
134 evidence that the transformer will: (i) improve patient health; (ii) enhance patient experience;
135 (iii) improve clinician experience, including reducing administrative burden; (iv) decrease total
136 medical expense; and (iv) promote health equity. Assigned values may account for the total time

137 and expense required to implement the transformer by a primary care provider. When assigning a
138 value to each primary care transformer, the board shall consider the primary care sub-capitation
139 and tiering system established in the MassHealth section 1115 demonstration waiver. The board
140 shall review the primary care transformers, at least every 3 years, to determine the
141 appropriateness of each transformer, its value, and whether additional transformers are
142 necessary.

143 A primary care provider shall only be granted credit for a primary care transformer if the
144 primary care provider attests to meeting the transformer's requirements.

145 (f) The board shall consider a primary care provider's performance on patient care quality
146 measures when establishing the baseline monthly per patient payment under subsection (d).
147 Patient care quality measures shall include, but not be limited to, established measures related to:
148 (i) care continuity, comprehensiveness, and coordination; (ii) patient access to primary care; and
149 (iii) patient experience. Each quality measure shall be patient-centered, appropriate for a primary
150 care setting, and supported by peer-reviewed, evidence-based research that the measure is
151 actionable and that its use will lead to improvements in patient health. The board shall establish
152 not more than 10 quality measures and shall require a primary care provider to only adopt 5 of
153 the quality measures, which shall include at least 2 measures of patient experience and 1 person-
154 centered primary care measure.

155 (g) The board shall consider the clinical and social complexity of a primary care
156 provider's patient panel when establishing the baseline monthly per patient payment under
157 subsection (d). Measures of the clinical and social complexity of a patient panel shall include,
158 but not be limited to, measures that promote health equity and measures such as MassHealth's

159 Neighborhood Stress Score. The board shall, to the extent possible, use measures of the clinical
160 and social complexity of a patient panel in a manner that minimizes opportunities to artificially
161 increase the clinical and social complexity of a patient panel.

162 (h) The board may establish a primary care provider tiering structure based on the type
163 and number of primary care transformers adopted by a primary care provider. This tiering
164 structure may be used by the board to determine the baseline monthly per patient payment. When
165 establishing the tiering structure, the board shall consider the primary care sub-capitation and
166 tiering system established in the MassHealth section 1115 demonstration waiver.

167 (i) The primary care prospective payment model shall include a voluntary opt-in process
168 that allows a primary care provider in the commonwealth to opt in to the payment model.

169 (j) The primary care prospective payment model shall require at least 95 per cent of
170 primary care payments made under the model to go directly to primary care providers for the
171 delivery of primary care services in the commonwealth.

172 (k) Health insurance coverage for a patient's primary care services delivered by a primary
173 care provider participating in the primary care prospective payment model shall not be subject to
174 any cost-sharing, including co-payments and co-insurance, and shall not be subject to any
175 deductible.

176 (l) Any carrier that provides health insurance coverage to a patient receiving primary care
177 services from a primary care provider participating in the primary care prospective payment
178 model shall comply with the requirements of said payment model, as described in this section.

179 (m) Payments made to primary care providers under the primary care prospective
180 payment model shall be included in the medical loss ratio calculated under section 6 of chapter
181 176J.

182 (n) Payments made to primary care providers under the primary care prospective payment
183 model shall be primary care expenditures for a primary care provider and a carrier for purposes
184 of complying with the primary care expenditure target established in section 9A.

185 (o) A Federally qualified community health center may receive a prospective monthly
186 payment for primary care services delivered to their commercially-insured patients, as
187 determined by the board. The payment shall be no less than what the federally qualified
188 community health center would receive through the Prospective Payment System rate.

189 (p) The board shall establish an attestation, public reporting, and audit process for
190 primary care providers that opt in to the primary care prospective payment model to ensure
191 compliance with this section. A primary care provider that does not comply with the
192 requirements of this section may be prohibited from participating in the primary care prospective
193 payment model until such noncompliance is rectified.

194 (q) The board shall review and revise the primary care prospective payment model as
195 necessary. Annually, the board shall submit a report summarizing it activities to the chair of the
196 commission's board, the clerks of the house of representatives and senate, the chairs of the house
197 and senate committees on ways and means, and the chairs of the joint committee on health care
198 financing.

199 (r) The commission shall promulgate rules and regulations necessary to implement this
200 section.

201 SECTION 6. Said chapter 6D, as so appearing, is hereby further amended by inserting
202 after section 10 the following section:-

203 Section 10A. (a) For the purposes of this section, “health care entity” shall mean any
204 entity identified by the center under section 18 of chapter 12C.

205 (b) The commission shall provide notice to all health care entities that have been
206 identified by the center under section 18 of chapter 12C for failure to meet the primary care
207 expenditure target. Such notice shall state that the center may analyze the performance of
208 individual health care entities in meeting the primary care expenditure target and, beginning in
209 calendar year 2025, the commission may require certain actions, as established in this section,
210 from health care entities so identified.

211 (c) In addition to the notice provided under subsection (b), the commission may require
212 any health care entity that is identified by the center under section 18 of chapter 12C for failure
213 to meet the primary care expenditure target to file and implement a performance improvement
214 plan. The commission shall provide written notice to such health care entity that they are
215 required to file a performance improvement plan. Within 45 days of receipt of such written
216 notice, the health care entity shall either:

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

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

220 (d) The health care entity may file any documentation or supporting evidence with the
221 commission to support the health care entity’s application to waive or extend the requirement to

222 file a performance improvement plan. The commission shall require the health care entity to
223 submit any other relevant information it deems necessary in considering the waiver or extension
224 application; provided, however, that such information shall be made public at the discretion of
225 the commission.

226 (e) The commission may waive or delay the requirement for a health care entity to file a
227 performance improvement plan in response to a waiver or extension request filed under
228 subsection (c) in light of all information received from the health care entity, based on a
229 consideration of the following factors: (1) the primary care baseline expenditures, costs, price
230 and utilization trends of the health care entity over time, and any demonstrated improvement to
231 increase the proportion of primary care expenditures; (2) any ongoing strategies or investments
232 that the health care entity is implementing to invest in or expand access to primary care services;
233 (3) whether the factors that led to the inability of the health care entity to meet the primary care
234 expenditure target can reasonably be considered to be unanticipated and outside of the control of
235 the entity; provided, that such factors may include, but shall not be limited to, market dynamics,
236 technological changes and other drivers of non-primary care spending such as pharmaceutical
237 and medical devices expenses; (4) the overall financial condition of the health care entity; and
238 (5) any other factors the commission considers relevant.

239 (f) If the commission declines to waive or extend the requirement for the health care
240 entity to file a performance improvement plan, the commission shall provide written notice to the
241 health care entity that its application for a waiver or extension was denied and the health care
242 entity shall file a performance improvement plan.

243 (g) The commission shall provide the department of public health any notice requiring a
244 health care entity to file and implement a performance improvement plan pursuant to this
245 section. In the event a health care entity required to file a performance improvement plan under
246 this section submits an application for a notice of determination of need under section 25C or 51
247 of chapter 111, the notice of the commission requiring the health care entity to file and
248 implement a performance improvement plan pursuant to this section shall be considered part of
249 the written record pursuant to said section 25C of chapter 111.

250 (h) A health care entity shall file a performance improvement plan: (1) within 45 days of
251 receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or
252 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
253 (3) if the health care entity is granted an extension, on the date given on such extension. The
254 performance improvement plan shall identify specific strategies, adjustments and action steps the
255 entity proposes to implement to increase the proportion of primary care expenditures. The
256 proposed performance improvement plan shall include specific identifiable and measurable
257 expected outcomes and a timetable for implementation.

258 (i) The commission shall approve any performance improvement plan that it determines
259 is reasonably likely to address the underlying cause of the entity's inability to meet the primary
260 care expenditure target and has a reasonable expectation for successful implementation.

261 (j) If the board determines that the performance improvement plan is unacceptable or
262 incomplete, the commission may provide consultation on the criteria that have not been met and
263 may allow an additional time period, up to 30 calendar days, for resubmission.

264 (k) Upon approval of the proposed performance improvement plan, the commission shall
265 notify the health care entity to begin immediate implementation of the performance improvement
266 plan. Public notice shall be provided by the commission on its website, identifying that the health
267 care entity is implementing a performance improvement plan. All health care entities
268 implementing an approved performance improvement plan shall be subject to additional
269 reporting requirements and compliance monitoring, as determined by the commission. The
270 commission shall provide assistance to the health care entity in the successful implementation of
271 the performance improvement plan.

272 (l) All health care entities shall, in good faith, work to implement the performance
273 improvement plan. At any point during the implementation of the performance improvement
274 plan the health care entity may file amendments to the performance improvement plan, subject to
275 approval of the commission.

276 (m) At the conclusion of the timetable established in the performance improvement plan,
277 the health care entity shall report to the commission regarding the outcome of the performance
278 improvement plan. If the performance improvement plan was found to be unsuccessful, the
279 commission shall either: (1) extend the implementation timetable of the existing performance
280 improvement plan; (2) approve amendments to the performance improvement plan as proposed
281 by the health care entity; (3) require the health care entity to submit a new performance
282 improvement plan under subsection (c); or (4) waive or delay the requirement to file any
283 additional performance improvement plans.

284 (n) Upon the successful completion of the performance improvement plan, the identity of
285 the health care entity shall be removed from the commission's website.

286 (o) The commission may submit a recommendation for proposed legislation to the joint
287 committee on health care financing if the commission determines that further legislative
288 authority is needed to achieve the health care quality and spending sustainability objectives of
289 section 9A, assist health care entities with the implementation of performance improvement
290 plans or otherwise ensure compliance with the provisions of this section.

291 (p) If the commission determines that a health care entity has: (1) willfully neglected to
292 file a performance improvement plan with the commission by the time required in subsection (h);
293 (2) failed to file an acceptable performance improvement plan in good faith with the
294 commission; (3) failed to implement the performance improvement plan in good faith; or (4)
295 knowingly failed to provide information required by this section to the commission or that
296 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity
297 of not more than $500,000. The commission shall seek to promote compliance with this section
298 and shall only impose a civil penalty as a last resort.

299 (q) The commission shall promulgate regulations necessary to implement this section.

300 (r) Nothing in this section shall be construed as affecting or limiting the applicability of
301 the health care cost growth benchmark established under section 9, and the obligations of a
302 health care entity thereto.

303 SECTION 7. Section 16 of chapter 12C of the General Laws, as so appearing in the 2020
304 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof
305 the following subsection:-

306 (a) The center shall publish an annual report based on the information submitted under
307 this chapter concerning health care provider, provider organization and private and public health

308 care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and
309 section 15 relative to quality data. The center shall compare the costs and cost trends with the
310 health care cost growth benchmark established by the health policy commission under section 9
311 of chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost
312 trends, and expenditures with the aggregate primary care expenditure target established under
313 section 9A of chapter 6D, and shall detail: (1) baseline information about cost, price, quality,
314 utilization and market power in the commonwealth's health care system; (2) cost growth trends
315 for care provided within and outside of accountable care organizations and patient-centered
316 medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals,
317 hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical
318 equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector
319 shall consider the effect of drug rebates and other price concessions in the aggregate without
320 disclosure of any product or manufacturer-specific rebate or price concession information, and
321 without limiting or otherwise affecting the confidential or proprietary nature of any rebate or
322 price concession agreement; (4) factors that contribute to cost growth within the
323 commonwealth's health care system and to the relationship between provider costs and payer
324 premium rates; (5) primary care expenditure trends as compared to the aggregate primary care
325 baseline expenditures, as defined in section 1 said chapter 6D; (6) the proportion of health care
326 expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the
327 impact of health care payment and delivery reform efforts on health care costs including, but not
328 limited to, the development of limited and tiered networks, increased price transparency,
329 increased utilization of electronic medical records and other health technology; (8) the impact of
330 any assessments including, but not limited to, the health system benefit surcharge collected under

331 section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of
332 unnecessary or duplicative services, with particular emphasis on imaging and other high-cost
333 services; (10) the prevalence and trends in adoption of alternative payment methodologies and
334 impact of alternative payment methodologies on overall health care spending, insurance
335 premiums and provider rates; (11) the development and status of provider organizations in the
336 commonwealth including, but not limited to, acquisitions, mergers, consolidations and any
337 evidence of excess consolidation or anti-competitive behavior by provider organizations; (12) the
338 impact of health care payment and delivery reform on the quality of care delivered in the
339 commonwealth; and (13) costs, cost trends, price, quality, utilization and patient outcomes
340 related to primary care services.

341 SECTION 8. Said section 16 of said chapter 12C, as so appearing, is hereby further
342 amended by adding the following subsections:-

343 (d) The center shall publish the aggregate primary care baseline expenditures in its annual
344 report.

345 (e) The center, in consultation with the commission, shall determine the primary care
346 baseline expenditures for individual health care entities and shall report to each health care entity
347 its respective baseline expenditures annually, by October 1.

348 SECTION 9. Said chapter 12C, as so appearing, is hereby further amended by striking
349 out section 18 and inserting in place thereof the following section:-

350 Section 18. The center shall perform ongoing analysis of data it receives under this
351 chapter to identify any payers, providers or provider organizations: (i) whose increase in health
352 status adjusted total medical expense is considered excessive and who threaten the ability of the

353 state to meet the health care cost growth benchmark established by the health care finance and
354 policy commission under section 10 of chapter 6D; or (ii) whose expenditures fail to meet the
355 primary care expenditure target under section 9A of chapter 6D. The center shall confidentially
356 provide a list of the payers, providers and provider organizations to the health policy commission
357 such that the commission may pursue further action under sections 10 and 10A of chapter 6D.

358 SECTION 10. Chapter 29 of the General Laws, as appearing in the 2020 Official Edition,
359 is hereby amended by inserting after section 2OOOOO the following section:-

360 Section 2PPPPP. (a) As used in this section, the following words shall have the following
361 meanings unless the context clearly requires otherwise:

362 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
363 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
364 176A; a nonprofit medical service corporation organized under chapter 176B; a health
365 maintenance organization organized under chapter 176G; and an organization entering into a
366 preferred provider arrangement under chapter 176I; provided, that this shall not include an
367 employer purchasing coverage or acting on behalf of its employees or the employees of 1 or
368 more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise
369 noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate or
370 contract that provides coverage solely for dental care services or visions care services.

371 "Provider", any person, corporation, partnership, governmental unit, state institution or
372 any other entity qualified under the laws of the commonwealth to perform or provide health care
373 services.

374 “Provider organization”, any corporation, partnership, business trust, association or
375 organized group of persons, which is in the business of health care delivery or management,
376 whether incorporated or not that represents 1 or more health care providers in contracting with
377 carriers for the payments of heath care services; provided, that "provider organization" shall
378 include, but not be limited to, physician organizations, physician-hospital organizations,
379 independent practice associations, provider networks, accountable care organizations and any
380 other organization that contracts with carriers for payment for health care services.

381 (b) There is hereby established and set up on the books of the commonwealth a separate
382 fund to be known as the primary care trust fund for the purpose of providing the prospective
383 monthly payments to primary care providers participating in the primary care prospective
384 payment model established in section 9B of chapter 6D. The fund shall be administered by the
385 health policy commission. There shall be credited to the fund: (i) an annual assessment on
386 carriers, providers, provider organizations, and for profit non-traditional healthcare corporations
387 and entities that provide, as part of a larger business model, primary care services in the
388 commonwealth, including, but not limited to, retailers, pharmacy benefits manager, and private
389 equity firms, in an amount and manner determined by the commission; (ii) revenue from
390 appropriations or other money authorized by the general court and specifically designated to be
391 credited to the fund; and (iii) interest earned on such revenues. Amounts credited to the fund
392 shall not be subject to further appropriation and any money remaining in the fund at the end of a
393 fiscal year shall not revert to the General Fund.

394 Funds may be used for scientific evaluation of the primary care prospective payment
395 model established under section 9B of chapter 6D.

396 (c) Not later than the first day of each month, the commission shall ensure that the
397 primary care trust fund transfers the necessary amount to cover the payments to primary care
398 provers required by the primary care prospective payment model established in section 9B of
399 chapter 6D.

400 (d) Annually, not later than October 1, the commission shall report to the clerks of the
401 house of representatives and senate, the chairs of the joint committee on health care financing,
402 and the chairs of the house and senate committees on ways and means on the fund's activity. The
403 report shall include, but not be limited to: (i) the source and amount of funds received; (ii) total
404 expenditures; and (iii) anticipated revenue and expenditure projections for the next calendar year.

405 SECTION 11. The regulations required by subsection (r) of section 9B of chapter 6D of
406 the General Laws shall be promulgated not later than January 1, 2025.

407 SECTION 12. Subsection (e) of section 16 of chapter 12C of the General Laws shall take
408 effect October 1, 2025.

409 SECTION 13. The primary care board, established in section 9B of chapter 6D of the
410 General Laws, shall convene its first meeting not later than March 1, 2025, and shall develop and
411 recommend the implementation of a primary care prospective payment model to the health
412 policy commission, established in said chapter 6D, not later than January 1, 2026.