

SENATE No. 770

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:

Cindy F. Friedman

DISTRICT/ADDRESS:

Fourth Middlesex

SENATE No. 770

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 770) of Cindy F. Friedman for legislation relative to primary care for you. Health Care Financing.

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Second General Court
(2021-2022)**

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 2018
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 3-year period to which the aggregate primary care expenditure target applies; provided, however,
7 that aggregate primary care baseline expenditures shall initially be calculated using calendar year
8 2021.

9 “Aggregate primary care expenditure target”, the targeted percentage change in total
10 expenditures on primary care in the commonwealth from aggregate primary care baseline
11 expenditures.

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

14 “Primary care baseline expenditures”, the sum of all primary care expenditures, as
15 defined by the center, by or attributed to an individual health care entity in the calendar year
16 preceding the 3-year period to which the primary care expenditure target applies; provided,
17 however, that primary care baseline expenditures shall initially be calculated using calendar year
18 2021.

19 “Primary care expenditure target”, the targeted percentage change in expenditures on
20 primary care by or attributed to an individual health care entity compared to the entity’s primary
21 care baseline expenditures.

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

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

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

37 SECTION 5. Said chapter 6D, as so appearing, is hereby further amended by inserting
38 after section 9 the following section:-

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

41 (b) The commission shall establish the aggregate primary care expenditure target as
42 follows:

43 (1) For the 3-year period ending with calendar year 2024, the aggregate primary care
44 expenditure target for each of the 3 years shall be equal to a 30 per cent increase above aggregate
45 primary care baseline expenditures, and the primary care expenditure target for each of the 3
46 years shall be equal to a 30 per cent increase above primary care baseline expenditures.

47 (2) For calendar years 2025 and beyond, the commission may modify the primary care
48 expenditure target and aggregate primary care expenditure target, to be effective for each year of
49 a 3-year period, provided that the primary care expenditure target and aggregate primary care
50 expenditure target shall be approved by a two-thirds vote of the board not later than December
51 31 of the final calendar year of the preceding 3-year period. If the commission does not act to
52 establish an updated primary care expenditure target and aggregate primary care expenditure
53 target pursuant to this subsection, the primary care expenditure target for each of the 3 years
54 shall be equal to a 30 per cent increase above primary care baseline expenditures, and the
55 aggregate primary care expenditure target for each of the 3 years shall be equal to a 30 per cent

56 increase above aggregate primary care baseline expenditures, until such time as the commission
57 acts to modify the primary care expenditure target and aggregate primary care expenditure target.
58 If the commission modifies the primary care expenditure target and aggregate primary care
59 expenditure target, the modification shall not take effect until the 3-year period beginning with
60 the next full calendar year.

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

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

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

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

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

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

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

93 (d) The health care entity may file any documentation or supporting evidence with the
94 commission to support the health care entity's application to waive or extend the requirement to
95 file a performance improvement plan. The commission shall require the health care entity to
96 submit any other relevant information it deems necessary in considering the waiver or extension
97 application; provided, however, that such information shall be made public at the discretion of
98 the commission.

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

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

116 (g) The commission shall provide the department of public health any notice requiring a
117 health care entity to file and implement a performance improvement plan pursuant to this
118 section. In the event a health care entity required to file a performance improvement plan under
119 this section submits an application for a notice of determination of need under section 25C or 51
120 of chapter 111, the notice of the commission requiring the health care entity to file and

121 implement a performance improvement plan pursuant to this section shall be considered part of
122 the written record pursuant to said section 25C of chapter 111.

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

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

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

137 (k) Upon approval of the proposed performance improvement plan, the commission shall
138 notify the health care entity to begin immediate implementation of the performance improvement
139 plan. Public notice shall be provided by the commission on its website, identifying that the health
140 care entity is implementing a performance improvement plan. All health care entities
141 implementing an approved performance improvement plan shall be subject to additional
142 reporting requirements and compliance monitoring, as determined by the commission. The

143 commission shall provide assistance to the health care entity in the successful implementation of
144 the performance improvement plan.

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

149 (m) At the conclusion of the timetable established in the performance improvement plan,
150 the health care entity shall report to the commission regarding the outcome of the performance
151 improvement plan. If the performance improvement plan was found to be unsuccessful, the
152 commission shall either: (1) extend the implementation timetable of the existing performance
153 improvement plan; (2) approve amendments to the performance improvement plan as proposed
154 by the health care entity; (3) require the health care entity to submit a new performance
155 improvement plan under subsection (c); or (4) waive or delay the requirement to file any
156 additional performance improvement plans.

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

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

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

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

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

176 SECTION 7. Subsection (a) of section 16 of chapter 12C of the General Laws, as
177 appearing in the 2018 Official Edition, is hereby amended by striking out, in line 2, the words
178 “sections 8, 9 and 10” and inserting in place thereof the following words:- this chapter.

179 SECTION 8. Said subsection (a) of said section 16 of said chapter 12C, as so appearing,
180 is hereby further amended by inserting after the words “commonwealth,” in line 9, the following
181 words:-

182 and shall compare the costs, cost trends, and expenditures with the aggregate primary
183 care expenditure target established under section 9A of said chapter 6D,.

184 SECTION 9. Said subsection (a) of said section 16 of said chapter 12C, as so appearing,
185 is hereby further amended by inserting, after the words “rates;” in line 24, the following words:-

186 (5) primary care expenditure trends as compared to the aggregate primary care baseline
187 expenditures, as defined in section 1 said chapter 6D; (6) the proportion of health care
188 expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the
189 impact of health care payment and delivery reform efforts on health care costs including, but not
190 limited to, the development of limited and tiered networks, increased price transparency,
191 increased utilization of electronic medical records and other health technology; (8) the impact of
192 any assessments including, but not limited to, the health system benefit surcharge collected under
193 section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of
194 unnecessary or duplicative services, with particular emphasis on imaging and other high-cost
195 services; (10) the prevalence and trends in adoption of alternative payment methodologies and
196 impact of alternative payment methodologies on overall health care spending, insurance
197 premiums and provider rates; (11) the development and status of provider organizations in the
198 commonwealth including, but not limited to, acquisitions, mergers, consolidations and any
199 evidence of excess consolidation or anti-competitive behavior by provider organizations; (12) the
200 impact of health care payment and delivery reform on the quality of care delivered in the
201 commonwealth; and (13) costs, cost trends, price, quality, utilization and patient outcomes
202 related to primary care services.

203 SECTION 10. Said section 16 of said chapter 12C, as so appearing, is hereby further
204 amended by adding the following subsections:-

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

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

210 SECTION 11. Said chapter 12C, as so appearing, is hereby further amended by striking
211 out section 18 and inserting in place thereof the following section:-

212 Section 18. The center shall perform ongoing analysis of data it receives under this
213 chapter to identify any payers, providers or provider organizations: (i) whose increase in health
214 status adjusted total medical expense is considered excessive and who threaten the ability of the
215 state to meet the health care cost growth benchmark established by the health care finance and
216 policy commission under section 10 of chapter 6D; or (ii) whose expenditures fail to meet the
217 primary care expenditure target under section 9A of chapter 6D. The center shall confidentially
218 provide a list of the payers, providers and provider organizations to the health policy commission
219 such that the commission may pursue further action under sections 10 and 10A of chapter 6D.

220 SECTION 12. Notwithstanding any general or special law to the contrary, there shall be a
221 Massachusetts Primary Care Alliance for Patients working group that develops recommendations
222 to assist health care entities in meeting their annual primary care expenditure target, as
223 established by section 9A of chapter 6D of the General Laws. The recommendations shall
224 include the development of legislation that establishes a global payment program for primary
225 care providers in the commonwealth, which shall include, but not be limited to: (i) a baseline per
226 member per month global payment, which shall be designed to reduce reimbursement rate

227 disparities amongst providers by combining some proportion of the provider’s historic payment
228 rates and a fixed statewide average rate; (ii) incentives in the form of add-on per member per
229 month payments for primary care providers that invest in evidence-based primary care
230 transformation activities, including, but not limited to, extended office hours, walk-in
231 availability, additional time with patients per encounter, telehealth, home care, palliative care,
232 integration of primary care and behavioral health care, and the hiring of community health
233 workers, health coaches, care managers and pharmacy consultants; (iii) an adjustment to the
234 baseline global payment based on risk to ensure an equitable allocation of resources and an
235 appropriate accounting for social determinants of health; (iv) an adjustment to the baseline global
236 payment based on quality, with an emphasis on evidence-based, patient-centered care; and (v)
237 any other global payment program features deemed necessary by the working group.

238 The Massachusetts Primary Care Alliance for Patients working group shall submit its
239 recommendations, including any legislation, to the clerks of the senate and house of
240 representatives not later than 6 months after passage of this legislation.

241 SECTION 13. Section 10 shall take effect January 1, 2022.