

HOUSE No.

The Commonwealth of Massachusetts

PRESENTED BY:

Richard M. Haggerty

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 Massachusetts primary care for you.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Richard M. Haggerty</i>	<i>30th Middlesex</i>	<i>1/16/2025</i>

HOUSE No.

[Pin Slip]

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Fourth General Court
(2025-2026)**

An Act relative to Massachusetts 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 two calendar years preceding
6 the year in which the aggregate primary care expenditure target applies.

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

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

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

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

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

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

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

35 SECTION 5. Said chapter 6D is hereby further amended by inserting after section
36 9 the following sections:-

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

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

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

45 (2) For the calendar year 2028, the aggregate primary care expenditure target and
46 the primary care expenditure target shall be equal to 12.5 per cent of total health care
47 expenditures in the commonwealth as determined by the commission;

48 (3) For the calendar year 2029, the aggregate primary care expenditure target and
49 the primary care expenditure target shall be equal to 15 per cent of total health care expenditures
50 in the commonwealth as determined by the commission; and

51 (4) For calendar years 2030 and beyond, if the commission determines that an
52 adjustment in the aggregate primary care expenditure target and the primary care expenditure
53 target is reasonably warranted, the commission may recommend modification to such targets,
54 provided, that such targets shall not be lower than 15 per cent of total health care expenditures in

55 the commonwealth or higher than 20 per cent of total health care expenditures in the
56 commonwealth.

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

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

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

76 “Primary care provider”, a health care professional qualified to provide general
77 medical care for common health care problems, who supervises, coordinates, prescribes or
78 otherwise provides or proposes health care services, initiates referrals for specialist care and
79 maintains continuity of care within the scope of practice; provided, that a “primary care
80 provider” shall include a provider organization that provides primary care services in the
81 commonwealth.

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

83 (b) There shall be within the commission a primary care council, which shall
84 consist of 25 members: the executive director of the commission or a designee, who shall serve
85 as co-chair; the secretary of the executive office of health and human services or a designee who
86 shall also serve as co-chair; the senate chair of the joint committee on health care financing or a
87 designee; the house chair of the joint committee on health care financing or a designee; the
88 commissioner of insurance or a designee; Assistant Secretary of MassHealth or a designee;
89 Executive Director of CHIA or designee; 1 member from the Massachusetts Primary Care
90 Alliance for Patients; 1 member from the Massachusetts Academy of Family Physicians; 1
91 member from the Massachusetts Chapter of the American Academy of Pediatrics; 1 member
92 from the Massachusetts American College of Physicians; 1 member from the Massachusetts
93 League of Community Health Centers; 1 member from Health Care For All Massachusetts; 1
94 member from the Massachusetts Medical Society; 1 member from the Massachusetts Association
95 of Physician Assistants; 1 member from the Massachusetts Coalition of Nurse Practitioners; 1
96 member from the Community Care Cooperative; 1 member from the Massachusetts chapter of
97 the national association of social workers with an expertise in behavioral health in a primary care
98 setting; 1 person from a rural health practice with expertise in primary care; 1 member from the

99 Massachusetts Health Quality Partners; 1 member from the Massachusetts Association of Health
100 Plans; 1 member from Blue Cross Blue Shield of Massachusetts; 1 member from the
101 Massachusetts Health and Hospital Association; 1 member from the Retailers Association of
102 Massachusetts; and 1 member from the Association Industries of Massachusetts.

103 All appointments shall serve a term of 3 years, but a person appointed to fill a
104 vacancy shall serve only for the unexpired term. An appointed member of the council shall be
105 eligible for reappointment. The members shall be appointed not later than 60 days after a
106 vacancy.

107 (c) The council shall develop and recommend a primary care prospective payment
108 model, to be implemented by the commission, that allows a primary care provider in the
109 commonwealth to opt in to receiving a monthly lump sum payment for all primary care services
110 delivered. Any recommendation of the council to establish a primary care prospective payment
111 model shall be approved by a two thirds vote of the board established in section 2; provided, that
112 the recommended payment model shall comply with the requirements of this section.

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

119 (1) a primary care provider's adoption of the primary care transformers
120 established in subsection (e); (2) the quality of patient care delivered by a primary care provider,

121 as described in subsection (f); and (3) the clinical and social risk of the primary care provider's
122 patient panel, as described in subsection (g).

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

143 The council shall assign a value to each primary care transformer based on the
144 strength of evidence that the transformer will: (i) improve patient health; (ii) enhance patient
145 experience; (iii) improve clinician experience, including reducing administrative burden; (iv)
146 decrease total medical expense; and (iv) promote health equity. Assigned values may account for
147 the total time and expense required to implement the transformer by a primary care provider.
148 When assigning a value to each primary care transformer, the council shall consider the primary
149 care sub-capitation and tiering system established in the MassHealth section 1115 demonstration
150 waiver. The council shall review the primary care transformers, at least every 3 years, to
151 determine the appropriateness of each transformer, its value, and whether additional transformers
152 are necessary.

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

155 (f) The council shall consider a primary care provider's performance on patient
156 care quality measures when establishing the baseline monthly per patient payment under
157 subsection (d). Patient care quality measures shall include, but not be limited to, established
158 measures related to: (i) care continuity, comprehensiveness, and coordination; (ii) patient access
159 to primary care; and (iii) patient experience. Each quality measure shall be patient-centered,
160 appropriate for a primary care setting, and supported by peer-reviewed, evidence-based research
161 that the measure is actionable and that its use will lead to improvements in patient health. The
162 council shall establish not more than 12 quality measures and shall require a primary care
163 provider to only adopt 6 of the quality measures, which shall include at least 1 measure of health
164 equity and at least 2 measures of patient experience. The Massachusetts Health Quality Partners
165 shall be consulted regarding the administration of the 2 measures of patient experience. The

166 council may consult with the EOHHS Massachusetts Quality Measure Alignment Taskforce
167 when establishing the quality measures.

168 (g) The council shall consider the medical and social complexity of a primary care
169 provider's patient panel when establishing the baseline monthly per patient payment under
170 subsection (d). Measures of the medical and social complexity of a patient panel shall include,
171 but not be limited to, measures that promote health equity and measures such as MassHealth's
172 Neighborhood Stress Score. The council shall, to the extent possible, use measures of the
173 medical and social complexity of a patient panel in a manner that minimizes opportunities to
174 artificially increase the medical and social complexity of a patient panel and does not encourage
175 entities to choose a low complexity patient panel. The council may consider the payer mix of a
176 patient panel when establishing the baseline monthly per patient payment under subsection (d).

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

182 (i) The primary care prospective payment model shall include a voluntary opt-in
183 process that allows a primary care entity in the commonwealth to opt in to the payment model.

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

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

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

195 (m) Payments made to primary care providers under the primary care prospective
196 payment model shall be included in the medical loss ratio calculated under section 6 of chapter
197 176J.

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

201 (o) A federally qualified community health center may receive a prospective
202 monthly payment for primary care services delivered to their commercially insured patients, as
203 determined by the council. The payment shall be no less than what the federally qualified
204 community health center would receive through the Prospective Payment System rate.

205 (p) The council shall establish an attestation, public reporting, and audit process
206 for primary care providers that opt in to the primary care prospective payment model to ensure
207 compliance with this section. A primary care provider that does not comply with the
208 requirements of this section may be prohibited from participating in the primary care prospective

209 payment model until such noncompliance is rectified. The primary care council shall establish
210 recommendations to the commission regarding annual audits for larger healthcare systems and
211 randomized audits for smaller systems and independent practices, with specific criteria for
212 determining system size classification. The commission shall provide technical assistance and
213 resources to smaller systems and practices to support their compliance with audit requirements
214 and procedures.

215 (q) The council shall review and revise the primary care prospective payment
216 model as necessary . Annually, the council shall submit a report summarizing its activities to the
217 chair of the commission’s board, the clerks of the house of representatives and senate, the chairs
218 of the house and senate committees on ways and means, and the chairs of the joint committee on
219 health care financing.

220 (r) Council shall recommend to the commission a payment mechanism by which
221 specialists shall be reimbursed at a reasonable rate for brief electronic or telephone consultations,
222 taking into consideration existing MassHealth payment methodologies as potential models for
223 implementation.

224 (s) Council shall recommend to the commission a payment mechanism by which
225 primary care providers may be reimbursed on a fee-for-service basis for specific outpatient
226 procedures, taking into consideration the importance of maintaining a broad scope of primary
227 care services and establishing appropriate incentive structures to support such practice patterns.

228 (t) The commission shall promulgate rules and regulations necessary to implement
229 this section.

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

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

234 (b) The commission shall provide notice to all health care entities that have been
235 identified by the center under section 18 of chapter 12C for failure to meet the primary care
236 expenditure target. Such notice shall state that the center may analyze the performance of
237 individual health care entities in meeting the primary care expenditure target and, beginning in
238 calendar year 2027, the commission may require certain actions, as established in this section,
239 from health care entities so identified.

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

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

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

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

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

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

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

272 (g) The commission shall provide the department of public health any notice
273 requiring a health care entity to file and implement a performance improvement plan pursuant to
274 this section. In the event a health care entity required to file a performance improvement plan
275 under this section submits an application for a notice of determination of need under section 25C
276 or 51 of chapter 111, the notice of the commission requiring the health care entity to file and
277 implement a performance improvement plan pursuant to this section shall be considered part of
278 the written record pursuant to said section 25C of chapter 111.

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

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

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

294 (k) Upon approval of the proposed performance improvement plan, the
295 commission shall notify the health care entity to begin immediate implementation of the
296 performance improvement plan. Public notice shall be provided by the commission on its
297 website, identifying that the health care entity is implementing a performance improvement plan.
298 All health care entities implementing an approved performance improvement plan shall be
299 subject to additional reporting requirements and compliance monitoring, as determined by the
300 commission. The commission shall provide assistance to the health care entity in the successful
301 implementation of the performance improvement plan.

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

306 (m) At the conclusion of the timetable established in the performance
307 improvement plan, the health care entity shall report to the commission regarding the outcome of
308 the performance improvement plan. If the performance improvement plan was found to be
309 unsuccessful, the commission shall either: (1) extend the implementation timetable of the
310 existing performance improvement plan; (2) approve amendments to the performance
311 improvement plan as proposed by the health care entity; (3) require the health care entity to
312 submit a new performance improvement plan under subsection (c); or (4) waive or delay the
313 requirement to file any additional performance improvement plans.

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

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

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

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

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

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

337 (a) The center shall publish an annual report based on the information submitted
338 under this chapter concerning health care provider, provider organization and private and public
339 health care payer costs and cost trends, section 13 of chapter 6D relative to market power
340 reviews and section 15 relative to quality data. The center shall compare the costs and cost trends
341 with the health care cost growth benchmark established by the health policy commission under
342 section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs,
343 cost trends, and expenditures with the aggregate primary care expenditure target established
344 under section 9A of chapter 6D, and shall detail: (1) baseline information about cost, price,
345 quality, utilization and market power in the commonwealth's health care system; (2) cost growth
346 trends for care provided within and outside of accountable care organizations and patient-
347 centered medical homes; (3) cost growth trends by provider sector, including but not limited to,
348 hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable
349 medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical
350 sector shall consider the effect of drug rebates and other price concessions in the aggregate
351 without disclosure of any product or manufacturer-specific rebate or price concession
352 information, and without limiting or otherwise affecting the confidential or proprietary nature of
353 any rebate or price concession agreement; (4) factors that contribute to cost growth within the
354 commonwealth's health care system and to the relationship between provider costs and payer
355 premium rates; (5) primary care expenditure trends as compared to the aggregate primary care
356 baseline expenditures, as defined in section 1 said chapter 6D; (6) the proportion of health care
357 expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the
358 impact of health care payment and delivery reform efforts on health care costs including, but not
359 limited to, the development of limited and tiered networks, increased price transparency,

360 increased utilization of electronic medical records and other health technology; (8) the impact of
361 any assessments including, but not limited to, the health system benefit surcharge collected under
362 section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of
363 unnecessary or duplicative services, with particular emphasis on imaging and other high-cost
364 services; (10) the prevalence and trends in adoption of alternative payment methodologies and
365 impact of alternative payment methodologies on overall health care spending, insurance
366 premiums and provider rates; (11) the development and status of provider organizations in the
367 commonwealth including, but not limited to, acquisitions, mergers, consolidations and any
368 evidence of excess consolidation or anti-competitive behavior by provider organizations; (12) the
369 impact of health care payment and delivery reform on the quality of care delivered in the
370 commonwealth; and (13) costs, cost trends, price, quality, utilization and patient outcomes
371 related to primary care services.

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

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

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

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

381 Section 18. The center shall perform ongoing analysis of data it receives under
382 this chapter to identify any payers, providers or provider organizations: (i) whose increase in
383 health status adjusted total medical expense is considered excessive and who threaten the ability
384 of the state to meet the health care cost growth benchmark established by the health care finance
385 and policy commission under section 10 of chapter 6D; or (ii) whose expenditures fail to meet
386 the primary care expenditure target under section 9A of chapter 6D. The center shall
387 confidentially provide a list of the payers, providers and provider organizations to the health
388 policy commission such that the commission may pursue further action under sections 10 and
389 10A of chapter 6D.

390 SECTION 10. Chapter 29 of the General Laws, as appearing in the 2020 Official
391 Edition, is hereby amended by inserting after section 200000 the following section:-

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

394 “Carrier”, an insurer licensed or otherwise authorized to transact accident or
395 health insurance under chapter 175; a nonprofit hospital service corporation organized under
396 chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health
397 maintenance organization organized under chapter 176G; and an organization entering into a
398 preferred provider arrangement under chapter 176I; provided, that this shall not include an
399 employer purchasing coverage or acting on behalf of its employees or the employees of 1 or
400 more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise
401 noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate or
402 contract that provides coverage solely for dental care services or visions care services.

403 “Provider”, any person, corporation, partnership, governmental unit, state
404 institution or any other entity qualified under the laws of the commonwealth to perform or
405 provide health care services.

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

413 (b) There is hereby established and set up on the books of the commonwealth a
414 separate fund to be known as the primary care stabilization fund for the purpose of providing the
415 prospective monthly payments to primary care providers participating in the primary care
416 prospective payment model established in section 9B of chapter 6D. The fund shall be
417 administered by the health policy commission . There shall be credited to the fund: (i) an annual
418 assessment on carriers, providers, provider organizations, and for profit non-traditional
419 healthcare corporations and entities that provide, as part of a larger business model, primary care
420 services in the commonwealth, including, but not limited to, retailers, pharmacy benefits
421 manager, and private equity firms, urgent care clinics, in an amount and manner determined by
422 the commission; (ii) revenue from appropriations or other money authorized by the general court
423 and specifically designated to be credited to the fund; and (iii) interest earned on such revenues.
424 Amounts credited to the fund shall not be subject to further appropriation and any money
425 remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

426 Funds may be used for adoption of and scientific evaluation of the primary care
427 prospective payment model established under section 9B of chapter 6D. Funds may be used to
428 support smaller, independent practices in their efforts to adopt transformers and increase primary
429 care infrastructure.

430 (c) Not later than the first day of each month, the commission shall ensure that the
431 primary care stabilization fund transfers the necessary amount to cover the payments to primary
432 care providers required by the primary care prospective payment model established in section 9B
433 of chapter 6D.

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

440 SECTION 11. The regulations required by subsection (r) of section 9B of chapter
441 6D of the General Laws shall be promulgated not later than January 1, 2026.

442 SECTION 12. Subsection (e) of section 16 of chapter 12C of the General Laws
443 shall take effect October 1, 2026.

444 SECTION 13. The primary care council, established in section 9B of chapter 6D
445 of the General Laws, shall convene its first meeting not later than March 1, 2026, and shall
446 develop and recommend the implementation of a primary care prospective payment model to the
447 health policy commission, established in said chapter 6D, not later than January 1, 2027.