

## Joint Committee on Health Care Financing 2025-2026 (194<sup>th</sup>) Bill Summary

**Bill Number:** House, No. 1370

**Title:** AN ACT RELATIVE TO MASSACHUSETTS PRIMARY CARE FOR YOU

**Sponsor:** Representative Richard M. Haggerty (Woburn)

**Hearing Date:** May 12, 2025

**Reporting Deadline:** July 11, 2025

**Prior History:**

**2023-2024** (S0750) Refile of a similar matter. S0750 referred to the Joint Committee on Health Care Financing. Public hearing on September 12, 2023. Reported Ought to Pass on April 8, 2024, and referred to Senate Ways & Means. No further action taken.

**2021-2022** (S0770 & S2774 [in part]) Refiles of similar matters. S0770 referred to the Joint Committee on Health Care Financing. Public hearing on September 14, 2021. Read Ought Not to Pass (JR10) in the Senate and placed on the Orders of the Day on August 8, 2022. No further action taken. S2774, “*An Act investing in the future of our health*”, filed by Governor Charles D. Baker on March 15, 2022, and referred to the Joint Committee on Health Care Financing on March 17, 2021. Public hearing on April 11, 2022. Read Ought Not to Pass (JR10) in the Senate and placed on the Orders of the Day on August 8, 2022. No further action taken.

**2019-2020** (H4134), Refiles of a similar matter. H4134 “*An Act to improve health care by investing in VALUE*”, filed by Governor Charles D. Baker, referred to the Joint Committee on Health Care Financing. Public hearing on January 28, 2020. House extended reporting deadline until Thursday, December 31, 2020 on June 22, 2020. Senate non-concurred on June 25, 2020. No further action taken.

**Similar Matters:** H2537 – Schwartz (Similar, Public Health); S867 – Friedman (Similar, Health Care Financing)

**Current Law:**

**M.G.L. Ch. 3 §38C** defines mandated benefit proposal and governs the review, evaluation, and reporting of mandated health benefit bills referred to the legislature.

**Chapter 6D of the General Laws** establishes the Health Policy Commission (HPC) to set health care cost growth goals, enhance provider organization transparency, monitor and review marketplace changes, and establish a health care cost growth benchmark for the average growth in total health care expenditures.

**M.G.L. Ch. 6D § 1** defines certain terms as they are to be understood within the context of Chapter 6D, which governs the operations and activities of HPC.

**M.G.L. Ch. 6D § 8 as amended by sections 17 through 21, inclusive, of chapter 343 of the acts of 2024, “*An Act enhancing the market review process [H5159]*”,** directs HPC to hold annual public hearings, based on the report submitted by the Center for Health Information and Analysis (CHIA) pursuant to section 16 of chapter 12. Within this section:

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**M.G.L. Ch. 6D § 9** directs HPC board to establish a health care cost growth benchmark for the average growth in total health care expenditures. The statute requires HPC to hold a public hearing to consider available data, information, and testimony from market participants and other interested parties. The statute also grants the Joint Committee on Health Care Financing the right to participate in the public hearing.

**M.G.L. Ch. 6D § 10** directs HPC to notify any health care entity identified by CHIA, pursuant to section 18 of chapter 12C, as having exceeded the health care cost growth benchmark for any given year. HPC may require that entity to file and implement a Performance Improvement Plan [PIP] to improve efficiency and reduce cost growth. In addition, if HPC finds that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, HPC may require any entity to file a PIP.

**M.G.L. Ch. 6D § 15** authorizes HPC to establish a process for certifying registered Accountable Care Organizations and promote alternative payment methodologies.

**M.G.L. Ch. 6D § 23** established within the HPC the Office of Health Resource Planning (OHR). OHR is charged with developing a State Health Plan as a forecast of anticipated demand, production, supply and distribution of health care resources on a state-wide and regional basis during a 5-year planning period to identify: (i) the anticipated needs for health care services, providers, programs, and facilities; (ii) the existing health care resources, providers, programs, and facilities available to meet those needs; (iii) the projected resources, including the health care workforce, necessary to meet those anticipated needs; (iv) recommendations for the appropriate supply and distribution of resources, workforce, programs, capacities, technologies and services on a statewide and regional basis; (v) the priorities for addressing those needs; and (vi) recommendations for any further legislative, regulatory, or other state action. This section also authorizes OHR, consultation with other state agencies, to conduct focused assessments of supply, distribution and capacity in relation to projected need of health care services, and to make recommendations to address the drivers of disparities and areas of misalignment of need, supply, distribution and capacity.

**M.G.L. Ch. 12 § 11N** authorizes the Office of the Attorney General (AGO) to monitor trends in the health care market; including but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market.

**Chapter 12C of the General Laws** establishes CHIA as an independent agency tasked with collecting and analyzing health care data and publishing annual reports on health care costs, cost trends, market power, and quality data in support of the annual health care cost trends hearings conducted by HPC.

**M.G.L. Ch. 12C § 1** defines certain terms as they are to be understood within the context of Chapter 12C, which governs the operations and activities of CHIA

**M.G.L. Ch. 12C §§ 8 & 9** direct CHIA to ensure uniform reporting by institutional providers, parent organizations, providers, and provider organizations of revenues, charges, costs, price, utilization of services, and other pertinent data necessary to identify health care trends.

**M.G.L. Ch. 12C § 10** directs CHIA to ensure uniform reporting by private and public health care payers of information necessary to analyze trends in health insurance costs and utilization.

**M.G.L. Ch. 12C § 12** declares CHIA to be the sole repository for health care data collected under sections 8, 9 and 10 of Chapter 12C, and directs CHIA to collect, store and maintain such data in a payer and provider claims database to be accessible to the public as set forth in this section.

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**M.G.L. Ch. 12C § 14, as amended by section 44 of chapter 343 of the acts of 2024, “An Act enhancing the market review process [H5159]”,** directs CHIA, in consultation with the Statewide Advisory Committee, to establish by March 1 in even-numbered years, the Standard Quality Measure Set (SQMS) for use in the following: (i) public and private contracts between payers & providers, provider organizations and ACOs which incorporate quality measures into payment terms, including the designation of a set of core measures & a set of non-core measures; (ii) provider tiering assignments in any health plan design; (iii) consumer transparency websites & other methods of providing consumer information; (iv) monitoring system-wide performance. This section also mandates the use of the SQMS “core measures” and allows for the use of optional “non-core measures” in contracts that incorporate quality measures into payment terms entered into by the GIC, MassHealth, and commercial health plans, Blue Cross / Blue Shield plans, HMO plans; PPO plans; & for use in the assignment of provider tiering in tiered network plans offered in the merged market under MGL c176J § 11.

**M.G.L. Ch. 12C § 16, as amended by section 25 of chapter 342 of the acts of 2024, “An Act relative to pharmaceutical access, costs and transparency [S3012]”,** requires CHIA to publish an annual report on health care cost trends based on data collected from health care providers, provider organizations, private and public health care payers, pharmaceutical manufacturing companies and pharmacy benefit managers under sections 8 through 10A of chapter 12C, market power reviews as required under section 13 of chapter 6D, and quality data collected under section 15 of chapter 12C.

**M.G.L. Ch. 12C § 18** directs the CHIA to perform an ongoing analysis of payers, providers or provider organizations whose increase in health status-adjusted total medical expense is excessive, and who threaten the Commonwealth’s ability to meet the health care cost growth benchmark. CHIA is directed to identify such health care entities and confidentially provide a list to the HPC such that the HPC may pursue further action under section 10 of chapter 6D, the performance improvement plan statute.

**M.G.L. Ch. 15A § 18** governs qualifying student health insurance programs.

**Chapter 19A of the General Laws** governs the Department of Elder Affairs, under the supervision and control of the secretary of elder affairs responsible for administering and coordinating a comprehensive system of long-term care benefits and services for elderly persons, including institutional, home-based and community-based care and services.

**Chapter 29 of the General Laws** governs state finance.

**M.G.L. Ch. 29 § 7H ½** states that, on or before Jan. 15<sup>th</sup> each year, the Secretary of A&F and the House and Senate Committees on Ways & Means will develop a Growth Rate of Potential (GSP). GSP is the long-run average growth rate of the Commonwealth’s economy, excluding fluctuations due to the business cycle.

**Chapters 32A and 32B of the General Laws** establishes contributory group general or blanket insurance for persons in the service of the Commonwealth and participating authorities and municipalities under the Group Insurance Commission (GIC).

**M.G.L. Chapter 111 §§ 25B through 25G, inclusive,** govern the Determination of Need process, which requires certain health care facilities to seek and receive a determination of need from DPH before making substantial capital expenditures, construct a health care facility or substantially change the service of the facility.

**M.G.L. Ch. 111 §§ 51 through 56, inclusive,** governs the licensing of hospitals and clinics by the DPH.

**Chapter 112 of the General Laws** governs the licensing and registration of health care professionals, the operation of the boards of registration with oversight over those professions and provides the statutory basis for the professional scope of practice for licensed health professionals.

**M.G.L. Ch. 118E § 1** designates the Executive Office of Health and Human Services (EOHHS) as the single state agency responsible for the administration of any programs of medical assistance and medical benefits established pursuant to Chapter 118E. The secretary of EOHHS is authorized to take actions, through the division of medical assistance and the secretary of aging and independence, as appropriate, in this capacity, in accordance with section 2 of Chapter 118E.

**M.G.L. Ch. 118E § 9A** authorizes the Division of Medical Assistance to implement the state Medicaid program (MassHealth) in accordance with the terms and conditions of a demonstration project approved by the Secretary pursuant to section 1115(a) of the Social Security Act, 42 USC Section 1315(a) or any other federal waiver or demonstration authority and lists beneficiary categories for whom MassHealth may provider medical benefits.

- On September 28, 2022, CMS approved the Commonwealth’s request to extend the MassHealth demonstration (Project Number 11-W-00030/1 and 21-W00071/1), in accordance with section 1115(a) of the Social Security Act (the Act), effective October 1, 2022, through December 31, 2027.

**M.G.L. Ch. 118E § 12** authorizes MassHealth to enter into any type of contracts with providers of medical services and establish rates for the provision of such services to its enrollees, as governed by sections 13 through 13K, inclusive, and sections 64 through 70, inclusive.

**M.G.L. Ch. 118E §§ 13, 13A, 13B, 13C, 13D, 13E1/2, 13F, 13J** provide for the review of MassHealth reimbursement rates or rate methodologies and requires rates to be established by contract and contingent upon performance and quality standards developed by EOHHS. Payment rates must be i) “adequate to meet the costs incurred by efficiently and economically operated facilities providing care and services in conformity with applicable state and federal laws and regulations and quality and safety standards” and ii) within the financial capacity of the commonwealth.

**M.G.L. Ch. 118E §§ 64 through 70**, inclusive, governs the operations of the Health Safety Net Office and the administration of the Health Safety Net Trust Fund. Health Safety Net reimburses hospitals and community health centers for a portion of the cost of reimbursable health services to eligible low-income, uninsured, or underinsured Massachusetts residents with household incomes at or below 300% of the FPL and who are deemed eligible. For recipients with a MAGI between 150% and 300% of the FPL, an annual deductible may apply.

**Chapter 123 of the General Laws** governs mental health services and programs under the purview of the Department of Mental Health.

**M.G.L. Chapter 175 § 108** governs individual accident and sickness health insurance policies, including the conditions under which the commissioner of insurance may approve or disapprove “of such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy.”

**M.G.L. Chapter 175 § 110** governs group accident and sickness health insurance policies.

**Chapter 176A of the General Laws** governs individual or group hospital service plans issued by a non-profit hospital service corporation [Blue Cross].

**Chapter 176B of the General Laws** governs the standards needed to establish, maintain and operate a non-profit medical service corporation [Blue Shield].

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**Chapter 176G of the General Laws** individual or group health maintenance contract issued by a Health Maintenance Organization [HMO].

**Chapter 176I of the General Laws** governs nongroup or group preferred provider plans [PPO] and authorizes the commissioner of insurance to promulgate regulations concerning such plans, including the conditions under which the commissioner of insurance may approve or disapprove of plans filed with the division.

**Chapter 176J of the General Laws** governs the merged individual and small group insurance market.

**M.G.L. Ch. 176J § 6** authorizes the commissioner of the Division of Insurance [DOI] to approve health insurance policies submitted to the division for the purpose of being provided in the Merged Market. Carriers offering small group health insurance plans, including carriers licensed under Chapters 175, 176A, 176B or 176G, shall file with DOI small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner of DOI shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged.

**Chapter 176Q of the General Laws** governs the Commonwealth Connector Authority and the operations and plan offerings available on the Health Insurance Connector to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups.

**M.G.L. Ch. 176Q § 3** identifies the powers and duties of the board of the Connector Authority. The board is authorized to determine applicant eligibility for purchasing insurance offered by the Connector Authority, including eligibility for premium assistance or cost-sharing subsidies for applicants at or below 300% of the federal poverty level.

**Section 80 of Chapter 343 of the Acts of 2024, “An Act enhancing the market review process”**, established the Primary Care Payment and Delivery Task Force comprised of 23 members to: (i) study primary care access, delivery and payment in the commonwealth; (ii) develop and issue recommendations to stabilize and strengthen the primary care system and the increase of recruitment and retention in the primary care workforce; and (iii) increase the financial investment in and patient access to primary care across the commonwealth. The Task Force convened its first public meeting on April 16, 2025. Recommendations to be developed by the Task Force include: definitions of service, creating standardized data reporting, establishing a primary care spending target for public and private payers, assessing impacts on health equity, and devising ways to increase the workforce supply and improve employment conditions. The Task Force is required to meet several deadlines for the completion of its recommendations, which are set as follows:

- Recommendations related to definitions and standardized data collections and reporting are due by September 15, 2025.
- Recommendations related to the primary care spending target for public and private payers are due by December 15, 2025.
- Recommendations related to payment models and plan design are due on March 15, 2026.
- Recommendations on service delivery are due on May 15, 2026.

**Section 514 of the Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA)**, provides that ERISA supersedes any state law as it relates to an employee benefit plan.

**Summary:**

**SECTIONS 1 & 2** of the proposed legislation amend section 1 of chapter 6D by inserting the following 4 new definitions:

- “Aggregate primary care baseline expenditures”, the sum of all primary care expenditures, as defined by CHIA, in the commonwealth in the calendar year preceding the year period to which the aggregate primary care expenditure target applies.
- “Aggregate primary care expenditure target”, the targeted sum, set by HPC, of all primary care expenditures, as defined by CHIA, in the commonwealth in the calendar year in which the aggregate primary care expenditure target applies.
- “Primary care baseline expenditures”, the sum of all primary care expenditures, as defined by CHIA, by or attributed to an individual health care entity in the calendar year preceding the year in which the primary care expenditure target applies.
- “Primary care expenditure target”, the targeted sum, set by HPC, of all primary care expenditures, as defined by CHIA, by or attributed to an individual health care entity in the calendar year in which the entity’s primary care expenditure target applies.

**SECTION 3 & 4** of the proposed legislation amend section 8 of chapter 6D to expand the scope of HPC’s health care cost trends annual public hearing and subsequent report to include an examination aggregate primary care expenditures in comparison the aggregate primary care expenditure target, as such data sets are def defined and reported and said benchmark is established elsewhere in this act.

**SECTION 5** of the proposed legislation inserts into Chapter 6D the following 2 new Sections:

**---The proposed section 9A** is comprised of the following 4 subsections:

- Subsections (a) and (b) direct HPC to annually establish both an aggregate primary care expenditure target and a primary care expenditure target as follows”
  - (b)(1) For the calendar year 2027, the targeted sums are by default set as equal to 10 % of total health care expenditures.
  - (b)(2) For the calendar year 2028, the targeted sums are by default set as equal to 12.5 % of total health care expenditures.
  - (b)(3) For the calendar year 2029, the targeted sums are by default set as equal to 15 % of total health care expenditures.
  - (b)(4) For the calendar year 2030 and beyond, the targeted sums are by default set as equal to 15 % of total health care expenditures, but if HPC determines that an adjustment in both targets is reasonably warranted, it may recommend setting the targets sums between 15% and 20% of total health care expenditures.
- Subsection (c) requires HPC to hold a public hearing prior to establishing the primary care targets under subsections (a) and (b), at which the commission shall examine the performance of health care entities in meeting the targets based on data collected and reported by CHIA under section 16C of chapter 12C. HPC is required to provide notice of its hearing at least 45 days in advance to the public and the Joint Committee on Health Care Financing, which may elect to participate in the hearing. HPC is also required invite a representative sample of providers, provider organizations, payers and such other interested parties appear as witnesses at the hearing and to allow for additional public testimony.
- Subsection (d) requires a 2/3rds vote of HPC board to approve a modification of the targeted sums for the calendar year 2030 and beyond paragraph (4) of subsection (d).

**---The proposed section 9B** is comprised of the following 20 subsections:

- Subsection (a) defines following the terms as understood within the context of the proposed Section 9B:
  - “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes or otherwise provides or proposes health care services, initiates referrals for specialist care and maintains continuity of care

within the scope of practice; provided, that a “primary care provider” shall include a provider organization that provides primary care services in the commonwealth.

- “Primary care service”, a service provided by a primary care provider.
- Subsection (b) establishes a Primary Care Council (Council) within HPC, consisting of the following 25 members:
  - 7 members by virtue of their offices, or their designees: the executive director of HPC, who shall serve as co-chair; the secretary of EOHHS, who shall serve as co-chair; and the House and Senate chairs of the Joint Committee on Health Care Financing; the commissioner of DOI, the EOHHS Assistant Secretary of MassHealth; and the executive director of CHIA;
  - 1 member from each of the following organizations 17 organization, to be appointed for 3-year terms: the Massachusetts Primary Care Alliance for Patients; Massachusetts Academy of Family Physicians; Massachusetts Chapter of the American Academy of Pediatrics; the Massachusetts American College of Physicians; the Massachusetts League of Community Health Centers; Health Care For All Massachusetts; the Massachusetts Medical Society; the Massachusetts Association of Physician Assistants; the Massachusetts Coalition of Nurse Practitioners; the Community Care Cooperative; the Massachusetts Chapter of the National Association of Social Workers;; 1 member from the Massachusetts Health Quality Partners; the Massachusetts Association of Health Plans; Blue Cross Blue Shield of Massachusetts; the Massachusetts Health and Hospital Association; the Retailers Association of Massachusetts; and
  - 1 additional member from a rural health practice with expertise in primary care.
- Subsection (c) authorizes the Council to develop and recommend to HPC a primary care prospective payment model that would, in compliance with this section, make a monthly lump sum payment for primary care services delivered by providers who volunteer to participate in the model. Any model recommended by the Council would be implemented by HPC following a affirmative 2/3ds vote of HPC board.
- Subsection (d) outlines design requirements for any primary care prospective payment model approved under subsection (c). The design requirements dictate that the model include a baseline monthly per patient payment. The baseline monthly per patient payment shall incorporate historical primary care spending at the provider, provider organization, and statewide levels; the primary care expenditure data published CHIA; and any other factors deemed relevant by the Council. The baseline monthly per patient payment shall be adjusted for:
  - (d)(1) a primary care provider’s adoption of the “primary care transformers “, as established by the Council under subsection (e);
  - (d)(2) a primary care provider’s performance on quality measures, as described in subsection (f); and
  - (d)(3) the clinical and social risk of a primary care provider’s patient panel, as described in subsection (g).
- Subsection (e) directs the Council to create a list of “primary care transformers”, evidence-based services that improve quality, increase access, enhance the patient experiences, or promote health equity. The Council is required to review its list of every 3 years and make alterations as necessary. The adoption of listed primary care transformers by a primary care provider shall increase the provider’s baseline monthly per patient payment. The Council shall, after consideration of the primary care sub-capitation and tiering systems established in the MassHealth section 1115 demonstration waiver, assign each primary care transformer a value based on the evidence that it will improve patient health and experience, improve the clinician experience and reduce administrative burden, decrease total medical expense, and promote health

equity. Assigned values may account for provider total time and expense required to implement the transformer. This subsection includes the following initial primary care transformers:

- (e)(i) employing community health workers or health coaches as part of the primary care team;
  - (e)(ii) investing in social determinants of health;
  - (e)(iii) collaborating with primary care-based clinical pharmacists;
  - (e)(iv) integrating behavioral health care with primary care
  - (e)(v) offering substance use disorder treatment, including medication-assisted treatment, telehealth services, including telehealth consultations with specialists, medical interpreter services, home care, patient advisory groups, and group visits
  - (e)(vi) using clinician optimization programs to reduce documentation burden, including, but not limited to, medical scribes and ambient voice technology;
  - (e)(vii) investing in care management, including employing social workers to help manage the care for patients with complicated health needs;
  - (e)(viii) establishing systems to facilitate end of life care planning and palliative care;
  - (e)(ix) developing systems to evaluate patient population health to help determine which preventative medicine interventions require patient outreach;
  - (e)(x) offering walk-in or same-day care appointments or extended hours of availability;
  - (e)(xi) providing medical education to learners;
  - (e)(xii) integrating oral health with primary care; and
  - (e)(xiii) any other primary care service deemed relevant by the council.
- Subsection (f) requires the Council consider performance on patient care quality measures when establishing the baseline monthly per patient payment under subsection (d). Additionally, the Council may consider the payer mix of a patient panel in establishing such payments. This subsection also directs the Council to establish a set of no more than 12 quality measures related to care continuity, comprehensiveness, and coordination; patient access to primary care; and patient experience. Primary care providers shall be required to adopt no more than 6 of the 12 quality measures, including at least 1 measure of health equity and at least 2 measures of patient experience. Such quality measure shall be patient-centered, appropriate for a primary care setting, and supported by peer-reviewed, evidence-based research that the measure is actionable and that its use will lead to improvements in patient health. The Council is required to consult with the Massachusetts Health Quality Partners on measures of patient experience, and it may consult with the EOHHS Massachusetts Quality Measure Alignment Taskforce when establishing the quality measures in general.
  - Subsection (g) requires the Council to consider patient panel medical and social complexity measures, including measures that promote health equity and measures such as MassHealth’s Neighborhood Stress Score, when establishing the baseline monthly per patient payment under subsection (d). The Council shall, to the extent possible, use patient panel medical and social complexity measures in a manner that minimizes opportunities to artificially increase the medical and social complexity of a patient panel and does not encourage entities to choose a low complexity patient panel.
  - Subsection (h) allows the Council the option to establish a provider tiering structure based on the type and number of primary care transformers adopted by provider and may consider such a tiering structure when establishing the baseline monthly per patient payment under subsection (d). The Council may consider the primary care sub-capitation and tiering system established in the MassHealth section 1115 demonstration waiver when establishing any a provider tiering structure.
  - Subsection (i) requires any primary care prospective payment model to include a voluntary opt-in process for primary care providers.

- Subsection (j) requires any primary care prospective payment model pass through at least 95% of payments to directly to primary care providers for the delivery of services.
- Subsections(k) prohibits health insurers from applying any cost-sharing from patients receiving primary care services delivered by a provider participating in the primary care prospective payment model.
- Subsection (l) requires health insurers providing coverage to a patient receiving primary care services from a provider participating in the primary care prospective payment model to comply with the requirements of this section.
- Subsection (m) declares that payments made to primary care providers under the primary care prospective payment model shall be included in the medical loss ratio calculated under section 6 of chapter 176J.
- Subsection (n) declares any payment made in compliance with the primary care prospective payment model shall consider expenditures for a primary care for both a provider and a carrier for purposes of complying with the targets established in the proposed section 9A.
- Subsection (o) allows the Council to make federally qualified community health center eligible for prospective monthly payment for primary care services delivered to their commercially insured patients, provided that any such payment shall be no less the rate of payment under the Prospective Payment System.
- Subsection (p) requires the Council to establish an attestation, public reporting, and audit processes for providers that opt in to the primary care prospective payment model under this section. Audit processes established by the Council shall vary based on the size of the provider system or practice. The Council is directed to provide technical assistance and resources to smaller systems and practices to support their compliance with audit requirements and procedures.
- Subsection (q) requires the Council to continually review and revise the primary care prospective payment model. This subsection also requires the Council to submit an annual report summarizing it activities to HPC, the House and the Senate Clerks, the chairs of the House and Senate Committee on Ways & Means, and the chairs of the Joint Committee on Health Care Financing.
- Subsection (r) requires the Council to recommend to HPC a payment model for specialists that engage in brief electronic or telephone consultations, taking into consideration existing MassHealth payment methodologies as potential models.
- Subsection (s) requires the Council to recommend to HPC a fee-for-service payment model for specific outpatient procedures delivered by primary care providers, “taking into consideration the importance of maintaining a broad scope of primary care services and establishing appropriate incentive structures to support such practice patterns.”
- Subsection (t) directs HPC to promulgate rules and regulations necessary to implement this section.

**SECTION 6** of the proposed legislation inserts into Chapter 6D a new Section 10A, consisting of the following 18 subsections:

- Subsection (a) defines the term “health care entity”, as understood within the context of the proposed Section 10A, as “any entity identified by [CHIA] under section 18 of chapter 12C.”

- Subsection (b) directs HPC to notify health care entities identified by CHIA as having exceeded the primary care expenditure target that CHIA may further analyze the entity’s performance against the target and that, beginning in calendar year 2027, the entity may be required may require certain actions under this section.
- Subsection (c) authorizes HPC to require any health care entity identified by CHIA as having exceeded the primary care expenditure target file and implement a performance improvement [PIP] and grants such entities 45 days following receipt of such notification to either file a PIP or an application for a waiver or extension.
- Subsection (d) allows health care entities applying for a PIP waiver or extension under subsection (b) to submit with its application any additional documents it considers relevant and also authorizes HPC to require the applicant to submit any additional information it deems necessary to its review of the application. This subsection also grants HPC discretionary authority to publicly release any information received from the applicant.
- Subsection (e) states that HPC may approve an application for a PIP waiver or extension application based on the following factors:
  - (e)(1) primary care baseline expenditures, costs, price and utilization trends over time, and any demonstrated improvement to increase the proportion of primary care expenditures;
  - (e)(2) any ongoing strategies or investments to invest in or expand primary care services;
  - (e)(3) whether a failure to meet the primary care expenditure target was due to factors that can reasonably be considered to be unanticipated and outside of the control of the applicant, including but not limited to, market dynamics, technological changes and other drivers of non-primary care spending such as pharmaceutical and medical devices expenses;
  - (e)(4) the overall financial condition of the applicant; and
  - (e)(5) any other factors HPC considers relevant.
- Subsection (f) directs HPC to provide applicants whose PIP waiver or extension application is denied a written notice of the denial and instructing the entity to file a PIP.
- Subsection (g) directs HPC to share with the Department of Public Health [DPH] any notice to a health care entity to file and implement a PIP under this section. This section also requires DPH make any notice so received part of the written record of any application it receives from the same entity for a determination of need [DON] “under section 25C or 51 of chapter 111.”
- Subsection (h) instructs health care entities required to file a PIP to do so within 45 days of the initial notice in subsection (c), the notice of an denied PIP waiver or extension in subsection (f), or on the date given on the notice of an approved PIP waiver or extension. Any PIP filed with HPC shall identify specific strategies, adjustments and action steps to be implemented to increased the entity’s proportion of primary care expenditure. Entities shall also identify in the PIP specific measurable expected outcomes and a timetable for implementation.
- Subsection (i) requires HPC to approve any PIP t determines is reasonably likely to address the underlying cause of an entity’s inability to meet the primary care expenditure target and has a reasonable expectation for successful implementation.
- Subsection (j) allows HPC to grant an additional 30 days for the resubmission of any PIP determined to be unacceptable or incomplete.

- Subsection (k) states that when an health care entity is notified by HPC that final approval of a filed PIP has been granted, the entity shall immediately begin implementation of the PIP and comply with any additional reporting requirements and compliance monitoring deemed necessary by HPC. This subsection also requires HPC to identify any health care entity implementing a PIP on its website and to assist entities in the implementation of a PIP.
- Subsection (l) obligates health care entities to implement a Pip in good faith. This subsection also permits entities to file amendments to an ongoing PIP, subject to the approval of HPC.
- Subsection (m) requires health care entity to submit a final report on the outcome of a concluded PIP. If HPC determines that a PIP was unsuccessful, HPC may take one of the following 4 actions:
  - (m)(1) extend original timetable;
  - (m)(2) approve amendments submitted by entity;
  - (m)(3) require submission of a new PIP; or
  - (m)(4) waive or delay requirement to file an additional PIP.
- Subsection (n) directs HPC to remove from its website health care entity identification required by subsection (k) upon the successful completion of a PIP.
- Subsection (o) authorizes HPC to submit a recommendation for proposed legislation to the Joint Committee on Health Care Financing if HPC determines that further legislative authority is needed to achieve the objectives of the primary care targets established in the proposed section 9A and to assist health care entities with the implementation of a PIP or otherwise ensure compliance with the provisions of this section.
- Subsection (p) authorizes HPC to assess a civil penalty of "not more than" \$500,000 on a health care entity that: (1) willfully neglects to file PIP; (2) fails to file an acceptable PIP "in good faith"; (3) fails to implement a performance improvement plan "in good faith"; (4) "knowingly" fails to provide required information or "knowingly" falsifies information.
- Subsection (q) requires HPC to promulgate regulations to implement this section.
- Subsection (r) states that this section shall not be construed as affecting or limiting the applicability of the health care cost growth benchmark established under section 9.

**SECTION 7** of the proposed legislation amends subsection (a) of section 16 of chapter 12C to broaden the scope of CHIA’s annual report on cost trends and health system performance to incorporate any data submitted pursuant to chapter 12C, and further expands the scope of data analyzed in the CHIA report to incorporate the new aggregate primary care expenditure target established in the proposed Section 9A of Chapter 6D. Subsection (a) is also amended to add a new category of health care information to be detailed in CHIA’s annual report, “ (13) costs, cost trends, price, quality, utilization and patient outcomes related to primary care services”.

**SECTION 8** of the proposed legislation adds the following 2 new subsections to section 16 of chapter 12C:

- Subsection (d) requires CHIA to publish the “aggregate primary care baseline expenditures” in the annual report produced pursuant to subsection (a).
- Subsection (e) directs CHIA, annually by October 1 and in consultation with HPC, to determine the “primary care baseline expenditures” for individual health care entities and report to each entity its respective baseline expenditures.

**SECTION 9** of the proposed legislation amends section 18 of chapter 12C by adding to CHIA’s health system cost growth monitoring duties new requirements to continually analyze all data received under chapter 12, identify any payer, provider or provider organization that fails to meet the new primary care expenditure target established in section 9A of chapter 6D, and to report such entities to HPC for a potential PIP under the new section 10A of chapter 6D.

**SECTION 10** of the proposed legislation inserts into Chapter 29 a new Section 2PPPPP, consisting of the following 4 subsections:

- Subsection (a) defines the following the terms as understood within the context of the proposed Section 9B: “Carrier”; “Provider”; and “Provider organization.”
- Subsection (b) establishes a new Primary Care Stabilization Fund to be administered by HPC and used to make the monthly payments to primary care providers who participate in the primary care prospective payment model approved under subsection (c) of the proposed section 9B of chapter 6D. Funds shall also be made available for the scientific evaluation of said model and to support the transition costs of participating small, independent practices. The fund shall be credited with money generated by a new assessment on “carriers, providers, provider organizations, and for profit non-traditional healthcare corporations and entities that provide, as part of a larger business model, primary care services in the commonwealth, including, but not limited to, retailers, pharmacy benefits manager, and private equity firms, urgent care clinics”. The assessment shall total an amount to be determined by HPC.
- Subsection (c) directs HPC make payments from the fund HPC to providers in an amount sufficient to cover monthly payments for services rendered under the primary care prospective payment model approved under subsection (c) of the proposed section 9B of chapter 6D.
- Subsection (d) requires HPC to annually, on or before October 1, file a report with the House and the Senate Clerks, the chairs of the House and Senate Committee on Ways & Means, and the chairs of the Joint Committee on Health Care Financing summarizing the Fund’s activities, including (i) the source and amount of funds received; (ii) total expenditures; and (iii) anticipated revenue and expenditure projections for the next calendar year.

**SECTION 11** of the proposed legislation directs HPC to issue regulations required by subsection (r) of the proposed section 9B of Chapter 6D, the payment model for specialists that engage in brief electronic or telephone consultations, no later than January 1, 2026.

**SECTION 12** of the proposed legislation established October 1, 2026 as the effective date for the proposed subsection (e) of section 16 of chapter 12C, which requires CHIA to determine the “primary care baseline expenditures” for individual health care entities and report to each entity its respective baseline expenditures.

**SECTION 13** of the proposed legislation requires the Primary Care Council established by subsection (b) of the proposed section 9B of chapter 6D to convene its first meeting not later than March 1, 2026. This section also requires that the Council recommend and that HPC implement primary care prospective payment model as authorized by subsection (c) of the proposed section 9B not later than January 1, 2027.