SENATE DOCKET, NO. 2017 FILED ON: 2/19/2021

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:	DISTRICT/ADDRESS:
Cindy F. Friedman	*Fourth Middlesex*

SENATE DOCKET, NO. 2017 FILED ON: 2/19/2021

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:

SECTION 1. Section 1 of chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of "After-hours care" the following definitions:-

"Aggregate primary care baseline expenditures", the sum of all primary care expenditures, as defined by the center, in the commonwealth in the calendar year preceding the 3-year period to which the aggregate primary care expenditure target applies; provided, however, that aggregate primary care baseline expenditures shall initially be calculated using calendar year 2021.

"Aggregate primary care expenditure target", the targeted percentage change in total expenditures on primary care in the commonwealth from aggregate primary care baseline expenditures.

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

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

"Primary care expenditure target", the targeted percentage change in expenditures on primary care by or attributed to an individual health care entity compared to the entity's primary care baseline expenditures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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