HOUSE DOCKET, NO. 3661 FILED ON: 1/17/2025

HOUSE . . . . . No. 1370

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:
Richard M. Haggerty	*30th Middlesex*	*1/17/2025*
Mike Connolly	*26th Middlesex*	*3/6/2025*

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HOUSE . . . . . No. 1370

By Representative Haggerty of Woburn, a petition (accompanied by bill, House, No. 1370) of Richard M. Haggerty and Mike Connolly relative to primary care and for the creation of a primary care council (including members of the General Court). Health Care Financing.

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:

SECTION 1. Section 1 of chapter 6D of the General Laws, as appearing in the 2020 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 two calendar years preceding the year in which the aggregate primary care expenditure target applies.

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

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 two calendar years preceding the year in which the primary care expenditure target applies.

"Primary care expenditure target", the targeted sum, set by the commission in section 9A, of all primary care expenditures, as defined by the center, 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. 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 is hereby further amended by inserting after section 9 the following sections:-

Section 9A. (a) The commission 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 and the primary care expenditure target as follows:

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

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

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

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

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

(c) Prior to establishing the aggregate primary care expenditure target and the 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 commission. 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.

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

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

"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.

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

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

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

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

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

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

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

(e) The primary care prospective payment model shall include a list of primary care transformers, created by the council, that, if adopted by a primary care provider, shall increase a primary care provider's baseline monthly per patient payment, as determined by the council. A primary care transformer shall be an evidence-based primary care service that improves primary care quality, increases primary care access, enhances a patient's primary care experience, or promotes health equity in primary care. A primary care transformer shall include, but not be limited to: (i) employing community health workers or health coaches as part of the primary care team; (ii) investing in social determinants of health; (iii) collaborating with primary care-based clinical pharmacists; (iv) integrating behavioral health care with primary care; (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; (vi) using clinician optimization programs to reduce documentation burden, including, but not limited to, medical scribes and ambient voice technology; (vii) investing in care management, including employing social workers to help manage the care for patients with complicated health needs; (viii) establishing systems to facilitate end of life care planning and palliative care; (ix) developing systems to evaluate patient population health to help determine which preventative medicine interventions require patient outreach; (x) offering walk-in or same-day care appointments or extended hours of availability; (xi) providing medical education to learners; (xii) integrating oral health with primary care; and (xiii) any other primary care service deemed relevant by the council.

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

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

(f) The council shall consider a primary care provider's performance on patient care quality measures when establishing the baseline monthly per patient payment under subsection (d). Patient care quality measures shall include, but not be limited to, established measures related to: (i) care continuity, comprehensiveness, and coordination; (ii) patient access to primary care; and (iii) patient experience. Each 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 shall establish not more than 12 quality measures and shall require a primary care provider to only adopt 6 of the quality measures, which shall include at least 1 measure of health equity and at least 2 measures of patient experience. The Massachusetts Health Quality Partners shall be consulted regarding the administration of the 2 measures of patient experience. The

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

(g) The council shall consider the medical and social complexity of a primary care provider's patient panel when establishing the baseline monthly per patient payment under subsection (d). Measures of the medical and social complexity of a patient panel shall include, but not be limited to, measures that promote health equity and measures such as MassHealth's Neighborhood Stress Score. The council shall, to the extent possible, use measures of the medical and social complexity of a patient panel 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. The council may consider the payer mix of a patient panel when establishing the baseline monthly per patient payment under subsection (d).

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

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

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

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

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

(m) 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.

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

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

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

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

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

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

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

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

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 2027, 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 entities 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. Section 16 of chapter 12C of the General Laws, as so appearing in the 2020 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The center shall publish an annual report based on the information submitted under this chapter concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data. The center shall compare the costs and cost trends with the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends, and expenditures with the aggregate primary care expenditure target established under section 9A of chapter 6D, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (4) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (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 8. 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 9. 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 10. Chapter 29 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after section 2OOOOO the following section:-

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

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

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

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

(b) There is hereby established and set up on the books of the commonwealth a separate fund to be known as the primary care stabilization fund for the purpose of providing the prospective monthly payments to primary care providers participating in the primary care prospective payment model established in section 9B of chapter 6D. The fund shall be administered by the health policy commission . There shall be credited to the fund: (i) an annual 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, in an amount and manner determined by the commission; (ii) revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund; and (iii) interest earned on such revenues. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

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

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

(d) Annually, not later than October 1, the commission shall report to the clerks of the house of representatives and senate, the chairs of the joint committee on health care financing, and the chairs of the house and senate committees on ways and means on the fund's activity. The report shall include, but not be limited to: (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. The regulations required by subsection (r) of section 9B of chapter 6D of the General Laws shall be promulgated not later than January 1, 2026.

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

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