

HOUSE No. 2537

The Commonwealth of Massachusetts

PRESENTED BY:

Greg Schwartz

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 access.

PETITION OF:

| NAME: | DISTRICT/ADDRESS: | DATE ADDED: |
|-------------------------------|--|------------------|
| <i>Greg Schwartz</i> | <i>12th Middlesex</i> | <i>1/17/2025</i> |
| <i>James C. Arena-DeRosa</i> | <i>8th Middlesex</i> | <i>3/6/2025</i> |
| <i>Christine P. Barber</i> | <i>34th Middlesex</i> | <i>3/16/2025</i> |
| <i>Mike Connolly</i> | <i>26th Middlesex</i> | <i>3/5/2025</i> |
| <i>Natalie M. Higgins</i> | <i>4th Worcester</i> | <i>8/6/2025</i> |
| <i>Vanna Howard</i> | <i>17th Middlesex</i> | <i>8/16/2025</i> |
| <i>Patrick Joseph Kearney</i> | <i>4th Plymouth</i> | <i>1/28/2025</i> |
| <i>Hadley Luddy</i> | <i>4th Barnstable</i> | <i>5/29/2025</i> |
| <i>William F. MacGregor</i> | <i>10th Suffolk</i> | <i>5/7/2025</i> |
| <i>Thomas W. Moakley</i> | <i>Barnstable, Dukes and Nantucket</i> | <i>6/27/2025</i> |
| <i>Samantha Montaño</i> | <i>15th Suffolk</i> | <i>5/14/2025</i> |
| <i>John Francis Moran</i> | <i>9th Suffolk</i> | <i>5/19/2025</i> |
| <i>David M. Rogers</i> | <i>24th Middlesex</i> | <i>6/17/2025</i> |
| <i>Lindsay N. Sabadosa</i> | <i>1st Hampshire</i> | <i>3/5/2025</i> |
| <i>Amy Mah Sangiolo</i> | <i>11th Middlesex</i> | <i>5/9/2025</i> |
| <i>Adam J. Scanlon</i> | <i>14th Bristol</i> | <i>3/21/2025</i> |
| <i>Mark D. Sylvia</i> | <i>10th Bristol</i> | <i>1/23/2025</i> |

HOUSE No. 2537

By Representative Schwartz of Newton, a petition (accompanied by bill, House, No. 2537) of Greg Schwartz and others relative to primary care access. Public Health.

The Commonwealth of Massachusetts

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

An Act relative to primary care access.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 1 of chapter 6D of the General Laws, as appearing in the 2020
2 Official Edition, is hereby amended by inserting after the definition of “After-hours care” the
3 following definitions:-

4 “Aggregate primary care baseline expenditures”, the sum of all primary care
5 expenditures, as defined by the center, in the commonwealth in the calendar year preceding the
6 year in which the aggregate primary care expenditure target applies.

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

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

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

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

18 SECTION 3. Said chapter 6D, as so appearing, is hereby amended by inserting after
19 section 3A, as inserted by section 3 of chapter 342 of the acts of 2024, the following section:-

20 Section 3B. (a) There shall be within the commission a primary care board to: (i) study
21 primary care access, delivery and payment in the commonwealth; (ii) develop and issue
22 recommendations to stabilize and strengthen the primary care system and the increase of
23 recruitment and retention in the primary care workforce; and (iii) increase the financial
24 investment in and patient access to primary care across the commonwealth.

25 (b) The board shall consist of: the secretary of health and human services or a designee,
26 who shall serve as co-chair; the executive director of the health policy commission or a designee,
27 who shall serve as co-chair; the assistant secretary for MassHealth or a designee; the executive
28 director of the center for health information and analysis or a designee; the commissioner of
29 insurance or a designee; the chairs of the joint committee on health care financing or their
30 designees; 1 member from the American Academy of Family Physicians Mass Chapter, Inc.; 1
31 member from the Massachusetts chapter of the American Academy of Pediatrics; 1 member
32 from a rural health care practice with expertise in primary care; 1 member from Community Care
33 Cooperative, Inc.; 1 member from the Massachusetts Medical Society with expertise in primary

34 care; 1 member from the Massachusetts Coalition of Nurse Practitioners, Inc. with expertise in
35 primary care or in delivering care in a community health center; 1 member from the
36 Massachusetts Association of Physician Associates, Inc. with expertise in primary care; 1
37 member from the Massachusetts chapter of the National Association of Social Workers, Inc. with
38 expertise in behavioral health in a primary care setting; 1 member from the Massachusetts
39 League of Community Health Centers, Inc.; 1 member from the Massachusetts Health and
40 Hospital Association, Inc.; 1 member from the Massachusetts Association of Health Plans, Inc.;
41 1 member from Blue Cross and Blue Shield of Massachusetts, Inc.; 1 member from the
42 Associated Industries of Massachusetts, Inc.; 1 member from the Retailers Association of
43 Massachusetts, Inc.; 1 member from Health Care For All, Inc.; 1 member from the
44 Massachusetts Chapter of the American College of Physicians; 1 member from the
45 Massachusetts Primary Care Alliance for Patients; and 1 member from Massachusetts Health
46 Quality Partners, Inc.

47 (c) The board shall develop recommendations to: (i) define primary care services, codes
48 and providers; (ii) develop a standard set of data reporting requirements for private and public
49 health care payers, providers and provider organizations to enable the commonwealth and private
50 and public health care payers to track payments for primary care services including, but not
51 limited to, fee-for-service, prospective payments, value-based payments and grants to primary
52 care providers, fees levied on a primary care provider by a provider organization or hospital
53 system of which the primary care provider is affiliated and provider spending on primary care
54 services; (iii) propose payment models to increase private and public reimbursement for primary
55 care services, including, but not limited to, an all-payer primary care capitation model; (iv)
56 assess the impact of health plan design on health equity and patient access to primary care

57 services; (v) monitor and track the needs of and service delivery to residents of the
58 commonwealth; (vi) create short-term and long-term workforce development plans to increase
59 the supply and distribution of and improve working conditions of primary care clinicians and
60 other primary care workers; and (vii) strengthen the integration of primary care and behavioral
61 health and increase investment in behavioral health. The board may make additional
62 recommendations and propose legislation necessary to carry out its recommendations.

63 (d) The board shall, in consultation with the center, define the data required to satisfy the
64 contents of this section. The center shall adopt regulations to require providers and private and
65 public health care payers to submit data or information necessary for the board to fulfill its duties
66 under this section. Any data collected shall be public and available through the Massachusetts
67 Primary Care Dashboard maintained by the center and Massachusetts Health Quality Partners,
68 Inc.

69 (e)(1) The board shall propose a standard all-payer primary care capitation model, under
70 which private payers shall pay participating providers or provider organizations a prospective,
71 per-member per-month payment for patients attributed to the participating providers or provider
72 organizations for primary care. The proposed model shall include, but not be limited to: (i)
73 definitions of primary care services, codes, and providers; (ii) per-member per-month rate
74 methodology; (iii) enhanced payments for advanced primary care services and investments; (iv)
75 patient cost-sharing limits for primary care; (v) member attribution methodology; (vi) primary
76 care quality measures; (vii) primary care reimbursement and spending reporting requirements for
77 participating providers or provider organizations; and (viii) audits of participating providers or
78 provider organizations.

79 (2) In developing the per-member per-month rate methodology, the board may consider
80 the historical monthly primary care spending per patient at the primary care provider or provider
81 organization level, the historical monthly primary care spending per patient statewide, the
82 primary care expenditure data published in the center’s annual report under section 16 of chapter
83 12C, and any other factors deemed relevant by the board. The per-member per-month payment
84 may be adjusted based on: (i) a participating provider or provider organization’s adoption of
85 advanced primary care services and investment in primary care services; (ii) the quality of
86 patient care delivered by a participating provider or provider organization; and (iii) the clinical
87 and social risk of patients attributed to a participating provider or provider organization for
88 primary care. The board shall consider the per-member per-month rate methodology established
89 in the MassHealth primary care sub-capitation program.

90 (3) The board shall identify advanced primary care services and investments in primary
91 care delivery that may qualify participating providers or provider organizations for enhanced
92 payments under the all-payer primary care capitation model. Advanced primary care services and
93 investments shall be evidence-informed or evidence-based, improve primary care quality,
94 increase primary care access, enhance a patient’s primary care experience, or promote health
95 equity in primary care. Advanced primary care services and investments shall include, but not be
96 limited to: (i) employing community health workers or health coaches as part of the primary care
97 team; (ii) investing in social determinants of health; (iii) collaborating with primary care-based
98 clinical pharmacists; (iv) integrating behavioral health care with primary care; (v) offering
99 substance use disorder treatment, including medication-assisted treatment, telehealth services,
100 including telehealth consultations with specialists, medical interpreter services, home care,
101 patient advisory groups, and group visits; (vi) using clinician optimization programs to reduce

102 documentation burden, including, but not limited to, medical scribes and ambient voice
103 technology; (vii) investing in care management, including employing social workers to help
104 manage the care for patients with complicated health needs; (viii) establishing systems to
105 facilitate end of life care planning and palliative care; (ix) developing systems to evaluate patient
106 population health to help determine which preventative medicine interventions require patient
107 outreach; (x) offering walk-in or same-day care appointments or extended hours of availability;
108 and (xi) any other primary care service deemed relevant by the board. The board shall consider
109 care delivery requirements established in the MassHealth primary care sub-capitation program.

110 (4) The board shall develop clinical tiers with minimum care delivery standards based on
111 advanced primary care services and investments identified in paragraph (3) and establish
112 enhanced payments for each clinical tier under the all-payer primary care capitation model.
113 Enhanced payments shall consider the strength of evidence that the advanced service or
114 investment will: (i) improve patient health; (ii) enhance patient experience; (iii) improve
115 clinician experience, including reducing administrative burden; (iv) decrease total medical
116 expense; and (iv) promote health equity. The board shall consider the clinical tiers established in
117 the MassHealth primary care sub-capitation program.

118 (5) The board shall identify not more than 8 quality measures related to: (i) care
119 continuity, comprehensiveness, and coordination; (ii) patient access to primary care; and (iii)
120 patient experience. 4 of the 8 quality measures shall be measures of patient experience and 1
121 shall be a person-centered primary care measure. Each quality measure shall be patient-centered,
122 appropriate for a primary care setting, and supported by peer-reviewed, evidence-based research
123 that the measure is actionable and that its use will lead to improvements in patient health. The
124 board shall develop standard reporting requirements for the quality measures and standard per-

125 member per-month rate adjustment methodology based on quality measures. The board shall
126 consider MassHealth quality indicators for managed care entities.

127 (6) The board shall identify measures of clinical and social complexity that promote
128 health equity and minimize opportunities to artificially increase the clinical and social
129 complexity of a patient panel. The board shall develop standard per-member per-month rate
130 adjustment methodology based on measures of clinical and social complexity.

131 (7) The board shall develop member attribution methodology to assign patients to
132 participating providers and provider organizations for primary care under the all-payer primary
133 care capitation model. The board shall consider the member attribution process established in the
134 MassHealth primary care sub-capitation program.

135 (8) The board shall develop an attestation, reporting and audit process for participating
136 providers or provider organizations. The board shall consider the attestation, reporting and audit
137 process established in the MassHealth primary care sub-capitation program.

138 SECTION 4. Section 8 of said chapter 6D, as so appearing, is hereby amended by
139 striking out subsection (a) and inserting in place thereof the following subsection:-

140 (a) Not later than October 1 of every year, the commission shall hold public hearings
141 based on the report submitted by the center under section 16 of chapter 12C comparing the
142 growth in total health care expenditures to the health care cost growth benchmark for the
143 previous calendar year and comparing the growth in actual aggregate primary care expenditures
144 for the previous calendar year to the aggregate primary care expenditure target. The hearings
145 shall examine health care provider, provider organization and private and public health care
146 payer costs, prices and cost trends, with particular attention to factors that contribute to cost

147 growth within the commonwealth’s health care system and challenge the ability of the
148 commonwealth’s health care system to meet the benchmark established under section 9 or the
149 aggregate primary care expenditure target established under section 9A.

150 SECTION 5. Said section 8 of said chapter 6D, as so appearing, is hereby further
151 amended by striking out, in line 94, the word “and” and inserting in place thereof the following
152 words:- , including primary care expenditures, and.

153 SECTION 6. Said chapter 6D is hereby further amended by inserting after section 9 the
154 following section:-

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

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

159 (1) For the calendar year 2026, the aggregate primary care expenditure target and the
160 primary care expenditure target shall be equal to 8 per cent of total health care expenditures in
161 the commonwealth;

162 (2) For the calendar year 2027, the aggregate primary care expenditure target and the
163 primary care expenditure target shall be equal to 10 per cent of total health care expenditures in
164 the commonwealth;

165 (3) For the calendar year 2028, the aggregate primary care expenditure target and the
166 primary care expenditure target shall be equal to 12 per cent of total health care expenditures in
167 the commonwealth; and

168 (4) For calendar years 2029 and beyond, if the commission determines that an adjustment
169 in the aggregate primary care expenditure target and the primary care expenditure target is
170 reasonably warranted, the commission may recommend modification to such targets, provided,
171 that such targets shall not be lower than 12 per cent of total health care expenditures in the
172 commonwealth.

173 (c) Prior to making any recommended modification to the aggregate primary care
174 expenditure target and the primary care expenditure target under paragraph (4) of subsection (b),
175 the commission shall hold a public hearing. The public hearing shall be based on the report
176 submitted by the center under section 16 of chapter 12C, comparing the aggregate primary care
177 expenditures to the aggregate primary care expenditure target, any other data submitted by the
178 center and such other pertinent information or data as may be available to the commission. The
179 hearings shall examine the performance of health care entities in meeting the primary care
180 expenditure target and the commonwealth's health care system in meeting the aggregate primary
181 care expenditure target. The commission shall provide public notice of the hearing at least 45
182 days prior to the date of the hearing, including notice to the joint committee on health care
183 financing. The joint committee on health care financing may participate in the hearing. The
184 commission shall identify as witnesses for the public hearing a representative sample of
185 providers, provider organizations, payers and such other interested parties as the commission
186 may determine. Any other interested parties may testify at the hearing.

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

190 SECTION 7. Said chapter 6D, as so appearing, is hereby further amended by inserting
191 after section 10 the following section:-

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

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

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

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

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

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

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

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

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

232 (g) The commission shall provide the department of public health any notice requiring a
233 health care entity to file and implement a performance improvement plan pursuant to this
234 section. In the event a health care entity required to file a performance improvement plan under
235 this section submits an application for a notice of determination of need under section 25C or 51
236 of chapter 111, the notice of the commission requiring the health care entity to file and
237 implement a performance improvement plan pursuant to this section shall be considered part of
238 the written record pursuant to said section 25C of chapter 111.

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

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

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

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

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

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

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

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

280 (p) If the commission determines that a health care entity has: (1) willfully neglected to
281 file a performance improvement plan with the commission by the time required in subsection (h);
282 (2) failed to file an acceptable performance improvement plan in good faith with the
283 commission; (3) failed to implement the performance improvement plan in good faith; or (4)
284 knowingly failed to provide information required by this section to the commission or that
285 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity
286 of not more than \$500,000 for a first violation, not more than \$750,000 for a second violation
287 and not more than the amount by which the health care entity failed to meet the primary care
288 expenditure target for a third or subsequent violation. The commission shall seek to promote
289 compliance with this section and shall only impose a civil penalty as a last resort.

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

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

294 SECTION 8. Section 1 of chapter 12C of the General Laws, as appearing in the 2020
295 Official Edition, is hereby amended by inserting after the definition of “Acute hospital” the
296 following definitions:-

297 “Aggregate primary care baseline expenditures”, the sum of all primary care expenditures
298 in the commonwealth in the calendar year preceding the year in which the aggregate primary
299 care expenditure target applies.

300 “Aggregate primary care expenditure target”, the targeted sum, set by the commission in
301 section 9A, of all primary care expenditures in the commonwealth in the calendar year in which
302 the aggregate primary care expenditure target applies.

303 SECTION 9. Said section 1 of said chapter 6D, as so appearing, is hereby further
304 amended by inserting after the definition of “Patient-centered medical home” the following
305 definitions:-

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

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

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

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

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

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

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

331 SECTION 12. Chapter 32A of the General Laws is hereby amended by inserting after
332 section 33 the following section:-

333 Section 34. (a) For the purposes of this section, the following words shall have the
334 following meanings:-

335 “All-payer primary care capitation model”, a standard value-based, prospective payment
336 model under which health insurers pay participating providers or provider organizations per-
337 member per-month payments for patients attributed to the participating providers or provider

338 organizations for primary care. The per-member per-month payment may be adjusted based on:
339 (i) a participating provider or provider organization's adoption of advanced primary care services
340 and investment in primary care services; (ii) the quality of patient care delivered by a
341 participating provider or provider organization; and (iii) the clinical and social risk of patients
342 attributed to a participating provider or provider organization for primary care; provided,
343 however, that implementation of the all-payer primary care capitation model complies with
344 division of insurance rules, regulations and guidelines.

345 "Division", the division of insurance.

346 (b) The commission shall implement the all-payer primary care capitation model in
347 accordance with division rules, regulations and guidelines, including, but not limited to: (i)
348 definitions of primary care services, codes, and providers; (ii) per-member per-month rate
349 methodology; (iii) enhanced payments for advanced primary care services and investments; (iv)
350 patient cost-sharing limits for primary care; (v) member attribution methodology; (vi) primary
351 care quality measures; (vii) primary care reimbursement and spending reporting requirements for
352 participating primary care providers and health care organizations; and (viii) audits of
353 participating primary care providers and health care organizations.

354 (c) The commission shall provide contracted primary care providers and health care
355 organizations with the option to participate in the all-payer primary care capitation model and
356 receive per-member per-month payments for any active or retired employee of the
357 commonwealth insured under the commission who is attributed to a primary care provider.

358 (d) Payments made to primary care providers and health care organizations participating
359 in the all-payer primary care capitation model shall be included in the health status adjusted total

360 medical expense and total medical expense calculated by the center for health information and
361 analysis under section 16 of chapter 12C.

362 (e) Participating primary care providers and health care organizations shall attest to
363 meeting the criteria for clinical tiers and submit to audits by the commission.

364 (f) Participating primary care providers and health care organizations shall submit
365 primary care expenditure reports and internal contracts related to primary care delivery and
366 payment to the division, center for health information and analysis and the health policy
367 commission in accordance with division rules, regulations and guidelines.

368 (g) Participating primary care providers and health care organizations shall select 4
369 quality measures, as defined by the division, to measure and report to the commission annually.

370 SECTION 13. Chapter 32A of the General Laws, as appearing in the 2022 Official
371 Edition, is further amended by inserting the following new section:-

372 Section 35. (a) For the purposes of this section, the following terms shall have the
373 following meanings unless the context clearly requires otherwise:

374 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

375 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
376 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

377 (b) Notwithstanding any general or special law to the contrary, the Commission shall
378 ensure that the rate of payment for any Federally Qualified Health Center services provided to a
379 patient by a community health center, shall be reimbursed in an amount at least equivalent to the
380 annual aggregate revenue that the health center would have received if reimbursed by

381 MassHealth pursuant to methodology that conforms with 42 U.S.C. § 1396a(bb) and
382 1396b(m)(2)(A)(ix) as they appear in Title 42 of the United States Code as of January 1, 2025.

383 SECTION 14. Chapter 118E of the General Laws, as appearing in the 2022 Official
384 Edition, is hereby amended by inserting after section 13d ½ the following new section:-

385 Section 13d ¾. (a) For purposes of this section, the term “community health center” shall
386 mean any entity reimbursed as a community health center under this chapter.

387 (b) Notwithstanding any general or special law to the contrary, reimbursement for
388 community health centers under this chapter, shall be in an amount at least equivalent to the
389 annual aggregate revenue that the health center would have received if reimbursed by
390 MassHealth pursuant to methodology that conforms with 42 U.S.C. § 1396a(bb) and
391 1396b(m)(2)(A)(ix) as they appear in Title 42 of the United States Code as of January 1, 2025.

392 SECTION 135. Chapter 118E of the General Laws, as appearing in the 2020 Official
393 Edition, is hereby amended by adding at the end thereof, the following section:-

394 Section 83. (a) The office shall make Graduate Medical Education payments for primary
395 care, including but not limited to internists, family medicine, pediatrics, and gerontology,
396 behavioral health, maternal health, including obstetrics and gynecology, and other physician
397 residency training in fields experiencing physician shortages, as determined by the secretary;
398 provided, that said payments may support community-based training for other health
399 professionals, including but not limited to, family medicine nurse practitioners, sexual and
400 reproductive health practitioners, ophthalmologists, optometrists, dentists, and dental hygienists.
401 Eligible recipients shall include community health centers and hospitals licensed in the
402 Commonwealth. Payments shall take into consideration MassHealth utilization and primary care,

403 behavioral health, and maternal health, including obstetrics and gynecology, and other physician
404 residency training in fields experiencing physician shortages; provided further, that the executive
405 office will prioritize placements at community-based settings, at organizations that serve a high
406 public payer mix.

407 (b) No later than July 1, 2025, the secretary, in consultation with the executive office of
408 administration and finance, shall identify an adequate amount of annual Medicaid graduate
409 medical education funding necessary to fulfill the requirements of this section, as well as state
410 and other funding sources for use for graduate medical education expenditures. The secretary
411 shall report its recommendations to the joint committee on healthcare finance and committees on
412 ways and means.

413 (c) The first annual payment to qualifying acute care hospitals and community health
414 centers under this section shall be made no later than October 1, 2025.

415 SECTION 14. Chapter 175 of the General law, as appearing in the 2020 Official Edition,
416 is hereby amended by inserting after section 47CCC the following section:

417 Section 47DDD. (a) For the purposes of this section, the following terms shall have the
418 following meanings unless the context clearly requires otherwise:

419 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

420 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
421 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

422 (b) Notwithstanding any general or special law to the contrary, an entity licensed by the
423 division of insurance and providing reimbursement to federally qualified health centers for

424 services provided to patients shall ensure that payment for any federally qualified health center
425 services provided to a patient, including, but not limited to, behavioral health services, telehealth
426 services, primary care services and dental services, as defined in 101 CMR 304.00, shall be
427 reimbursed in an amount on an annual basis not less than equivalent to the annual aggregate
428 revenue that the health center would have received if reimbursed by MassHealth pursuant to
429 methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in
430 Title 42 of the United States Code as of January 1, 2023.

431 (c) Notwithstanding any general or special law to the contrary, an entity licensed by the
432 division of insurance and providing reimbursement to federally qualified health centers for
433 services provided to patients, including, but not limited to, non-profit hospital service
434 corporations, medical service corporations, dental service corporations, health maintenance
435 organizations and preferred provider organizations, or any other entity not specifically
436 enumerated hereunder licensed by the division of insurance and providing reimbursement to
437 federally qualified health centers for services provided to patients, shall: (i) ensure that payment
438 for any federally qualified health center services provided to a patient shall be reimbursed in an
439 amount on an annual basis not less than equivalent to the annual aggregate revenue that the
440 health center would have received if reimbursed by MassHealth pursuant to methodology that
441 conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the
442 United States Code as of January 1, 2023; and (ii) submit an annual report to the division of
443 insurance as a condition of their licensure evidencing that the total reimbursement to federally
444 qualified health centers for services provided to patients in the prior year was equivalent to the
445 annual aggregate revenue the health center would have received if reimbursed by MassHealth.

446 (d) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
447 renewed within or without the commonwealth shall not be required to reimburse a health care
448 provider not contracted under the plan except as described in subclause (i) of clause (4) of
449 subsection (a) of section 6 of chapter 176O.

450 (e) The division of insurance shall consult with MassHealth to receive technical
451 assistance regarding the per visit payment rate for each federally qualified health center for a
452 given year. MassHealth shall provide the division of insurance with a proxy rate for any federally
453 qualified health center who has not received an individual prospective payment system rate and
454 the division of insurance shall make available to health plans upon request the necessary
455 prospective payment system rate information regarding their contracted federally qualified health
456 centers so that the health plan can ensure compliance with this requirement.

457 SECTION 157. Chapter 175 of the General Laws is hereby amended by inserting after
458 section 47CCC, as inserted by section 31 of chapter 342 of the acts of 2024, the following
459 section:-

460 Section 47DDD. (a) For the purposes of this section, the following words shall have the
461 following meanings:-

462 “All-payer primary care capitation model”, a standard value-based, prospective payment
463 model under which health insurers pay participating providers or provider organizations per-
464 member per-month payments for patients attributed to the participating providers or provider
465 organizations for primary care. The per-member per-month payment may be adjusted based on:

466 (i) a participating provider or provider organization’s adoption of advanced primary care services
467 and investment in primary care services; (ii) the quality of patient care delivered by a

468 participating provider or provider organization; and (iii) the clinical and social risk of patients
469 attributed to a participating provider or provider organization for primary care; provided,
470 however, that implementation of the all-payer primary care capitation model complies with
471 division of insurance rules, regulations and guidelines.

472 “Division”, the division of insurance.

473 “Provider organization”, as defined in section 1 of chapter 6D.

474 (b) Any policy, contract, agreement, plan or certificate of insurance issued, delivered or
475 renewed within the commonwealth and which is considered creditable coverage under section 1
476 of chapter 111M shall implement the all-payer primary care capitation model in accordance with
477 division rules, regulations and guidelines, including, but not limited to: (i) definitions of primary
478 care services, codes, and providers; (ii) per-member per-month rate methodology; (iii) enhanced
479 payments for advanced primary care services and investments; (iv) patient cost-sharing limits for
480 primary care; (v) member attribution methodology; (vi) primary care quality measures; (vii)
481 primary care reimbursement and spending reporting requirements for participating primary care
482 providers and provider organizations; and (viii) audits of participating primary care providers
483 and provider organizations.

484 (c) The carrier shall provide contracted primary care providers and provider organizations
485 with the option to participate in the all-payer primary care capitation model and receive per-
486 member per-month payments for enrollees attributed to the primary care provider or provider
487 organization for primary care.

488 (d) Payments made to primary care providers and provider organizations participating in
489 the all-payer primary care capitation model shall be included in the health status adjusted total

490 medical expense and total medical expense calculated by the center for health information and
491 analysis under section 16 of chapter 12C.

492 (e) Participating primary care providers and provider organizations shall attest to meeting
493 the criteria for clinical tiers and submit to audits by the commission.

494 (f) Participating primary care providers and provider organizations shall submit primary
495 care expenditure reports and internal contracts related to primary care delivery and payment to
496 the division, center for health information and analysis and the health policy commission in
497 accordance with division rules, regulations and guidelines.

498 (g) Participating primary care providers and provider organizations shall select 4 quality
499 measures, as defined by the division, to measure and report to the commission annually.

500 SECTION 168. Chapter 176A of the General Laws is hereby amended by inserting after
501 section 8DD, as inserted by section 33 of chapter 342 of the acts of 2024, the following section:-

502 Section 8EE. (a) For the purposes of this section, the following words shall have the
503 following meanings:-

504 “All-payer primary care capitation model”, a standard value-based, prospective payment
505 model under which health insurers pay participating providers or provider organizations per-
506 member per-month payments for patients attributed to the participating providers or provider
507 organizations for primary care. The per-member per-month payment may be adjusted based on:

508 (i) a participating provider or provider organization’s adoption of advanced primary care services
509 and investment in primary care services; (ii) the quality of patient care delivered by a
510 participating provider or provider organization; and (iii) the clinical and social risk of patients

511 attributed to a participating provider or provider organization for primary care; provided,
512 however, that implementation of the all-payer primary care capitation model complies with
513 division of insurance rules, regulations and guidelines.

514 “Division”, the division of insurance.

515 “Primary care provider”, a health care professional qualified to provide general medical
516 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
517 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
518 maintains continuity of care within the scope of practice.

519 “Provider organization”, as defined in section 1 of chapter 6D.

520 (b) Any contract between a subscriber and the corporation under an individual or group
521 hospital service plan that is delivered, issued or renewed within the commonwealth shall
522 implement the all-payer primary care capitation model in accordance with division rules,
523 regulations and guidelines, including, but not limited to: (i) definitions of primary care services,
524 codes, and providers; (ii) per-member per-month rate methodology; (iii) enhanced payments for
525 advanced primary care services and investments; (iv) patient cost-sharing limits for primary care;
526 (v) member attribution methodology; (vi) primary care quality measures; (vii) primary care
527 reimbursement and spending reporting requirements for participating providers and provider
528 organizations; and (viii) audits of participating providers and provider organizations.

529 (c) The carrier shall provide contracted primary care providers and provider organizations
530 with the option to participate in the all-payer primary care capitation model and receive per-
531 member per-month payments for enrollees attributed to the primary care provider or provider
532 organization for primary care.

533 (d) Payments made to primary care providers and provider organizations participating in
534 the all-payer primary care capitation model shall be included in the health status adjusted total
535 medical expense and total medical expense calculated by the center for health information and
536 analysis under section 16 of chapter 12C.

537 (e) Participating primary care providers and provider organizations shall attest to meeting
538 the criteria for clinical tiers and submit to audits by the commission.

539 (f) Participating primary care providers and provider organizations shall submit primary
540 care expenditure reports and internal contracts related to primary care delivery and payment to
541 the division, center for health information and analysis and the health policy commission in
542 accordance with division rules, regulations and guidelines.

543 (g) Participating primary care providers and provider organizations shall select 4 quality
544 measures, as defined by the division, to measure and report to the commission annually.

545 SECTION 19. Chapter 176A of the General Laws, as appearing in the 2022 Official
546 Edition, is hereby amended by inserting after Section 38 the following new section:-

547 Section 39. (a) For the purposes of this section, the following terms shall have the
548 following meanings unless the context clearly requires otherwise:

549 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

550 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
551 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

552 (b) Notwithstanding any general or special law to the contrary, any corporation organized
553 under this chapter shall ensure that the rate of payment for any Federally Qualified Health Center

554 services provided to a patient by a community health center, shall be reimbursed in an amount at
555 least equivalent to the annual aggregate revenue that the health center would have received if
556 reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. § 1396a(bb)
557 and 1396b(m)(2)(A)(ix) as they appear in Title 42 of the United States Code as of January 1,
558 2023.

559 (c) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
560 renewed within or without the Commonwealth shall not be required to reimburse a health care
561 provider for a health care service that is not a covered benefit under the plan or reimburse a
562 health care provider not contracted under the plan except as described in subclause (i) of clause
563 (4) of subsection (a) of section 6 of chapter 176O.

564 SECTION 20. Section 1 of Chapter 176B of the General Laws, as appearing in the 2024
565 Official Edition, is hereby amended by inserting after the definition of “Dependent” the
566 following new definitions:-

567 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

568 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
569 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

570 SECTION 21. Chapter 176B of the General Laws, as so appearing is hereby further
571 amended by inserting after Section 25 the following new section:-

572 Section 26: (a) Notwithstanding any general or special law to the contrary, any medical
573 service plan organized under this chapter shall ensure that the rate of payment for any Federally
574 Qualified Health Center services provided to a patient by a community health center, shall be

575 reimbursed in an amount at least equivalent to the annual aggregate revenue that the health
576 center would have received if reimbursed by MassHealth pursuant to methodology that conforms
577 with 42 U.S.C. § 1396a(bb) and 1396b(m)(2)(A)(ix) as they appear in Title 42 of the United
578 States Code as of January 1, 2023.

579 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
580 renewed within or without the Commonwealth shall not be required to reimburse a health care
581 provider for a health care service that is not a covered benefit under the plan or reimburse a
582 health care provider not contracted under the plan except as described in subclause (i) of clause
583 (4) of subsection (a) of section 6 of chapter 176O.

584 SECTION 1722. Chapter 176B of the General Laws is hereby amended by inserting after
585 section 4DDD, as inserted by section 34 of chapter 342 of the acts of 2024, the following
586 section:-

587 Section 4EEE. (a) For the purposes of this section, the following words shall have the
588 following meanings:-

589 “All-payer primary care capitation model”, a standard value-based, prospective payment
590 model under which health insurers pay participating providers or provider organizations per-
591 member per-month payments for patients attributed to the participating providers or provider
592 organizations for primary care. The per-member per-month payment may be adjusted based on:
593 (i) a participating provider or provider organization’s adoption of advanced primary care services
594 and investment in primary care services; (ii) the quality of patient care delivered by a
595 participating provider or provider organization; and (iii) the clinical and social risk of patients
596 attributed to a participating provider or provider organization for primary care; provided,

597 however, that implementation of the all-payer primary care capitation model complies with
598 division of insurance rules, regulations and guidelines.

599 “Division”, the division of insurance.

600 “Provider organization”, as defined in section 1 of chapter 6D.

601 (b) A subscription certificate under an individual or group medical service agreement
602 delivered, issued or renewed within the commonwealth and which is considered creditable
603 coverage under section 1 of chapter 111M shall implement the all-payer primary care capitation
604 model in accordance with division rules, regulations and guidelines, including, but not limited to:
605 (i) definitions of primary care services, codes, and providers; (ii) per-member per-month rate
606 methodology; (iii) enhanced payments for advanced primary care services and investments; (iv)
607 patient cost-sharing limits for primary care; (v) member attribution methodology; (vi) primary
608 care quality measures; (vii) primary care reimbursement and spending reporting requirements for
609 participating primary care providers and provider organizations; and (viii) audits of participating
610 primary care providers and provider organizations.

611 (c) The carrier shall provide contracted primary care providers and provider organizations
612 with the option to participate in the all-payer primary care capitation model and receive per-
613 member per-month payments for enrollees attributed to the primary care provider or provider
614 organization for primary care.

615 (d) Payments made to primary care providers and provider organizations participating in
616 the all-payer primary care capitation model shall be included in the health status adjusted total
617 medical expense and total medical expense calculated by the center for health information and
618 analysis under section 16 of chapter 12C.

619 (e) Participating primary care providers and provider organizations shall attest to meeting
620 the criteria for clinical tiers and submit to audits by the commission.

621 (f) Participating primary care providers and provider organizations shall submit primary
622 care expenditure reports and internal contracts related to primary care delivery and payment to
623 the division, center for health information and analysis and the health policy commission in
624 accordance with division rules, regulations and guidelines.

625 (g) Participating primary care providers and provider organizations shall select 4 quality
626 measures, as defined by the division, to measure and report to the commission annually.

627 SECTION 23. Section 1 of Chapter 176E of the General Laws, as appearing in the 2022
628 Official Edition, is hereby amended by inserting after the definition of “Dental Service
629 Corporation” the following new definitions:-

630 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

631 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
632 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

633 SECTION 24. Said Chapter 176E is further amended by inserting after section 15A the
634 following new section:-

635 Section 15B. (a) Notwithstanding any general or special law to the contrary, any Dental
636 Service Corporation organized under this chapter shall ensure that the rate of payment for any
637 Federally Qualified Health Center services provided to a patient by a community health center,
638 shall be reimbursed in an amount at least equivalent to the annual aggregate revenue that the
639 health center would have received if reimbursed by MassHealth pursuant to methodology that

640 conforms with 42 U.S.C. § 1396a(bb) and 1396b(m)(2)(A)(ix) as they appear in Title 42 of the
641 United States Code as of January 1, 2023.

642 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
643 renewed within or without the Commonwealth shall not be required to reimburse a health care
644 provider for a health care service that is not a covered benefit under the plan or reimburse a
645 health care provider not contracted under the plan except as described in subclause (i) of clause
646 (4) of subsection (a) of section 6 of chapter 176O.

647 SECTION 25. Section 1 of Chapter 176G of the General Laws, as appearing in the 2022
648 Official Edition, is hereby amended by inserting after the definition of “Evidence of Coverage”
649 the following new definitions:-

650 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

651 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
652 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

653 SECTION 1826. Chapter 176G of the General Laws is hereby amended by inserting after
654 section 4VV, as inserted by section 35 of chapter 342 of the acts of 2024, the following section:-

655 Section 4WW. (a) For the purposes of this section, the following words shall have the
656 following meanings:-

657 “All-payer primary care capitation model”, a standard value-based, prospective payment
658 model under which health insurers pay participating providers or provider organizations per-
659 member per-month payments for patients attributed to the participating providers or provider
660 organizations for primary care. The per-member per-month payment may be adjusted based on:

661 (i) a participating provider or provider organization’s adoption of advanced primary care services
662 and investment in primary care services; (ii) the quality of patient care delivered by a
663 participating provider or provider organization; and (iii) the clinical and social risk of patients
664 attributed to a participating provider or provider organization for primary care; provided,
665 however, that implementation of the all-payer primary care capitation model complies with
666 division of insurance rules, regulations and guidelines.

667 “Division”, the division of insurance.

668 “Provider organization”, as defined in section 1 of chapter 6D.

669 (b) An individual group health maintenance contract that is issued or renewed within or
670 without the commonwealth and which is considered creditable coverage under section 1 of
671 chapter 111M shall implement the all-payer primary care capitation model in accordance with
672 division rules, regulations and guidelines, including, but not limited to: (i) definitions of primary
673 care services, codes, and providers; (ii) per-member per-month rate methodology; (iii) enhanced
674 payments for advanced primary care services and investments; (iv) patient cost-sharing limits for
675 primary care; (v) member attribution methodology; (vi) primary care quality measures; (vii)
676 primary care reimbursement and spending reporting requirements for participating primary care
677 providers and provider organizations; and (viii) audits of participating primary care providers
678 and provider organizations.

679 (c) The carrier shall provide contracted primary care providers and provider organizations
680 with the option to participate in the all-payer primary care capitation model and receive per-
681 member per-month payments for enrollees attributed to the primary care provider or provider
682 organization for primary care.

683 (d) Payments made to primary care providers and provider organizations participating in
684 the all-payer primary care capitation model shall be included in the health status adjusted total
685 medical expense and total medical expense calculated by the center for health information and
686 analysis under section 16 of chapter 12C.

687 (e) Participating primary care providers and provider organizations shall attest to meeting
688 the criteria for clinical tiers and submit to audits by the commission.

689 (f) Participating primary care providers and provider organizations shall submit primary
690 care expenditure reports and internal contracts related to primary care delivery and payment to
691 the division, center for health information and analysis and the health policy commission in
692 accordance with division rules, regulations and guidelines.

693 (g) Participating primary care providers and provider organizations shall select 4 quality
694 measures, as defined by the division, to measure and report to the commission annually.

695 SECTION 27. Said Chapter 176G is further amended by inserting after section 33 the
696 following new section:-

697 Section 34. (a) Notwithstanding any general or special law to the contrary, any Health
698 Maintenance Organization organized under the laws of the Commonwealth shall ensure that the
699 rate of payment for any Federally Qualified Health Center services provided to a patient by a
700 community health center, shall be reimbursed in an amount at least equivalent to the annual
701 aggregate revenue that the health center would have received if reimbursed by MassHealth
702 pursuant to methodology that conforms with 42 U.S.C. § 1396a(bb) and 1396b(m)(2)(A)(ix) as
703 they appear in Title 42 of the United States Code as of January 1, 2023.

704 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
705 renewed within or without the Commonwealth shall not be required to reimburse a health care
706 provider for a health care service that is not a covered benefit under the plan or reimburse a
707 health care provider not contracted under the plan except as described in subclause (i) of clause
708 (4) of subsection (a) of section 6 of chapter 176O.

709 SECTION 28. Section 1 of Chapter 176I of the General Laws, as appearing in the 2022
710 Official Edition, is hereby amended by inserting after the definition of “Emergency Care” the
711 following new definitions:-

712 “Federally Qualified Health Center”, any entity receiving a grant under 42 U.S.C. 254B.

713 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
714 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

715 SECTION 29. Said Chapter 176I, as so appearing, is further amended by inserting after
716 section 13 the following new section:-

717 Section 14. (a) Notwithstanding any general or special law to the contrary, any preferred
718 provider contract shall ensure that the rate of payment for any Federally Qualified Health Center
719 services provided to a patient by a community health center, shall be reimbursed in an amount at
720 least equivalent to the annual aggregate revenue that the health center would have received if
721 reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. § 1396a(bb)
722 and 1396b(m)(2)(A)(ix) as they appear in Title 42 of the United States Code as of January 1,
723 2023.

724 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
725 renewed within or without the Commonwealth shall not be required to reimburse a health care
726 provider for a health care service that is not a covered benefit under the plan or reimburse a
727 health care provider not contracted under the plan except as described in subclause (i) of clause
728 (4) of subsection (a) of section 6 of chapter 176O.

729 SECTION 1930. Section 80 of chapter 343 of the acts of 2024 is hereby repealed.

730 SECTION 2031. Not later than June 15, 2026, the primary care board established under
731 section 3B of chapter 6D shall issue its report of the findings and recommendations under
732 clauses (i) and (ii) of subsection (c) of section 3B of chapter 6D with the clerks of the house of
733 representatives and the senate, the house and senate committees on ways and means, the joint
734 committee on health care financing, the center for health information and analysis, the health
735 policy commission and the division of insurance.

736 SECTION 2321. Not later than September 15, 2026, the primary care board established
737 under section 3B of chapter 6D shall issue its report of the findings and recommendations under
738 clause (iii) of subsection (c) of section 3B of chapter 6D with the clerks of the house of
739 representatives and the senate, the house and senate committees on ways and means, the joint
740 committee on health care financing, the center for health information and analysis, the health
741 policy commission and the division of insurance.

742 SECTION 3322. Not later than December 15, 2026, the primary care board established
743 under section 3B of chapter 6D shall issue its report of the findings and recommendations under
744 clauses (iv) and (v) of subsection (c) of section 3B of chapter 6D with the clerks of the house of
745 representatives and the senate, the house and senate committees on ways and means, the joint

746 committee on health care financing, the center for health information and analysis, the health
747 policy commission and the division of insurance.

748 SECTION 3423. Not later than March 15, 2027, the primary care board established under
749 section 3B of chapter 6D shall issue its report of the findings and recommendations under
750 clauses (vi) and (vii) of subsection (c) of section 3B of chapter 6D with the clerks of the house of
751 representatives and the senate, the house and senate committees on ways and means, the joint
752 committee on health care financing, the center for health information and analysis, the health
753 policy commission and the division of insurance.

754 SECTION 2354. Subsection (e) of section 16 of chapter 12C of the General Laws shall
755 take effect October 1, 2026.

756 SECTION 2365. Sections 12, 14, 15, 16, and 17 shall apply to all contracts entered into,
757 renewed or amended on or after July 1, 2028.

758 SECTION 2376. The center for health information and analysis shall define “primary
759 care expenditures” for the purposes of analyzing and reporting primary care baseline
760 expenditures for health entities pursuant to section 16 of chapter 12C and comparing primary
761 care baseline expenditures of health entities against the primary care expenditure target pursuant
762 to section 18 of chapter 12C not later than June 30, 2027. The center shall consider
763 recommendations from the primary care board established under section 3B of chapter 6D when
764 defining “primary care expenditures”.

765 SECTION 2378. The division of insurance shall promulgate rules and regulations for
766 implementation of the all-payer primary care capitation model by carriers under sections 12, 14,
767 15, 16, and 17 not later than December 31, 2027. Rules and regulations shall include, but not be

768 limited to: (i) definitions of primary care services, codes, and providers; (ii) per-member per-
769 month rate methodology; (iii) enhanced payments for advanced primary care services and
770 investments; (iv) patient cost-sharing limits for primary care; (v) member attribution
771 methodology; (vi) primary care quality measures; (vii) primary care reimbursement and spending
772 reporting requirements for participating providers and provider organizations; and (viii) audits of
773 participating providers and provider organizations. The division shall require the same all-payer
774 primary care capitation model to be implemented by carriers under sections 12, 14, 15, 16, and
775 17. The division shall consider recommendations from the primary care board established under
776 section 3B of chapter 6D when developing and implementing rules and regulations.