HOUSE . . . . . No. 5630

Text of House document No. 5618, being House amendments of the Senate Bill relative to primary care for you (Senate bill No. 3141), as amended by the House. July 30, 2026.

The Commonwealth of Massachusetts

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

By striking out all after the enacting clause and inserting in place thereof the following:–

SECTION 1. Section 1 of chapter 6D of the General Laws, as appearing in the 2024 Official Edition, is hereby amended by inserting after the definition of "After-hours care" the following 2 definitions:-

"Aggregate primary care expenditures", the annual per capita sum of all primary care expenditures in the commonwealth.

"Aggregate primary care expenditure target", the target amount of aggregate primary care expenditures for a calendar year, as established pursuant to section 9A.

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 4 definitions:-

"Primary care", the provision of coordinated, comprehensive medical services, on both a first-contact and a continuous basis, by a primary care provider.

"Primary care expenditures", payments for primary care services and other payments that directly support the delivery of primary care services, which shall be limited to the following:

(i) payments for services delivered by a primary care provider in an outpatient setting, by telehealth, or in a patient's home, nursing facility or other residential care setting;

(ii) payments for preventive medicine services delivered by a primary care provider, including examinations, screenings, assessments and counseling;

(iii) payments for the administration of injections, infusions and vaccines by a primary care provider;

(iv) payments for care coordination, care management, transitional care management and chronic disease management delivered by or under the direction of a primary care provider;

(v) payments for behavioral health services delivered in a primary care setting by a primary care provider or by a behavioral health clinician integrated into a primary care practice;

(vi) payments for preventive obstetric and gynecologic evaluation and management services, including annual preventive visits, screening services, and such other obstetric and gynecologic services as the center may determine function as primary care services; and

(vii) non-claims payments that support the delivery of primary care, including population health payments, practice infrastructure payments, care management payments, performance and quality payments, shared savings payments net of recoupments, capitation, sub-capitation and full-risk payments, and other non-claims payments designated by the center.

"Primary care infrastructure support", capital, operating or in-kind support furnished by a provider or provider organization to build or sustain its capacity to deliver primary care services, including clinical and information technology, data infrastructure, practice management support, workforce recruitment, training and development, and cross-subsidization of primary care

operating losses by the provider or provider organization's other operations; provided, however, that "primary care infrastructure support" shall not include any amount included in primary care expenditures.

"Primary care investment", the total commitment of financial resources by a provider or provider organization to support the delivery of primary care services, consisting of the provider or provider organization's total primary care expenditures and primary care infrastructure support.

SECTION 3. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Primary care provider" the following definition:-

"Primary care services", health care services furnished by a primary care provider to promote health, prevent disease, diagnose and treat illness and injury and provide ongoing, comprehensive and coordinated care.

SECTION 4. Section 8 of said chapter 6D, as so appearing, is hereby amended by inserting after the word "year", in line 6, the following words:- and comparing the growth in aggregate primary care expenditures to the aggregate primary care expenditure target established in section 9A.

SECTION 5. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word "models", in line 62, the following words:- , primary care.

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

Section 9A. (a) The commission shall administer and monitor the aggregate primary care expenditure target for the commonwealth. The commission shall prominently publish the applicable aggregate primary care expenditure target and the methodology used to calculate it on its website.

(b)(1) The aggregate primary care expenditure target for calendar year 2030 shall be the dollar amount produced by multiplying 9 per cent by total health care expenditures in the commonwealth for calendar year 2030.

(2) The aggregate primary care expenditure target for calendar year 2033 shall be the dollar amount produced by multiplying 12 per cent by total health care expenditures in the commonwealth for calendar year 2033.

(3) The aggregate primary care expenditure target for calendar year 2036 and each year thereafter shall be the dollar amount produced by multiplying 15 per cent by total health care expenditures in the commonwealth for the applicable calendar year.

(c) Beginning in calendar year 2028, the center shall monitor and annually report the commonwealth's progress toward the applicable target next due pursuant to subsection (b), including, for each calendar year, the actual aggregate primary care expenditures for such year and their percentage of total health care expenditures in the commonwealth. Nothing in this subsection shall require the commonwealth to attain a specified level of annual progress before the applicable target year.

(d) The commission, in collaboration with the center, the group insurance commission and the division of insurance, shall monitor the implementation of this section with the goal of ensuring that any increase in primary care spending does not result in an increase in the growth

of overall health care expenditure trends or any net new increase in health insurance premiums and cost-sharing.

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

SECTION 7. Section 10 of said chapter 6D of the General Laws, as so appearing, is hereby amended by striking out subsections (b) through (f), inclusive, and inserting in place thereof the following 6 subsections:-

(b) The commission shall provide notice to all health care entities that have been identified by the center under section 18 of chapter 12C as exceeding the health care cost growth benchmark for any given year. Such notice shall state that the center may analyze the cost growth and, where applicable, the primary care investment of each health care entity and the commission may require certain actions, as established in this section, from health care entities so identified.

(c) For calendar year 2015, if the commission finds, based on the center' annual report, the commission's annual cost trend hearings or any other pertinent information, that the average percentage change in cumulative total health care expenditures from 2013 to 2014 exceeded the average health care cost growth benchmark from 2013 to 2014, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in section 9, the commission shall establish procedures to assist health care entities to improve efficiency and reduce cost growth by requiring certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2016, if the commission finds, based on the center's annual report, the commission's annual cost trend hearings or any other pertinent information, that the

percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 9, the commission shall establish procedures to assist health care entities to improve efficiency and reduce cost growth by requiring certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2028, if the commission finds, based on the center's annual report, the commission's annual cost trend hearings or any other pertinent information, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 9, and future aggregate primary care expenditure targets, as established in section 9A, the commission shall establish procedures to assist health care entities to improve efficiency, increase primary care investment, and reduce cost growth by requiring certain health care entities to file and implement a primary care commitment, where applicable, or a performance improvement plan.

(d)(1) For each health care entity identified by the center under section 18 of chapter 12C, the commission may, after reviewing the analysis of the health care entity's primary care investment conducted by the center pursuant to section 18A of said chapter 12C, its growth in health status adjusted total medical expense, and any other information as the commission considers relevant, pursue the following actions: (i) conclude its review without further action; (ii) require, where applicable, the health care entity to file a primary care commitment under section 10A, or (iii) require the health care entity to file a performance improvement plan under subsection (e).

(2) The commission may require a health care entity to propose a primary care commitment under clause (ii) of paragraph (1) where the commission identifies significant concerns about the health care entity's growth in health status adjusted total medical expense and determines that: (i) the center's analysis under section 18A of chapter 12C or any other pertinent information indicate, where applicable, that inadequate primary care investment by the health care entity is plausibly contributing to the health care entity's growth in health status adjusted total medical expense; (ii) a primary care commitment could reasonably be expected to address such concerns; (iii) the entity has been identified under section 18 of chapter 12C in any prior year and, (iv) where the entity has previously entered into a primary care commitment under section 10A, the outcomes described in the center's analysis are materially inconsistent with the outcomes that the commitment was reasonably expected to produce; and (v) based on the entity's overall financial condition, that the entity has the capacity to increase its primary care investment.

(3) Nothing in this subsection shall be construed to require the commission to first require a primary care commitment before requiring a performance improvement plan.

(e) 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 as exceeding the health care cost growth benchmark established under section 9 to file a performance improvement plan with the commission. The commission shall provide written notice to such health care entity that they are required to file a performance improvement plan. Within 45 days of receipt of such written notice, the health care entity shall either:

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

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

(f) 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 pursuant to subsection (e). 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.

(g) 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 (e) in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce health status adjusted total medical expenses;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but shall not be limited to, age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) the overall financial condition of the health care entity;

(5) a significant difference between the growth rate of potential gross state product and the actual economic growth benchmark, as determined under section 7H1/2 of chapter 29;

(6) any primary care commitment filed or implemented under section 10A, and

(7) any other factors the commission considers relevant.

SECTION 8. Said section 10 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 146, the words “subsection (d)” and inserting in place thereof the following:- subsection (e).

SECTION 9. Said section 10 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 159 and 160, the words “or third-party administrators shall be excluded from this definition.”.

SECTION 10. Said chapter 6D 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 a clinic, hospital, ambulatory surgical center, physician organization, or accountable care organization that provides primary care services, or a payer; provided, however, that physician contracting units with a patient panel of 15,000 or fewer, or which represents providers who collectively receive less than $25,000,000 in annual net patient service revenue from carriers shall be exempt.

(b) If the commission requires a health care entity to propose a primary care commitment under clause (ii) of paragraph (1) of subsection (d) of section 10, the commission shall provide written notice to the health care entity that includes the analysis prepared by the center pursuant to section 18A of chapter 12C.

(c) Within 60 days of receipt of such notice, the health care entity shall file a proposed primary care commitment with the commission. The primary care commitment shall be generated by the health care entity and shall contain an explanation of the following: (i) the expected effect of the proposed increase in primary care investments on the quality of and access to primary care services for patients served by the health care entity, including, as applicable, reduced appointment wait times, as measured by the third next available appointment for new and established patients, toward a goal of routine primary care appointments being available within 7 calendar days; (ii) the amount by which the commitment is expected to increase the health care entity's primary care expenditures; and (iii) how the commitment is expected to address the factors contributing to the health care entity's growth in health status adjusted total medical expense, which may include expected reductions in utilization by the health care entity's patient population that could be avoided through more accessible or more effective primary care.

(d) A provider or provider organization may propose a primary care commitment that may include, but shall not be limited to: (i) increases in the payment rates the provider organization pays to primary care providers and primary care practices, including practices it owns or controls and primary care practices with which it contracts; (ii) care management and care coordination staffing; (iii) behavioral health integration; (iv) appointment access, including same-day and next-day capacity, extended hours and telehealth; (v) primary care scheduling, population health and clinical information infrastructure; and (vi) increases in the health care entity's primary care infrastructure support.

(e) A payer may propose a primary care commitment that may include, but shall not be limited to: (i) increases in contracted payment rates for primary care services; (ii) non-claims payments to primary care providers, including care management, population health and practice

infrastructure payments; (iii) adoption of, or increases in payment under, a qualifying advanced primary care payment model approved under section 31 of chapter 176O; (iv) reductions in the administrative burden borne by primary care providers with which it contracts, including reductions in prior authorization requirements applicable to primary care services; (v) benefit design that improves member access to primary care, including reductions in member cost-sharing for primary care services; and (vi) such other measures as support the delivery of primary care to the payer's members. A primary care commitment proposed by a payer shall: (A) describe the sources from which the proposed investments will be funded, which may include reallocation of existing expenditures, reductions in administrative expense, or projected reductions in avoidable utilization by the payer's members; and (B) demonstrate that the commitment will not result in a net new increase in premiums or member cost-sharing. The commission shall transmit a copy of any primary care commitment proposed by a payer to the commissioner of insurance.

(f) The commission shall accept a proposed primary care commitment that it determines is reasonably likely to: (i) improve the access of patients and members served by the health care entity to primary care; (ii) contribute to the attainment by the commonwealth of the aggregate primary care expenditure target established under section 9A; and (iii) address the factors contributing to the health care entity's growth in health status adjusted total medical expense. If the commission determines a proposed commitment to be unacceptable or incomplete, it may provide consultation on the criteria that have not been met and may allow an additional period of up to 30 calendar days for resubmission; provided, however, that all aspects of the primary care commitment shall be proposed by the health care entity and the commission shall not require specific elements for acceptance.

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

SECTION 11. Section 11 of said chapter 6D, as appearing in the 2024 Official Edition, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) The commission shall require that all provider organizations report the following information for registration and renewal: (i) organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations, parent entities, corporate affiliates, significant equity investors, health care real estate investment trusts, management services organizations and community advisory boards; (ii) the number of affiliated health care professional full-time equivalents and the number of professionals affiliated with or employed by the organization; (iii) with respect to provider organizations that provide primary care services: (A) each acquisition of or affiliation with a primary care practice during the reporting year; (B) the disaggregated number of full-time equivalent primary care physicians, nurses, nurse practitioners, physician assistants and care coordinators; (C) the organization's current primary care patient panel; (D) information regarding provider capacity, which shall include, but not be limited to, patient panel size and wait times measured as the third next available appointment for new and established patients; (E) for each primary care practice site operated by or affiliated with the provider organization, the site of service, whether the site is licensed as a hospital or as a hospital satellite or outpatient department, whether the organization billed for primary care services furnished at the site on a provider-based basis, and whether any such site was licensed or reclassified as a hospital satellite or outpatient department during the reporting year; and (F) information about movement of funds, including the distribution of claims and non-claims payments from payers to providers,

including primary care providers employed and affiliated with the provider organization and the allocation of expenses to support primary care providers; (iv) the name and address of licensed facilities; and (v) such other information as the commission considers appropriate.

SECTION 11A. Said chapter 6D is hereby further amended by inserting after section 22 the following section:-

Section 22A. (a) For the purposes of this section, "pharmacy desert" shall have the same meaning as defined in section 38A of chapter 112.

(b) The office of health resource planning, established under section 22, shall conduct a focused assessment not less than every 5 years on supply, distribution and capacity of pharmacy and pharmacological services pursuant to subsection (b) of said section 22. The office, when conducting its focused assessment, shall also identify the number of existing and potential pharmacy deserts in the commonwealth and conduct an analysis of their impact or potential impact on access to pharmacy and pharmacological services for residents of existing and potential pharmacy deserts.

(c) The focused assessment shall include: (i) an assessment on impacted neighborhoods and patient populations; (ii) an assessment on the impact of pharmacy deserts on access to medications and health care outcomes; (iii) an assessment of the geographical and financial barriers to obtaining medications faced by individuals living in pharmacy deserts; (iv) an assessment of the average distance and travel time to a pharmacy from an impacted neighborhood, and the transportation options available; (v) an assessment on the impact of pharmacy deserts on overall health care costs, including the costs of emergency department visits and hospitalizations; (vi) an assessment on the factors contributing to the closures of pharmacies

across the commonwealth, including population changes, local market dynamics and pharmacy density, changes in consumer purchasing behavior, reimbursement pressure, and supply-side constraints; and (vii) policy recommendations to address current pharmacy deserts and limit the creation of new ones.

(d) The office shall, upon completion of the focused assessment required under subsection (b), present to the board of the commission its findings, and shall file a report with the commission, the center, the department of public health, and the clerks of the senate and house of representatives, the house and senate committees on ways and means, the joint committee on health care financing.

SECTION 12. Section 1 of chapter 12C of the General Laws, as appearing in the 2024 Official Edition, is hereby amended by inserting after the definition of "acute hospital" the following 2 definitions:-

"Aggregate primary care expenditures", the annual per capita sum of all primary care expenditures in the commonwealth.

"Aggregate primary care expenditure target", the target amount of aggregate primary care expenditures for a calendar year, as established pursuant to section 9A of chapter 6D.

SECTION 13. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Hospital service corporation" the following definition:-

"Independent primary care practice", a medical practice providing primary care services that is majority owned by licensed primary care providers who furnish primary care services through the practice and that is not controlled by any other person or entity.

SECTION 14. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "pharmacy benefit manager" the following 6 definitions:-

"Primary care", the provision of coordinated, comprehensive medical services, on both a first-contact and a continuous basis, by a primary care provider.

"Primary care expenditures", payments for primary care services and other payments that directly support the delivery of primary care services, which shall be limited to the following:

(i) payments for services delivered by a primary care provider in an outpatient setting, by telehealth, or in a patient's home, nursing facility or other residential care setting;

(ii) payments for preventive medicine services delivered by a primary care provider, including examinations, screenings, assessments and counseling;

(iii) payments for the administration of injections, infusions and vaccines by a primary care provider;

(iv) payments for care coordination, care management, transitional care management and chronic disease management delivered by or under the direction of a primary care provider;

(v) payments for behavioral health services delivered in a primary care setting by a primary care provider or by a behavioral health clinician integrated into a primary care practice;

(vi) payments for preventive obstetric and gynecologic evaluation and management services, including annual preventive visits, screening services, and such other obstetric and gynecologic services as the center determines function as primary care services; and

(vii) non-claims payments that support the delivery of primary care, including population health payments, practice infrastructure payments, care management payments, performance and quality payments, shared savings payments net of recoupments, capitation, sub-capitation and full-risk payments, and other non-claims payments designated by the center.

"Primary care infrastructure support", capital, operating or in-kind support furnished by a provider or provider organization to build or sustain its capacity to deliver primary care services, including clinical and information technology, data infrastructure, practice management support, workforce recruitment, training and development, and cross-subsidization of primary care operating losses by the provider or provider organization's other operations; provided, however, that "primary care infrastructure support" shall not include any amount included in primary care expenditures.

"Primary care investment", the total commitment of financial resources by a provider or provider organization to support the delivery of primary care services, consisting of the provider or provider organization's total primary care expenditures and primary care infrastructure support.

"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.

"Primary care services", health care services furnished by a primary care provider to promote health, prevent disease, diagnose and treat illness and injury and provide ongoing, comprehensive and coordinated care.

SECTION 15. Said chapter 12C is hereby further amended by inserting after section 15 the following section:-

Section 15A. (a) The center shall promulgate regulations establishing the billing codes, provider types and payment categories used to identify expenditures within each category of primary care expenditures set forth in clauses (i) to (vii), inclusive, in the definition of "primary care expenditures" in section 1; provided, however, that the center's regulations shall not exclude a category of expenditure described in said definition, or establish a category of expenditure not described in said definition.

(b) The regulations shall: (i) establish methodologies for measuring and tracking pediatric primary care expenditures separately from adult primary care expenditures; (ii) establish methodologies for measuring primary care expenditures by municipality and by rural cluster, as designated by the department of public health; (iii) measure both primary care expenditures and total health care expenditures net of prescription drug rebates; and (iv) be informed by, and to the extent appropriate aligned with, methodologies used in other states, to facilitate cross-state comparison.

(c) The center shall develop a methodology for identifying, measuring and reporting non-claims payments that directly support the delivery of primary care and primary care infrastructure support. For any capitated, sub-capitated or full-risk payment, the center shall develop a methodology for determining the portion that is attributable to primary care services

and for tracing the portion of any such payment that is allocated to and retained at the primary care practice level.

(d) The center shall minimize administrative burden by relying on existing data submissions by payers, providers and provider organizations to implement this section.

(e) The center shall publish on its website the complete list of billing codes, provider types and payment categories identified under subsection (a).

SECTION 16. Section 16 of said chapter 12C, as so appearing, is hereby amended by adding the following subsection:-

(d) The center shall publish in its annual report (i) the aggregate primary care expenditures together with the commonwealth's performance against the aggregate primary care expenditure target, and (ii) aggregate, de-identified information regarding primary care investment analyses conducted pursuant to section 18A.

SECTION 17. Section 18 of said chapter 12C, as so appearing, is hereby amended by adding the following paragraph:-

For a health care entity, as defined in subsection (a) of section 10A of chapter 6D, that is identified by the center and referred to the commission under this section, the center shall also provide the commission with an analysis of the health care entity's primary care investment conducted pursuant to section 18A.

SECTION 18. Said chapter 12C is hereby further amended by inserting after section 18 the following section:-

Section 18A. (a) The center shall conduct an analysis of the primary care investment of each health care entity, as defined in subsection (a) of section 10A of chapter 6D, for which the center is required to provide an analysis to the commission under section 18. The analysis shall evaluate (i) the primary care expenditures by or attributed to each entity, (ii) the entity's primary care expenditures expressed as a percentage of the entity's health status adjusted total medical expense, (iii) the entity's primary care infrastructure support, where applicable, (iv) the year-over-year change in primary care expenditures for the previous 3 years, and (v) the matters described in subsections (b) to (e), inclusive, as applicable to the entity.

(b) In the case of providers and provider organizations, the analysis in subsection (a) shall address the following:

(i) the entity's capacity to increase its primary care investment without material adverse effect on its financial condition and without materially contributing to growth in its health status adjusted total medical expense, based on an assessment of the entity's operating margin and financial trend, the size and health adjusted status of its attributed patient population and its share of the market in which it principally operates;

(ii) the extent to which the entity's attributed patient population experiences utilization that could be avoided through more accessible or more effective primary care, based on an assessment of the rate of emergency department visits by the entity's patients that are classified as non-emergent, or as emergent but treatable in a primary care setting, preventable hospitalizations and the rate of unplanned hospital readmissions of the entity's patients within 30 days of discharge, risk-standardized in the manner used by the center in its annual report on hospital-wide all-payer readmissions;

(iii) the primary care needs of the population the entity serves, based on an assessment of the clinical and social acuity of its attributed patient population, the share of that population residing in municipalities or rural clusters identified by the department of public health as having limited primary care access and the difference between primary care expenditures in the entity's principal market and the aggregate primary care expenditure target; and

(iv) the effect of the entity's conduct on the primary care market in which it operates, based on an assessment of the entity's acquisitions of or affiliations with primary care practices, conversion of independent primary care practices to employed practices, its reclassification of primary care practice sites as hospital satellites or outpatient departments, its use of provider-based billing for primary care services and the portion of the payments it receives for primary care services that is allocated to and retained at the primary care practice level.

(c) In the case of payers, the analysis in subsection (a) shall address the following:

(i) the extent to which the payer's payment and administrative practices support the delivery of primary care, as determined by an assessment of its primary care expenditures as a share of the total health care expenditures attributed to the payer;

(ii) the trend in contracted rates paid by the payer for primary care evaluation and management services;

(iii) the extent to which primary care providers and provider organizations with which the payer contracts have elected to participate in a qualifying advanced primary care payment model approved under section 31 of chapter 176O;

(iv) the extent to which the payer's prior authorization, utilization management and other administrative requirements applicable to primary care services and services commonly ordered or furnished by primary care providers support or impede timely access to primary care; and

(v) such other payment or administrative practices affecting primary care as the center considers appropriate.

(d) In conducting the analysis in subsection (a), the center shall take into account, as applicable, the following factors: (i) the extent to which workforce shortages constrain investment capacity for reasons outside the entity's control; (ii) the entity's organizational mission and scope of services, including the proportion of its services that are specialty or tertiary in nature; (iii) the extent to which the entity serves a disproportionate share of patients covered by public health care payers including the volume of services it provides that are reimbursed by the health safety net trust fund established in section 66 of chapter 118E; (iv) whether a limited capacity to increase primary care investment is attributable to the entity's payer mix, financial condition or the acuity of the population it serves; and (v) recent capital or operating investments in primary care infrastructure, including care management staffing, behavioral health integration and appointment scheduling systems, and other primary care infrastructure support that may not be reflected in claims-based expenditure data.

(e) The center shall conduct the analysis using data collected pursuant to this chapter and chapter 6D and shall not impose new data collection requirements for the purpose of this section.

(f) The analysis shall not be a public record as defined by clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66 and shall be provided only to the commission and to the entity to which it pertains.

(g) The center shall promulgate regulations necessary to implement this section.

SECTION 19. Chapter 23G of the General Laws is hereby amended by adding the following section:-

Section 50. (a) For the purposes of this section, “high public payer community hospital” shall have the same meaning as in section 25C¾ of chapter 111.

(b) There shall be established and set up on the books of the commonwealth a fund to be known as the Community Hospital Capital Access Fund, to be administered by the agency without further appropriation.

(c) The fund shall be credited with: (i) contributions received pursuant to subsection (p) of section 25C of chapter 111; (ii) appropriations, bond premiums or other monies authorized by the general court and specifically designated for credit to the fund; (iii) gifts, grants and donations from public or private sources; (iv) investment income earned on amounts in the fund; and (v) fees, premiums, loan repayments or other amounts received by the agency in connection with the use of the fund under subsection (d). Amounts remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall remain available for expenditure in subsequent fiscal years.

(d) The agency may use amounts in the fund to: (i) establish and maintain debt service reserve funds or other reserve accounts in support of bonds or notes issued by or on behalf of a high public payer community hospital; provided that the agency’s obligation with respect to any such reserve fund or account shall be limited to the amount deposited in the fund or account; (ii) provide grants and loans for construction, renovation or other capital expenditures for patient

care activities at a high public payer community hospital; and (iii) pay the reasonable and necessary costs of administering the fund.

(e) Not later than October 1 of each year, the agency shall report to the clerks of the house of representatives and the senate, the house and senate committees on ways and means, and the joint committee on health care financing on the following: (i) the contributions received from amounts required pursuant to subsection (p) of section 25C of chapter 111 during the preceding fiscal year; (ii) the amount, recipient and purpose of each expenditure or commitment from the fund; and (iii) an assessment of the fund's effect on the availability and cost of capital for high public payer community hospitals.

SECTION 20. Chapter 29 of the General Laws is hereby amended by striking out section 2FFFF and inserting in place thereof the following section:-

Section 2FFFF. (a) There shall be established upon the books of the commonwealth a separate fund to be known as the Health Care Workforce Transformation Fund, hereinafter called the fund. The purpose of the fund shall be to: (i) expand education, training and career pathways; (ii) recruit and retain the health care workforce; (iii) improve equitable access to high-quality health care services; (iv) promote culturally competent and community-based care; and (v) support the commonwealth's attainment of the aggregate primary care expenditure target established under section 9A of chapter 6D.

(b) The fund shall be administered by the secretary of health and human services, in consultation with the secretary of labor and workforce development, the commissioner of higher education, and the Health Care Workforce Advisory Council established under section 25M of

chapter 111. The secretary of health and human services shall establish criteria for the allocation of the fund, which shall be posted on the executive office of health and human services' website.

(c) There shall be credited to the fund: (i) such amounts as may be transferred from the commonwealth federal matching and debt reduction fund under section 2EEEEEE, inserted by section 2 of chapter 214 of the acts of 2024; (ii) repayments received from participants in the workforce loan repayment program under section 25N of chapter 111; (iii) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund; and (iv) any gifts, grants, private contributions, investment income earned on the fund's assets and all other sources. Money remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(d)(1) In each fiscal year through fiscal year 2036, not less than 80 per cent of available funds shall be expended or obligated for the recruitment, training, retention or geographic distribution of primary care providers. Expenditures under this subsection shall include, but shall not be limited to:

(i) the health care workforce loan repayment program established under section 25N of chapter 111, to the extent that repayment assistance is awarded to primary care providers;

(ii) the primary care residency grant program established under section 25N ½ of chapter 111; and

(iii) the primary care workforce development and loan forgiveness grant program established under section 25N¾ of chapter 111.

(e) Monies in the fund may also be expended for the following purposes:

(i) addressing documented workforce shortages and improving retention in the health care industry;

(ii) expanding clinical education and training capacity, including clinical placements, preceptorships, clerkships and rural rotations, and supporting faculty development and instructional resources;

(iii) expanding educational pathways, including accelerated and advanced degree programs, apprenticeships and training and career advancement for currently employed or unemployed health care workers;

(iv) providing scholarships, tuition assistance, stipends, loan repayment and other educational assistance;

(v) reducing health disparities and expanding the delivery of culturally and linguistically responsive care;

(vi) supporting emerging care delivery models, regional partnerships, educational innovation and workforce planning.

(f) The secretary may award competitive grants from the fund to carry out the purposes of this section. Eligible applicants shall include, but shall not be limited to: public and private institutions of higher education, vocational technical schools and school districts; hospitals, community health centers, behavioral health providers, primary care practices and other health care providers; workforce development boards, one-stop career centers and municipalities; nonprofit and community-based organizations; employers, employer associations, labor

organizations and joint labor-management partnerships; and any partnership among such applicants.

(g) The secretary shall annually report to the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on public health, the joint committee on health care financing and the joint committee on labor and workforce development on the administration of the fund. The report shall include: (i) the revenue credited to the fund and the amount of expenditures attributable to administrative costs; (ii) an assessment of statewide and regional workforce needs and educational capacity, and progress toward statewide priorities; (iii) the impact of the fund on health care workforce shortages and on access to primary care; and (iv) any recommendations for future investments or for legislative or administrative changes necessary to carry out the purposes of this section. The report shall be posted on the executive office of health and human services' website.

SECTION 21. Section 2EEEEEE of said chapter 29, as appearing in the 2024 Official Edition, is hereby amended by striking out, in line 73, the words "and (iii)" and inserting in place thereof the following words:- (iii) protecting the commonwealth from the elimination, reduction or material delay of federal funds upon a determination by the secretary that the elimination, reduction or material delay of such federal funds would materially impact public health, safety or welfare or the fiscal stability of the commonwealth or any of its political subdivisions, in accordance with guidance issued by the executive office for administration and finance; (iv) improving the financial stability of hospitals and community health centers in the commonwealth that provide health care to low-income, uninsured or underinsured residents, including by transferring any amounts in the fund to the Health Safety Net Trust Fund established in section 66 of chapter 118E, in accordance with guidance issued by the executive office for

administration and finance in consultation with the executive office of health and human services; (v) funding pay-as-you-go capital for any capital project or program up to the amount otherwise authorized by the general court for such project or program in chapter 238 of the acts of 2024, in accordance with guidance issued by the executive office for administration and finance; (vi) strengthening the primary care and health care workforce of the commonwealth, including by transferring any amounts in the fund to the Health Care Workforce Transformation Fund established in section 2FFFF; and (vii).

SECTION 22. Chapter 32A of the General Laws is hereby amended by inserting after section 17AA, inserted by section 39 of chapter 137 of the acts of 2026, the following 3 sections:-

Section 17BB. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Federally qualified health center", a community health center as defined in 101 C.M.R. 304 for which the division of medical assistance has established a prospective payment system rate.

"Federally qualified health center services", services provided by a federally qualified health center for which reimbursement is determined under the medical and behavioral health prospective payment system methodology applicable to federally qualified health centers pursuant to 101 C.M.R. 304.

(b) The commission shall ensure that the total reimbursement payable with respect to an encounter for federally qualified health center services covered by the commission and provided to a patient by a federally qualified health center is not less than the applicable rate that the

federally qualified health center would have received from MassHealth for the same encounter as of January 1 of the applicable calendar year, determined in accordance with the prospective payment system methodology established under 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as implemented by MassHealth and in effect on January 1, 2025.

(c) The commission shall consult with the division of medical assistance for technical assistance regarding the prospective payment system rate and methodology for each federally qualified health center for the applicable year.

Section 17CC. (a) For the purposes of this section, the terms "health care facility" and "health care provider" shall have the same meanings as defined in section 1 of chapter 111O.

(b) The commission shall not deny, limit or condition coverage for an otherwise covered health care service solely because the service is delivered by a health care provider participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Health care services delivered through an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, and the rates of payment for an otherwise covered service shall not be reduced solely because the service was delivered through an approved mobile integrated health care program.

(c) Coverage provided pursuant to this section may be subject to a deductible, copayment or coinsurance applicable to a health care service delivered through an approved mobile integrated health care program; provided, however, that the deductible, copayment or coinsurance shall not exceed the deductible, copayment or coinsurance applicable to the same service when provided in a health care facility.

Section 17DD. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Biomarker", a molecular, genetic or biochemical characteristic, including gene mutations, characteristics of genes or protein expression, that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.

"Biomarker testing", the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing performed at a laboratory facility that is either CLIA-certified or CLIA-waived by the federal Food and Drug Administration; provided, however, that biomarker testing shall not include testing for the purpose of screening in asymptomatic individuals

"CLIA certified", holding a certificate issued by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform testing on human specimens.

"CLIA waived", holding a certificate of waiver issued under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform only those tests categorized as waived by the federal Food and Drug Administration under 42 C.F.R. section 493.15.

"Clinical utility", the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. Clinical utility shall be established by any of the following:

(i) the labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) a test indicated in the FDA-approved labeling of a drug, including as a companion diagnostic;

(iii) warnings and precautions in the FDA-approved labeling of a drug;

(iv) a national coverage determination of the federal Centers for Medicare and Medicaid Services, or a local coverage determination issued by the Medicare Administrative Contractor; or

(v) a nationally recognized clinical practice guideline.

"Nationally recognized clinical practice guidelines", evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy, including, but not limited to those of the National Comprehensive Cancer Network or the American Society of Clinical Oncology.

(b) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for biomarker testing, pursuant to criteria established under subsection (c); provided, that coverage shall be applied in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) Biomarker testing shall be covered when the test: (i) is conducted at either a CLIA-certified or CLIA-waived laboratory and (ii) provides clinical utility to the enrollee, as demonstrated by medical and scientific evidence establishing that the result will be used to select, initiate, exclude, or discontinue a specific therapy, or to determine appropriate dosing of a specific therapy.

(d) In the case of coverage that requires prior authorization, a carrier or a utilization review organization subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider and any entity requesting authorization of the service within 5 business days. If additional delay would result in significant risk to the insured's health or well-being, a carrier or a utilization review organization shall approve or deny the request within 48 hours. If a response by a carrier or utilization review organization is not received within the time required under this subsection, said request or appeal shall be deemed granted.

(e) The patient and prescribing practitioner shall have access to a clear, readily accessible and convenient processes to request an exception to a coverage policy or an adverse utilization review determination. The process shall be made readily accessible on the carrier's website.

SECTION 23. Said chapter 32A is hereby further amended by adding the following 2 sections:-

Section 35. The commission shall offer, to each primary care provider with which it contracts, a qualifying advanced primary care payment model meeting the requirements established by the commissioner of insurance under section 31 of chapter 176O. Participation shall be at the election of the primary care provider or provider organization. The commission

shall annually report to the commissioner of insurance the information described in subsection (i) of said section 31 of said chapter 176O.

Section 36. The commission shall make available to an insured the estimated rebates and shall comply with the requirements applicable to a carrier under section 32 of chapter 176O. Any pharmacy benefit manager, affiliated entity or third-party administrator acting on behalf of the commission shall be subject to said section 32 of said chapter 176O to the same extent as if acting on behalf of a carrier. Annually, not later than April 1, the commission shall file with the commissioner of insurance the report described in subsection (d) of said section 32 of said chapter 176O.

SECTION 23A. Section 24N of chapter 111 of the General Laws, as most recently amended by section 28 of chapter 73 of the acts of 2025, is hereby further amended by striking out subsections (c) and (d) and inserting in place thereof the following subsections:-

(c) There shall be a vaccine program advisory council consisting of the commissioner of public health or a designee, who shall serve as chair; the medical director of the universal immunization program of the department of public health established under section 24I; the executive director for the center for health information and analysis or a designee; the executive director of the commonwealth health insurance connector authority or a designee; 1 person to be appointed by the director of Medicaid, who shall be a representative of managed care organizations contracting with MassHealth; 3 persons to be appointed by the commissioner of insurance, each of whom shall be a representative of 1 of the 3 health insurance companies having the most insured lives in the commonwealth; and 7 persons to be appointed by the commissioner of public health, 1 of whom shall be a representative of an employer that self-

insures for health coverage who shall be appointed from lists of nominees submitted by statewide associations of employers, 1 of whom shall be a member of the Massachusetts Medical Society, 1 of whom shall be a member of the Massachusetts chapter of the American Academy of Pediatrics, 1 of whom shall be a member of the Massachusetts Academy of Family Physicians, and 3 of whom shall be physicians licensed to practice in the commonwealth and who shall have expertise in the area of childhood vaccines. The council shall recommend the amount of funding needed each fiscal year by calculating the total non-federal program cost.

(d) Under regulations adopted by the commissioner of public health, each surcharge payor in the commonwealth shall pay to the commissioner of public health, for deposit in the Vaccine Purchase Trust Fund, a routine childhood immunizations surcharge assessed by the commissioner. By January 1 of each year, the commissioner of public health shall determine the total amount of the surcharge for the current fiscal year by determining the final amount required to be included in the Vaccine Purchase Trust Fund for the current fiscal year to cover the estimated costs to purchase, store and distribute immunizations for routine childhood immunizations and to administer the fund and the immunization registry, established pursuant to section 24M. The amount shall take into consideration the limitations on expenditures described in subsection (b) any anticipated surplus or deficit in the trust fund, and shall exclude any costs anticipated to be covered by federal contribution. Any increase in the surcharge amount for the prior fiscal year shall not be more than the percentage set as the health care cost growth benchmark, established under section 9 of chapter 6D, unless the commissioner of public health submits a detailed report to the clerks of the house of representatives and senate who shall forward the report to the house and senate committees on ways and means, the house and senate

chairs of the joint committee on public health and the house and senate chairs of the joint committee on health care financing explaining the need for the increase.

SECTION 24. Section 25C of chapter 111 of the General Laws, as amended by section 180 of chapter 102 of the acts of 2026, is hereby further amended by adding the following subsection:-

(p) Notwithstanding any general or special law or regulation to the contrary, the department shall require, as a condition of approval of an application for a determination of need for a substantial capital expenditure, that the applicant pay an amount equal to not less than 2 per cent of the capital expenditure amount of a proposed project, which shall be transmitted by the department to the Community Hospital Capital Access Fund established in section 50 of chapter 23G; provided, however, that this subsection shall not apply to a determination of need application filed by, or for the direct benefit of, a high public payer community hospital, as defined in section 25C¾; and provided further, that the aggregate amount of all required contributions imposed with respect to the proposed project, including the contribution required under this subsection, shall not exceed 5 per cent of the capital expenditure amount of the proposed project.

SECTION 25. Said chapter 111 is hereby further amended by inserting after section 25C½ the following section:-

Section 25C¾. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“High public payer community hospital”, (i) an acute care hospital established under chapter 147 of the acts of 1995 and its corporate affiliates; (ii) a non-state, government public

hospital system established pursuant to chapter 147 of the acts of 1996; or (iii) an acute care hospital classified as a community-high public payer hospital by the center for health information and analysis in its most recently published Massachusetts Acute Hospital Profiles, or successor publication.

"Priority review designation", a designation issued by the department entitling an applicant to the review procedures set forth in this section.

"Qualifying priority project", a proposed project by a high public payer community hospital or another provider that is a joint venture partner, corporate affiliate or clinical affiliate with a high public payer community hospital that addresses a documented state or regional unmet health care need, including but not limited to: (i) increased capacity for primary care, behavioral health or maternal health services; (ii) services provided in a health professional shortage area or medically underserved area; (iii) innovative models of care delivery that support the goals of the state health resource plan established under section 22 of chapter 6D; or (iv) any other category so designated by the department, consistent with the state health resource plan.

(b) An applicant for a qualifying priority project may request priority review designation not less than 30 days before filing notice of intent for a determination of need application. The department shall grant or deny a request for priority review designation within 30 days of its submission.

(c) Within 15 days after a grant of priority review designation, the department shall convene a scoping conference with the applicant to identify which, if any, application requirements, supporting documentation or review factors applicable to the determination of

need application may be permitted to be verified following approval, consistent with subsection (f).

(d) An applicant with priority review designation may submit application materials, supporting documentation and other information required for a determination of need application on a rolling basis, as each is completed, rather than as a single, complete application, and the department may commence its review of each submission upon receipt.

(e) The department shall issue a decision on an application with priority review designation within 60 days after the initial filing of the determination of need application, notwithstanding that additional application materials may be submitted pursuant to subsection (d). To the extent feasible, the department shall conduct any independent cost analysis, and the health policy commission shall conduct any cost and market impact review under section 13 of chapter 6D, concurrently with its review under this section.

(f) If the department determines that an application requirement, supporting documentation or review factor of a qualifying proposed project can be verified following approval, the department may issue a conditional determination of need, conditioned on the applicant's compliance with post-approval reporting requirements established by the department. The department may revoke a conditional determination of need, or require a corrective action plan, upon an applicant's failure to comply with post-approval reporting requirements.

(g) The department may, by regulation, set a reduced filing fee otherwise applicable to an application with priority review designation filed by, or on behalf of, a high public payer community hospital or its joint venture partner, corporate affiliate, or clinical affiliate experiencing material financial hardship.

SECTION 25A. Said chapter 111 is hereby further amended adding the following section:-

Section 251. (a) The department shall implement a provider immunization brand choice requirement as part of the commonwealth's universal immunization program pursuant to sections 24I and 24N and in any other existing or future immunization program for children or adults administered through the state using local, state or federal funds.

(b)(1) Pursuant to the provider immunization brand choice requirement, for all categories of immunizations included in the programs described in subsection (a), all healthcare providers participating in these programs shall be able to select any brand or type of any immunization, including any combination immunization and dosage form, as long as the immunization is licensed or authorized for emergency use by the federal Food and Drug Administration, recommended by the national Centers for Disease Control and Prevention Advisory Committee on Immunization Practices or is recommended by national professional medical societies.

(2) The universal immunization program shall reflect adequate patient and provider immunization brand choice to preserve clinical judgement for healthcare providers, enhance vaccine confidence, stabilize the vaccine supply and encourage access to future vaccines. The department may exclude certain brand vaccines based on concerns for the health and safety of patients or excessive purchase cost in comparison to comparable agents. This section shall not apply in the event of a shortage or delay in vaccine availability, disaster or public health emergency, terrorist attack, hostile military or paramilitary action or extraordinary law enforcement emergency.

SECTION 26. Section 2 of chapter 111O of the General Laws, as appearing in the 2024 Official Edition, is hereby amended by adding the following 3 subsections:-

(c) The department may establish by regulation application and registration fees for mobile integrated health care programs approved pursuant to this chapter; provided, however, that the department may waive or reduce application and registration fees for a mobile integrated health care program that primarily provides behavioral health services.

(d) An approved mobile integrated health care program shall, to the extent practicable, notify and coordinate ongoing care with a patient's primary care provider regarding services rendered not later than 72 hours after the encounter to support continuity of care.

(e) An approved mobile integrated health care program may accept a referral from a patient's primary care provider for chronic disease management, post-discharge follow-up or preventive care services.

SECTION 26A. Chapter 112 of the General Laws is hereby amended by inserting after section 38 the following section:-

Section 38A. (a) For the purposes of this section, a "pharmacy desert" shall mean an area where there is no or limited access to pharmacies due to factors including, but not limited to: (i) geographic location, specifically areas where the nearest pharmacy is more than 2 miles away in urban areas, more than 5 miles away in suburban areas, and more than 15 miles away in rural areas; (ii) distance and travel time, defined as travel time exceeding 15 minutes by car or 30 minutes by public transportation; (iii) limited access to transportation, both public and private, including areas with infrequent public transit services or where at least 20 per cent of the population lacks access to private vehicles.

(b) Any entity that intends to close a pharmacy or pharmacy department registered by the board for the transaction of a drug business, as defined in section 37, shall notify the board in writing not less than 60 days before the proposed closure date. The entity shall send a copy of the notice to the members of the general court who represent the municipality in which the pharmacy or pharmacy department is located, and the clerk of the municipality in which the pharmacy or pharmacy department is located, who shall distribute the notice to the appropriate local officials. Within 15 days of receipt of the notice of the intended closing, the board shall conduct a review to determine whether the intended closing is likely to result in the creation of a pharmacy desert based on the most recent focused assessment performed by the office of health resource planning pursuant to section 22A of chapter 6D. If the board finds that the intended closing is likely to result in the creation of a pharmacy desert, the board shall conduct a public hearing not less than 30 calendar days prior to the proposed closure date set out in the entity's notice. At the public hearing, the board shall present information on alternative sources of pharmacy services available to impacted consumers and allow interested parties the opportunity to share comments and concerns about the proposed closure. Such interested parties may include, but not be limited to, impacted residents, municipal government officials, the members of the general court who represent the municipality in which the pharmacy or pharmacy department is located, local health care providers, and neighborhood associations or other community associations.

SECTION 27. Chapter 118E of the General Laws is hereby amended by inserting after section 10AA, inserted by section 72 of chapter 137 of the acts of 2026, the following 2 sections:-

Section 10BB. (a) For the purposes of this section, the terms "health care facility" and "health care provider" shall have the same meanings as defined in section 1 of chapter 111O.

(b) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall not deny, limit or condition coverage for an otherwise covered health care service solely because the service is delivered by a health care provider participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Health care services delivered through an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, and the rates of payment for an otherwise covered service shall not be reduced solely because the service was delivered through an approved mobile integrated health care program.

(c) Coverage provided pursuant to this section may be subject to a deductible, copayment or coinsurance applicable to a health care service delivered through an approved mobile integrated health care program; provided, however, that the deductible, copayment or coinsurance shall not exceed the deductible, copayment or coinsurance applicable to the same service when provided in a health care facility.

Section 10CC. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Biomarker", a molecular, genetic or biochemical characteristic, including gene mutations, characteristics of genes or protein expression, that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.

"Biomarker testing", the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing performed at a laboratory facility that is either CLIA-certified or CLIA-waived by the federal Food and Drug Administration; provided, however, that biomarker testing shall not include testing for the purpose of screening in asymptomatic individuals

"CLIA certified", holding a certificate issued by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform testing on human specimens.

"CLIA waived", holding a certificate of waiver issued under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform only those tests categorized as waived by the federal Food and Drug Administration under 42 C.F.R. section 493.15.

"Clinical utility", the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. Clinical utility shall be established by any of the following:

(i) the labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) a test indicated in the FDA-approved labeling of a drug, including as a companion diagnostic;

(iii) warnings and precautions in the FDA-approved labeling of a drug;

(iv) a national coverage determination of the federal Centers for Medicare and Medicaid Services, or a local coverage determination issued by the Medicare Administrative Contractor; or

(v) a nationally recognized clinical practice guideline.

"Nationally recognized clinical practice guidelines", evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy, including, but not limited to those of the National Comprehensive Cancer Network or the American Society of Clinical Oncology.

(b) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for biomarker testing, pursuant to criteria established under subsection (c); provided, that coverage shall be applied in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) Biomarker testing shall be covered when the test: (i) is conducted at either a CLIA-certified or CLIA-waived laboratory; and (ii) provides clinical utility to the enrollee, as demonstrated by medical and scientific evidence establishing that the result will be used to select, initiate, exclude or discontinue a specific therapy, or to determine appropriate dosing of a specific therapy.

(d) In the case of coverage that requires prior authorization, a carrier or a utilization review organization subject to this section shall approve or deny a prior authorization request and

notify the enrollee, the enrollee's health care provider and any entity requesting authorization of the service within 5 business days. If additional delay would result in significant risk to the insured's health or well-being, a carrier or a utilization review organization shall approve or deny the request within 48 hours. If a response by the division or utilization review organization is not received within the time required under this subsection, said request or appeal shall be deemed granted.

(e) The patient and prescribing practitioner shall have access to a clear, readily accessible and convenient processes to request an exception to a coverage policy or an adverse utilization review determination. The process shall be made readily accessible on the carrier's website.

SECTION 28. Said chapter 118E is hereby further amended by inserting after section 13D½ the following section:-

Section 13D¾. (a) For the purposes of this section, the term "community health center" shall mean any entity reimbursed as a community health center under this chapter.

(b) Notwithstanding any general or special law to the contrary, and to the maximum extent permitted under federal law and in a manner that preserves the maximum available federal financial participation, reimbursement for community health centers under this chapter, shall be determined using the prospective payment system methodology that conforms with 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as in effect on January 1, 2025.

SECTION 29. Chapter 175 of the General Laws is hereby amended by inserting after section 47DDD, inserted by section 77 of chapter 137 of the acts of 2026, the following 3 sections:-

Section 47EEE. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Federally qualified health center", a community health center as defined in 101 C.M.R. 304 for which the division of medical assistance has established a prospective payment system rate.

"Federally qualified health center services", services provided by a federally qualified health center for which reimbursement is determined under the medical and behavioral health prospective payment system methodology applicable to federally qualified health centers pursuant to 101 C.M.R. 304.

(b) Any carrier offering a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall ensure that the total reimbursement payable with respect to an encounter for federally qualified health center services covered by the carrier and provided to a patient by a federally qualified health center is not less than the applicable rate that the federally qualified health center would have received from MassHealth for the same encounter as of January 1 of the applicable calendar year, determined in accordance with the prospective payment system methodology established under 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as implemented by MassHealth and in effect on January 1, 2025.

(c) The division of insurance shall consult with the division of medical assistance for technical assistance regarding the prospective payment system rate and methodology for each federally qualified health center for the applicable year.

Section 47FFF. (a) For the purposes of this section, the terms “health care facility” and “health care provider” shall have the same meanings as defined in section 1 of chapter 111O.

(b) Any carrier offering a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall not deny, limit or condition coverage for an otherwise covered health care service solely because the service is delivered by a health care provider participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Health care services delivered through an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, and the rates of payment for an otherwise covered service shall not be reduced solely because the service was delivered through an approved mobile integrated health care program.

(c) Coverage provided pursuant to this section may be subject to a deductible, copayment or coinsurance applicable to a health care service delivered through an approved mobile integrated health care program; provided, however, that the deductible, copayment or coinsurance shall not exceed the deductible, copayment or coinsurance applicable to the same service when provided in a health care facility.

Section 47GGG. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Biomarker”, a molecular, genetic or biochemical characteristic, including gene mutations, characteristics of genes or protein expression, that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic

responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.

"Biomarker testing", the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing performed at a laboratory facility that is either CLIA-certified or CLIA-waived by the federal food and drug administration; provided, however, that biomarker testing does not include testing for the purpose of screening in asymptomatic individuals

"CLIA certified", holding a certificate issued by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988, 42 U.S.C. section 263 authorizing a laboratory to perform testing on human specimens.

"CLIA waived", holding a certificate of waiver issued under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform only those tests categorized as waived by the federal Food and Drug Administration under 42 C.F.R. section 493.15.

"Clinical utility", the test result that provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. Clinical utility shall be established by any of the following:

(i) the labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) a test indicated in the FDA-approved labeling of a drug, including as a companion diagnostic;

(iii) warnings and precautions in the FDA-approved labeling of a drug;

(iv) a national coverage determination of the federal Centers for Medicare and Medicaid Services, or a local coverage determination issued by the Medicare Administrative Contractor; or

(v) a nationally recognized clinical practice guideline.

"Nationally recognized clinical practice guidelines", evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy, including, but not limited to those of the National Comprehensive Cancer Network or the American Society of Clinical Oncology.

(b) Any carrier offering a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for biomarker testing, pursuant to criteria established under subsection (c); provided, that coverage shall be applied in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) Biomarker testing shall be covered when the test: (i) is conducted at either a CLIA-certified or CLIA-waived laboratory and (ii) provides clinical utility to the enrollee, as demonstrated by medical and scientific evidence establishing that the result will be used to

select, initiate, exclude or discontinue a specific therapy, or to determine appropriate dosing of a specific therapy.

(d) In the case of coverage that requires prior authorization, a carrier or a utilization review organization subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider and any entity requesting authorization of the service within 5 business days. If additional delay would result in significant risk to the insured's health or well-being, a carrier or a utilization review organization shall approve or deny the request within 48 hours. If a response by a carrier or utilization review organization is not received within the time required under this subsection, said request or appeal shall be deemed granted.

(e) The patient and prescribing practitioner shall have access to a clear, readily accessible and convenient processes to request an exception to a coverage policy or an adverse utilization review determination. The process shall be made readily accessible on the carrier's website.

SECTION 29A. Section 11 of chapter 175M of the General Laws, as appearing in the 2024 Official Edition, is hereby amended by adding the following subsection:-

(f) An employer with not more than 25 employees shall be permitted to submit a private plan subject to the requirements of paragraph (1) of subsection (a) to the department directly; provided, that such employer shall be exempt from the requirements set forth in clause (i) and (iii) of paragraph (2) of subsection (a).

SECTION 30. Chapter 176A of the General Laws hereby amended by inserting after section 8EEE, inserted by section 81 of said chapter 137, the following 3 sections:-

Section 8FFF. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Federally qualified health center", a community health center as defined in 101 C.M.R. 304 for which the division of medical assistance has established a prospective payment system rate.

"Federally qualified health center services", services provided by a federally qualified health center for which reimbursement is determined under the medical and behavioral health prospective payment system methodology applicable to federally qualified health centers pursuant to 101 C.M.R. 304.

(b) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall ensure that the total reimbursement payable with respect to an encounter for federally qualified health center services covered by the contract and provided to a patient by a federally qualified health center is not less than the applicable rate that the federally qualified health center would have received from MassHealth for the same encounter as of January 1 of the applicable calendar year, determined in accordance with the prospective payment system methodology established under 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as implemented by MassHealth and in effect on January 1, 2025.

(c) The division of insurance shall consult with the division of medical assistance for technical assistance regarding the prospective payment system rate and methodology for each federally qualified health center for the applicable year.

Section 8GGG. (a) For the purposes of this section, the terms “health care facility” and “health care provider” shall have the same meanings as defined in section 1 of chapter 111O.

(b) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall not deny, limit or condition coverage for an otherwise covered health care service solely because the service is delivered by a health care provider participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Health care services delivered through an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, and the rates of payment for an otherwise covered service shall not be reduced solely because the service was delivered through an approved mobile integrated health care program.

(c) Coverage provided pursuant to this section may be subject to a deductible, copayment or coinsurance applicable to a health care service delivered through an approved mobile integrated health care program; provided, however, that the deductible, copayment or coinsurance shall not exceed the deductible, copayment or coinsurance applicable to the same service when provided in a health care facility.

Section 8HHH. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Biomarker”, a molecular, genetic or biochemical characteristic, including gene mutations, characteristics of genes or protein expression, that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic

responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.

"Biomarker testing", the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing performed at a laboratory facility that is either CLIA-certified or CLIA-waived by the federal food and drug administration; provided, however, that biomarker testing does not include testing for the purpose of screening in asymptomatic individuals

"CLIA certified", holding a certificate issued by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform testing on human specimens.

"CLIA waived", holding a certificate of waiver issued under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform only those tests categorized as waived by the federal Food and Drug Administration under 42 C.F.R. section 493.15.

"Clinical utility", the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. Clinical utility shall be established by any of the following:

(i) the labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) a test indicated in the FDA-approved labeling of a drug, including as a companion diagnostic;

(iii) warnings and precautions in the FDA-approved labeling of a drug;

(iv) a national coverage determination of the federal Centers for Medicare and Medicaid Services, or a local coverage determination issued by the Medicare Administrative Contractor; or

(v) a nationally recognized clinical practice guideline.

"Nationally recognized clinical practice guidelines", evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy, including, but not limited to those of the National Comprehensive Cancer Network or the American Society of Clinical Oncology.

(b) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for biomarker testing, pursuant to criteria established under subsection (c); provided, that coverage shall be applied in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) Biomarker testing shall be covered when the test: (i) is conducted at either a CLIA-certified or CLIA-waived laboratory and (ii) provides clinical utility to the enrollee, as demonstrated by medical and scientific evidence establishing that the result will be used to

select, initiate, exclude, or discontinue a specific therapy, or to determine appropriate dosing of a specific therapy.

(d) In the case of coverage which requires prior authorization, a carrier or a utilization review organization subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider and any entity requesting authorization of the service within 5 business days. If additional delay would result in significant risk to the insured's health or well-being, a carrier or a utilization review organization shall approve or deny the request within 48 hours. If a response by a carrier or utilization review organization is not received within the time required under this subsection, said request or appeal shall be deemed granted.

(e) The patient and prescribing practitioner shall have access to a clear, readily accessible, and convenient processes to request an exception to a coverage policy or an adverse utilization review determination. The process shall be made readily accessible on the carrier's website.

SECTION 31. Chapter 176B of the General Laws is hereby amended by inserting after section 4EEE, inserted by section 82 of said chapter 137, the following 3 sections:-

Section 4FFF. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Federally qualified health center", a community health center as defined in 101 C.M.R. 304 for which the division of medical assistance has established a prospective payment system rate.

"Federally qualified health center services", services provided by a federally qualified health center for which reimbursement is determined under the medical and behavioral health prospective payment system methodology applicable to federally qualified health centers pursuant to 101 C.M.R. 304.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall ensure that the total reimbursement payable with respect to an encounter for federally qualified health center services covered by the subscription and provided to a patient by a federally qualified health center is not less than the applicable rate that the federally qualified health center would have received from MassHealth for the same encounter as of January 1 of the applicable calendar year, determined in accordance with the prospective payment system methodology established under 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as implemented by MassHealth and in effect on January 1, 2025.

(c) The division of insurance shall consult with the division of medical assistance for technical assistance regarding the prospective payment system rate and methodology for each federally qualified health center for the applicable year.

Section 4GGG. (a) For the purposes of this section, the terms "health care facility" and "health care provider" shall have the same meanings as defined in section 1 of chapter 111O.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall not deny, limit or condition coverage for an otherwise covered health care service solely because the service is delivered by a health care provider participating in a mobile integrated health care program approved by the

department of public health pursuant to chapter 111O. Health care services delivered through an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, and the rates of payment for an otherwise covered service shall not be reduced solely because the service was delivered through an approved mobile integrated health care program.

(c) Coverage provided pursuant to this section may be subject to a deductible, copayment or coinsurance applicable to a health care service delivered through an approved mobile integrated health care program; provided, however, that the deductible, copayment or coinsurance shall not exceed the deductible, copayment or coinsurance applicable to the same service when provided in a health care facility.

Section 4HHH. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Biomarker", a molecular, genetic or biochemical characteristic, including gene mutations, characteristics of genes or protein expression, that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.

"Biomarker testing", the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome and whole transcriptome sequencing performed at a laboratory facility that is either CLIA-certified or CLIA-waived by the federal

food and drug administration; provided, however, that biomarker testing does not include testing for the purpose of screening in asymptomatic individuals

"CLIA certified", holding a certificate issued by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform testing on human specimens.

"CLIA waived", holding a certificate of waiver issued under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform only those tests categorized as waived by the federal Food and Drug Administration under 42 C.F.R. section 493.15.

"Clinical utility", the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. Clinical utility shall be established by any of the following:

(i) the labeled indications for a test approved or cleared by the federal Food and Drug Administration;

(ii) a test indicated in the FDA-approved labeling of a drug, including as a companion diagnostic;

(iii) warnings and precautions in the FDA-approved labeling of a drug;

(iv) a national coverage determination of the federal Centers for Medicare and Medicaid Services, or a local coverage determination issued by the Medicare Administrative Contractor; or

(v) a nationally recognized clinical practice guideline.

"Nationally recognized clinical practice guidelines", evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy, including, but not limited to those of the National Comprehensive Cancer Network or the American Society of Clinical Oncology.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for biomarker testing, pursuant to criteria established under subsection (c); provided, that coverage shall be applied in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) Biomarker testing shall be covered when the test: (i) is conducted at either a CLIA-certified or CLIA-waived laboratory and (ii) provides clinical utility to the enrollee, as demonstrated by medical and scientific evidence establishing that the result will be used to select, initiate, exclude, or discontinue a specific therapy, or to determine appropriate dosing of a specific therapy.

(d) In the case of coverage which requires prior authorization, a carrier or a utilization review organization subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider and any entity requesting authorization of the service within 5 business days. If additional delay would result in significant risk to the insured's health or well-being, a carrier or a utilization review organization shall approve or deny the request within 48 hours. If a response by a carrier or utilization review organization is not

received within the time required under this subsection, said request or appeal shall be deemed granted.

(e) The patient and prescribing practitioner shall have access to a clear, readily accessible, and convenient processes to request an exception to a coverage policy or an adverse utilization review determination. The process shall be made readily accessible on the carrier's website.

SECTION 32. Chapter 176E of the General Laws is hereby amended by inserting after section 15A the following section:-

Section 15B. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Federally qualified health center", a community health center as defined in 101 C.M.R. 304 for which the division of medical assistance has established a prospective payment system rate.

"Federally qualified health center services", services provided by a federally qualified health center for which reimbursement is determined under the dental prospective payment system methodology applicable to federally qualified health centers pursuant to 101 C.M.R. 304.

(b) A dental service corporation organized under this chapter shall ensure that the total reimbursement payable with respect to an encounter for federally qualified health center services covered by the dental service corporation and provided to a patient by a federally qualified health center is not less than the applicable rate that the federally qualified health center would have received from MassHealth for the same encounter as of January 1 of the applicable calendar

year, determined in accordance with the prospective payment system methodology established under 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as implemented by MassHealth and in effect on January 1, 2025.

(c) The division of insurance shall consult with the division of medical assistance for technical assistance regarding the prospective payment system rate and methodology for each federally qualified health center for the applicable year.

SECTION 33. Chapter 176G of the General Laws is hereby amended by inserting after section 4WW, inserted by section 83 of chapter 137 of the acts of 2026, the 3 following sections:-

Section 4XX. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Federally qualified health center", a community health center as defined in 101 C.M.R. 304 for which the division of medical assistance has established a prospective payment system rate.

"Federally qualified health center services", services provided by a federally qualified health center for which reimbursement is determined under the medical and behavioral health prospective payment system methodology applicable to federally qualified health centers pursuant to 101 C.M.R. 304.

(b) A health maintenance organization organized pursuant to this chapter shall ensure that the total reimbursement payable with respect to an encounter for federally qualified health center services covered by the health maintenance organization and provided to a patient by a federally

qualified health center is not less than the applicable rate that the federally qualified health center would have received from MassHealth for the same encounter as of January 1 of the applicable calendar year, determined in accordance with the prospective payment system methodology established under 42 U.S.C. sections 1396a(bb) and 1396b(m)(2)(A)(ix), as implemented by MassHealth and in effect on January 1, 2025.

(c) The division of insurance shall consult with the division of medical assistance for technical assistance regarding the prospective payment system rate and methodology for each federally qualified health center for the applicable year.

Section 4YY. (a) For the purposes of this section, the terms “health care facility” and “health care provider” shall have the same meanings as defined in section 1 of chapter 111O.

(b) A health maintenance organization organized pursuant to this chapter shall not deny, limit or condition coverage for an otherwise covered health care service solely because the service is delivered by a health care provider participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Health care services delivered through an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, and the rates of payment for an otherwise covered service shall not be reduced solely because the service was delivered through an approved mobile integrated health care program.

(c) Coverage provided pursuant to this section may be subject to a deductible, copayment or coinsurance applicable to a health care service delivered through an approved mobile integrated health care program; provided, however, that the deductible, copayment or

coinsurance shall not exceed the deductible, copayment or coinsurance applicable to the same service when provided in a health care facility.

Section 4ZZ. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Biomarker", a molecular, genetic or biochemical characteristic, including gene mutations, characteristics of genes or protein expression, that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.

"Biomarker testing", the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing performed at a laboratory facility that is either CLIA-certified or CLIA-waived by the federal food and drug administration; provided, however, that biomarker testing does not include testing for the purpose of screening in asymptomatic individuals

"CLIA certified", holding a certificate issued by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform testing on human specimens.

"CLIA waived", holding a certificate of waiver issued under the Clinical Laboratory Improvement Amendments of 1988 authorizing a laboratory to perform only those tests categorized as waived by the federal Food and Drug Administration under 42 C.F.R. section 493.15.

"Clinical utility", the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. Clinical utility shall be established by any of the following: (i) the labeled indications for a test approved or cleared by the federal Food and Drug Administration; (ii) a test indicated in the FDA-approved labeling of a drug, including as a companion diagnostic; (iii) warnings and precautions in the FDA-approved labeling of a drug; (iv) a national coverage determination of the federal Centers for Medicare and Medicaid Services, or a local coverage determination issued by the Medicare Administrative Contractor; or (v) a nationally recognized clinical practice guideline.

"Nationally recognized clinical practice guidelines", evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy, including, but not limited to those of the National Comprehensive Cancer Network or the American Society of Clinical Oncology.

(b) A health maintenance organization organized pursuant to this chapter shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for biomarker testing, pursuant to criteria established under subsection (c); provided, that coverage shall be applied in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

(c) Biomarker testing shall be covered when the test: (i) is conducted at either a CLIA-certified or CLIA-waived laboratory; and (ii) provides clinical utility to the enrollee, as demonstrated by medical and scientific evidence establishing that the result will be used to

select, initiate, exclude or discontinue a specific therapy, or to determine appropriate dosing of a specific therapy.

(d) In the case of coverage that requires prior authorization, a carrier or a utilization review organization subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider and any entity requesting authorization of the service within 5 business days. If additional delay would result in significant risk to the insured's health or well-being, a carrier or a utilization review organization shall approve or deny the request within 48 hours. If a response by a carrier or utilization review organization is not received within the time required under this subsection, said request or appeal shall be deemed granted.

(e) The patient and prescribing practitioner shall have access to a clear, readily accessible and convenient processes to request an exception to a coverage policy or an adverse utilization review determination. The process shall be made readily accessible on the carrier's website.

SECTION 33A. Section 1 of chapter 176J of the General Laws, as appearing in the 2024 Official Edition, is hereby amended by inserting after the definition of "Health benefit plan" the following definition:-

"Health screening benefits", a fixed dollar amount payable to an insured, without regard to the amount of any expenses incurred and without regard to benefits payable under any other coverage, upon proof that a test or diagnostic procedure, including a laboratory or radiological service, was performed in connection with a routine physical examination or preventive care visit.

SECTION 33B. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the word “plans”, in line 206, the second time it appears, the following words:- ; provided, however, that accident only, hospital indemnity insurance policies, disability income insurance and specified disease insurance may also offer health screening benefits.

SECTION 33C. Section 1 of chapter 176M of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Health plan” the following definition:-

“Health screening benefits”, a fixed dollar amount payable to an insured, without regard to the amount of any expenses incurred and without regard to benefits payable under any other coverage, upon proof that a test or diagnostic procedure, including a laboratory or radiological service, was performed in connection with a routine physical examination or preventive care visit.

SECTION 33D. Said section 1 of said chapter 176M, as so appearing, is hereby further amended by inserting after the figure “176K”, in line 218, the following words:- ; provided, however, that accident only, hospital indemnity insurance policies, disability income insurance and specified disease may also offer health screening benefits.

SECTION 33E. Section 1 of chapter 176N of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Health plan” the following definition:-

“Health screening benefits”, a fixed dollar amount payable to an insured, without regard to the amount of any expenses incurred and without regard to benefits payable under any other coverage, upon proof that a test or diagnostic procedure, including a laboratory or radiological

service, was performed in connection with a routine physical examination or preventive care visit.

SECTION 33F. Said section 1 of said chapter 176N, as so appearing, is hereby further amended by inserting after the figure “176K”, in line 42, the following words:- ; provided, however, that accident only, hospital indemnity insurance policies, disability income insurance and specified disease insurance may also offer health screening benefits.

SECTION 34. Chapter 176O of the General Laws is hereby amended by inserting after section 12B the following section:-

Section 12C. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Artificial intelligence”, an engineered or machine-based system that varies in its level of autonomy and that can, for a given set of human-defined explicit or implicit objectives, make predictions, recommendations or decisions influencing real or virtual environments.

“Automated utilization review tool”, artificial intelligence, an algorithm or other software tool used to conduct, or to generate information relied upon in, utilization review based in whole or in part on medical necessity.

(b) This section shall apply to a carrier or utilization review organization that uses an automated utilization review tool, or that contracts with or otherwise acts through an entity that uses an automated utilization review tool in connection with a prospective, concurrent or retrospective review of a request for a covered benefit. A carrier shall remain responsible for compliance with this section by any entity acting on its behalf.

(c) An automated utilization review tool shall base its output on the enrollee's medical and other relevant clinical information, the individual clinical circumstances presented by the requesting provider and other relevant clinical information contained in the enrollee's medical or other clinical record, and shall not base its output solely on a group dataset. An automated utilization review tool shall comply with all applicable provisions of this chapter and applicable state and federal law.

(d) An automated utilization review tool shall not be the sole basis for an adverse determination, and shall not supplant the decision-making of a health care provider. An adverse determination shall be made only by a licensed physician or other licensed health care professional, who shall review the requesting provider's recommendation, the enrollee's medical or other clinical history and the enrollee's individual clinical circumstances.

(e) A carrier or utilization review organization that uses an automated utilization review tool shall: (i) disclose the use of such tool, in plain language, on its public website and to each health care provider in the carrier's network; and (ii) state in each written notice of an adverse determination whether a utilization review tool was used in connection with the determination and describe the role the tool played.

(f) A carrier or utilization review organization shall periodically evaluate the performance, use and outcomes of an automated utilization review tool and modify or discontinue use as necessary to improve accuracy and reliability. A carrier or utilization review organization shall use enrollee data only for purposes consistent with applicable state and federal privacy laws, and shall not use patient data beyond the data's intended and stated purpose, consistent with the federal Health Insurance Portability and Accountability Act of 1996.

(g) A carrier or utilization review organization shall, upon request, make available to the division for audit or compliance review the criteria and guidelines applied by an automated utilization review tool, a description of the categories of data used to develop and train the tool, the tool's intended use and the outcomes of its use, and shall retain records sufficient to permit such review for not less than 6 years. Information provided to the division under this subsection that constitutes a trade secret or proprietary information shall not be a public record as defined in clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

(h) An automated utilization review tool shall not be designed or used in a manner that discriminates, directly or indirectly, against an enrollee in violation of state or federal law, and shall be fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the United States Department of Health and Human Services.

(i) A carrier shall report annually to the division, in a form prescribed by the commissioner, the number of requests for coverage reviewed with the assistance of an automated utilization review tool, the number and percentage of adverse determinations issued in connection with such review and the number and percentage of such adverse determinations reversed on internal grievance or external review.

(j) A violation of this section shall constitute an unfair method of competition or an unfair or deceptive act or practice in the business of insurance under section 3 of chapter 176D. If the commissioner determines that a carrier or utilization review organization is not in compliance with this section, the commissioner shall notify it of the violation and impose a corrective action plan. A carrier or utilization review organization that fails to come into compliance within the

period established by the commissioner shall be subject to a fine of not more than $5,000 for each day the violation continues.

(k) The commissioner shall promulgate regulations to implement this section.

SECTION 35. Said chapter 176O is hereby further amended by adding the following 2 sections:-

Section 31. (a) As used in this section, “primary care expenditures” and “provider organization” shall have the same meanings as in section 1 of chapter 6D.

(b) There shall be an advanced primary care payment program administered by the commissioner. The commissioner shall: (i) approve 1 or more standard advanced primary care payment models developed pursuant to subsection (c); (ii) establish, in consultation with the primary care payment collaborative established in subsection (c), minimum standards and requirements for qualifying advanced primary care payment models; (iii) approve any alternative advanced primary care payment model submitted by a carrier that meets the minimum standards and requirements established pursuant to clause (ii); and (iv) monitor and evaluate the implementation of the program.

(c) (1) There shall be a primary care payment collaborative to advise the commissioner in the development and administration of the advanced primary care payment program established under this section. The collaborative shall develop 1 or more standard advanced primary care payment models for approval by the commissioner and shall advise the commissioner regarding minimum standards and requirements for qualifying advanced primary care payment models, best practices in primary care payment reform and the implementation and evaluation of the program.

(2) The collaborative shall consist of the executive director of the health policy commission or their designee; the executive director of the center for health information and analysis, or their designee; and members appointed by the commissioner representing carriers, primary care providers, provider organizations, employers, consumer organizations, health equity organizations and such other entities as the commissioner deems appropriate.

(d) A qualifying advanced primary care payment model shall be designed to support value-based, patient-centered primary care and shall include, at a minimum:

(i) capitation paid on a prospective, per-member per-month basis for primary care services furnished to members attributed to a participating provider;

(ii) a methodology for attributing members to a participating provider, which shall take into account a member's established primary care relationship and utilization over a period of not less than 24 months;

(iii) a risk adjustment for the clinical and social acuity and complexity of a participating provider's attributed member population and accounting for differences between adult and pediatric primary care;

(iv) the incentive payment required by subsection (f);

(v) support for chronic disease management and preventive care;

(vi) integration of behavioral health services within the primary care setting;

(vii) medication management and care coordination activities;

(viii) expanded access to primary care services, including same-day or urgent appointments and after-hours access;

(ix) timely provision by the carrier to the participating provider of data necessary to manage the care of attributed members;

(x) standards governing the exchange of data between a participating provider and carrier for purposes of the carrier's reporting obligations under subsection (i), including the form and frequency of such exchange; and

(xi) such additional elements as the commissioner considers necessary to advance high-quality, coordinated and cost-effective primary care.

(e) To reduce unnecessary administrative burden on participating providers, the commissioner shall, to the maximum extent practicable, require consistency and alignment among qualifying advanced primary care payment models with respect to reporting requirements, quality measures, data submission standards, administrative forms and processes, and any other common administrative function. Nothing in this section shall be construed to require uniformity in the amount of any base per-member per-month payment, incentive payment, risk adjustment methodology or other payment design feature.

(f) A qualifying advanced primary care payment model shall provide for an incentive payment, in addition to the base per-member per-month payment, to a participating provider that demonstrates meaningful improvement in or performance exceeding a standard established by the commissioner with respect to: (i) the time within which an established patient may obtain an appointment with the provider; (ii) the time within which a new patient may obtain an appointment with the provider; (iii) the growth in members attributed to the provider under the

model; (iv) any growth in serving patient populations and communities with identified shortages in primary care accessibility; and (v) such measures of clinical quality and patient experience as the commissioner shall establish; provided, that the commissioner shall select such measures applicable to primary care from the standard quality measure set established under section 14 of chapter 12C.

(g) A qualifying advanced primary care payment model shall provide that a participating provider receiving only the base per-member per-month payment shall receive, for its attributed members, aggregate reimbursement for primary care services not less than the amount the provider would have received for such services under the carrier's applicable fee-for-service payment methodology.

(h) Each carrier shall adopt not less than 1 qualifying advanced primary care payment model approved by the commissioner and shall offer such model to each primary care provider and provider organization with which it contracts. A carrier may satisfy this subsection by adopting a standard advanced primary care payment model approved under clause (ii) of subsection (b) or by submitting an alternative model for approval under clause (iii) of said subsection (b). Participation shall be at the election of the primary care provider or provider organization.

(i) Annually, each carrier shall submit to the commissioner, in a form and manner prescribed by the commissioner: (i) an attestation demonstrating compliance with this section; (ii) the number of primary care providers and provider organizations that have elected to participate in the model and the number that have declined; (iii) information regarding implementation of its approved model and its required elements; (iv) data necessary to evaluate

quality, utilization, member outcomes, primary care expenditures and other performance measures identified by the commissioner, including performance on the measures described in subsection (f) and the incentive payments earned under the model, which the carrier shall obtain from participating providers pursuant to its contracts with them; and (v) any additional information the commissioner determines necessary to monitor implementation and evaluate the effectiveness of the program.

(j) The commissioner may promulgate regulations pursuant to chapter 30A, issue bulletins and guidance and establish reporting requirements as necessary to implement, administer and enforce this section, including establishing reporting requirements, attestation forms and corrective action processes, and may suspend or withdraw approval of an advanced primary care payment model that no longer meets the minimum standards and requirements established pursuant to this section.

(k) A carrier shall make its approved advanced primary care payment model available to the sponsor of a self-insured health benefit plan it administers. If such a sponsor elects in writing to adopt the model, the carrier shall administer it on the same terms as apply to the health benefit plans the carrier issues. Nothing in this subsection shall require a sponsor of a self-insured health benefit plan to adopt such a model.

Section 32. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Affiliated entity”, as defined in section 1 of chapter 176Y.

"Base price concession", a price concession provided by a pharmaceutical manufacturer that is tied to formulary placement or utilization of a prescription drug and that is not contingent on price protection, inflation or the achievement of specified performance criteria

"Cost-sharing", as defined in section 1 of chapter 176Y.

"Estimated rebate", any: (i) negotiated price concessions, whether described as a rebate or otherwise, including, but not limited to, base price concessions, and reasonable estimates of any price protection rebates and performance-based price concessions that may accrue, directly or indirectly, to a carrier, pharmacy benefit manager, affiliated entity or other party on a carrier's behalf during a carrier's plan year from a pharmaceutical manufacturing company, dispensing pharmacy or other party to the transaction based on the amounts the carrier received in the prior quarter or reasonably expects to receive in the current quarter; and (ii) reasonable estimates of any price concessions, fees and other administrative costs that are passed through, or are reasonably anticipated to be passed through to the carrier, pharmacy benefit manager, affiliated entity or other party on the carrier's behalf and that serve to reduce the carrier's prescription drug liabilities for the plan year based on the amounts the carrier received in the prior quarter or reasonably expects to receive in the current quarter.

"Performance-based price concession", a price concession, or portion thereof, that is contingent on achieving specified performance criteria, including but not limited, to clinical outcomes, specified utilization thresholds or market-share targets; provided, however, that a price concession, or portion thereof, shall not be considered a performance-based price concession to the extent it is based on a prescription drug's formulary placement, tier status or

continued formulary coverage, or on utilization of such drug that is not subject to a specified utilization threshold.

"Pharmacy benefit manager", as defined in section 1 of chapter 176Y.

"Price protection rebate", a negotiated price concession that accrues directly or indirectly to the carrier, or other party on behalf of the carrier, including a pharmacy benefit manager or affiliated entity, in the event of an increase in the wholesale acquisition cost of a drug that is greater than a specified threshold.

"Third-party administrator", as defined in section 1 of chapter 176Y.

(b) A carrier, pharmacy benefit manager or affiliated entity shall make available to an insured not less than 80 per cent of the estimated rebates received by or reasonably expected to be received by such carrier, or any pharmacy benefit manager or affiliated entity, by reducing the amount of defined cost-sharing that the carrier would otherwise charge at the point of sale, except that the reduction amount shall not result in a credit at the point of sale. Neither the insured nor the carrier shall be responsible for any difference between the estimated rebate amount and the actual rebate amount the carrier receives; provided, that such estimates were calculated in good faith.

(c) Nothing in this section shall preclude a pharmacy benefit manager or affiliated entity from decreasing an insured's defined cost-sharing by an amount equal to or greater than that required under subsection (b).

(d) Annually, not later than April 1, a carrier shall file with the division a report in the manner and form determined by the commissioner demonstrating the manner in which the carrier

has complied with this section. If the commissioner determines that a carrier has not complied with this section, the commissioner shall notify the carrier of such noncompliance and a date by which the carrier must demonstrate compliance. If the carrier does not come into compliance by such date, the division shall impose a fine not to exceed $5,000 for each day during which such noncompliance continues.

(e) In implementing the requirements of this section, the division shall only regulate a carrier or pharmacy benefit manager or affiliated entity to the extent permissible under applicable federal law.

(f) A pharmacy benefit manager, affiliated entity or any third-party administrator shall not publish or otherwise disclose information regarding the actual amount of rebates a carrier receives on a specific product or therapeutic class of products, or on a manufacturer or pharmacy-specific basis. Such information shall be considered to be a trade secret and confidential commercial information, shall not be a public record as defined by clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66 and shall not be disclosed directly or indirectly, or in a manner that would allow for the identification of an individual product, therapeutic class of products or manufacturer, or in a manner that would have the potential to compromise the financial, competitive or proprietary nature of the information. A pharmacy benefit manager or affiliated entity shall impose the confidentiality protections and requirements of this section on any agent or third-party administrator that performs health care or administrative services on behalf of the pharmacy benefit manager that may receive or have access to rebate related information.

SECTION 36. Section 1 of chapter 176Y of the General Laws, as appearing in the 2024 Official Edition, is hereby amended by inserting before the definition of "Carrier" the following definition:-

"Affiliated entity", an entity that directly or indirectly owns, is owned by, is under common ownership with, is vertically integrated with, has an investment interest in or is otherwise affiliated with a pharmacy benefit manager and that has a material financial interest in, or exercises operational control over, 1 or more stages of the prescription drug supply chain including, but not limited to, pharmacy services, claims adjudication, rebate administration, third-party administrator services, data aggregation or prescription drug reimbursement; provided, however, that "affiliated entity" shall not include a pharmaceutical manufacturing company, or an entity providing patient support or copayment assistance services on behalf of such a company, unless the company or entity directly or indirectly owns, is owned by, or is under common ownership with a pharmacy benefit manager.

SECTION 37. Said section 1 of said chapter 176Y, as so appearing, is hereby further amended by inserting after the definition of "Commissioner" the following definition:-

"Cost-sharing", any copayment, coinsurance, deductible or any other amount owed by an insured under the terms of the insured's health benefit plan, or as required by a pharmacy benefit manager or affiliated entity.

SECTION 38. Said section 1 of said chapter 176Y, as so appearing, is hereby further amended by inserting after the definition of "Pharmacy benefit manager" the following definition:-

"Third-party administrator", any person that directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, arranges alternative access to or funding for prescription drugs, or adjusts or settles claims on behalf of residents of the commonwealth or residents of another state from offices in this commonwealth, in connection with health insurance coverage.

SECTION 39. Said chapter 176Y is hereby further amended by adding the following section:-

Section 5. (a) When calculating an insured's contribution to any applicable cost-sharing requirement, a carrier shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person. If under federal law application of this requirement would result in health savings account ineligibility under section 223 of the federal Internal Revenue Code, this requirement shall apply for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the insured has satisfied the minimum deductible under section 223 of the federal Internal Revenue Code, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible under section 223 has been satisfied.

(b) A carrier, pharmacy benefit manager, affiliated entity or third-party administrator shall not directly or indirectly set, alter, implement or condition the terms of health benefit plan coverage, including the benefit design, based in whole or in part on information about the availability or amount of financial or product assistance available for a prescription drug.

(c) The division shall promulgate regulations as necessary to implement this section.

SECTION 39A. Section 75 of chapter 260 of the acts of 2020 is hereby amended by striking out the figure “2027”, inserted by section 31 of chapter 248 of the acts of 2024, and inserting in place thereof the following figure:- 2029.

SECTION 40. Notwithstanding any general or special law to the contrary, the comptroller, at the direction of the secretary of administration and finance, shall transfer $25,000,000 from the Commonwealth Federal Matching and Debt Reduction Fund established in section 2EEEEEE of chapter 29 of the General Laws, inserted by section 2 of chapter 214 of the acts of 2024, to the Health Care Workforce Transformation Fund established in section 2FFFF of chapter 29 of the General Laws.

SECTION 40A. The office for health resource planning shall conduct a focused assessment of pharmacy deserts required under section 22A of chapter 6D, inserted by section 22A, and submit its first report to the health policy commission by not later than September 1, 2027.

SECTION 40B. Section 26A shall go into effect on October 1, 2027.

SECTION 41. The center for health information and analysis shall promulgate regulations pursuant to section 15A of chapter 12C of the General Laws, inserted by section 15, not later than January 1, 2027.

SECTION 42. The health policy commission shall promulgate regulations pursuant to subsection (e) of section 9A of chapter 6D of the General Laws, inserted by section 6, and subsection (g) of section 10A of said chapter 6D, inserted by section 10, not later than April 1, 2027.

SECTION 43. The center for health information and analysis shall promulgate regulations pursuant to subsection (g) of section 18A of said chapter 12C, inserted by section 18, not later than July 1, 2027.

SECTION 44. Section 17BB of chapter 32A of the General Laws, inserted by section 22; section 47EEE of chapter 175, inserted by section 29; section 8FFF of chapter 176A of the General Laws, inserted by section 30; section 4FFF of chapter 176B of the General Laws, inserted by section 31; section 15B of chapter 176E of the General Laws, inserted by section 32; and section 4XX of chapter 176G of the General Laws, inserted by section 33, shall apply to health benefit plans delivered, issued for delivery or renewed on or after January 1, 2027.

SECTION 45. Section 17CC of chapter 32A of the General Laws, inserted by section 22; section 10BB of chapter 118E of the General Laws, inserted by section 27; section 47FFF of chapter 175 of the General Laws, inserted by section 29; section 8GGG of chapter 176A of the General Laws, inserted by section 30; section 4GGG of chapter 176B of the General Laws, inserted by section 31; and section 4YY of chapter 176G of the General Laws, inserted by section 33, shall apply to health benefit plans delivered, issued for delivery or renewed on or after January 1, 2027.

SECTION 46. Section 5 of chapter 176Y of the General Laws, inserted by section 39, shall apply to health benefit plans delivered, issued for delivery or renewed on or after January 1, 2028.

SECTION 47. Every carrier, as defined in section 1 of chapter 176O of the General Laws, shall offer at least 1 qualifying advanced primary care payment model approved pursuant

to section 31 of said chapter 176O, inserted by section 35, to each contracting primary care provider or provider organization by not later than January 1, 2028.

SECTION 48. Section 32 of chapter 176O of the General Laws, inserted by section 35, and section 36 of chapter 32A of the General Laws, inserted by section 23, shall apply to health benefit plans delivered, issued for delivery or renewed on or after January 1, 2029.

SECTION 49. Section 34 of this act shall take effect on January 1, 2027.

SECTION 50. Section 4C of chapter 260 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

Civil actions alleging a defendant sexually abused a minor may be commenced at any time after the acts alleged to have caused an injury or condition occurred.

SECTION 51. Said chapter 260 is hereby amended by striking out section 4C 1/2 and inserting in place thereof the following section:-

Section 4C½. Civil actions alleging that a defendant negligently supervised a person who sexually abused a minor or that a defendant’s conduct caused or contributed to the sexual abuse of a minor by another person may be commenced at any time after the acts alleged to have caused an injury or condition occurred. For the purposes of this section, “sexual abuse” shall have the same meaning as in section 4C.

SECTION 52. Said chapter 260 is hereby further amended by inserting after section 4C ½ the following section:

Section 4C ¾. Notwithstanding any provision of law which imposes a period of limitations to the contrary and the provisions of any other law pertaining to the filing of a notice of claim or a notice of intention to file a claim as a condition precedent to commencement of an action or special proceeding, every civil claim or cause of action brought against a party alleging sexual abuse of a minor, as that term is defined in section 4C, or negligent supervision contributing to the sexual abuse of a minor under section 4C ½, or a predecessor statute that prohibited such conduct at the time of the act, which is barred as of the effective date of this section because the applicable period of limitations has expired or the plaintiff previously failed to file a notice of claim or a notice of intention to file a claim, is hereby revived, and action thereon may be commenced no later than 2 years after the effective date of this section. In any such claim or action, dismissal of a previous action, ordered before the effective date of this section, on grounds that such previous claim was time barred or for failure of a party to file a notice of claim or a notice of intention to file a claim, shall not be grounds for dismissal of a revival action pursuant to this section.

Notwithstanding any provision of law which limits the liability or damages for any organization or employer or their officers, directors, trustees, employees or volunteers, every civil claim or cause of action brought against a party alleging sexual abuse of a minor, as that term is defined in section 4C, or negligent supervision contributing to the sexual abuse of a minor under section 4C ½, or a predecessor statute that prohibited such conduct at the time of the act, which was subject to limits on liability or damages at the time of the act, shall not be subject to any limitations for revived actions brought pursuant to this section.

SECTION 53. Section 5B of said chapter 260 is hereby amended by striking out, in lines 5 and 6, inclusive, the words “three years next after the cause of action accrues” and inserting in

place thereof the following words:- 3 years next after the cause of action accrues; provided, however, that an action commenced under 20 U.S.C. §§1681-1688 for sexual abuse of a minor, as that term is defined in section 4C, or negligent supervision contributing to the sexual abuse of a minor under section 4C ½, shall be governed by the provisions of sections 4C and 4C½.

SECTION 54. Section 85K of chapter 231 of the General Laws, as so appearing, is hereby amended by inserting, in line 12, after the word “costs” the following words:- provided, however, that claims of sexual abuse of a minor, as that term is defined in section 4C of chapter 260, and claims of negligent supervision contributing to the sexual abuse of a minor under section 4C ½ of chapter 260, shall not be subject to a limitation on damages.

SECTION 55. Section 85V of said chapter 231 is hereby amended by inserting after clause (iii) the following clause:-

(iv) claims of sexual abuse of a minor as the term is defined in section 4C of chapter 260 and claims of negligent supervision contributing to the sexual abuse of a minor under section 4C ½ of chapter 260.

SECTION 56. Section 85W of said chapter 231 is hereby amended by inserting, in line 11, after the word “person” the following language:-

; provided further, however, that the immunity conferred in this section shall not apply to claims related to child sexual abuse, as defined in section 4C of chapter 260, and claims of negligent supervision contributing to the sexual abuse of a minor under section 4C ½ of chapter 260.

SECTION 57. Section 2 of chapter 258 of the General Laws, as so appearing, is hereby amended by inserting, in line 12, after the word “damages” the following words:- provided further, however, that claims of sexual abuse of a minor, as that term is defined in section 4C of chapter 260, and claims of negligent supervision contributing to the sexual abuse of a minor under section 4C ½ of chapter 260, shall not be subject to a limitation on damages.

SECTION 58. Subsection (j) of section 10 of said chapter 258 is hereby amended by inserting after paragraph (4) the following paragraph:- (5) any claim by or on behalf of a person who alleges they were sexually abused as a minor, as that term is defined in section 4C of chapter 260 and claims of negligent supervision contributing to the sexual abuse of a minor under section 4C ½ of chapter 260.

SECTION 59. Section 63 of chapter 277 of the General Laws, as so appearing, is hereby amended by inserting, in line 13, as amended by sections 9 and 10 of chapter 277 of the acts of 2024, after the word “sections” the following number:- 13H,.

SECTION 60. Said section 63 of said chapter 277 is hereby further amended by inserting, in line 27, as amended by sections 9 and 10 of chapter 277 of the Acts of 2024, after the number “23,” the following number:- 24,.

; and by striking out the title and inserting in place thereof the following title: “An Act strengthening primary care and advancing health care affordability”.