SENATE . . . . . No. 3116

The Commonwealth of Massachusetts

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

SENATE, June 11, 2026.

The committee on Senate Ways and Means to whom was referred the Senate Bill relative to primary care for you (Senate, No. 867), - reports, recommending that the same ought to pass with an amendment substituting a new draft with the same title (Senate, No. 3116).

For the committee,
Michael J. Rodrigues

FILED ON: 6/11/2026

SENATE . . . . . No. 3116

The Commonwealth of Massachusetts

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

An Act relative to primary care for you.

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

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

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

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

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

"Independent primary care practice", a medical practice owned by 1 or more licensed primary care providers that provides primary care services and is not owned or controlled by another entity, including, but not limited to, a health system, private equity company or corporation.

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

"Primary care", the provision of integrated, accessible health care services for people of all ages provided as first-contact, longitudinal care by a licensed primary care clinician, including physicians and their care teams, which may include, but shall not be limited to, nurses, nurse practitioners, physician assistants and care coordinators.

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

"Primary care expenditure target", the targeted sum set by the commission pursuant to section 9A of all primary care expenditures as defined by the center by or attributed to an individual health care entity in the calendar year in which the entity's primary care expenditure target applies.

SECTION 4. 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", services that are person-centered and team-based and delivered by a primary care provider, including, problem-focused office visits, preventative office visits

and services, routine evaluation and management, management of chronic conditions, administration of immunizations and injections, in-home and nursing facility visits, routine screening and assessments, integrated behavioral health care, coordination of care and other services as defined by the primary care technical advisory council.

SECTION 5. Said chapter 6D is hereby further amended by inserting after section 3A the following section:-

Section 3B. (a) There shall be within the commission an office of primary care policy and payment. The office, in coordination with the primary care technical advisory council established in subsection (c) and in consultation with the division of insurance, shall: (i) study primary care access, delivery and payment in the commonwealth; (ii) develop a uniform primary care payment model across all carriers, including the group insurance commission established in section 3 of chapter 32A, that: (A) takes into account considerations of both adult and pediatric primary care; and (B) takes into account and makes reasonable adjustments to reflect differences across commercial market plan types including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations and point-of-service; (iii) develop and issue regulations to stabilize and strengthen the primary care system, improve primary care workforce recruitment and retention, strengthen the integration of primary care and behavioral health services and increase the financial investment in and patient access to primary care; and (iv) develop recommendations to ensure that increases to primary care expenditures do not add to overall health care spending.

(b)(1) The office shall, in coordination with the primary care technical advisory council established pursuant to subsection (c) and in consultation with the division of insurance, establish

a standard primary care capitated payment model under which commercial payers shall pay participating providers or provider organizations a prospective, per-member per-month payment for patients attributed to the participating provider or provider organization for primary care which, for the purposes of this section shall be the advanced primary care payment model. The advanced primary care payment model shall include, but not be limited to, guidelines on: (i) covered primary care services; (ii) per-member per-month rate methodology; (iii) enhanced payments for advanced primary care services and investments; (iv) member attribution methodology, including a 24-month look-back of utilization; (v) risk adjustment, including social risk adjustment methodology; (vi) primary care quality measures; (vii) primary care reimbursement and a set of spending reporting requirements for participating providers or provider organizations; (viii) audits of participating providers or provider organizations; (ix) the timely provisioning of data from payers to primary care providers to effectively manage care; (x) patient cost-sharing limits or prohibitions on cost-sharing; and (xi) ensuring payers provide reimbursement for medically necessary services that are not covered by the advanced primary care payment model.

(2) A provider or provider organization required to register pursuant to section 11 shall adopt and implement the advanced primary care payment model developed by the office of primary care policy and payment pursuant to this section and in accordance with division rules, regulations and guidelines.

(3) For enrollees attributed to a primary care provider or provider organization for primary care: (i) all provider and provider organizations required to register pursuant to section 11 shall implement the advanced primary care payment model in contracts with carriers, and in

contracts with the group insurance commission; and (ii) all other primary care practices shall have the option to participate in the advanced primary care payment model.

(4) Payments made to primary care providers and provider organizations participating in the advanced primary care payment model shall be included in the health status adjusted total medical expense and total medical expense calculated by the center for health information and analysis under section 16 of chapter 12C.

(5) Participating primary care providers and provider organizations, except for participating independent primary care practices, shall provide such attestations and reports and submit to such audits as may be required by the office of primary care policy and payment pursuant to this section.

(c) There shall be within the commission a primary care technical advisory council, which shall advise the office of primary care policy and payment regarding the development of the advanced primary care payment model. The members of the primary care technical advisory council shall consist of: (i) the director of MassHealth, who shall serve as co-chair; (ii) the commissioner of insurance, who shall serve as co-chair; (iii) the executive director of the center for health information and analysis; and (iv) 8 persons to be appointed by the executive director of the health policy commission, of whom 1 shall be an expert in health care payment methodologies from Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be an expert in health care payment methodologies nominated by Massachusetts Association of Health Plans, Inc., 1 of whom shall be an actuary with experience in developing health care payment methodologies, 1 of whom shall be an expert in health care quality measurement; 3 of whom shall be primary care physicians with expertise in delivering care, at least 1 of whom shall be a

primary care physician with experience managing primary care physician practices, including independent practices, multi-specialty practices or community health centers and practices owned or affiliated with hospital-based systems and 1 of whom shall be an expert in primary care from Health Care for All, Inc.

(d) The primary care technical advisory council, in coordination with the office of primary care policy and payment and in consultation with the division of insurance, shall: (i) designate additional primary care services that may be included within the advanced primary care payment model including, but not limited to, laboratory testing, diagnostic testing and imaging, obstetrics and medication; (ii) define the services that comprise integrated behavioral health; and (iii) define allowable and nonallowable expenditures by or imposed by a health care system on the practice and clearly identify expenditures that directly support a primary care practice's direct services.

(e) The advanced primary care payment model shall include:

(1) a per-member per-month rate methodology; provided, however, that as a part of the methodology, the office of primary care and payment shall, in coordination with the primary care technical advisory council and in consultation with the division of insurance, consider the historical monthly primary care spending per patient at the primary care provider or provider organization level, the historical statewide monthly primary care spending per patient, the primary care expenditure data published in the center's annual report under section 16 of chapter 12C, relevant differences in adult and pediatric primary care and any other factors deemed relevant by the office. The per-member per-month payment shall be adjusted based on: (i) a participating provider or provider organization's adoption of advanced primary care services and

investment in primary care services; (ii) the quality of patient care delivered by a participating provider or provider organization; and (iii) the clinical and social risk of patients attributed to a participating provider or provider organization for primary care; provided, however, that there shall be a comprehensive accounting for the differences between pediatric and adult care. A primary care practice shall generate at least as much revenue as a fee-for-service payment model generates in relation to historical monthly primary care spending per patient at the primary care provider or provider organization level.

(2) The office of primary care policy and payment, in coordination with the primary care technical advisory council and in consultation with the division of insurance, shall: (i) identify advanced primary care services and investments in primary care delivery that may qualify participating providers or provider organizations for enhanced payments under the advanced primary care payment model; and (ii) consider enhanced primary care services and investments that are: (A) evidence-informed or evidence-based; (B) improve primary care quality; (C) increase primary care access; (D) enhance a patient's primary care experience; (E) promote health equity in primary care for children and adults; (F) reduce avoidable hospitalizations and emergency department utilization; and (G) manage chronic diseases more effectively. In determining the enhanced payment rates, the office shall consider the strength of evidence that the advanced service or investment will: (i) improve patient health; (ii) enhance patient experience; (iii) improve clinician experience, including reducing administrative burden; (iv) decrease total medical expense; and (v) promote health equity. Enhanced primary care services and investments may include, but shall not be limited to: (i) integrating behavioral health services with primary care; (ii) investing in social determinants of health; (iii) using clinician optimization programs to reduce documentation burden; (iv) investing in care management; (v)

offering walk-in or same-day care appointments and extended hours of availability; (vi) providing medication-assisted treatment; and (vii) delivering any other primary care services that may be deemed relevant by the office, in coordination with the primary care technical advisory council and in consultation with the division of insurance. There shall be a structure to implement the enhanced primary care services and investments which may include, but shall not be limited to, clinical tiers.

(3) The statewide advisory committee convened pursuant to section 14 of chapter 12C shall, in consultation with Massachusetts Health Quality Partners, Inc. and the center for health information and analysis and subject to the review and approval by the office of primary care policy and payment, the primary care technical advisory council and the division of insurance, identify a limited set of primary care quality and outcome measures; provided, however, that at least 1 such measure shall be related to patient experience. Each quality measure shall be appropriate for a primary care setting and supported by peer-reviewed, evidence-based research that the measure is actionable and that its use will lead to improvements in patient health; provided, however, that such quality measures shall not add to the administrative burden of the primary care practices. The office, in consultation with the primary care technical advisory council and the division of insurance, shall: (i) develop standard measurement and reporting requirements for the quality and outcome measures including, but not limited to, standardized survey questions and consistent data collection methods; (ii) develop separate annual retroactive payment methodology based on quality measures; and (iii) consider and seek to align the measures with the MassHealth quality indicators for managed care entities, the standard quality measure set and the aligned measure set.

(4) The office of primary care policy and payment, in coordination with the primary care technical advisory council and in consultation with the division of insurance, shall: (i) identify measures of clinical and social complexity that promote health equity and minimize opportunities to artificially increase the clinical and social complexity of a patient panel; and (ii) develop standard rate adjustment methodology based on measures of clinical and social complexity measured at the individual patient level and rolled up into the practice level to determine the per-month rate adjustment; provided, however, that practices determined to have above-average clinical or social complexity shall receive an enhanced per-member per-month advanced primary care payment rate as determined by the developed methodology.

(5) The office of primary care policy and payment, in coordination with the primary care technical advisory council and in consultation with the division of insurance, shall: (i) develop member attribution methodology to assign patients to participating providers or provider organizations for adult and pediatric primary care under the advanced primary care payment model; provided, however, that patients with existing primary care relationships shall be matched according to the established primary care relationship; and (ii) establish a uniform attribution methodology used by all payers, including a process to attribute patients to an established primary care provider.

(6) The office of primary care policy and payment shall, in coordination with the primary care technical advisory council, the center for health information and analysis and the division of insurance, develop and maintain a mandatory attestation, reporting and audit process for participating providers or provider organizations; provided, however, that such process shall not apply to independent primary care practices. Such process shall seek to ensure that primary care payments under the model are directed to primary care practices or for supports that directly

benefit primary care practices; provided, however, that not less than 90 per cent of the per-member per-month payment to participating providers or provider organizations shall be directly allocated to and retained at the practice level, with not more than 10 per cent of the per-member per-month payment distributed at the system level for use in system-level services that benefit or are otherwise used by primary care practices participating in the system.

(7) The office of primary care policy and payment, in coordination with the primary care technical advisory council and in consultation with the division of insurance, shall: (i) develop the advanced primary care payment model, which shall be implemented uniformly across all carriers and the group insurance commission; (ii) make appropriate adjustments to reflect differences across commercial market plan types including, but not limited to, health maintenance organizations, preferred provider organizations, exclusive provider organizations and point-of-service; and (iii) consider the establishment and implementation of primary care subcontracts for use in contracts between commercial payers and health systems to promote transparency and accountability and to ensure that increased investments in primary care reach individual primary care practices.

(8) No carrier or the group insurance commission shall require prior authorization for any primary care service provided by a primary care practice that receives a per-member per-month payment under the advanced primary care payment model.

(f) The office of primary care policy and payment shall, in coordination with the primary care technical advisory council and in consultation with the division of insurance, conduct ongoing monitoring and analysis of statewide implementation of the advanced primary care

payment model and shall make adjustments to the advanced primary care payment model pursuant to applicable regulations.

(g) Annually, not later than December 31, the office of primary care policy and payment shall: (i) in coordination with the primary care technical advisory council and in consultation with the division of insurance, report on the progress of statewide implementation of recommendations issued by the office under clauses (i) to clause (x), inclusive, of paragraph (1) of subsection (b); and (ii) in consultation with the primary care technical advisory council, report on proposals to facilitate and improve implementation of the office's recommendations based on the office's ongoing monitoring and analysis of statewide implementation of the office's recommendations. The report shall be filed with the clerks of the senate and house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the center for health information and analysis and the division of insurance.

(h) The office of primary care policy and payment shall, in coordination with the primary care technical advisory council and in consultation with the division of insurance, develop regulations to implement this section, which shall take effect on approval by the board of the commission; provided, however, that prior to implementing such regulations, the office shall hold not less than 1 public hearing.

SECTION 6. Section 8 of said chapter 6D, as appearing in the 2024 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

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

SECTION 7. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word "care", in line 95, the following words:- and primary care.

SECTION 8. Said chapter 6D is hereby further amended by inserting after section 9 the following section:-

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

(b)(1) For the calendar year 2028, the aggregate primary care expenditure target shall be equal to 9 per cent of total health care expenditures in the commonwealth and the primary care expenditure target shall be equal to 9 per cent of the total health care expenditures attributable to each health care entity.

(2) For the calendar year 2029, the aggregate primary care expenditure target shall be equal to 12 per cent of total health care expenditures in the commonwealth and the primary care

expenditure target shall be equal to 12 per cent of the total health care expenditures attributable to each health care entity.

(3) For the calendar year 2030, the aggregate primary care expenditure target shall be equal to 15 per cent of total health care expenditures in the commonwealth and the primary care expenditure target shall be equal to 15 per cent of the total health care expenditures attributable to each health care entity.

(4) For calendar years 2031 and thereafter, if the commission determines that an adjustment in the aggregate primary care expenditure target and the primary care expenditure target is reasonably warranted, the commission may recommend modification to such targets; provided, however, that such targets shall not be lower than 15 per cent of total health care expenditures in the commonwealth.

(5) The commission, in collaboration with the center for health information and analysis, 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. The commission shall hold payers and providers accountable for any such increases pursuant to section 10A.

(6) The commission shall consider the projections of the rate of increase of total health care expenditures in the commonwealth for each given year and shall adjust the aggregate primary care expenditure target and the primary care expenditure targets proportionately.

(c) Prior to making any recommended modification to the aggregate primary care expenditure target and the primary care expenditure target under paragraph (4) of subsection (b),

the commission shall hold a public hearing to examine: (i) the report submitted by the center under section 16 of chapter 12C, comparing the aggregate primary care expenditures to the aggregate primary care expenditure target; (ii) any other data submitted by the center; (iii) the performance of health care entities in meeting the primary care expenditure target; (iv) the performance of the commonwealth's health care system in meeting the aggregate primary care expenditure target; and (v) other pertinent information or data as may be available to the commission.

The commission shall provide notice of the public hearing not less than 45 days in advance, which shall include notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify a representative sample of providers, provider organizations, payers and such other interested parties as the commission may determine as witnesses for the public hearing; provided, however, that any interested party may testify.

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

SECTION 9. 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 an entity identified by the center under section 18 of chapter 12C.

(b) The commission shall provide written notice to any health care entity identified by the center under section 18 of chapter 12C for its failure to meet the primary care expenditure target

or if increased primary care spending results in growth in overall health care expenditure trends or any net new increase in health insurance premiums and cost-sharing; provided, however, that the growth calculation shall not include pharmaceutical spending. Such notice shall be delivered not more than 45 days after the release of the center's published annual report pursuant to section 16 of chapter 12C and shall state that the center may analyze the performance of individual health care entities in meeting the primary care expenditure target and the commission shall require certain actions established in this section.

(c) The commission may require any health care entity that is identified by the center under section 18 of chapter 12C for its failure to meet the primary care expenditure target or if increased primary care spending results in growth in overall health care expenditure trends or any net new increase in health insurance premiums and cost-sharing, to file and implement a performance improvement plan; provided, however, that such growth calculation shall not include pharmaceutical spending. The commission shall provide written notice to the health care entity that it is required to file a performance improvement plan not more than 45 days after the release of the center's published annual report as described in section 16 of said chapter 12C. Not more than 45 days after receipt of such notice, the health care entity shall either: (i) file a performance improvement plan with the commission; or (ii) file an application with the commission to waive or extend the requirement to file a performance improvement plan.

(d) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the requirement to file a performance improvement plan within 15 days of receipt of written notice to the health care entity that it is required to file a performance improvement plan. The commission shall require the health care entity to submit any other relevant information it deems necessary in

considering the waiver or extension application; provided, however, that such information may be made public as determined by the commission.

(e) The commission may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under subsection (c) within 15 days of the health care entity's submission of an application to waive or extend the requirement to file a performance improvement plan, based on a consideration of: (i) the primary care baseline expenditures, costs, price and utilization trends of the health care entity over time and any demonstrated improvement to increase the proportion of primary care expenditures; (ii) ongoing strategies or investments that the health care entity is implementing to invest in or expand access to primary care services; (iii) if the inability of the health care entity to meet the primary care expenditure target or increased primary care spending can reasonably be considered to be unanticipated and outside of the control of the entity; (iv) the overall financial condition of the health care entity; and (v) other factors the commission considers relevant. If the commission chooses to extend the requirement for a health care entity to file a performance improvement plan in response to an extension request, the deadline for submission of the performance improvement plan by the health care entity shall be at the commission's discretion.

(f) If the commission denies the request to waive or extend the requirement for the health care entity to file a performance improvement plan, the commission shall provide written notice of such denial to the health care entity not more than 15 days after the health care entity's submission of such request. Upon receipt of written notice of such denial, the health care entity shall file a performance improvement plan not more than 45 days thereafter.

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

(h) The performance improvement plan shall identify specific strategies, adjustments and action steps the entity proposes to implement to increase the proportion of primary care expenditures and shall include specific identifiable and measurable expected outcomes and a timetable for implementation.

(i) The commission shall approve a performance improvement plan: (i) if it determines the plan is reasonably likely to be successfully implemented and will address the underlying cause of the entity's inability to meet the primary care expenditure target; or (ii) to limit growth in overall health care expenditure trends or any net new increase in health insurance premiums and cost-sharing to offset growth in primary care expenditures; provided, however, that the growth calculation shall not include pharmaceutical spending.

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

(k) Upon approval of a performance improvement plan, the commission shall notify the health care entity to begin its immediate implementation and shall public notice thereof on the commission's website, identifying that the health care entity is implementing a performance improvement plan. Any health care entity implementing a performance improvement plan shall be subject to such additional reporting, audits and compliance monitoring as may be required by the commission. The commission shall assist health care entities in implementing performance improvement plans.

(l) If the commission chooses not to require a performance improvement plan from a health care entity identified under section 18 of chapter 12C for failure to meet the primary care expenditure target or if increased primary care spending results in growth in overall health care expenditure trends or any net new increase in health insurance premiums and cost-sharing, the commission shall publish a report not more than 45 days after the release of the center for health information and analysis' published annual report as described in section 16 of chapter 12C, detailing its reasoning for not requiring a performance improvement plan from the health care entity.

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

(n) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the commission on the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the

commission shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity to submit a new performance improvement plan under subsection (c); or (iv) waive or delay the requirement to file additional performance improvement plans.

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

(p) If the commission determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the commission by the time required in subsection (h); (ii) failed to file an acceptable performance improvement plan in good faith with the commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide or knowingly falsified information required by this section to the commission, the commission may place restrictions, including suspending new member attribution to the health care entity, and may assess a civil penalty to the health care entity of not more than $500,000 for a first violation, not more than $750,000 for a second violation and not more than the amount by which the health care entity failed to meet the primary care expenditure target for a third or subsequent violation. The commission shall promote compliance with this section and shall only impose a civil penalty as a last resort.

(q) The commission shall promulgate regulations, consistent with applicable federal laws and regulations, as necessary to implement this section.

(r) Nothing in this section shall be construed to affect or limit the applicability of the health care cost growth benchmark established pursuant to section 9 and the obligations of a health care entity pursuant thereto.

SECTION 10. 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) the disaggregated number of full-time equivalent primary care physicians, nurses, nurse practitioners, physician assistants and care coordinators; (iv) the organization's current primary care patient panel; (v) information regarding provider capacity which shall include, but not be limited to, patient panel size and wait times; (vi) the name and address of licensed facilities; and (vii) information about movement of funds, including the distribution of claims and nonclaims 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; and (viii) such other information as the commission considers appropriate.

SECTION 11. Section 1 of chapter 12C of the General Laws, as so appearing, is hereby amended by inserting after the definition of “acute hospital” the following 2 definitions:-

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

“Aggregate primary care expenditure target”, the targeted sum, set by the commission pursuant to section 9A of chapter 6D, of all primary care expenditures in the commonwealth in the calendar year in which the aggregate primary care expenditure target applies.

SECTION 12. 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 4 definitions:-

“Primary care”, the provision of integrated, accessible health care services for people of all ages provided as first-contact, longitudinal care by a licensed primary care clinician, such as physicians and their care teams, including, but not limited to, nurses, nurse practitioners, physician assistants and care coordinators.

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

“Primary care expenditure target”, the targeted sum set by the commission pursuant to section 9A of chapter 6D of all primary care expenditures, as defined by the center, by or

attributed to an individual health care entity in the calendar year in which the entity's primary care expenditure target applies.

"Primary care services", services that are person-centered and team-based and delivered by a primary care provider including, problem-focused office visits, preventative office visits and services, routine evaluation and management, management of chronic conditions, administration of immunizations and injections, in-home and nursing facility visits, routine screening and assessments, integrated behavioral health care, coordination of care and any other services as defined by the primary care technical advisory council.

SECTION 13. Section 10 of said chapter 12C, as so appearing, is hereby amended by inserting after the word "chapter 176X", in line 32, the following words:- and information about expenses for administering prospective review and utilization review as defined in section 1 of said chapter 176O.

SECTION 14. Said chapter 12C is hereby further amended by inserting after section 15 the following section:-

Section 15A. (a) The center shall define "primary care expenditures" for the purposes of: (i) analyzing and reporting annual aggregate primary care baseline expenditures pursuant to subsection (d) of section 16 and comparing primary care baseline expenditures against the targets established by the health policy commission pursuant to section 9A of chapter 6D; and (ii) for health entities pursuant to said section 16 and comparing primary care baseline expenditures of health entities against the primary care expenditure target pursuant to section 18. The center shall consult with the office of primary care policy and payment and the primary care technical advisory council established in section 3B of said chapter 6D to determine the primary care

services, codes and providers to be included in the definition of primary care expenditures. The center shall review and revise the definition of "primary care expenditures" annually, as appropriate, in coordination with the primary care technical advisory council and the office of primary care policy and payment.

(b) The center shall develop a methodology for defining and measuring primary care spending based on summary level reporting from commercial and public payers. The methodology shall: (i) incorporate a designated list of primary care services by code and a list of provider types and non-claims payments to support primary care; (ii) align with primary care services as defined by the primary care technical advisory council pursuant to subsection (c) of section 3B of chapter 6D and be informed by, to the extent appropriate, methodologies used in other states; and (iii) allow for the measurement and tracking of pediatric primary care expenditures. The center shall post detailed information on its website on the methodology and data specifications it used to define and measure primary care expenditures.

(c) The center shall report annually on primary care expenditures, including as a share of total statewide health care expenditures, delineated by member, insurance type, a range of age groups, payer and managing clinician group.

SECTION 15. Section 16 of said chapter 12C, as so appearing, is hereby amended by adding the following 2 subsections:-

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

(e) The center, in consultation with the commission, shall determine the primary care baseline expenditures for individual health care entities and shall report to each health care entity its respective primary care baseline expenditures annually, not later than October 1.

SECTION 16. Said chapter 12C is hereby further amended by striking out section 18, as so appearing, and inserting in place thereof the following section:-

Section 18. The center shall perform ongoing analysis of data it receives under this chapter to identify any payers, providers or provider organizations: (i) whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the commonwealth to meet the health care cost growth benchmark established by the health care finance and policy commission under section 10 of chapter 6D; or (ii) for providers or provider organizations that provide primary care services whose expenditures fail to meet the primary care expenditure target under section 9A of said chapter 6D or if increased primary care spending results in growth in overall health care expenditure trends or a net new increase in health insurance premiums and cost-sharing; provided, however, that the growth calculation shall not include pharmaceutical spending. The center shall confidentially provide a list of the payers, providers and provider organizations to the health policy commission such that the commission may pursue further action under sections 10 and 10A of said chapter 6D.

SECTION 17. Chapter 15A of the General Laws is hereby amended by inserting after section 18 the following section:-

Section 18A. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Feed Schedule.

"MassHealth fee schedule", the claims-based rates component of the alternative payment methodology for medical and behavioral health services established in 101 CMR 304.00, or any successor regulation, as in effect as of July 1 of the preceding rate year of any given year.

(b) Notwithstanding any general or special law to the contrary, a student health insurance program or plan authorized under section 18 shall ensure that the rate of payment for any federally qualified health center services that are covered by the student health insurance program or plan and that are provided to a patient by a federally qualified health center, shall be in an amount at least equivalent to the applicable rate that the federally qualified health center would have received if reimbursed for such services under the MassHealth fee schedule and pursuant to the methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix).

(c) The division shall consult with MassHealth to receive technical assistance regarding the per visit payment rate for each federally qualified health center for a given year.

SECTION 18. Chapter 32A of the General Laws is hereby amended by adding the following 2 sections:-

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

"Advanced primary care payment model", the payment model developed by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

"Division", the division of insurance.

"Independent primary care practice", a medical practice owned by 1 or more licensed primary care provider that provides primary care services and is not owned or controlled by another entity including, but not limited to, a health system, private equity company or corporation.

"Primary care provider", as defined in section 1 of chapter 6D.

"Provider organization", as defined in said section 1 of said chapter 6D.

(b) The commission shall implement the advanced primary care payment model in accordance with division rules, regulations and guidelines and any applicable federal laws and regulations.

(c) The commission shall implement the advanced primary care model in contracts with provider organizations required to register pursuant to section 11 of chapter 6D and shall provide all other contracted primary care providers with the option to participate in the advanced primary care payment model.

(d) Payments made to primary care providers and provider organizations participating in the advanced primary care payment model shall be included in the health status adjusted total medical expense and total medical expense calculated by the center for health information and analysis under section 16 of chapter 12C.

(e) Participating primary care providers and provider organizations, except for participating independent primary care practices, shall provide such attestations and reports and submit to such audits as may be required by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

Section 36. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Feed Schedule.

"MassHealth fee schedule", the claims-based rates component of the alternative payment methodology for medical and behavioral health services established in 101 CMR 304.00, or any successor regulation, as in effect as of July 1 of the preceding rate year of any given year.

(b) Notwithstanding any general or special law to the contrary, the commission shall ensure that the rate of payment for any federally qualified health center services that are covered by the commission and that are provided to a patient by a federally qualified health center shall be in an amount at least equivalent to the applicable rate that the federally qualified health center would have received if reimbursed under the MassHealth fee schedule and pursuant to the methodology that conforms with 42 U.S.C. 1396b(m)(2)(A)(ix).

SECTION 19. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 88. (a) The executive office of health and human services, in consultation with the Massachusetts League of Community Health Centers, Inc., shall develop a graduate medical education payment for post-graduate residency and other training in community-based primary care, behavioral health and other areas of physician or provider shortage in community-based healthcare settings; provided, however, that such payments may support community-based training for other health professionals. The majority of eligible post-graduate residency placements in each year shall be in a community health center which shall mean an entity receiving funding pursuant to 42 U.S.C. 254b. The executive office shall seek to obtain the maximum amount of federal reimbursement for such payments.

SECTION 20. Chapter 175 of the General Laws is hereby amended by inserting after section 47CCC the following 2 sections:-

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

"Advanced primary care payment model", the payment model developed by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

"Division", the division of insurance.

"Independent primary care practice", a medical practice owned by 1 or more licensed primary care provider that provides primary care services and is not owned or controlled by

another entity including, but not limited to, a health system, private equity company or corporation.

"Primary care provider", as defined in section 1 of chapter 6D.

"Provider organization", as defined in said section 1 of said chapter 6D.

(b) Any carrier offering a policy, contract, agreement, plan or certificate of insurance to be issued, delivered or renewed within the commonwealth shall adopt and implement the advanced primary care payment model in accordance with division rules, regulations and guidelines and any applicable federal laws and regulations.

(c) The carrier shall implement the advanced primary care payment model in contracts with provider organizations required to register pursuant to section 11 of chapter 6D and provide all other primary care practices with the option to participate in the advanced primary care payment model for enrollees attributed to the primary care provider or provider organization for primary care.

(d) Payments made to primary care providers and provider organizations participating in the advanced primary care payment model shall be included in the health status adjusted total medical expense and total medical expense calculated by the center for health information and analysis under section 16 of chapter 12C.

(e) Participating primary care providers and provider organizations, except for participating independent primary care practices, shall provide such attestations and reports and submit to such audits as may be required by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

Section 47EEE. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Feed Schedule.

"MassHealth fee schedule", the claims-based rates component of the alternative payment methodology for medical and behavioral health services established in 101 CMR 304.00, or any successor regulation, as in effect as of July 1 of the preceding rate year of any given year.

(b) Any carrier offering a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall ensure that the rate of payment for any federally qualified health center services that are covered by the carrier offering a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth and that are provided to a patient by a federally qualified health center shall be in an amount at least equivalent to the applicable rate that the federally qualified health center would have received if reimbursed for such services under MassHealth fee schedule and pursuant to the methodology that conforms with 42 U.S.C. section 1396b(m)(2)(A)(ix).

(c) The division shall consult with MassHealth to receive technical assistance regarding the per visit payment rate for each federally qualified health center for a given year.

SECTION 21. Chapter 176A of the General Laws hereby amended by inserting after section 8DDD the following 2 sections:-

Section 8EEE. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Advanced primary care payment model", the payment model developed by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

"Division", the division of insurance.

"Independent primary care practice", a medical practice owned by 1 or more licensed primary care providers that provides primary care services and is not owned or controlled by another entity including, but not limited to, a health system, a private equity company or a corporation.

"Primary care provider", as defined in section 1 of chapter 6D.

"Provider organization", as defined in said section 1 of said chapter 6D.

(b) A nonprofit hospital service corporation offering an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall implement the advanced primary care payment model in accordance with division rules, regulations and guidelines and any applicable federal laws and regulations.

(c) Nonprofit hospital service corporations shall: implement the advanced primary care payment model in contracts with provider organizations required to register pursuant to section 11 of chapter 6D and provide all other primary care practices with the option to participate in the

advanced primary care payment model for enrollees attributed to the primary care provider or provider organization for primary care.

(d) Payments made to primary care providers and provider organizations participating in the advanced primary care payment model shall be included in the health status adjusted total medical expense and total medical expense calculated by the center for health information and analysis under section 16 of chapter 12C.

(e) Participating primary care providers and provider organizations, except for participating independent primary care practices, shall provide such attestations and reports and submit to such audits as may be required by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

Section 8FFF. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described defined in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Fee Schedule101 CMR 304.00.

"MassHealth fee schedule", the claims-based rates component of the alternative payment methodology for medical and behavioral health services established in 101 CMR 304.00, or any successor regulation, as in effect as of July 1 of preceding rate year of any given year.

(b) Any contract between a subscriber and a nonprofit hospital service corporation pursuant to an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall ensure that the rate of payment for the federally qualified health center services that are covered by the contract between a subscriber and a nonprofit hospital service corporation pursuant to an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth and that are provided to a patient by a federally qualified health center shall be in an amount at least equivalent to the applicable rate that the federally qualified health center would have received if reimbursed for such services under the MassHealth fee schedule and pursuant to methodology that conforms with 42 U.S.C. section 1396b(m)(2)(A)(ix).

(c) The division shall consult with MassHealth to receive technical assistance regarding the per visit payment rate for each federally qualified health center for any given year.

SECTION 22. Chapter 176B of the General Laws is hereby amended by inserting after section 4DDD the following 3 sections:-

Section 4EEE. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

“Advanced primary care payment model”, the payment model developed by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

“Division”, the division of insurance.

“Independent primary care practice”, a medical practice owned by 1 or more licensed primary care providers that provides primary care services and is not owned or controlled by

another entity including, but not limited to, a health system, private equity company or corporation.

"Primary care provider", as defined in section 1 of chapter 6D.

"Provider organization", as defined in said section 1 of said chapter 6D.

(b) Any medical service corporation offering a subscription certificate pursuant to an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall implement the advanced primary care payment model, as developed by the office of primary care policy and payment pursuant to section 3B of chapter 6D and in accordance with division rules, regulations and guidelines and applicable federal laws and regulations.

(c) The carrier shall implement the advanced primary care payment model in contracts with provider organizations required to register pursuant to section 11 of chapter 6D and provide all other primary care practices with the option to participate in the advanced primary care payment model for enrollees attributed to the primary care provider or provider organization for primary care.

(d) Payments made to primary care providers and provider organizations participating in the advanced primary care payment model shall be included in the health status adjusted total medical expense and total medical expense calculated by the center for health information and analysis pursuant to section 16 of chapter 12C.

(e) Participating primary care providers and provider organizations, except for participating independent primary care practices, shall provide such attestations and reports and

submit to such audits as may be required by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

Section 4FFF. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described defined in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Fee Schedule101 CMR 304.00.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount at least equivalent to the applicable rate that the community health center would have received if reimbursed by MassHealth pursuant to rates in effect as of July 1 of the preceding rate year and methodology that conforms with 42 U.S.C. section 1396b(m)(2)(A)(ix).

(c) The division shall consult with MassHealth to receive technical assistance regarding the per visit payment rate for each federally qualified health center for any given year.

SECTION 23. Chapter 176E of the General Laws is hereby amended by inserting after section 15A the following section:-

Section 15B. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described defined in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Fee Schedule101 CMR 304.00.

MassHealth fee schedule", the claims-based rates component of the alternative payment methodology for medical and behavioral health services established in 101 CMR 304.00, or any successor regulation, as in effect as of July 1 of preceding rate year of any given year.

(b) Notwithstanding any general or special law to the contrary, a dental service corporation organized under this chapter shall ensure that the rate of payment for any federally qualified health center services that are covered by the dental service corporation and that are provided to a patient by a federally qualified health center shall be in an amount at least equivalent to the applicable rate that the federally qualified health center would have received if reimbursed for such services under the MassHealth fee schedule and pursuant to the methodology that conforms with 42 U.S.C. section 1396b(m)(2)(A)(ix).

(c) The division shall consult with MassHealth to receive technical assistance regarding the per visit payment rate for each federally qualified health center for a given year.

SECTION 24. Chapter 176G of the General Laws is hereby amended by inserting after section 4VV the following 2 sections:-

Section 4WW. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Advanced primary care payment model", the payment model developed by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

"Division", the division of insurance.

"Independent primary care practice", a medical practice owned by 1 or more licensed primary care providers which that provides primary care services and is not owned or controlled by another entity including, but not limited to, a health system, private equity company or corporation.

"Primary care provider", as defined in section 1 of chapter 6D.

"Provider organization", as defined in said section 1 of said chapter 6D.

(b) A health maintenance organization offering a policy, contract, agreement, plan or certificate to be issued or renewed within the commonwealth shall implement the advanced primary care payment model in accordance with division rules, regulations and guidelines and any applicable federal laws and regulations.

(c) Health maintenance organizations shall implement the advanced primary care payment model in contracts with provider organizations required to register pursuant to section 11 of chapter 6D and provide all other primary care practices with the option to participate in the

advanced primary care payment model for enrollees attributed to the primary care provider or provider organization for primary care.

(d) Payments made to primary care providers and provider organizations participating in the advanced primary care payment model shall be included in the health status adjusted total medical expense and total medical expense calculated by the center for health information and analysis pursuant to section 16 of chapter 12C.

(e) Participating primary care providers and provider organizations, except for participating independent primary care practices, shall provide such attestations and reports and submit to such audits as may be required by the office of primary care policy and payment pursuant to section 3B of chapter 6D.

Section 4XX. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Division", the division of insurance.

"Federally qualified health center", as defined as a "community health center" in 101 CMR 614.00.

"Federally qualified health center services", medical and behavioral health services described defined in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Fee Schedule101 CMR 304.00.

"MassHealth fee schedule", the claims-based rates component of the alternative payment methodology for medical and behavioral health services established in 101 CMR 304.00, or any successor regulation, as in effect as of July 1 of preceding rate year of any given year.

(b) Notwithstanding any general or special law to the contrary, a health maintenance organization organized pursuant to this chapter shall ensure that the rate of payment for any federally qualified health center services that are covered by the health maintenance organization and that are provided to a patient by a federally qualified health center shall be in an amount at least equivalent to the applicable rate that the federally qualified health center would have received if reimbursed for such services under the MassHealth fee schedule and pursuant to methodology that conforms with 42 U.S.C. section 1396b(m)(2)(A)(ix).

(c) The division shall consult with MassHealth to receive technical assistance regarding the per visit payment rate for each federally qualified health center for a given year.

SECTION 25. Section 80 of chapter 343 of the acts of 2024 is hereby repealed.

SECTION 26. Subsection (e) of section 16 of chapter 12C of the General Laws shall take effect October 1, 2027.

SECTION 27. The office of primary care policy and payment, in coordination with the primary care technical advisory council, and in consultation with the division of insurance, shall seek to align each component and requirement of the initial advanced primary care payment model with MassHealth's primary care sub-capitation program as set forth in section 3B of chapter 6D.

SECTION 30. The first annual report pursuant to subsection (g) of section 3A of chapter 6D shall not be published until the office of primary care policy and payment has issued all recommendations under clause (i) through clause (xi) of subsection (b)(1).

SECTION 31. The center for health information and analysis shall define “primary care expenditures” pursuant to sections 16 and 18 of chapter 12C not later than June 30, 2027.

SECTION 32. The division of insurance shall issue final guidance governing the implementation of the advanced primary care payment model described in section 3B of chapter 6D under sections 5, 18, 20, 21, 22 and 24 not later than December 31, 2027.

SECTION 33. The division of insurance shall promulgate final rules and regulations for the issuance of payments to community health centers under sections 17, 20, 21, 22, 23 and 24 not later than January 1, 2027.

SECTION 34. The executive office of health and human services shall promulgate any rules and regulations necessary to implement section 88 of chapter 118E within 180 days of the effective date of this act.