

**SENATE . . . . . No. 3116**

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**The Commonwealth of Massachusetts**

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

**SENATE . . . . . No. 3116**

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**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:*

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

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

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

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

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

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

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

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

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

31 SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further  
32 amended by inserting after the definition of “Primary care provider” the following definition:-

33 “Primary care services”, services that are person-centered and team-based and delivered  
34 by a primary care provider, including, problem-focused office visits, preventative office visits

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

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

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

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

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

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

76 (3) For enrollees attributed to a primary care provider or provider organization for  
77 primary care: (i) all provider and provider organizations required to register pursuant to section  
78 11 shall implement the advanced primary care payment model in contracts with carriers, and in

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

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

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

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

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

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

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

114 (1) a per-member per-month rate methodology; provided, however, that as a part of the  
115 methodology, the office of primary care and payment shall, in coordination with the primary care  
116 technical advisory council and in consultation with the division of insurance, consider the  
117 historical monthly primary care spending per patient at the primary care provider or provider  
118 organization level, the historical statewide monthly primary care spending per patient, the  
119 primary care expenditure data published in the center's annual report under section 16 of chapter  
120 12C, relevant differences in adult and pediatric primary care and any other factors deemed  
121 relevant by the office. The per-member per-month payment shall be adjusted based on: (i) a  
122 participating provider or provider organization's adoption of advanced primary care services and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

266 (5) The commission, in collaboration with the center for health information and analysis,  
267 the group insurance commission and the division of insurance, shall monitor the implementation  
268 of this section with the goal of ensuring that any increase in primary care spending does not  
269 result in an increase in the growth of overall health care expenditure trends or any net new  
270 increase in health insurance premiums and cost-sharing. The commission shall hold payers and  
271 providers accountable for any such increases pursuant to section 10A.

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

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

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

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

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

293 SECTION 9. Said chapter 6D is hereby further amended by inserting after section 10 the  
294 following section:-

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

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

299 or if increased primary care spending results in growth in overall health care expenditure trends  
300 or any net new increase in health insurance premiums and cost-sharing; provided, however, that  
301 the growth calculation shall not include pharmaceutical spending. Such notice shall be delivered  
302 not more than 45 days after the release of the center's published annual report pursuant to section  
303 16 of chapter 12C and shall state that the center may analyze the performance of individual  
304 health care entities in meeting the primary care expenditure target and the commission shall  
305 require certain actions established in this section.

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

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

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

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

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

343 (g) The commission shall provide to the department of public health any notice requiring  
344 a health care entity to file and implement a performance improvement plan pursuant to this  
345 section. If a health care entity required to file a performance improvement plan under this section  
346 submits an application for a notice of determination of need under sections 25C or 51 of chapter  
347 111, the notice of the commission requiring the health care entity to file and implement a  
348 performance improvement plan pursuant to this section shall be considered part of the written  
349 record pursuant to said section 25C of said chapter 111.

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

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

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

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

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

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

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

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

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

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

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

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

409 SECTION 10. Section 11 of said chapter 6D, as appearing in the 2024 Official Edition, is  
410 hereby amended by striking out subsection (b) and inserting in place thereof the following  
411 subsection:-

412 (b) The commission shall require that all provider organizations report the following  
413 information for registration and renewal: (i) organizational charts showing the ownership,  
414 governance and operational structure of the provider organization, including any clinical  
415 affiliations, parent entities, corporate affiliates, significant equity investors, health care real estate  
416 investment trusts, management services organizations and community advisory boards; (ii) the  
417 number of affiliated health care professional full-time equivalents and the number of  
418 professionals affiliated with or employed by the organization; (iii) the disaggregated number of  
419 full-time equivalent primary care physicians, nurses, nurse practitioners, physician assistants and  
420 care coordinators; (iv) the organization's current primary care patient panel; (v) information  
421 regarding provider capacity which shall include, but not be limited to, patient panel size and wait  
422 times; (vi) the name and address of licensed facilities; and (vii) information about movement of  
423 funds, including the distribution of claims and nonclaims payments from payers to providers,  
424 including primary care providers employed and affiliated with the provider organization and the  
425 allocation of expenses to support primary care providers; and (viii) such other information as the  
426 commission considers appropriate.

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

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

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

435 SECTION 12. Said section 1 of said chapter 12C, as so appearing, is hereby further  
436 amended by inserting after the definition of “pharmacy benefit manager” the following 4  
437 definitions:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

510 “Division”, the division of insurance.

511 “Federally qualified health center”, as defined as a “community health center” in 101  
512 CMR 614.00.

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

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

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

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

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

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

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

534 “Division”, the division of insurance.

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

539 “Primary care provider”, as defined in section 1 of chapter 6D.

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

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

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

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

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

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

558 “Division”, the division of insurance.

559 “Federally qualified health center”, as defined as a “community health center” in 101  
560 CMR 614.00.

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

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

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

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

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

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

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

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

590 “Division”, the division of insurance.

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

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

595 “Primary care provider”, as defined in section 1 of chapter 6D.

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

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

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

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

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

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

616 “Division”, the division of insurance.

617 “Federally qualified health center”, as defined as a “community health center” in 101  
618 CMR 614.00.

619 “Federally qualified health center services”, medical and behavioral health services  
620 described in 42 U.S.C. 1396(a)(2)(C) that have a rate established in the MassHealth Fee  
621 Schedule.

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

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

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

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

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

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

641 “Division”, the division of insurance.

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

646 “Primary care provider”, as defined in section 1 of chapter 6D.

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

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

652 (c) Nonprofit hospital service corporations shall: implement the advanced primary care  
653 payment model in contracts with provider organizations required to register pursuant to section  
654 11 of chapter 6D and provide all other primary care practices with the option to participate in the

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

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

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

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

667 “Division”, the division of insurance.

668 “Federally qualified health center”, as defined as a “community health center” in 101  
669 CMR 614.00.

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

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

676 (b) Any contract between a subscriber and a nonprofit hospital service corporation  
677 pursuant to an individual or group hospital service plan that is delivered, issued or renewed  
678 within the commonwealth shall ensure that the rate of payment for the federally qualified health  
679 center services that are covered by the contract between a subscriber and a nonprofit hospital  
680 service corporation pursuant to an individual or group hospital service plan that is delivered,  
681 issued or renewed within the commonwealth and that are provided to a patient by a federally  
682 qualified health center shall be in an amount at least equivalent to the applicable rate that the  
683 federally qualified health center would have received if reimbursed for such services under the  
684 MassHealth fee schedule and pursuant to methodology that conforms with 42 U.S.C. section  
685 1396b(m)(2)(A)(ix).

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

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

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

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

694 “Division”, the division of insurance.

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

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

699 “Primary care provider”, as defined in section 1 of chapter 6D.

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

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

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

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

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

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

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

722 “Division”, the division of insurance.

723 “Federally qualified health center”, as defined as a “community health center” in 101  
724 CMR 614.00.

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

728 (b) A subscription certificate under an individual or group medical service agreement  
729 delivered, issued or renewed within the commonwealth shall ensure that the rate of payment for  
730 any federally qualified health center services provided to a patient by a community health center  
731 shall be reimbursed in an amount at least equivalent to the applicable rate that the community  
732 health center would have received if reimbursed by MassHealth pursuant to rates in effect as of  
733 July 1 of the preceding rate year and methodology that conforms with 42 U.S.C. section  
734 1396b(m)(2)(A)(ix).

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

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

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

741 “Division”, the division of insurance.

742 “Federally qualified health center”, as defined as a “community health center” in 101  
743 CMR 614.00.

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

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

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

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

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

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

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

765 “Division”, the division of insurance.

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

770 “Primary care provider”, as defined in section 1 of chapter 6D.

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

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

776 (c) Health maintenance organizations shall implement the advanced primary care  
777 payment model in contracts with provider organizations required to register pursuant to section  
778 11 of chapter 6D and provide all other primary care practices with the option to participate in the

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

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

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

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

791 “Division”, the division of insurance.

792 “Federally qualified health center”, as defined as a “community health center” in 101  
793 CMR 614.00.

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

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

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

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

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

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

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

817 SECTION 30. The first annual report pursuant to subsection (g) of section 3A of chapter  
818 6D shall not be published until the office of primary care policy and payment has issued all  
819 recommendations under clause (i) through clause (xi) of subsection (b)(1).

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

822 SECTION 32. The division of insurance shall issue final guidance governing the  
823 implementation of the advanced primary care payment model described in section 3B of chapter  
824 6D under sections 5, 18, 20, 21, 22 and 24 not later than December 31, 2027.

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

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