

SENATE No. 3141

Senate, June 18, 2016 -- Text of the Senate Bill relative to primary care for you (Senate, No. 3141) (being the text of Senate, No. 3116, printed as amended)

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; provided, however, that such expenditures
7 shall not include pharmaceuticals, including medically-administered drugs.

8 “Aggregate primary care expenditure target”, the targeted sum set by the commission
9 pursuant to section 9A of all primary care expenditures as defined by the center, in the
10 commonwealth in the calendar year in which the aggregate primary care expenditure target
11 applies; provided, however, that such expenditures shall not include pharmaceuticals, including
12 medically-administered drugs.

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

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

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

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

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

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

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

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

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

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

56 care; and (iv) develop recommendations to ensure that increases to primary care expenditures do
57 not add to overall health care spending.

58 (b)(1) The office shall, in coordination with the primary care technical advisory council
59 established pursuant to subsection (c) and in consultation with the division of insurance, establish
60 a standard primary care capitated payment model under which commercial payers shall pay
61 participating providers or provider organizations a prospective, per-member per-month payment
62 for patients attributed to the participating provider or provider organization for primary care
63 which, for the purposes of this section shall be the advanced primary care payment model. The
64 advanced primary care payment model shall include, but not be limited to, guidelines on: (i)
65 covered primary care services; (ii) per-member per-month rate methodology; (iii) enhanced
66 payments for advanced primary care services and investments; (iv) member attribution
67 methodology, including a 24-month look-back of utilization; (v) risk adjustment, including social
68 risk adjustment methodology; (vi) primary care quality measures; (vii) primary care
69 reimbursement and a set of spending reporting requirements for participating providers or
70 provider organizations; (viii) audits of participating providers or provider organizations; (ix) the
71 timely provisioning of data from payers to primary care providers to effectively manage care; (x)
72 patient cost-sharing limits or prohibitions on cost-sharing; and (xi) ensuring payers provide
73 reimbursement for medically necessary services that are not covered by the advanced primary
74 care payment model.

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

79 (3) For enrollees attributed to a primary care provider or provider organization for
80 primary care: (i) all provider and provider organizations required to register pursuant to section
81 11 that provides primary care services shall implement the advanced primary care payment
82 model in contracts with carriers, and in contracts with the group insurance commission; and (ii)
83 all other primary care practices shall have the option to participate in the advanced primary care
84 payment model.

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

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

93 (c) There shall be within the commission a primary care technical advisory council,
94 which shall advise the office of primary care policy and payment regarding the development of
95 the advanced primary care payment model. The members of the primary care technical advisory
96 council shall consist of: (i) the director of MassHealth, who shall serve as co-chair; (ii) the
97 commissioner of insurance, who shall serve as co-chair; (iii) the executive director of the center
98 for health information and analysis; and (iv) 8 persons to be appointed by the executive director
99 of the health policy commission, of whom 1 shall be an expert in health care payment
100 methodologies from Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be an

101 expert in health care payment methodologies nominated by Massachusetts Association of Health
102 Plans, Inc., 1 of whom shall be an actuary with experience in developing health care payment
103 methodologies, 1 of whom shall be an expert in health care quality measurement; 3 of whom
104 shall be primary care physicians with expertise in delivering care, at least 1 of whom shall be a
105 primary care physician with experience managing primary care physician practices, including
106 independent practices, multi-specialty practices or community health centers and practices
107 owned or affiliated with hospital-based systems and 1 of whom shall be an expert in primary care
108 from Health Care for All, Inc.

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

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

118 (1) a per-member per-month rate methodology; provided, however, that as a part of the
119 methodology, the office of primary care and payment shall, in coordination with the primary care
120 technical advisory council and in consultation with the division of insurance, consider the
121 historical monthly primary care spending per patient at the primary care provider or provider
122 organization level, the historical statewide monthly primary care spending per patient, the

123 primary care expenditure data published in the center’s annual report under section 16 of chapter
124 12C, relevant differences in adult and pediatric primary care and any other factors deemed
125 relevant by the office. The per-member per-month payment shall be adjusted based on: (i) a
126 participating provider or provider organization’s adoption of advanced primary care services and
127 investment in primary care services; (ii) the quality of patient care delivered by a participating
128 provider or provider organization; and (iii) the clinical and social risk of patients attributed to a
129 participating provider or provider organization for primary care; provided, however, that there
130 shall be a comprehensive accounting for the differences between pediatric and adult care. A
131 primary care practice shall generate at least as much revenue as a fee-for-service payment model
132 generates in relation to historical monthly primary care spending per patient at the primary care
133 provider or provider organization level.

134 (2) The office of primary care policy and payment, in coordination with the primary care
135 technical advisory council and in consultation with the division of insurance, shall: (i) identify
136 advanced primary care services and investments in primary care delivery that may qualify
137 participating providers or provider organizations for enhanced payments under the advanced
138 primary care payment model; and (ii) consider enhanced primary care services and investments
139 that are: (A) evidence-informed or evidence-based; (B) improve primary care quality; (C)
140 increase primary care access; (D) enhance a patient’s primary care experience; (E) promote
141 health equity in primary care for children and adults; (F) reduce avoidable hospitalizations and
142 emergency department utilization; and (G) manage chronic diseases more effectively. In
143 determining the enhanced payment rates, the office shall consider the strength of evidence that
144 the advanced service or investment will: (i) improve patient health; (ii) enhance patient
145 experience; (iii) improve clinician experience, including reducing administrative burden; (iv)

146 decrease total medical expense; and (v) promote health equity. Enhanced primary care services
147 and investments may include, but shall not be limited to: (i) integrating behavioral health
148 services with primary care including use of the psychiatric collaborative care model; (ii)
149 investing in social determinants of health; (iii) using clinician optimization programs to reduce
150 documentation burden; (iv) investing in care management; (v) offering walk-in or same-day care
151 appointments and extended hours of availability; (vi) providing medication-assisted treatment;
152 and (vii) delivering any other primary care services that may be deemed relevant by the office, in
153 coordination with the primary care technical advisory council and in consultation with the
154 division of insurance. There shall be a structure to implement the enhanced primary care services
155 and investments which may include, but shall not be limited to, clinical tiers.

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

169 payment methodology based on quality measures; and (iii) consider and seek to align the
170 measures with the MassHealth quality indicators for managed care entities, the standard quality
171 measure set and the aligned measure set.

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

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

189 (6) The office of primary care policy and payment shall, in coordination with the primary
190 care technical advisory council, the center for health information and analysis and the division of

191 insurance, develop and maintain a mandatory attestation, reporting and audit process for
192 participating providers or provider organizations; provided, however, that such process shall not
193 apply to independent primary care practices. Such process shall seek to ensure that primary care
194 payments under the model are directed to primary care practices or for supports that directly
195 benefit primary care practices; provided, however, that not less than 90 per cent of the per-
196 member per-month payment to participating providers or provider organizations shall be directly
197 allocated to and retained at the practice level, with not more than 10 per cent of the per-member
198 per-month payment distributed at the system level for use in system-level services that benefit or
199 are otherwise used by primary care practices participating in the system.

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

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

213 (f) The office of primary care policy and payment shall, in coordination with the primary
214 care technical advisory council and in consultation with the division of insurance, conduct
215 ongoing monitoring and analysis of statewide implementation of the advanced primary care
216 payment model and shall make adjustments to the advanced primary care payment model
217 pursuant to applicable regulations.

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

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

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

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

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

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

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

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

256 expenditure target shall be equal to 9 per cent of the total health care expenditures attributable to
257 each health care entity.

258 (2) For the calendar year 2029, the aggregate primary care expenditure target shall be
259 equal to 12 per cent of total health care expenditures in the commonwealth and the primary care
260 expenditure target shall be equal to 12 per cent of the total health care expenditures attributable
261 to each health care entity.

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

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

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

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

280 (c) Prior to making any recommended modification to the aggregate primary care
281 expenditure target and the primary care expenditure target under paragraph (4) of subsection (b),
282 the commission shall hold a public hearing to examine: (i) the report submitted by the center
283 under section 16 of chapter 12C, comparing the aggregate primary care expenditures to the
284 aggregate primary care expenditure target; (ii) any other data submitted by the center; (iii) the
285 performance of health care entities in meeting the primary care expenditure target; (iv) the
286 performance of the commonwealth's health care system in meeting the aggregate primary care
287 expenditure target; and (v) other pertinent information or data as may be available to the
288 commission.

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

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

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

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

302 (b) The commission shall provide written notice to any health care entity identified by the
303 center under section 18 of chapter 12C for its failure to meet the primary care expenditure target
304 or if increased primary care spending results in growth in overall health care expenditure trends
305 or any net new increase in health insurance premiums and cost-sharing; provided, however, that
306 the growth calculation shall not include pharmaceutical spending. Such notice shall be delivered
307 not more than 45 days after the release of the center’s published annual report pursuant to section
308 16 of chapter 12C and shall state that the center may analyze the performance of individual
309 health care entities in meeting the primary care expenditure target and the commission shall
310 require certain actions established in this section.

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

320 performance improvement plan with the commission; or (ii) file an application with the
321 commission to waive or extend the requirement to file a performance improvement plan.

322 (d) The health care entity may file any documentation or supporting evidence with the
323 commission to support the health care entity's application to waive or extend the requirement to
324 file a performance improvement plan within 15 days of receipt of written notice to the health
325 care entity that it is required to file a performance improvement plan. The commission shall
326 require the health care entity to submit any other relevant information it deems necessary in
327 considering the waiver or extension application; provided, however, that such information may
328 be made public as determined by the commission.

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

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

348 (g) The commission shall provide to the department of public health any notice requiring
349 a health care entity to file and implement a performance improvement plan pursuant to this
350 section. If a health care entity required to file a performance improvement plan under this section
351 submits an application for a notice of determination of need under sections 25C or 51 of chapter
352 111, the notice of the commission requiring the health care entity to file and implement a
353 performance improvement plan pursuant to this section shall be considered part of the written
354 record pursuant to said section 25C of said chapter 111.

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

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

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

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

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

384 (m) All health care entities shall, in good faith, work to implement the performance
385 improvement plan. At any point during the implementation of the performance improvement

386 plan the health care entity may file amendments to the performance improvement plan which
387 amendments shall be subject to approval of the commission.

388 (n) At the conclusion of the timetable established in the performance improvement plan,
389 the health care entity shall report to the commission on the outcome of the performance
390 improvement plan. If the performance improvement plan was found to be unsuccessful, the
391 commission shall either: (i) extend the implementation timetable of the existing performance
392 improvement plan; (ii) approve amendments to the performance improvement plan as proposed
393 by the health care entity; (iii) require the health care entity to submit a new performance
394 improvement plan under subsection (c); or (iv) waive or delay the requirement to file additional
395 performance improvement plans.

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

398 (p) If the commission determines that a health care entity has: (i) willfully neglected to
399 file a performance improvement plan with the commission by the time required in subsection (h);
400 (ii) failed to file an acceptable performance improvement plan in good faith with the
401 commission; (iii) failed to implement the performance improvement plan in good faith; or (iv)
402 knowingly failed to provide or knowingly falsified information required by this section to the
403 commission, the commission may place restrictions, including suspending new member
404 attribution to the health care entity, and may assess a civil penalty to the health care entity of not
405 more than \$500,000 for a first violation, not more than \$750,000 for a second violation and not
406 more than the amount by which the health care entity failed to meet the primary care expenditure

407 target for a third or subsequent violation. The commission shall promote compliance with this
408 section and shall only impose a civil penalty as a last resort.

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

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

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

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

429 including primary care providers employed and affiliated with the provider organization and the
430 allocation of expenses to support primary care providers; and (viii) such other information as the
431 commission considers appropriate.

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

434 “Aggregate primary care baseline expenditures”, the sum of all primary care expenditures
435 in the commonwealth in the calendar year preceding the year in which the aggregate primary
436 care expenditure target applies; provided, however, that such expenditures shall not include
437 pharmaceuticals, including medically-administered drugs.

438 “Aggregate primary care expenditure target”, the targeted sum, set by the commission
439 pursuant to section 9A of chapter 6D, of all primary care expenditures in the commonwealth in
440 the calendar year in which the aggregate primary care expenditure target applies; provided,
441 however, that such expenditures shall not include pharmaceuticals, including medically-
442 administered drugs.

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

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

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

454 “Primary care expenditure target”, the targeted sum set by the commission pursuant to
455 section 9A of chapter 6D of all primary care expenditures, as defined by the center, by or
456 attributed to an individual health care entity that provides primary care services in the calendar
457 year in which the entity’s primary care expenditure target applies.

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

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

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

470 Section 15A. (a) The center shall define “primary care expenditures” for the purposes of:
471 (i) analyzing and reporting annual aggregate primary care baseline expenditures pursuant to

472 subsection (d) of section 16 and comparing primary care baseline expenditures against the targets
473 established by the health policy commission pursuant to section 9A of chapter 6D; and (ii) for
474 health entities pursuant to said section 16 and comparing primary care baseline expenditures of
475 health entities against the primary care expenditure target pursuant to section 18. The center shall
476 consult with the office of primary care policy and payment and the primary care technical
477 advisory council established in section 3B of said chapter 6D to determine the primary care
478 services, codes and providers to be included in the definition of primary care expenditures. The
479 center shall review and revise the definition of “primary care expenditures” annually, as
480 appropriate, in coordination with the primary care technical advisory council and the office of
481 primary care policy and payment.

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

491 (c) The center shall report annually on primary care expenditures, including as a share of
492 total statewide health care expenditures, delineated by member, municipality, rural cluster as
493 defined by the department of public health, insurance type, a range of age groups, payer and
494 managing clinician group.

495 SECTION 15. Section 16 of said chapter 12C, as appearing in the 2024 Official Edition,
496 is hereby amended by adding the following 2 subsections:-

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

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

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

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

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

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

520 “Federally qualified health center”, a community health center as defined in 101 CMR
521 614.00.

522 “Federally qualified health center services”, medical and behavioral health services
523 described in 42 U.S.C. 1396d(1)(2)(A) and further defined in 101 CMR 304.00 that have a
524 prospective payment system rate established by MassHealth.

525 (b) Notwithstanding any general or special law to the contrary, any student health
526 insurance program or plan authorized pursuant to section 18 shall ensure that the rate of payment
527 for any federally qualified health center services covered by the student health insurance
528 program or plan and provided to a patient by a federally qualified health center shall be an
529 amount equal to or greater than the applicable rate that the federally qualified health center
530 would have received if reimbursed for such services by MassHealth and pursuant to the
531 methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix) pursuant to rates
532 as of July 1 of the preceding rate year.

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

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

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

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

541 “Division”, the division of insurance.

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

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

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

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

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

555 (d) Payments made to primary care providers and provider organizations participating in
556 the advanced primary care payment model shall be included in the health status adjusted total

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

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

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

565 “Federally qualified health center”, a community health center as defined in 101 CMR
566 614.00.

567 “Federally qualified health center services”, medical and behavioral health services
568 described in 42 U.S.C. 1396d(1)(2)(A) and further defined in 101 CMR 304.00 that have a
569 prospective payment system rate established by MassHealth.

570 (b) Notwithstanding any general or special law to the contrary, the commission shall
571 ensure that the rate of payment for any federally qualified health center services covered by the
572 commission and provided to a patient by a federally qualified health center shall be an amount
573 equal to or greater than the applicable rate that the federally qualified health center would have
574 received if reimbursed for such services by MassHealth and pursuant to the methodology that
575 conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix) pursuant to rates as of July 1 of the
576 preceding rate year.

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

579 Section 37. (a) For the purposes of this section, “serious mental illness” shall mean a
580 condition, as described by the most recent edition of the Diagnostic and Statistical Manual of
581 Mental Disorders published by the American Psychiatric Association, in which an individual
582 over the age of 18 has a diagnosable mental, behavioral or emotional disorder that causes serious
583 functional impairment, substantially interfering with or limiting 1 or more major life activities.

584 (b) The commission shall not impose a prior authorization requirement or delay on
585 prescribing and shall follow step therapy protocol pursuant to section 12A of chapter 176O for a
586 serious mental illness drug approved by the United States Food and Drug Administration.

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

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

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

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

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

604 “Division”, the division of insurance.

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

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

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

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

615 (c) The carrier shall implement the advanced primary care payment model in contracts
616 with provider organizations required to register pursuant to section 11 of chapter 6D that
617 provides primary care services and provide all other primary care practices with the option to

618 participate in the advanced primary care payment model for enrollees attributed to the primary
619 care provider or provider organization for primary care.

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

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

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

630 “Federally qualified health center”, a community health center as defined in 101 CMR
631 614.00.

632 “Federally qualified health center services”, medical and behavioral health services
633 described in 42 U.S.C. 1396d(1)(2)(A) and further defined in 101 CMR 304.00 that have a
634 prospective payment system rate established by MassHealth.

635 (b) Any carrier offering a policy, contract, agreement, plan or certificate of insurance
636 issued, delivered or renewed within the commonwealth shall ensure that the rate of payment for
637 any federally qualified health center services covered by such carrier and provided to a patient by
638 a federally qualified health center shall be an amount equal to or greater than the applicable rate

639 that the federally qualified health center would have received if reimbursed for such services by
640 MassHealth and pursuant to the methodology that conforms with 42 U.S.C. 1396a(bb) and
641 1396b(m)(2)(A)(ix) pursuant to rates as of July 1 of the preceding rate year.

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

644 Section 47FFF. (a) For the purposes of this section, “serious mental illness” shall mean a
645 condition, as described by the most recent edition of the Diagnostic and Statistical Manual of
646 Mental Disorders published by the American Psychiatric Association, in which an individual
647 over the age of 18 has a diagnosable mental, behavioral or emotional disorder that causes serious
648 functional impairment, substantially interfering with or limiting 1 or more major life activities.

649 (b) Notwithstanding any other provision of law, any carrier offering a policy, contract,
650 agreement, plan or certificate of insurance issued, delivered or renewed within the
651 commonwealth shall not impose a prior authorization requirement or delay on prescribing and
652 shall follow step therapy protocol pursuant to section 12A of chapter 176O for a serious mental
653 illness drug approved by the United States Food and Drug Administration.

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

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

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

660 “Division”, the division of insurance.

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

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

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

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

671 (c) Nonprofit hospital service corporations shall: implement the advanced primary care
672 payment model in contracts with provider organizations required to register pursuant to section
673 11 of chapter 6D that provides primary care services and provide all other primary care practices
674 with the option to participate in the advanced primary care payment model for enrollees
675 attributed to the primary care provider or provider organization for primary care.

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

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

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

686 “Federally qualified health center”, a community health center as defined in 101 CMR
687 614.00.

688 “Federally qualified health center services”, medical and behavioral health services
689 described in 42 U.S.C. 1396d(1)(2)(A) and further defined in 101 CMR 304.00 that have a
690 prospective payment system rate established by MassHealth.

691 (b) Any contract between a subscriber and a nonprofit hospital service corporation
692 pursuant to an individual or group hospital service plan that is delivered, issued or renewed
693 within the commonwealth shall ensure that the rate of payment for any federally qualified health
694 center services covered by the contract between a subscriber and a nonprofit hospital service and
695 provided to a patient by a federally qualified health center shall be an amount equal to or greater
696 than the applicable rate that the federally qualified health center would have received if
697 reimbursed for such services by MassHealth and pursuant to the methodology that conforms with
698 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix) pursuant to rates as of July 1 of the preceding rate
699 year.

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

702 Section 8GGG. (a) For the purposes of this section, “serious mental illness” shall mean a
703 condition, as described by the most recent edition of the Diagnostic and Statistical Manual of
704 Mental Disorders published by the American Psychiatric Association, in which an individual
705 over the age of 18 has a diagnosable mental, behavioral or emotional disorder that causes serious
706 functional impairment, substantially interfering with or limiting 1 or more major life activities.

707 (b) Notwithstanding any other provision of law, a nonprofit hospital service corporation
708 shall not impose a prior authorization requirement or delay on prescribing and shall follow step
709 therapy protocol pursuant to section 12A of chapter 176O for a serious mental illness drug
710 approved by the United States Food and Drug Administration.

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

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

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

717 “Division”, the division of insurance.

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

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

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

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

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

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

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

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

745 “Federally qualified health center”, community health center as defined in 101 CMR
746 614.00.

747 “Federally qualified health center services”, medical and behavioral health services
748 described in 42 U.S.C. 1396d(1)(2)(A) and further defined in 101 CMR 304.00 that have a
749 prospective payment system rate established by MassHealth.

750 (b) A subscription certificate under an individual or group medical service agreement
751 delivered, issued or renewed within the commonwealth shall ensure that the rate of payment for
752 any federally qualified health center services covered by such subscription certificate and
753 provided to a patient by a federally qualified health center shall be an amount equal to or greater
754 than the applicable rate that the federally qualified health center would have received if
755 reimbursed for such services by MassHealth and pursuant to the methodology that conforms with
756 42 U.S.C. § 1396a(bb) and 1396b(m)(2)(A)(ix) pursuant to rates as of July 1 of the preceding
757 rate year.

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

760 Section 4GGG. (a) For the purposes of this section, “serious mental illness”, shall mean a
761 condition, as described by the most recent edition of the Diagnostic and Statistical Manual of
762 Mental Disorders published by the American Psychiatric Association, in which an individual
763 over the age of 18 has a diagnosable mental, behavioral or emotional disorder that causes serious
764 functional impairment, substantially interfering with or limiting 1 or more major life activities.

765 (b) Notwithstanding any other provision of law, a subscription certificate under an
766 individual or group medical service agreement delivered, issued or renewed within the

767 commonwealth shall not impose a prior authorization requirement or delay on prescribing and
768 shall follow step therapy protocol pursuant to section 12A of chapter 176O for a serious mental
769 illness drug approved by the United States Food and Drug Administration.

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

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

774 “Federally qualified health center”, a community health center as defined in 101 CMR
775 614.00.

776 “Federally qualified health center services”, dental services described in 42 U.S.C.
777 1396d(l)(2)(A) and further defined in 101 CMR 304.00 that have a prospective payment system
778 rate established by MassHealth.

779 (b) A dental service corporation organized under this chapter shall ensure that the rate of
780 payment for any federally qualified health center services covered by such dental service
781 corporation and provided to a patient by a federally qualified health center shall be an amount
782 equal to or greater than the applicable rate that the federally qualified health center would have
783 received if reimbursed for such services by MassHealth and pursuant to the methodology that
784 conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix) pursuant to rates as of July 1 of the
785 preceding rate year.

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

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

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

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

794 “Division”, the division of insurance.

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

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

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

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

805 (c) Health maintenance organizations shall implement the advanced primary care
806 payment model in contracts with provider organizations required to register pursuant to section
807 11 of chapter 6D that provides primary care services and provide all other primary care practices

808 with the option to participate in the advanced primary care payment model for enrollees
809 attributed to the primary care provider or provider organization for primary care.

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

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

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

820 “Federally qualified health center”, a community health center as defined in 101 CMR
821 614.00.

822 “Federally qualified health center services”, medical and behavioral health services
823 described in 42 U.S.C. 1396d(1)(2)(A) and further defined in 101 CMR 304.00 that have a
824 prospective payment system rate established by MassHealth.

825 (b) A health maintenance organization organized pursuant to this chapter shall ensure that
826 the rate of payment for any federally qualified health center services covered by such health
827 maintenance organization and provided to a patient by a federally qualified health center shall be
828 an amount equal to or greater than the applicable rate that the federally qualified health center

829 would have received if reimbursed for such services by MassHealth and pursuant to the
830 methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix) pursuant to rates
831 as of July 1 of the preceding rate year.

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

834 Section 4YY. (a) For the purposes of this section, “serious mental illness”, shall mean a
835 condition, as described by the most recent edition of the Diagnostic and Statistical Manual of
836 Mental Disorders published by the American Psychiatric Association, in which an individual
837 over the age of 18 has a diagnosable mental, behavioral or emotional disorder that causes serious
838 functional impairment, substantially interfering with or limiting 1 or more major life activities.

839 (b) Notwithstanding any other provision of law, a health maintenance organization
840 organized pursuant to this chapter shall not impose a prior authorization requirement or delay on
841 prescribing and shall follow step therapy protocol pursuant to section 12A of chapter 176O for a
842 serious mental illness drug approved by the United States Food and Drug Administration.

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

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

846 SECTION 27. The office of primary care policy and payment, in coordination with the
847 primary care technical advisory council, and in consultation with the division of insurance, shall
848 seek to align each component and requirement of the initial advanced primary care payment

849 model with MassHealth’s primary care sub-capitation program as set forth in section 3B of
850 chapter 6D of the General Laws.

851 SECTION 28. The first annual report pursuant to subsection (g) of section 3A of chapter
852 6D of the General Laws shall not be published until the office of primary care policy and
853 payment has issued all recommendations under clause (i) through clause (xi) of subsection
854 (b)(1).

855 SECTION 29. The center for health information and analysis shall define “primary care
856 expenditures” pursuant to sections 16 and 18 of chapter 12C of the General Laws not later than
857 June 30, 2027.

858 SECTION 30. The division of insurance shall issue final guidance governing the
859 implementation of the advanced primary care payment model described in section 3B of chapter
860 6D of the General Laws under sections 5, 18, 20, 21, 22 and 24 not later than December 31,
861 2027.

862 SECTION 31. The division of insurance shall promulgate final rules and regulations for
863 the issuance of payments to community health centers under sections 17, 20, 21, 22, 23 and 24
864 not later than January 1, 2027.

865 SECTION 32. The executive office of health and human services shall promulgate any
866 rules and regulations necessary to implement section 88 of chapter 118E of the General Laws
867 within 180 days of the effective date of this act.