SENATE DOCKET, NO. 1906 FILED ON: 1/17/2025

SENATE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Cindy F. Friedman

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to primary care for you.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Cindy F. Friedman	*Fourth Middlesex*

SENATE DOCKET, NO. 1906 FILED ON: 1/17/2025

SENATE . . . . . No.

[Pin Slip]

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *750* OF 2023-2024.]

The Commonwealth of Massachusetts

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

An Act relative to primary care for you.

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

SECTION 1. Section 1 of chapter 6D of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after the definition of "After-hours care" the following definitions:-

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

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

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

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

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

SECTION 3. Chapter 6D of the General Laws, as amended by section 3 of chapter 342 of the acts of 2024, is hereby amended by inserting after section 3A the following section:-

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

(b) The board shall consist of: the secretary of health and human services or a designee, who shall serve as co-chair; the executive director of the health policy commission or a designee, who shall serve as co-chair; the assistant secretary for MassHealth or a designee; the executive director of the center for health information and analysis or a designee; the commissioner of insurance or a designee; the chairs of the joint committee on health care financing or their designees; 1 member from the American Academy of Family Physicians Mass Chapter, Inc.; 1 member from the Massachusetts chapter of the American Academy of Pediatrics; 1 member

from a rural health care practice with expertise in primary care who shall be appointed by the secretary of health and human services; 1 member from Community Care Cooperative, Inc.; 1 member from the Massachusetts Medical Society with expertise in primary care; 1 member from the Massachusetts Coalition of Nurse Practitioners, Inc. with expertise in primary care or in delivering care in a community health center; 1 member from the Massachusetts Association of Physician Associates, Inc. with expertise in primary care; 1 member from the Massachusetts chapter of the National Association of Social Workers, Inc. with expertise in behavioral health in a primary care setting; 1 member from the Massachusetts League of Community Health Centers, Inc.; 1 member from the Massachusetts Health and Hospital Association, Inc.; 1 member from the Massachusetts Association of Health Plans, Inc.; 1 member from Blue Cross and Blue Shield of Massachusetts, Inc.; 1 health care executive with expertise in the delivery of primary care in a community setting and expertise in health benefit plan design, who shall be appointed by the executive director of the health policy commission; 1 member from the Associated Industries of Massachusetts, Inc.; 1 member from the Retailers Association of Massachusetts, Inc.; 1 member from Health Care For All, Inc.; 1 member from the Massachusetts Chapter of the American College of Physicians; 1 member from the Massachusetts Primary Care Alliance for Patients; and 1 member from Massachusetts Health Quality Partners, Inc.

(c) The board shall develop recommendations to: (i) define primary care services, codes and providers; (ii) develop a standard set of data reporting requirements for private and public health care payers, providers and provider organizations to enable the commonwealth and private and public health care payers to track payments for primary care services including, but not limited to, fee-for-service, prospective payments, value-based payments and grants to primary care providers, fees levied on a primary care provider by a provider organization or hospital

system of which the primary care provider is affiliated and provider spending on primary care services; (iii) propose payment models to increase private and public reimbursement for primary care services, including, but not limited to, an all-payer primary care capitation model; (iv) assess the impact of health plan design on health equity and patient access to primary care services; (v) monitor and track the needs of and service delivery to residents of the commonwealth; (vi) create short-term and long-term workforce development plans to increase the supply and distribution of and improve working conditions of primary care clinicians and other primary care workers; and (vii) strengthen the integration of primary care and behavioral health and increase investment in behavioral health. The board may make additional recommendations and propose legislation necessary to carry out its recommendations.

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

(e)(1) The board shall propose a standard all-payer primary care capitation model, under which private payers shall pay participating providers or provider organizations a prospective, per-member per-month payment for patients attributed to the participating provider or provider organization for primary care. The proposed model shall include, but not be limited to: (i) definitions of primary care services, codes, and providers; (ii) per-member per-month rate methodology; (iii) enhanced payments for advanced primary care services and investments; (iv) patient cost-sharing limits for primary care; (v) member attribution methodology; (vi) primary

care quality measures; (vii) primary care reimbursement and spending reporting requirements for participating providers or provider organizations; and (viii) audits of participating providers or provider organizations.

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

(3) The board shall identify advanced primary care services and investments in primary care delivery that may qualify participating providers or provider organizations for enhanced payments under the all-payer primary care capitation model. Advanced primary care services and investments shall be evidence-informed or evidence-based, improve primary care quality, increase primary care access, enhance a patient's primary care experience, or promote health equity in primary care. Advanced primary care services and investments shall include, but not be limited to: (i) employing community health workers or health coaches as part of the primary care team; (ii) investing in social determinants of health; (iii) collaborating with primary care-based clinical pharmacists; (iv) integrating behavioral health care with primary care; (v) offering

substance use disorder treatment, including medication-assisted treatment, telehealth services, including telehealth consultations with specialists, medical interpreter services, home care, patient advisory groups, and group visits; (vi) using clinician optimization programs to reduce documentation burden, including, but not limited to, medical scribes and ambient voice technology; (vii) investing in care management, including employing social workers to help manage the care for patients with complicated health needs; (viii) establishing systems to facilitate end of life care planning and palliative care; (ix) developing systems to evaluate patient population health to help determine which preventative medicine interventions require patient outreach; (x) offering walk-in or same-day care appointments or extended hours of availability; and (xi) any other primary care service deemed relevant by the board. The board shall consider care delivery requirements established in the MassHealth primary care sub-capitation program.

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

(5) The board shall identify not more than 8 quality measures related to: (i) care continuity, comprehensiveness, and coordination; (ii) patient access to primary care; and (iii) patient experience. 4 of the 8 quality measures shall be measures of patient experience and 1 shall be a person-centered primary care measure. Each quality measure shall be patient-centered,

appropriate for a primary care setting, and supported by peer-reviewed, evidence-based research that the measure is actionable and that its use will lead to improvements in patient health. The board shall develop standard reporting requirements for the quality measures and standard per-member per-month rate adjustment methodology based on quality measures. The board shall consider MassHealth quality indicators for managed care entities.

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

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

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

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

(a) Not later than October 1 of every year, the commission shall hold public hearings based on the report submitted by the center under section 16 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year and comparing the growth in actual aggregate primary care expenditures

for the previous calendar year to the aggregate primary care expenditure target. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and challenge the ability of the commonwealth's health care system to meet the benchmark established under section 9 or the aggregate primary care expenditure target established under section 9A.

SECTION 5. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word "health", in line 95, the following words:- and primary care.

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

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

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

(1) For the calendar year 2027, the aggregate primary care expenditure target and the primary care expenditure target shall be equal to 8 per cent of total health care expenditures in the commonwealth;

(2) For the calendar year 2028, the aggregate primary care expenditure target and the primary care expenditure target shall be equal to 10 per cent of total health care expenditures in the commonwealth;

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

(4) For calendar years 2030 and beyond, if the commission determines that an adjustment in the aggregate primary care expenditure target and the primary care expenditure target is reasonably warranted, the commission may recommend modification to such targets, provided, that such targets shall not be lower than 12 per cent of total health care expenditures in the commonwealth.

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

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

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

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

(b) The commission shall provide notice to all health care entities that have been identified by the center under section 18 of chapter 12C for failure to meet the primary care expenditure target. Such notice shall state that the center may analyze the performance of individual health care entities in meeting the primary care expenditure target and, beginning in calendar year 2027, the commission may require certain actions, as established in this section, from health care entities so identified.

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

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

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

(d) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application; provided, however, that such information shall be made public at the discretion of the commission.

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

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

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

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

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

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

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

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

(m) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the commission regarding the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the commission shall either: (1) extend the implementation timetable of the existing performance improvement plan; (2) approve amendments to the performance improvement plan as proposed by the health care entity; (3) require the health care entity to submit a new performance

improvement plan under subsection (c); or (4) waive or delay the requirement to file any additional performance improvement plans.

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

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

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

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

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

SECTION 8. Section 1 of chapter 12C of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after the definition of "Acute hospital" the following definitions:-

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

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

SECTION 9. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Patient-centered medical home" the following definitions:-

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

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

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

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

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

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

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

SECTION 12. Chapter 15A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after section 18 the following new section:-

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

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

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

(b) Notwithstanding any general or special law to the contrary, any student health insurance program or plan authorized under Section 18 of Chapter 15A shall ensure that the rate of payment for any Federally Qualified Health Center services provided to a patient by a community health center, shall be reimbursed in an amount at least equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. § 1396a(bb) and 1396b(m)(2)(A)(ix) as they appear in Title 42 of the United States Code as of January 1, 2025.

SECTION 13. Chapter 32A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out section 31 and inserting in place thereof the following sections:-

Section 31. (a) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission benefits on a nondiscriminatory basis for medically necessary emergency services programs, as defined in section 1 of chapter 175. Services delivered by emergency services programs shall be deemed medically necessary and shall not require prior authorization. Services delivered by emergency service programs shall be covered with no patient cost-sharing; provided, however, that cost-

sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) The commission shall ensure that payment for outpatient services delivered by emergency services programs through a mental health center designated as a community behavioral health center pursuant to section 13D½ of chapter 118E shall be structured as a bundled rate per encounter using the same Healthcare Common Procedure Coding System code adopted by MassHealth and at a rate no less than the prevailing MassHealth rate for the same set of bundled services.

Section 31A. (a) For the purposes of this section, the following terms shall have the following meanings:

"Behavioral health urgent care provider", a mental health center designated as a behavioral health urgent care provider under 130 CMR 429.000.

"Behavioral health urgent care services", shall include, but not be limited to: (i) diagnostic psychiatric evaluations; (ii) individual, group, couple, and family therapy; (iii) psychotherapy for crisis; (iv) case consultation; (v) family consultation; or (vi) evaluation and management medication visits provided by a designated behavioral health urgent care provider.

(b) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission benefits on a nondiscriminatory basis for medically necessary behavioral health urgent care services provided by a behavioral health urgent care provider. Services delivered by a behavioral health urgent care provider shall be deemed medically necessary and shall not require prior authorization. Services delivered by a behavioral health urgent care provider shall be covered with no patient cost-sharing; provided,

however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(c) The commission shall ensure that payment for any services provided by a behavioral health urgent care provider include a rate add-on of at least 20 per cent over any negotiated fee schedule, provided that a carrier shall not lower a negotiated fee schedule to comply with this section. For purposes of this section, a carrier shall pay a rate add-on of at least 20 per cent for all behavioral health urgent care services delivered by a behavioral health urgent care provider regardless of whether the presenting reason for care is determined to be an urgent behavioral health need.

SECTION 14. Said chapter 32A, as so appearing, is hereby amended by inserting after section 33 the following 2 sections:-

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

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

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

"Division", the division of insurance.

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

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

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

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

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

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

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

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

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

(b) Notwithstanding any general or special law to the contrary, the commission shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount not less than equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

SECTION 15. Section 1 of chapter 175 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Emergency services programs" and inserting in place thereof the following definition:-

"Emergency services programs", community-based organizations providing emergency psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) emergency service provider community-based locations; (iv) emergency departments of acute care hospitals or satellite emergency facilities; (v) youth community crisis stabilization services; (vi) adult community crisis stabilization services; and (vii) a mental health center designated as a community behavioral health center pursuant to section 13D½ of chapter 118E, including outpatient behavioral health bundled services delivered by these centers.

SECTION 16. Said chapter 175, as so appearing, is hereby amended by striking out section 47RR and inserting in place thereof the following section:-

Section 47RR. (a) An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency services programs as defined in section 1. Services delivered by emergency services programs shall be deemed medically necessary and shall not require prior authorization. Services delivered by emergency service programs shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall ensure that reimbursement for outpatient services delivered by emergency services programs through a mental health center designated as a community behavioral health center pursuant to section 13D½ of chapter 118E, shall be structured as a bundled rate per encounter using the same Healthcare Common Procedure Coding System code adopted by MassHealth and at a rate no less than the prevailing MassHealth rate for the same set of bundled services.

SECTION 17. Chapter 175 of the General Laws, as amended by section 31 of chapter 342 of the acts of 2024, is hereby amended by inserting after section 47CCC the following 3 sections:-

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

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

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

"Division", the division of insurance.

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

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

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

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

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

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

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

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

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

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

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

(b) Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth and which is considered creditable coverage under section 1 of chapter 111M shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount not less than equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb)

and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

(c) Any entity licensed by the division of insurance and providing reimbursement to federally qualified health centers for services provided to patients, including, but not limited to, non-profit hospital service corporations, medical service corporations, dental service corporations, health maintenance organizations and preferred provider organizations or any other entity not specifically enumerated hereunder licensed by the division of insurance and providing reimbursement to federally qualified health centers for services provided to patients, shall submit an annual report to the division of insurance as a condition of their licensure evidencing that the total reimbursement to federally qualified health centers for services provided to patients in the prior year was equivalent to the annual aggregate revenue the health center would have received if reimbursed by MassHealth.

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

Section 47FFF. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Behavioral health urgent care provider", a mental health center designated as a behavioral health urgent care provider under 130 CMR 429.000.

"Behavioral health urgent care services", shall include, but not be limited to: (i) diagnostic psychiatric evaluations; (ii) individual, group, couple, and family therapy; (iii) psychotherapy for crisis; (iv) case consultation; (v) family consultation; or (vi) evaluation and management medication visits provided by a designated behavioral health urgent care provider.

(b) An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary behavioral health urgent care services provided by a behavioral health urgent care provider. Services delivered by a behavioral health urgent care provider shall be deemed medically necessary and shall not require prior authorization. Services delivered by a behavioral health urgent care provider shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(c) An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall ensure that payment for any services provided by a behavioral health urgent

care provider include a rate add-on of at least 20 per cent over any negotiated fee schedule, provided that a carrier shall not lower a negotiated fee schedule to comply with this section. For purposes of this section, a carrier shall pay a rate add-on of at least 20 per cent for all behavioral health urgent care services delivered by a behavioral health urgent care provider regardless of whether the presenting reason for care is determined to be an urgent behavioral health need.

SECTION 18. Chapter 176A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out section 8TT and inserting in place thereof the following section:-

Section 8TT. (a) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency services programs, as defined in section 1 of chapter 175. Services delivered by emergency services programs shall be deemed medically necessary and shall not require prior authorization. Services delivered by emergency service programs shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the commonwealth shall ensure that reimbursement for outpatient services delivered by emergency services programs through a mental health center designated as a community behavioral health center pursuant to section 13D½ of chapter 118E, shall be structured as a bundled rate per encounter

using the same Healthcare Common Procedure Coding System code adopted by MassHealth and at a rate no less than the prevailing MassHealth rate for the same set of bundled services.

SECTION 19. Chapter 176A of the General Laws, as amended by section 33 of chapter 342 of the acts of 2024, is hereby amended by inserting after section 8DDD the following 3 sections:-

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

"All-payer primary care capitation model", a standard value-based, prospective payment model under which health insurers pay participating providers or provider organizations per-member per-month payments for patients attributed to the participating providers or provider organizations for primary care. The per-member per-month payment may be adjusted based on: (i) a participating provider or provider organization's adoption of advanced primary care services and investment in primary care services; (ii) the quality of patient care delivered by a participating provider or provider organization; and (iii) the clinical and social risk of patients attributed to a participating provider or provider organization for primary care; provided, however, that implementation of the all-payer primary care capitation model complies with division of insurance rules, regulations and guidelines.

"Division", the division of insurance.

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

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

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

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

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

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

(f) Participating primary care providers and provider organizations shall submit primary care expenditure reports and internal contracts related to primary care delivery and payment to

the division, the center for health information and analysis and the health policy commission in accordance with division rules, regulations and guidelines.

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

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

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

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

(b) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount not less than equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

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

"Behavioral health urgent care provider", a mental health center designated as a behavioral health urgent care provider under 130 CMR 429.000.

"Behavioral health urgent care services", shall include, but not be limited to: (i) diagnostic psychiatric evaluations; (ii) individual, group, couple, and family therapy; (iii) psychotherapy for crisis; (iv) case consultation; (v) family consultation; or (vi) evaluation and management medication visits provided by a designated behavioral health urgent care provider.

(b) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary behavioral health urgent care services provided by a behavioral health urgent care provider. Services delivered by a behavioral health urgent care provider shall be deemed medically necessary and shall not require prior authorization. Services delivered by a behavioral health urgent care provider shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(c) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the commonwealth shall ensure that payment for any services provided by a behavioral health urgent care provider include a rate add-on of at least 20 per cent over any negotiated fee schedule, provided that a carrier shall not lower a negotiated fee schedule to comply with this section. For purposes of this section, a carrier shall pay a rate add-on of at least 20 per cent for all behavioral health urgent care services delivered by a behavioral health urgent care provider regardless of whether the presenting reason for care is determined to be an urgent behavioral health need.

SECTION 20. Chapter 176B of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out section 4TT and inserting in place thereof the following section:-

Section 4TT. (a) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency services programs, as defined in section 1 of chapter 175. Services delivered by emergency services programs shall be deemed medically necessary and shall not require prior authorization. Services delivered by emergency service programs shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within or without the commonwealth shall ensure that reimbursement for outpatient services delivered by emergency services programs through a mental health center designated as a community behavioral health center pursuant to section 13D½ of chapter 118E, shall be structured as a bundled rate per encounter using the same Healthcare Common Procedure Coding System code adopted by MassHealth and at a rate no less than the prevailing MassHealth rate for the same set of bundled services.

SECTION 21. Chapter 176B of the General Laws, as amended by section 34 of chapter 342 of the acts of 2024, is hereby amended by inserting after section 4DDD the following 3 sections:-

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

"All-payer primary care capitation model", a standard value-based, prospective payment model under which health insurers pay participating providers or provider organizations per-member per-month payments for patients attributed to the participating providers or provider organizations for primary care. The per-member per-month payment may be adjusted based on: (i) a participating provider or provider organization's adoption of advanced primary care services and investment in primary care services; (ii) the quality of patient care delivered by a participating provider or provider organization; and (iii) the clinical and social risk of patients attributed to a participating provider or provider organization for primary care; provided, however, that implementation of the all-payer primary care capitation model complies with division of insurance rules, regulations and guidelines.

"Division", the division of insurance.

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

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

participating primary care providers and provider organizations; and (viii) audits of participating primary care providers and provider organizations.

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

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

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

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

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

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

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

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

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth and which is considered creditable coverage under section 1 of chapter 111M shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount not less than equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

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

"Behavioral health urgent care provider", a mental health center designated as a behavioral health urgent care provider, under 130 CMR 429.000.

"Behavioral health urgent care services", shall include, but not be limited to: (i) diagnostic psychiatric evaluations; (ii) individual, group, couple, and family therapy; (iii) psychotherapy for crisis; (iv) case consultation; (v) family consultation; and (vi) evaluation and management medication visits provided by a designated behavioral health urgent care provider.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary behavioral health urgent care services provided by a behavioral health urgent care provider. Services delivered by a behavioral health urgent care

provider shall be deemed medically necessary and shall not require prior authorization. Services delivered by a behavioral health urgent care provider shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(c) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within or without the commonwealth shall ensure that payment for any services provided by a behavioral health urgent care provider include a rate add-on of at least 20 per cent over any negotiated fee schedule, provided that a carrier shall not lower a negotiated fee schedule to comply with this section. For purposes of this section, a carrier shall pay a rate add-on of at least 20 per cent for all behavioral health urgent care services delivered by a behavioral health urgent care provider regardless of whether the presenting reason for care is determined to be an urgent behavioral health need.

SECTION 22. Chapter 176E of the General Laws, as so appearing in the 2022 Official Edition, is hereby amended by inserting after section 15A the following section:-

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

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

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

(b) Notwithstanding any general or special law to the contrary, any dental service corporation organized under this chapter shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount not less than equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

SECTION 23. Chapter 176G of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out section 4LL and inserting in place thereof the following section:-

Section 4LL. (a) An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency services programs, as defined in section 1 of chapter 175. Services delivered by emergency services programs shall be deemed medically necessary and shall not require prior authorization. Services delivered by emergency service programs shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall ensure that reimbursement for outpatient services delivered by emergency services programs through a mental health center designated as a community behavioral health center pursuant to section 13D½ of chapter 118E, shall be structured as a

bundled rate per encounter using the same Healthcare Common Procedure Coding System code adopted by MassHealth and at a rate no less than the prevailing MassHealth rate for the same set of bundled services.

SECTION 24. Chapter 176G of the General Laws, as amended by section 35 of chapter 342 of the acts of 2024, is hereby amended by inserting after section 4VV the following 3 sections:-

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

"All-payer primary care capitation model", a standard value-based, prospective payment model under which health insurers pay participating providers or provider organizations per-member per-month payments for patients attributed to the participating providers or provider organizations for primary care. The per-member per-month payment may be adjusted based on: (i) a participating provider or provider organization's adoption of advanced primary care services and investment in primary care services; (ii) the quality of patient care delivered by a participating provider or provider organization; and (iii) the clinical and social risk of patients attributed to a participating provider or provider organization for primary care; provided, however, that implementation of the all-payer primary care capitation model complies with division of insurance rules, regulations and guidelines.

"Division", the division of insurance.

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

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

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

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

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

(f) Participating primary care providers and provider organizations shall submit primary care expenditure reports and internal contracts related to primary care delivery and payment to

the division, the center for health information and analysis and the health policy commission in accordance with division rules, regulations and guidelines.

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

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

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

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

(b) Notwithstanding any general or special law to the contrary, any health maintenance organization organized under this chapter shall ensure that the rate of payment for any federally qualified health center services provided to a patient by a community health center shall be reimbursed in an amount not less than equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

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

"Behavioral health urgent care provider", a mental health center designated as a behavioral health urgent care provider under 130 CMR 429.000.

"Behavioral health urgent care services", shall include, but not be limited to: (i) diagnostic psychiatric evaluations; (ii) individual, group, couple, and family therapy; (iii) psychotherapy for crisis; (iv) case consultation; (v) family consultation; or (vi) evaluation and management medication visits provided by a designated behavioral health urgent care provider.

(b) An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary behavioral health urgent care services provided by a behavioral health urgent care provider. Services delivered by a behavioral health urgent care provider shall be deemed medically necessary and shall not require prior authorization. Services delivered by a behavioral health urgent care provider shall be covered with no patient cost-sharing; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(c) An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall ensure that payment for any services provided by a behavioral health urgent care provider include a rate add-on of at least 20 per cent over any negotiated fee schedule, provided that a carrier shall not lower a negotiated fee schedule to comply with this section. For purposes of this section, a carrier shall pay a rate add-on of at least 20 per cent for all behavioral health urgent care services delivered by a behavioral health urgent care provider regardless of whether the presenting reason for care is determined to be an urgent behavioral health need.

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

SECTION 26. Not later than June 15, 2026, the primary care board established under section 3B of chapter 6D shall issue its report of the findings and recommendations under clauses (i) and (ii) of subsection (c) of section 3B of chapter 6D with the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

SECTION 27. Not later than September 15, 2026, the primary care board established under section 3B of chapter 6D shall issue its report of the findings and recommendations under clause (iii) of subsection (c) of section 3B of chapter 6D with the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

SECTION 28. Not later than December 15, 2026, the primary care board established under section 3B of chapter 6D shall issue its report of the findings and recommendations under clauses (iv) and (v) of subsection (c) of section 3B of chapter 6D with the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on health care financing, the center for health information and analysis, the health policy commission and the division of insurance.

SECTION 29. Not later than March 15, 2027, the primary care board established under section 3B of chapter 6D shall issue its report of the findings and recommendations under clauses (vi) and (vii) of subsection (c) of section 3B of chapter 6D with the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint

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

SECTION 30. Subsection (e) of section 16 of chapter 12C of the General Laws shall take effect October 1, 2026.

SECTION 31. Sections 12 through 24, inclusive, shall apply to all contracts entered into, renewed or amended on or after July 1, 2028.

SECTION 32. The center for health information and analysis shall define “primary care expenditures” for the purposes of analyzing and reporting primary care baseline expenditures for health entities pursuant to section 16 of chapter 12C and comparing primary care baseline expenditures of health entities against the primary care expenditure target pursuant to section 18 of chapter 12C not later than June 30, 2027. The center shall consider recommendations from the primary care board established under section 3B of chapter 6D when defining “primary care expenditures”.

SECTION 33. The division of insurance shall promulgate rules and regulations for implementation of the all-payer primary care capitation model by carriers under sections 14, 17, 19, 21 and 24 not later than December 31, 2027. Rules and regulations shall include, but not be limited to: (i) definitions of primary care services, codes, and providers; (ii) per-member per-month rate methodology; (iii) enhanced payments for advanced primary care services and investments; (iv) patient cost-sharing limits for primary care; (v) member attribution methodology; (vi) primary care quality measures; (vii) primary care reimbursement and spending reporting requirements for participating providers and provider organizations; and (viii) audits of participating providers and provider organizations. The division shall require the same all-payer

primary care capitation model to be implemented by carriers under sections 14, 17, 19, 21 and 24. The division shall consider recommendations from the primary care board established under section 3B of chapter 6D when developing and implementing rules and regulations.

SECTION 34. The division of insurance shall promulgate rules and regulations for the issuance of payments to community health centers under sections 12, 14, 17, 19, 21, 22 and 24 not later than January 1, 2027.