Committee on Public Health
Bill Summary

Bill No.	H2537
Title:	*An Act relative to primary care access*
Sponsor:	Representative Greg Schwartz
Committee:	Public Health
Hearing Date:	June 23, 2025
Similar Matters:	None
Prior History:	New File
Reporting Deadline:	August 22, 2025

Current Law:

- **M.G.L. Chapter 6D § 1** pertains to the health policy commission (HPC) and definitions used throughout the chapter.
- **M.G.L. Chapter 6D § 3** pertains to the powers and duties of the board governing the HPC
- **M.G.L. Chapter 6D § 8** pertains to the HPC's public hearings, witnesses, and annual report.
- **M.G.L. Chapter 6D § 9** pertains to pharmaceutical drug pricing; manufacturer disclosure of pricing information; determination of supplemental rebate, and proposed value or reasonableness of pricing of a drug.
- **M.G.L. Chapter 6D § 10** pertains to the health care cost growth benchmark; modification.
- **M.G.L. Chapter 12 C § 1** pertains to the center for health information and analysis (CHIA) and definitions used throughout the chapter.
- **M.G.L. Chapter 12C § 16** pertains to CHIA's annual report based on the information submitted under Sections 8, 9, 10 and hearings.
- **M.G.L. Chapter 12C § 18** pertains to CHIA's analysis of data received under Secs. 6, 9 and 10 to identify excessive increases in health status adjusted total medical expenses.
- **M.G.L. Chapter 32A** pertains to contributory group general or blanket insurance for persons in the service of the commonwealth.
- **M.G.L. Chapter 118E** pertains to the division of medical assistance.
- **M.G.L. Chapter 175** pertains to insurance.
- **M.G.L. Chapter 176A** pertains to non-profit hospital service corporations.
- **M.G.L. Chapter 176B § 1** pertains to medical service corporations and definitions used throughout the chapter.

- **M.G.L. Chapter 176E § 1** pertains to dental service corporations and definitions used throughout the chapter.
- **M.G.L. Chapter 176G § 1** pertains to health maintenance organizations and definitions used throughout the chapter.
- **M.G.L. Chapter 176I § 1** pertains to preferred provider arrangements and definitions used throughout the chapter.
- **Chapter 343 § 80 of the Acts of 2024** establishes a task force to study primary care access, delivery and payment in the commonwealth; 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 increase the financial investment in and patient access to primary care across the commonwealth.

Summary:

This bill takes a multipronged approach to strengthen Massachusetts' primary care system by:

- establishing a Primary Care Board within the Health Policy Commission (HPC) to develop recommendations for improving access, workforce recruitment and retention, payment models, and integration with behavioral health;
- introducing an all-payer primary care capitation model to be used by both public and private payors;
- setting expenditure targets for primary care as a share of total health spending—starting at 10% in 2027 and increasing to 12% in 2028;
- requiring public and private reimbursement rates for federally qualified health centers to align with MassHealth reimbursement rates; and,
- establishing graduate medical education payments for primary care specialties and other physician residency training in fields experiencing physician shortages.

SECTIONS 1-2 amend M.G.L Chapter 6D § 1 by inserting definitions for "Aggregate primary care baseline expenditures", "Aggregate primary care expenditure target", "Primary care baseline expenditures", and "Primary care expenditure target".

SECTION 3 amends M.G.L. Chapter 6D as amended by Chapter 342 § 3 of the acts of 2024 by inserting a new section: Section 3B.

Subsection (a) establishes a primary care board within the health policy commission (HPC). The primary care board will study primary care access, delivery, and payment in the Commonwealth; develop and issue recommendations to stabilize and strengthen the primary care system, increase recruitment and retention in the primary care workforce, and enhance the financial investment in and patient access to primary care across the Commonwealth.

Subsection (b) outlines the membership of the primary care board, which will consist of 25 members representing legislative, clinical, insurance, and patient advocacy stakeholders.

Subsection (c) directs the board to develop recommendations that:

- define primary care services, codes, and providers;
- develop standardized data reporting requirements for private and public health care payers, providers, and provider organizations;
- propose payment models increasing private and public reimbursement rates for primary care services, including, but not limited to, an all-payer primary care capitation model;
- assess how health plan design impacts health equity and patient access to primary care services;
- monitor and track the needs of and service delivery to Massachusetts residents;
- create short and long-term primary care workforce development plans; and,
- strengthen the integration of primary care and behavioral health care services while increasing investment in behavioral health.

The board may make additional recommendations outside those outlines and propose legislation necessary to implement recommendations.

Subsection (d) ensures the board, in consultation with the center for health information and analysis (CHIA), defines the data necessary to fulfill the requirements outlined in this section. CHIA must adopt necessary regulations to require providers and private and public health payers to submit any information or data the board needs to fulfill its duties pursuant to this section.

Subsection (e) inserts eight paragraphs that:

- Instruct the board to propose a standard all-payer primary care capitation model where private payers will pay participating providers or provider organizations a prospective, per-member per-month payment for patients attributed to the participating providers or provider organizations for primary care. The clause also outlines several factors of the proposed model
- Directs the board, when developing the per-member per-month rate methodology, to consider the per-member per-month rate methodology established by the MassHealth primary care sub-capitation program. The board may also 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 CHIA's annual report, and any other factors the board deems relevant. This clause also outlines factors that the board may use to adjust the per-member per-month payment rate.
- Ensures the board identifies advanced primary care services and investments in primary care delivery that may make participating providers or provider organizations eligible for enhanced payments under the all-payer primary care capitation model. Advanced primary care services and investments identified by the board must be evidence-informed or evidence-based, improve primary care quality or increase primary care access, enhance primary care experiences, or promote health equity in primary care. The board must consider care delivery requirements established under the MassHealth primary care sub-capitation

program. This paragraph also outlines several types of health care services that the board must identify as advanced primary care services and investments eligible for enhanced payments under the all-payer primary care capitation model.

- Requires the board to develop clinical tiers with minimum care delivery standards based on the board's identified advanced primary care services and investments. The board must establish enhanced payments for each clinical tier, considering the clinical tiers established in the MassHealth primary care sub-capitation program and the strength of evidence that the advanced service or investment will improve patient health or experience, enhance clinician experience, decrease total medical expenses, and promote health equity.
- Directs the board to identify no more than eight quality measures related to care continuity, comprehensiveness, and coordination; patient access to primary care; and patient experience. When identifying quality measures, the board must consider MassHealth quality indicators for managed care entities. Four of these quality measures must measure patient experience, and one must be a person-centered primary care measure. Quality measures must meet specific standards, including being supported by peer-reviewed, evidence-based research that demonstrates the measure is actionable and will lead to improved patient health. Additionally, the board must develop quality measure reporting requirements and a standard per-member per-month rate adjustment methodology based on identified quality measures.
- Mandates the board to identify measures of clinical and social complexity, promoting health equity and reducing opportunities to artificially increase the clinical and social complexity of patient panels. The board also must develop a standard per-member per-month rate adjustment methodology based on these measures.
- Ensures the board develops a member attribution methodology to allocate patients to participating providers and provider organizations for primary care under the all-payer primary care capitation model. When developing this methodology, the board should consider the member attribution process established in the MassHealth primary care sub-capitation program.
- Required the board to create an attestation, reporting, and audit process for participating providers or provider organizations. They should consider the attestation, reporting, and audit process established in the MassHealth primary care sub-capitation program.

SECTION 4 amends M.G.L. Chapter 6D § 8 by striking out subsection (a) and inserting new language that directs the health policy commission (HPC) to compare the growth in aggregate primary care expenditures for the previous calendar year to the aggregate primary care expenditure target in its annual report. This section also inserts language to ensure that as the HPC holds public hearings based on its annual report to examine various health care provider and payer costs, prices, and cost trends, the hearings also challenge the ability of the state's

health care system to meet the aggregate primary care expenditure target or the benchmark established under M.G.L. Chapter 6D § 9.

SECTION 5 further amends M.G.L. Chapter 6D by inserting a new section, Section 9A.

Subsection (a) directs the HPC to establish an aggregate primary care expenditure target for Massachusetts.

Subsection (b) establishes a progression timeline for the HPC to follow once it sets the aggregate primary care expenditure target. For calendar year 2027, the aggregate primary care expenditure target and the primary care expenditure target should be equivalent to 10% of the total health care expenditures in the state; thereafter, it will increase to 12% in calendar year 2028. If the HPC determines it needs to adjust the aggregate primary care expenditure target and the primary care expenditure target for calendar years 2029 and beyond, it may recommend modifications so long as the targets are not lower than 12% of the total health care expenditures in the state.

Subsection (c) mandates that the HPC hold a public hearing before making any recommended modifications to the aggregate primary care expenditure target and the primary care expenditure target. The hearing will examine health care entities' performance in meeting the primary care expenditure target and the state's health care system in meeting the aggregate primary care expenditure target. HPC must issue a public hearing notice at least 45 days prior and inform the joint committee on health care financing.

Subsection (d) further amends M.G.L. Chapter 6D by inserting a new section, Section 10A.

Subsection (a) defines "health care entity".

Subsection (b) instructs the HPC to notify all health care entities identified by the center for health information and analysis (CHIA) for failing to meet the primary care expenditure target.

Subsection (c) allows the HPC to require any health care entity that CHIA identifies as failing to meet the primary care expenditure target to file and enact a performance improvement plan. If the HPC requires a health care entity to implement a performance improvement plan, it must issue written notice to said health care entity. Selected health care entities have 45 days after receiving this written notice to respond to the HPC's request by filing an improvement plan or filing an application to waive or extend the requirement to file an improvement plan.

Subsection (d) enables health care entities to file documentation or supporting evidence with the HPC to support its application to waive or extend the requirement to file an improvement plan. The HPC can require health care entities to submit additional relevant information it deems necessary to consider said application, provided that this information can be made public at the HPC's discretion.

Subsection (e) allows the HPC to 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 by a health care entity under subsection (c).

Subsection (f) states that if the HPC declines to waive or extend the requirement for the health care entity to file an improvement, it must issue its decision in a written notice to said health care entity. The health care entity will then have to file a performance improvement plan with the HPC.

Subsection (g) directs the HPC to provide the department of public health (DPH) any notice requiring a health care entity to file and implement a performance improvement plan. If a health care entity submits an application for a notice of determination of need to DPH, the HPC's notice requiring said entity to implement an improvement plan will be considered a part of written record under M.G.L. Chapter 111 §25C.

Subsection (h) sets a timeline for health care entities to file performance improvement plans with the HPC, depending on whether they requested a waiver or extension on this requirement and whether that application was accepted or denied. Proposed performance improvement must meet certain standards outlined in this subsection.

Subsection (i) directs the HPC to approve performance improvement plans it determines are reasonably likely to address the underlying cause of the entity's inability to meet the primary care expenditure target and have reasonable expectations for successful plan implementation.

Subsection (j) states that if the primary care board finds a health care entity's performance improvement plan to be unacceptable or incomplete, the HPC can provide feedback on unmet criteria and allow the health care entity an additional 30 calendar days to revise and resubmit its plan.

Subsection (k) states that once the HPC approves a health care entity's proposed performance improvement plan, it must notify said entity to immediately begin implementation. The HPC will provide health care entities with assistance to ensure the successful implementation of performance improvement plans and determine additional reporting and compliance monitoring requirements for these health care entities.

Subsection (l) instructs all health care entities implementing performance improvement plans to do so in good faith and enables said health care entities to file amendments to performance improvement plans at any time during the implementation period. These amendments are subject to HPC approval.

Subsection (m) directs health care entities to report to the HPC the outcome of its performance improvement plan when concluded. If the performance improvement plan was not successful, the HPC may extend the implementation timetable for said entity's existing improvement plan; approve any amendments the health care entity submitted for its existing performance improvement plan; require the health care entity to submit a new performance improvement plan; or wave or delay the requirement for the health care entity to file any additional improvement plans.

Subsection (n) states that once a health care entity successfully completes a performance improvement plan, it will be removed from the HPC's website.

Subsection (o) enables the HPC to submit recommendations for proposed legislation to the joint committee on health care financing if it determines that further legislative authority is necessary achieve the health care quality and spending sustainability objectives pursuant to section 9A, assist health care entities in the implementation of performance improvement plans, or otherwise ensure compliance with the provisions of this section.

Subsection (p) outlines civil penalties the HPC may assess from health care entities it determines have willfully neglected to file a performance improvement plan within the timeline established in subsection (h); in good faith failed to either file an acceptable performance improvement plan or implement a performance improvement plan; or knowingly failed to provide the HPC with information required under this sesion or knowingly falsified information provided.

Subsection (q) instructs the HPC to promulgate the necessary regulations to implement provisions of this section.

Subsection (r) states that nothing in this section should 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.

SECTION 8 amends M.G.L. Chapter 12C § 1 by inserting definitions for "Aggregate primary care baseline expenditures", "Aggregate primary care expenditure target".

SECTION 9 amends M.G.L. Chapter 6D § 1 by inserting definitions for "Primary care baseline expenditures", and "Primary care expenditure target".

SECTION 10 amends M.G.L. Chapter 12C § 16 by inserting two new subsections: subsections (d) and (e).

Subsection (d) mandates CHIA to publish the aggregate primary care baseline expenditures in its annual report.

Subsection (e) instructs CHIA, in consultation with the HPC, to determine primary care baseline expenditures for individual health care entities. They must report to each health care entity to inform them of their respective primary care baseline expenditures by October 1 of each year.

SECTION 11 amends M.G.L. Chapter 12C § 18 by striking the section in its entirety and inserting new language. This language directs CHIA to perform ongoing analysis of the data it receives under this chapter to identify payers, providers, or provider organizations who meet the following conditions:

- display an increase in health status adjusted total medical expense or total medical expense that is considered excessive and threatens the state's ability to meet the health care cost growth benchmark set by HPC;
- display expenditures that fail to meet the primary care expenditure target, given that the provider or provider organization delivers primary care services.

CHIA will confidentially provide a list of the payer, providers, and provider organizations meeting any of the above conditions to the HPC such that they may pursue further actions under sections 10 and 10A of M.G.L. Chapter 6D.

SECTION 12 amends M.G.L. Chapter 32A by inserting a new section, Section 34.

Subsection (a) defines “All-payer primary care capitation model”, and “Division”.

Subsection (b) directs the group insurance commission (GIC) to implement the all-payer primary care capitation model in accordance with applicable division rules, regulations, and guidelines.

Subsection (c) requires the GIC to provide contracted primary care providers and health care organizations with the option to participate in the all-payer primary care capitation model.

Subsection (d) states that payments made to primary care providers and health care organizations participating in the all-payer primary care capitation model will be included in the health status adjusted total medical expense and total medical expense calculated by CHIA.

Subsection (e) ensures that primary care providers and health care organizations will attest to meeting the criteria for clinical tiers and submit to audits by the GIC.

Subsection (f) directs primary care providers and health care organizations participating in the all-payer primary care capitation model to submit primary care expenditure reports and internal contracts related to primary care delivery and payment to the division, CHIA, and the HPC.

Subsection (g) instructs primary care providers and health care organizations participating in the all-payer primary care capitation model to select four quality measures, as defined by the division, to track and report to the GIC each year.

SECTION 13 amends M.G.L. Chapter 32A by inserting a new section: Section 35.

Subsection (a) defines “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

Subsection (b) directs the GIC to ensure that the payment rate for any Federally Qualified Health Center Services provided to a patient at a community health center is reimbursed at an amount that is at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

SECTION 14 amends M.G.L. Chapter 118E by inserting a new section: Section 13d ¾.

Subsection (a) defines “community health center” as used throughout this chapter.

Subsection (b) states that community health centers will be reimbursed in an amount at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

SECTION 135 further amends M.G.L. Chapter 118E by adding a new section: Section 83.

Subsection (a) directs the office to make Graduate Medical Education payments for a number of primary care specialties enumerated in the bill, as well as other physician residency training in fields experiencing physician shortages, as determined by the secretary; given that these payments may support community-based training for other health professionals enumerated in the bill. Eligible recipients for these payments include community health centers and hospitals licensed in the Commonwealth. Payments will take into consideration several factors, including MassHealth utilization and residency fields experiencing physician shortages. The executive office must prioritize placements in community-based settings and organizations that serve a high proportion of public payers.

Subsection (b) states that the secretary, in consultation with the executive office of administration and finance, will determine an adequate amount of annual Medicaid graduate medical education funding needed to fulfill the requirements of this section, as well as state and other funding sources that can be used for graduate medical education expenditures, no later than July 1, 2025.

Subsection (c) states that the first annual payment made to qualified acute care hospitals and community health centers under this section will be made no later than October 1, 2025.

SECTION 14 amends M.G.L. Chapter 175 by inserting a new section: Section 47DDD.

Subsection (a) defines “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

Subsection (b) ensures that any entity licensed by the division of insurance that is providing reimbursements to federally qualified health centers for patient services will ensure that health services, including, but not limited to behavioral health services, telehealth services, primary care services and dental services, will be reimbursed in an amount on an annual basis at least equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

Subsection (c) states that entities licensed by the division of insurance (DOI) that are providing reimbursement to federally qualified health centers for patient services, 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 listed in this subsection licensed by the DOI that provides reimbursement to federally qualified health centers for patient services will do the following:

- ensure that these reimbursements are at an amount on an annual basis at least equivalent to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth; and,
- submit an annual report to DOI displaying that its total reimbursement to federally qualified health centers for patient health care services during the previous year was equal to the annual aggregate revenue the health center would have received if reimbursed by MassHealth. This report will be considered as a DOI licensure condition.

Subsection (d) states that a policy, contract, agreement, plan, or certificate of insurance issued, delivered, or renewed within or without the Commonwealth will not be required to reimburse a health care provider not contracted under the plan unless certain conditions are met.

Subsection (e) directs DOI to consult with MassHealth for technical assistance relating to the per-visit payment rate for each federally qualified health center in a given year. MassHealth will also provide DOI with an approximate individual prospective payment system rate for any federally qualified health center that has not yet received one.

SECTION 157 further amends M.G.L. Chapter 175 as amended by Chapter 342 § 31 of the acts of 2024, by inserting a new section: Section 47DDD.

Subsection (a) defines “All-payer primary care capitation model”, “Division”, and “Provider organization”.

Subsection (b) requires any policy, contract, agreement, plan, or certificate of insurance issued, delivered, or renewed in Massachusetts that is also considered creditable coverage pursuant to M.G.L. Chapter 111M § 1 to implement the all-payer primary care capitation model in accordance with applicable division rules, regulations, and guidelines.

Subsection (c) requires the carrier to offer contracted primary care providers and provider organizations the option to participate in the all-payer primary care capitation model.

Subsection (d) states that payments made to primary care providers and provider organizations participating in the all-payer primary care capitation model will be included in the health status adjusted total medical expense and total medical expense calculated by CHIA.

Subsection (e) ensures that primary care providers and provider organizations will attest to meeting the criteria for clinical tiers and submit to audits by the commission.

Subsection (f) directs primary care providers and provider organizations participating in the all-payer primary care capitation model to submit primary care expenditure reports and internal contracts related to primary care delivery and payment to the division, CHIA, and the HPC.

Subsection (g) instructs primary care providers and provider organizations participating in the all-payer primary care capitation model to select four quality measures, as defined by the division, to track and report to the commission each year.

SECTION 168 amends M.G.L. Chapter 176A as amended by Chapter 342 § 33 of the acts of 2024 by inserting a new section: Section 8EE.

Subsection (a) defines “All-payer primary care capitation model”, “Division”, “Primary care provider”, and “Provider organization”.

Subsection (b) ensures that any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued, or renewed within Massachusetts will implement the all-payer primary care capitation model in accordance with division rules, regulations, and guidelines.

Subsection (c) requires the carrier to offer contracted primary care providers and provider organizations the option to participate in the all-payer primary care capitation model.

Subsection (d) states that payments made to primary care providers and provider organizations participating in the all-payer primary care capitation model will be included in the health status adjusted total medical expense and total medical expense calculated by CHIA.

Subsection (e) ensures that primary care providers and provider organizations will attest to meeting the criteria for clinical tiers and submit to audits by the commission.

Subsection (f) directs primary care providers and provider organizations participating in the all-payer primary care capitation model to submit primary care expenditure reports and internal contracts related to primary care delivery and payment to the division, CHIA, and the HPC.

Subsection (g) instructs primary care providers and provider organizations participating in the all-payer primary care capitation model to select four quality measures, as defined by the division, to track and report to the commission each year.

SECTION 19 further amends M.G.L. Chapter 176A by inserting a new section: Section 39.

Subsection (a) defines “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

Subsection (b) directs any corporation organized under this chapter to ensure that the payment rate for any Federally Qualified Health Center Services provided to a patient at a community health center is reimbursed at an amount that is at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

Subsection (c) states that a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the Commonwealth will not be required to reimburse a health care provider for a health care service that is not a covered benefit under a health plan or reimburse a health care provider not contracted under said plan except if certain conditions are met.

SECTION 20 amends M.G.L. Chapter 176B § 1 by inserting definitions for “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

SECTION 21 further amends M.G.L. Chapter 176B by inserting a new section: Section 26.

Subsection (a) directs any medical service plan organized under this chapter to ensure that the payment rate for any Federally Qualified Health Center Services provided to a patient at a community health center is reimbursed at an amount that is at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

Subsection (b) states that a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the Commonwealth will not be required to reimburse a health care provider for a health care service that is not a covered benefit under a health plan or reimburse a health care provider not contracted under said plan except if certain conditions are met.

SECTION 1722 amends M.G.L. Chapter 176B, as amended by Chapter 342 § 34 of the acts of 2024, by inserting a new section: Section 4EEE.

Subsection (a) defines “All-payer primary care capitation model”, “Division”, and “Provider organization”.

Subsection (b) requires a subscription certificate under an individual or group medical service agreement issued, delivered, or renewed in Massachusetts that is also considered creditable coverage pursuant to M.G.L. Chapter 111M § 1 to implement the all-payer primary care capitation model in accordance with applicable division rules, regulations, and guidelines.

Subsection (c) requires the carrier to offer contracted primary care providers and provider organizations the option to participate in the all-payer primary care capitation model.

Subsection (d) states that payments made to primary care providers and provider organizations participating in the all-payer primary care capitation model will be included in the health status adjusted total medical expense and total medical expense calculated by CHIA.

Subsection (e) ensures that primary care providers and provider organizations will attest to meeting the criteria for clinical tiers and submit to audits by the commission.

Subsection (f) directs primary care providers and provider organizations participating in the all-payer primary care capitation model to submit primary care expenditure reports and internal contracts related to primary care delivery and payment to the division, CHIA, and the HPC.

Subsection (g) instructs primary care providers and provider organizations participating in the all-payer primary care capitation model to select four quality measures, as defined by the division, to track and report to the commission each year.

SECTION 23 amends M.G.L. Chapter 176E § 1 by inserting definitions for “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

SECTION 24 further amends M.G.L. Chapter 176E by inserting a new section: Section 15B.

Subsection (a) requires Dental Service Corporations organized under this chapter to ensure that the payment rate for any Federally Qualified Health Center Services provided to a patient at a community health center is reimbursed at an amount that is at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

Subsection (b) states that a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the Commonwealth will not be required to reimburse a health care provider for a health care service that is not a covered benefit under a health plan or reimburse a health care provider not contracted under said plan except if certain conditions are met.

SECTION 25 amends M.G.L. Chapter 176G § 1 by inserting definitions for “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

SECTION 1826 further amends M.G.L. Chapter 176 as amended by Chapter 342 § 35 of the acts of 2024, by inserting a new section: Section 4WW.

Subsection (a) defines “All-payer primary care capitation model”, “Division”, and “Provider organization”.

Subsection (b) requires individual group health maintenance contracts issued, delivered, or renewed in Massachusetts that are also considered creditable coverage pursuant to M.G.L. Chapter 111M § 1 to implement the all-payer primary care capitation model in accordance with applicable division rules, regulations, and guidelines.

Subsection (c) requires the carrier to offer contracted primary care providers and provider organizations the option to participate in the all-payer primary care capitation model.

Subsection (d) states that payments made to primary care providers and provider organizations participating in the all-payer primary care capitation model will be included in the health status adjusted total medical expense and total medical expense calculated by CHIA.

Subsection (e) ensures that primary care providers and provider organizations will attest to meeting the criteria for clinical tiers and submit to audits by the commission.

Subsection (f) directs primary care providers and provider organizations participating in the all-payer primary care capitation model to submit primary care expenditure reports and internal contracts related to primary care delivery and payment to the division, CHIA, and the HPC.

Subsection (g) instructs primary care providers and provider organizations participating in the all-payer primary care capitation model to select four quality measures, as defined by the division, to track and report to the commission each year.

SECTION 27 further amends M.G.L. Chapter 176G by inserting a new section: Section 34.

Subsection (a) directs any Health Maintenance Organization organized under Massachusetts state laws to ensure that the payment rate for any Federally Qualified Health Center Services provided to a patient at a community health center is reimbursed at an amount that is at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

Subsection (b) states that a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the Commonwealth will not be required to reimburse a health care provider for a health care service that is not a covered benefit under a health plan or reimburse a health care provider not contracted under said plan except if certain conditions are met.

SECTION 28 amends M.G.L. Chapter 176I § 1 by inserting definitions for “Federally Qualified Health Center” and “Federally Qualified Health Center Services”.

SECTION 29 further amends M.G.L. Chapter 176I by inserting a new section: Section 14.

Subsection (a) directs any preferred provider contract to ensure that the payment rate for any Federally Qualified Health Center Services provided to a patient at a community health center is reimbursed at an amount that is at least equal to the annual aggregate revenue that the health center would have received if reimbursed by MassHealth.

Subsection (b) states that a policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without the Commonwealth will not be required to reimburse a health care provider for a health care service that is not a covered benefit under a health plan or reimburse a health care provider not contracted under said plan except if certain conditions are met.

SECTION 1930 repeals Chapter 343§ 80 of the Acts of 2024. The repealed language established a task force within the HPC charged with studying primary care access, delivery and payment in the commonwealth; developing recommendations to stabilize and strengthen the primary care system and the increase of recruitment and retention in the primary care workforce; and increasing the financial investment in and patient access to primary care across the Commonwealth.

SECTION 2031 states that the primary care board must issue its report regarding its findings and recommendations under clauses (i) and (ii) of subsection (c) of section 3B of chapter 6D to the house and senate clerks, the house and senate ways and means committees, the joint committee on health care financing, CHIA, HPC, and DOI by June 15, 2026.

SECTION 2321 states that the primary care board must issue its report regarding its findings and recommendations under clauses (iii) of subsection (c) of section 3B of chapter 6D to the house and senate clerks, the house and senate ways and means committees, the joint committee on health care financing, CHIA, HPC, and DOI by September 15, 2026.

SECTION 3322 states that the primary care board must issue its report regarding its findings and recommendations under clauses (iv) and (v) of subsection (c) of section 3B of chapter 6D to the house and senate clerks, the house and senate ways and means committees, the joint committee on health care financing, CHIA, HPC, and DOI by December 15, 2026.

SECTION 3422 states that the primary care board must issue its report regarding its findings and recommendations under clauses (vi) and (vii) of subsection (c) of section 3B of chapter 6D to the house and senate clerks, the house and senate ways and means committees, the joint committee on health care financing, CHIA, HPC, and DOI by March 15, 2026.

SECTION 2354 states that Subsection (e) of section 16 of chapter 12C of the General Laws will take effect October 1, 2026.

SECTION 2365 states that sections 12, 14, 15, 16, and 17 will apply to all contracts entered into, renewed, or amended on or after July 1, 2028.

SECTION 2376 directs CHIA to define “primary care expenditures.” When defining this term, CHIA must consider recommendations from the primary care board.

SECTION 2378 requires DOI to promulgate rules and regulations to implement the all-payer primary care capitation model by carriers under sections 12, 14, 15, 16, and 17 by December 31, 2027. When developing and implementing these rules and regulations, they should consider recommendations from the primary care board. DOI also must require carriers under sections 12, 14, 15, 16, and 17 to implement the same all-payer primary care capitation.