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

SENATE . . . . . No. 867

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*	
Rebecca L. Rausch	*Norfolk, Worcester and Middlesex*	*1/28/2025*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*2/21/2025*
Mike Connolly	*26th Middlesex*	*3/5/2025*
James B. Eldridge	*Middlesex and Worcester*	*3/18/2025*
Adam J. Scanlon	*14th Bristol*	*3/21/2025*
Julian Cyr	*Cape and Islands*	*3/28/2025*
Michael D. Brady	*Second Plymouth and Norfolk*	*3/28/2025*
Margaret R. Scarsdale	*1st Middlesex*	*5/8/2025*
Pavel M. Payano	*First Essex*	*5/10/2025*
Jason M. Lewis	*Fifth Middlesex*	*5/15/2025*
John F. Keenan	*Norfolk and Plymouth*	*5/15/2025*
William J. Driscoll, Jr.	*Norfolk, Plymouth and Bristol*	*5/16/2025*
Jacob R. Oliveira	*Hampden, Hampshire and Worcester*	*6/6/2025*

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SENATE . . . . . No. 867

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 867) of Cindy F. Friedman, Rebecca L. Rausch, Joanne M. Comerford and Mike Connolly for legislation relative to primary care for you. Health Care Financing.

[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.

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

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

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

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

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

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

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

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

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

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

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

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

81 (2) In developing the per-member per-month rate methodology, the board may consider
82 the historical monthly primary care spending per patient at the primary care provider or provider
83 organization level, the historical monthly primary care spending per patient statewide, the
84 primary care expenditure data published in the center's annual report under section 16 of chapter
85 12C, and any other factors deemed relevant by the board. The per-member per-month payment
86 may be adjusted based on: (i) a participating provider or provider organization's adoption of
87 advanced primary care services and investment in primary care services; (ii) the quality of
88 patient care delivered by a participating provider or provider organization; and (iii) the clinical
89 and social risk of patients attributed to a participating provider or provider organization for
90 primary care. The board shall consider the per-member per-month rate methodology established
91 in the MassHealth primary care sub-capitation program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

337 "Federally Qualified Health Center Services", as such term is defined in 42 U.S.C.
338 1396(a)(2)(C), and as further defined in 101 CMR 304.00.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

401 "Division", the division of insurance.

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

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

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

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

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

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

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

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

429 "Federally Qualified Health Center Services", as such term is defined in 42 U.S.C.
430 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

431 (b) Notwithstanding any general or special law to the contrary, the commission shall
432 ensure that the rate of payment for any federally qualified health center services provided to a
433 patient by a community health center shall be reimbursed in an amount not less than equivalent
434 to the annual aggregate revenue that the health center would have received if reimbursed by
435 MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and
436 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

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

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

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

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

462 (b) An individual policy of accident and sickness insurance issued pursuant to section
463 108 that provides hospital expense and surgical expense insurance or a group blanket or general
464 policy of accident and sickness insurance issued pursuant to section 110 that provides hospital
465 expense and surgical expense insurance that is issued or renewed within or without the
466 commonwealth shall ensure that reimbursement for outpatient services delivered by emergency
467 services programs through a mental health center designated as a community behavioral health
468 center pursuant to section 13D½ of chapter 118E, shall be structured as a bundled rate per
469 encounter using the same Healthcare Common Procedure Coding System code adopted by
470 MassHealth and at a rate no less than the prevailing MassHealth rate for the same set of bundled
471 services.

472 SECTION 17. Chapter 175 of the General Laws, as amended by section 31 of chapter
473 342 of the acts of 2024, is hereby amended by inserting after section 47CCC the following 3
474 sections:-

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

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

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

487 "Division", the division of insurance.

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

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

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

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

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

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

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

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

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

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

518 "Federally Qualified Health Center Services", as such term is defined in 42 U.S.C.
519 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

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

526 and 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1,
527 2025.

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

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

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

547 “Behavioral health urgent care provider”, a mental health center designated as a
548 behavioral health urgent care provider under 130 CMR 429.000.

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

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

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

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

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

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

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

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

593 SECTION 19. Chapter 176A of the General Laws, as amended by section 33 of chapter
594 342 of the acts of 2024, is hereby amended by inserting after section 8DDD the following 3
595 sections:-

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

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

608 "Division", the division of insurance.

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

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

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

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

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

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

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

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

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

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

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

642 "Federally Qualified Health Center Services", as such term is defined in 42 U.S.C.
643 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

644 (b) Any contract between a subscriber and the corporation under an individual or group
645 hospital service plan that is delivered, issued or renewed within the commonwealth shall ensure
646 that the rate of payment for any federally qualified health center services provided to a patient by
647 a community health center shall be reimbursed in an amount not less than equivalent to the
648 annual aggregate revenue that the health center would have received if reimbursed by
649 MassHealth pursuant to methodology that conforms with 42 U.S.C. 1396a(bb) and
650 1396b(m)(2)(A)(ix), as appearing in Title 42 of the United States Code as of January 1, 2025.

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

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

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

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

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

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

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

688 (b) A subscription certificate under an individual or group medical service agreement
689 delivered, issued or renewed within or without the commonwealth shall ensure that
690 reimbursement for outpatient services delivered by emergency services programs through a
691 mental health center designated as a community behavioral health center pursuant to section
692 13D½ of chapter 118E, shall be structured as a bundled rate per encounter using the same
693 Healthcare Common Procedure Coding System code adopted by MassHealth and at a rate no less
694 than the prevailing MassHealth rate for the same set of bundled services.

695 SECTION 21. Chapter 176B of the General Laws, as amended by section 34 of chapter
696 342 of the acts of 2024, is hereby amended by inserting after section 4DDD the following 3
697 sections:-

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

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

710 "Division", the division of insurance.

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

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

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

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

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

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

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

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

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

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

741 “Federally Qualified Health Center Services”, as such term is defined in 42 U.S.C.
742 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

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

751 4GGG. (a) For the purposes of this section, the following terms shall have the following
752 meanings unless the context clearly requires otherwise:

753 “Behavioral health urgent care provider”, a mental health center designated as a
754 behavioral health urgent care provider, under 130 CMR 429.000.

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

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

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

768 (c) A subscription certificate under an individual or group medical service agreement
769 delivered, issued or renewed within or without the commonwealth shall ensure that payment for
770 any services provided by a behavioral health urgent care provider include a rate add-on of at least
771 20 per cent over any negotiated fee schedule, provided that a carrier shall not lower a negotiated
772 fee schedule to comply with this section. For purposes of this section, a carrier shall pay a rate
773 add-on of at least 20 per cent for all behavioral health urgent care services delivered by a
774 behavioral health urgent care provider regardless of whether the presenting reason for care is
775 determined to be an urgent behavioral health need.

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

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

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

781 "Federally Qualified Health Center Services", as such term is defined in 42 U.S.C.
782 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

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

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

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

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

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

808 SECTION 24. Chapter 176G of the General Laws, as amended by section 35 of chapter
809 342 of the acts of 2024, is hereby amended by inserting after section 4VV the following 3
810 sections:-

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

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

823 "Division", the division of insurance.

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

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

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

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

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

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

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

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

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

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

854 "Federally Qualified Health Center Services", as such term is defined in 42 U.S.C.
855 1396d(a)(2)(C), and as further defined in 101 CMR 304.00.

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

863 4YY. (a) For the purposes of this section, the following terms shall have the following
864 meanings unless the context clearly requires otherwise:

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

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

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

880 (c) An individual or group health maintenance contract that is issued or renewed within
881 or without the commonwealth shall ensure that payment for any services provided by a
882 behavioral health urgent care provider include a rate add-on of at least 20 per cent over any
883 negotiated fee schedule, provided that a carrier shall not lower a negotiated fee schedule to
884 comply with this section. For purposes of this section, a carrier shall pay a rate add-on of at least
885 20 per cent for all behavioral health urgent care services delivered by a behavioral health urgent
886 care provider regardless of whether the presenting reason for care is determined to be an urgent
887 behavioral health need.

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

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

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

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

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

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

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

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

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

924 SECTION 33. The division of insurance shall promulgate rules and regulations for
925 implementation of the all-payer primary care capitation model by carriers under sections 14, 17,
926 19, 21 and 24 not later than December 31, 2027. Rules and regulations shall include, but not be
927 limited to: (i) definitions of primary care services, codes, and providers; (ii) per-member per-
928 month rate methodology; (iii) enhanced payments for advanced primary care services and
929 investments; (iv) patient cost-sharing limits for primary care; (v) member attribution
930 methodology; (vi) primary care quality measures; (vii) primary care reimbursement and spending
931 reporting requirements for participating providers and provider organizations; and (viii) audits of
932 participating providers and provider organizations. The division shall require the same all-payer

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

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