

SENATE No.

The Commonwealth of Massachusetts

PRESENTED BY:

Cindy F. Friedman

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

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

An Act to increase investment in behavioral health care in the Commonwealth.

PETITION OF:

NAME:

Cindy F. Friedman

DISTRICT/ADDRESS:

Fourth Middlesex

SENATE No.

[Pin Slip]

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. 1248 OF 2023-2024.]

The Commonwealth of Massachusetts

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

An Act to increase investment in behavioral health care in the Commonwealth.

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

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

4 “Aggregate behavioral health baseline expenditures”, the sum of all behavioral health
5 expenditures, as defined by the center, in the commonwealth in the calendar year preceding the
6 3-year period to which the aggregate behavioral health expenditure target applies; provided,
7 however, that aggregate behavioral health baseline expenditures shall initially be calculated
8 using calendar year 2025.

9 “Aggregate behavioral health expenditure target”, the targeted rate of growth for
10 aggregate behavioral health baseline expenditures for a particular calendar year, as a percentage
11 established by the board.

12 SECTION 2. Said section 1 of said chapter 6D, as so appearing, is hereby further
13 amended by inserting after the definition of “Alternative payment methodologies or methods”
14 the following definitions:-

15 “Behavioral health baseline expenditures”, the sum of all behavioral health expenditures,
16 as defined by the center, by or attributed to an individual health care entity in the calendar year
17 preceding the 3-year period to which the behavioral health expenditure target applies; provided,
18 however, that behavioral health baseline expenditures shall initially be calculated using calendar
19 year 2025.

20 “Behavioral health expenditure target”, the targeted rate of growth for behavioral health
21 baseline expenditures for a particular calendar year, as a percentage established by the board.

22 SECTION 3. Section 8 of said chapter 6D, as so appearing, is hereby amended by
23 striking out subsection (a), as amended by section 6 of chapter 342 and section 16 of chapter 343
24 of the acts of 2024, and inserting in place thereof the following subsection:-

25 (a) Not later than October 1 of every year, the commission shall hold public hearings
26 based on the report submitted by the center under section 16 of chapter 12C comparing the
27 growth in total health care expenditures to the health care cost growth benchmark for the
28 previous calendar year and comparing the growth in actual aggregate behavioral health
29 expenditures for the previous calendar year to the aggregate behavioral health expenditure target.
30 The hearings shall examine the costs, prices and cost trends of health care providers, provider
31 organizations, private and public health care payers, pharmaceutical manufacturing companies
32 and pharmacy benefit managers and any relevant impact of significant equity investors, health
33 care real estate investment trusts, management services organizations on such costs, prices and

34 cost trends, with particular attention to factors that contribute to cost growth within the
35 commonwealth's health care system, and trends in annual primary care and behavioral health
36 expenditures, and factors that challenge the ability of the commonwealth's health care system to
37 meet the benchmark or the aggregate behavioral health expenditure target established under
38 section 9A.

39 SECTION 4. Said section 8 of said chapter 6D, as so appearing, is hereby further
40 amended by striking out subsection (g), as amended by section 6 of chapter 342 and section 16 of
41 chapter 343 of the acts of 2024, and inserting in place thereof the following subsection:-

42 (g) The commission shall compile an annual report concerning spending trends, including
43 primary care and behavioral health expenditures, and the underlying factors influencing said
44 spending trends. The report shall be based on the commission's analysis of information provided
45 at the hearings by witnesses, providers, provider organizations and payers, registration data
46 collected pursuant to section 11, data collected or analyzed by the center pursuant to sections 8 to
47 10A, inclusive, of chapter 12C and any other available information that the commission
48 considers necessary to fulfill its duties under this section, as defined in regulations promulgated
49 by the commission. The report shall be submitted to the house and senate committees on ways
50 and means and the joint committee on health care financing and shall be published and available
51 to the public not later than December 31 of each year. The report shall include recommendations
52 for strategies to increase the efficiency of the health care system and promote affordability for
53 individuals and families, recommendations on the specific spending trends that impede the
54 commonwealth's ability to meet the health care cost growth benchmark and the aggregate
55 behavioral health expenditure target, and draft legislation necessary to implement said
56 recommendations.

57 SECTION 5. Said chapter 6D is hereby further amended by inserting after section 9 the
58 following section:-

59 Section 9A. (a) The board shall establish an aggregate behavioral health expenditure
60 target for the commonwealth, which the commission shall prominently publish on its website.

61 (b) The commission shall establish the aggregate behavioral health expenditure target as
62 follows:

63 (1) For the 3-year period ending with calendar year 2028, the aggregate behavioral health
64 expenditure target in year 1, in year 2, and in year 3 shall be 30 per cent higher than aggregate
65 behavioral health baseline expenditures, and the behavioral health expenditure target in year 1, in
66 year 2, and in year 3 shall be 30 per cent higher than behavioral health baseline expenditures.

67 (2) For calendar years 2029 and beyond, the commission may modify the behavioral
68 health expenditure target and aggregate behavioral health expenditure target, to be effective for
69 each year of a 3-year period, provided that the behavioral health expenditure target and aggregate
70 behavioral health expenditure target shall be approved by a two-thirds vote of the board not later
71 than December 31 of the final calendar year of the preceding 3-year period. If the commission
72 does not act to establish an updated behavioral health expenditure target and aggregate
73 behavioral health expenditure target pursuant to this subsection, the behavioral health
74 expenditure target for each of the 3 years shall be 30 per cent higher than behavioral health
75 baseline expenditures, and the aggregate behavioral health expenditure target for each of the 3
76 years shall be 30 per cent higher than aggregate behavioral health baseline expenditures, until
77 such time as the commission acts to modify the behavioral health expenditure target and
78 aggregate behavioral health expenditure target. If the commission modifies the behavioral health

79 expenditure target and aggregate behavioral health expenditure target, the modification shall not
80 take effect until the 3-year period beginning with the next full calendar year.

81 (c) Prior to establishing the behavioral health expenditure target and aggregate behavioral
82 health expenditure target, the commission shall hold a public hearing. The public hearing shall be
83 based on the report submitted by the center under section 16 of chapter 12C, comparing the
84 actual aggregate expenditures on behavioral health services to the aggregate behavioral health
85 expenditure target, any other data submitted by the center and such other pertinent information or
86 data as may be available to the commission. The hearings shall examine the performance of
87 health care entities in meeting the behavioral health expenditure target and the commonwealth's
88 health care system in meeting the aggregate behavioral health expenditure target. The
89 commission shall provide public notice of the hearing at least 45 days prior to the date of the
90 hearing, including notice to the joint committee on health care financing. The joint committee on
91 health care financing may participate in the hearing. The commission shall identify as witnesses
92 for the public hearing a representative sample of providers, provider organizations, payers and
93 such other interested parties as the commission may determine. Any other interested parties may
94 testify at the hearing.

95 SECTION 6. Said chapter 6D is hereby further amended by inserting after section 10 the
96 following section:-

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

99 (b) The commission shall provide notice to all health care entities that have been
100 identified by the center under section 18 of chapter 12C for failure to meet the behavioral health

101 expenditure target. Such notice shall state that the center may analyze the performance of
102 individual health care entities in meeting the behavioral health expenditure target and, beginning
103 in calendar year 2029, the commission may require certain actions, as established in this section,
104 from health care entities so identified.

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

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

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

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

120 (e) The commission may waive or delay the requirement for a health care entity to file a
121 performance improvement plan in response to a waiver or extension request filed under
122 subsection (c) in light of all information received from the health care entity, based on a

123 consideration of the following factors: (1) the behavioral health baseline expenditures, costs,
124 price and utilization trends of the health care entity over time, and any demonstrated
125 improvement to increase the proportion of behavioral health expenditures; (2) any ongoing
126 strategies or investments that the health care entity is implementing to invest in or expand access
127 to behavioral health services; (3) whether the factors that led to the inability of the health care
128 entity to meet the behavioral health expenditure target can reasonably be considered to be
129 unanticipated and outside of the control of the entity; provided, that such factors may include,
130 but shall not be limited to, market dynamics, technological changes and other drivers of non-
131 behavioral health spending such as pharmaceutical and medical devices expenses; (4) the overall
132 financial condition of the health care entity; and (5) any other factors the commission considers
133 relevant.

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

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

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

153 (i) The commission shall approve any performance improvement plan that it determines
154 is reasonably likely to address the underlying cause of the entity's inability to meet the
155 behavioral health expenditure target and has a reasonable expectation for successful
156 implementation.

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

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

166 commission shall provide assistance to the health care entity in the successful implementation of
167 the performance improvement plan.

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

172 (m) At the conclusion of the timetable established in the performance improvement plan,
173 the health care entity shall report to the commission regarding the outcome of the performance
174 improvement plan. If the performance improvement plan was found to be unsuccessful, the
175 commission shall either: (1) extend the implementation timetable of the existing performance
176 improvement plan; (2) approve amendments to the performance improvement plan as proposed
177 by the health care entity; (3) require the health care entity to submit a new performance
178 improvement plan under subsection (c); or (4) waive or delay the requirement to file any
179 additional performance improvement plans.

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

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

187 (p) If the commission determines that a health care entity has: (1) willfully neglected to
188 file a performance improvement plan with the commission by the time required in subsection (h);
189 (2) failed to file an acceptable performance improvement plan in good faith with the
190 commission; (3) failed to implement the performance improvement plan in good faith; or (4)
191 knowingly failed to provide information required by this section to the commission or that
192 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity
193 of not more than \$500,000. The commission shall seek to promote compliance with this section
194 and shall only impose a civil penalty as a last resort.

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

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

199 SECTION 7. Subsection (a) of section 16 of chapter 12C of the General Laws, as
200 appearing in the 2022 Official Edition, is hereby amended by striking out the first paragraph, as
201 amended by section 25 of chapter 342 of the acts of 2024, and inserting in place thereof the
202 following paragraph:-

203 (a) The center shall publish an annual report based on the information submitted under:
204 (i) sections 8 to 10A, inclusive, concerning health care provider, provider organization, private
205 and public health care payer, pharmaceutical manufacturing company and pharmacy benefit
206 manager costs and cost and price trends; (ii) section 13 of chapter 6D relative to cost and market
207 impact reviews; and (iii) section 15 relative to quality data. The center shall compare the costs
208 and cost trends with the health care cost growth benchmark established by the health policy

209 commission under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall
210 compare the costs, cost trends, and expenditures with the aggregate behavioral health
211 expenditure target established under section 9A of chapter 6D, and shall detail: (1) baseline
212 information about cost, price, quality, utilization and market power in the commonwealth's
213 health care system; (2) cost growth trends for care provided within and outside of accountable
214 care organizations and patient-centered medical homes; (3) cost growth trends by provider
215 sector, including but not limited to, hospitals, hospital systems, non-acute providers,
216 pharmaceuticals, medical devices and durable medical equipment; provided, however, that any
217 detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates
218 and other price concessions in the aggregate without disclosure of any product or manufacturer-
219 specific rebate or price concession information, and without limiting or otherwise affecting the
220 confidential or proprietary nature of any rebate or price concession agreement; (4) factors that
221 contribute to cost growth within the commonwealth's health care system and to the relationship
222 between provider costs and payer premium rates; (5) behavioral health expenditure trends as
223 compared to the aggregate behavioral health baseline expenditures, as defined in section 1 of
224 chapter 6D; (6) the proportion of health care expenditures reimbursed under fee-for-service and
225 alternative payment methodologies; (7) the impact of health care payment and delivery reform
226 efforts on health care costs including, but not limited to, the development of limited and tiered
227 networks, increased price transparency, increased utilization of electronic medical records and
228 other health technology; (8) the impact of any assessments including, but not limited to, the
229 health system benefit surcharge collected under section 68 of chapter 118E, on health insurance
230 premiums; (9) trends in utilization of unnecessary or duplicative services, with particular
231 emphasis on imaging and other high-cost services; (10) the prevalence and trends in adoption of

232 alternative payment methodologies and impact of alternative payment methodologies on overall
233 health care spending, insurance premiums and provider rates; (11) the development and status of
234 provider organizations in the commonwealth including, but not limited to, acquisitions, mergers,
235 consolidations and any evidence of excess consolidation or anti-competitive behavior by
236 provider organizations; (12) the impact of health care payment and delivery reform on the quality
237 of care delivered in the commonwealth; and (13) costs, cost trends, price, quality, utilization and
238 patient outcomes related to behavioral health service subcategories, as described in section 21A.

239 SECTION 8. Said section 16 of said chapter 12C, as so appearing, is hereby further
240 amended by adding the following subsections:-

241 (d) The center shall publish the aggregate behavioral health baseline expenditures in its
242 annual report, beginning in the center's 2026 annual report.

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

246 SECTION 9. Said chapter 12C, as so appearing, is hereby further amended by striking
247 out section 18 and inserting in place thereof the following section:-

248 Section 18. The center shall perform ongoing analysis of data it receives under this
249 chapter to identify any payers, providers or provider organizations whose: (i) increase in health
250 status adjusted total medical expense is considered excessive and who threaten the ability of the
251 state to meet the health care cost growth benchmark established by the commission under section
252 10 of chapter 6D; or (ii) expenditures fail to meet the behavioral health expenditure target under
253 section 9A of chapter 6D. The center shall confidentially provide a list of the payers, providers

254 and provider organizations to the commission such that the commission may pursue further
255 action under sections 10 and 10A of chapter 6D.

256 SECTION 10. Notwithstanding any general or special law to the contrary, there shall be a
257 special task force to develop guiding principles and practice specifications that will assist health
258 care entities in meeting their annual behavioral health expenditure target, as established by
259 section 9A of chapter 6D of the General Laws.

260 The task force shall consist of 21 individuals: the executive director of the health policy
261 commission or a designee, who shall serve as chair; the secretary of health and human services
262 or a designee; the executive director of the center for health information and analysis or a
263 designee; the senate chair of the joint committee on health care financing or a designee; the
264 house chair of the joint committee on health care financing or a designee; and 16 members to be
265 appointed by the chair, 1 of whom shall be a representative of the Association for Behavioral
266 Healthcare, 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts,
267 Inc., 1 of whom shall be a representative of the Children’s Mental Health Campaign, 1 of whom
268 shall be a representative from Health Care For All, 1 of whom shall be a representative of the
269 Massachusetts Association for Mental Health, Inc., 1 of whom shall be a representative of
270 Massachusetts Association of Behavioral Health Systems, 1 of whom shall be a representative of
271 the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of the
272 Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the
273 Massachusetts League of Community Health Centers, 1 of whom shall be from a healthcare
274 consumer organization that advocates on behalf of adults who receive behavioral health care
275 services, 1 of whom shall be from a healthcare consumer organization that advocates on behalf
276 of children who receive behavioral health services, 1 of whom shall be a representative from a

277 behavioral health provider group, 1 of whom shall have expertise in the behavioral health
278 treatment of Black, Indigenous, and People of Color, 1 of whom shall have expertise in the
279 behavioral health treatment of the lesbian, gay, bisexual, transgender, and queer community, 1 of
280 whom shall have expertise in the treatment of individuals with a mental health condition, and 1
281 of whom shall have expertise in the treatment of individuals with a substance use disorder.

282 The task force shall make recommendations on the guiding principles and practice
283 specifications by which health care entities are required to meet their annual behavioral health
284 expenditure target, as established by section 9A of chapter 6D of the General Laws. The guiding
285 principles and practice specifications may include, but are not limited to: (i) the adoption and
286 dissemination of practices that promote health; (ii) person-centered and whole person care
287 delivery; (iii) early intervention and urgent care services that mitigate morbidity and mortality
288 risks; (iv) integrated behavioral health and primary care, including the psychiatric collaborative
289 care model; (v) non-medical supports such a recovery coaches and peer specialists in care
290 transformation efforts; and (vi) emphasis on ambulatory and community-based services.

291 The task force shall submit a report and recommendations to the clerks of the senate and
292 house of representatives not later than 6 months after passage of this legislation. The executive
293 director of the health policy commission shall also make the report and recommendations
294 publicly available on the commission's website.

295 SECTION 11. Subsection (e) of section 16 of chapter 12C of the General Laws shall take
296 effect October 1, 2026.