SENATE DOCKET, NO. 1197 FILED ON: 1/15/2025

SENATE . . . . . No. 1399

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

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SENATE . . . . . No. 1399

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 1399) of Cindy F. Friedman for legislation to increase investment in behavioral health care in the Commonwealth. Mental Health, Substance Use and Recovery.

[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:

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

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

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

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

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

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

(a) Not later than October 1 of every year, the commission shall hold public hearings based on the report submitted by the center under section 16 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year and comparing the growth in actual aggregate behavioral health expenditures for the previous calendar year to the aggregate behavioral health expenditure target. The hearings shall examine the costs, prices and cost trends of health care providers, provider

organizations, private and public health care payers, pharmaceutical manufacturing companies and pharmacy benefit managers and any relevant impact of significant equity investors, health care real estate investment trusts, management services organizations on such costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system, and trends in annual primary care and behavioral health expenditures, and factors that challenge the ability of the commonwealth's health care system to meet the benchmark or the aggregate behavioral health expenditure target established under section 9A.

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

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

commonwealth's ability to meet the health care cost growth benchmark and the aggregate behavioral health expenditure target, and draft legislation necessary to implement said recommendations.

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

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

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

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

(2) For calendar years 2029 and beyond, the commission may modify the behavioral health expenditure target and aggregate behavioral health expenditure target, to be effective for each year of a 3-year period, provided that the behavioral health expenditure target and aggregate behavioral health expenditure target shall be approved by a two-thirds vote of the board not later than December 31 of the final calendar year of the preceding 3-year period. If the commission does not act to establish an updated behavioral health expenditure target and aggregate behavioral health expenditure target pursuant to this subsection, the behavioral health expenditure target for each of the 3 years shall be 30 per cent higher than behavioral health baseline expenditures, and the aggregate behavioral health expenditure target for each of the 3

years shall be 30 per cent higher than aggregate behavioral health baseline expenditures, until such time as the commission acts to modify the behavioral health expenditure target and aggregate behavioral health expenditure target. If the commission modifies the behavioral health expenditure target and aggregate behavioral health expenditure target, the modification shall not take effect until the 3-year period beginning with the next full calendar year.

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

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

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

(b) The commission shall provide notice to all health care entities that have been identified by the center under section 18 of chapter 12C for failure to meet the behavioral health expenditure target. Such notice shall state that the center may analyze the performance of individual health care entities in meeting the behavioral health expenditure target and, beginning in calendar year 2029, the commission may require certain actions, as established in this section, from health care entities so identified.

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

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

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

(d) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity’s application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension

application; provided, however, that such information shall be made public at the discretion of the commission.

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

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

(g) The commission shall provide the department of public health any notice requiring a health care entity to file and implement a performance improvement plan pursuant to this

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

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

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

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

(k) Upon approval of the proposed performance improvement plan, the commission shall notify the health care entity to begin immediate implementation of the performance improvement

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

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

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

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

(o) The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative

authority is needed to achieve the health care quality and spending sustainability objectives of section 9A, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section.

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

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

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

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

(a) The center shall publish an annual report based on the information submitted under: (i) sections 8 to 10A, inclusive, concerning health care provider, provider organization, private and public health care payer, pharmaceutical manufacturing company and pharmacy benefit

manager costs and cost and price trends; (ii) section 13 of chapter 6D relative to cost and market impact reviews; and (iii) section 15 relative to quality data. The center shall compare the costs and cost trends with the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends, and expenditures with the aggregate behavioral health expenditure target established under section 9A of chapter 6D, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (4) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (5) behavioral health expenditure trends as compared to the aggregate behavioral health baseline expenditures, as defined in section 1 of chapter 6D; (6) the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the impact of health care payment and delivery reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology; (8) the impact of any assessments including, but not limited to, the

health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services; (10) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; (11) the development and status of provider organizations in the commonwealth including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; (12) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth; and (13) costs, cost trends, price, quality, utilization and patient outcomes related to behavioral health service subcategories, as described in section 21A.

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

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

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

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

Section 18. The center shall perform ongoing analysis of data it receives under this chapter to identify any payers, providers or provider organizations whose: (i) increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the

state to meet the health care cost growth benchmark established by the commission under section 10 of chapter 6D; or (ii) expenditures fail to meet the behavioral health expenditure target under section 9A of chapter 6D. The center shall confidentially provide a list of the payers, providers and provider organizations to the commission such that the commission may pursue further action under sections 10 and 10A of chapter 6D.

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

The task force shall consist of 21 individuals: the executive director of the health policy commission or a designee, who shall serve as chair; the secretary of health and human services or a designee; the executive director of the center for health information and analysis or a designee; the senate chair of the joint committee on health care financing or a designee; the house chair of the joint committee on health care financing or a designee; and 16 members to be appointed by the chair, 1 of whom shall be a representative of the Association for Behavioral Healthcare, 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Children's Mental Health Campaign, 1 of whom shall be a representative from Health Care For All, 1 of whom shall be a representative of the Massachusetts Association for Mental Health, Inc., 1 of whom shall be a representative of Massachusetts Association of Behavioral Health Systems, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, 1 of whom shall be from a healthcare

consumer organization that advocates on behalf of adults who receive behavioral health care services, 1 of whom shall be from a healthcare consumer organization that advocates on behalf of children who receive behavioral health services, 1 of whom shall be a representative from a behavioral health provider group, 1 of whom shall have expertise in the behavioral health treatment of Black, Indigenous, and People of Color, 1 of whom shall have expertise in the behavioral health treatment of the lesbian, gay, bisexual, transgender, and queer community, 1 of whom shall have expertise in the treatment of individuals with a mental health condition, and 1 of whom shall have expertise in the treatment of individuals with a substance use disorder.

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

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

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