

**SENATE . . . . . No. 1248**

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**The Commonwealth of Massachusetts**

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PRESENTED BY:

***Cindy F. Friedman***

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*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.

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PETITION OF:

NAME:

*Cindy F. Friedman*

DISTRICT/ADDRESS:

*Fourth Middlesex*

**SENATE . . . . . No. 1248**

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By Ms. Friedman, a petition (accompanied by bill, Senate, No. 1248) of Cindy F. Friedman for legislation to increase investment in behavioral health care in the Commonwealth. Mental Health, Substance Use and Recovery.

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[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE SENATE, NO. 1287 OF 2021-2022.]

**The Commonwealth of Massachusetts**

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**In the One Hundred and Ninety-Third General Court  
(2023-2024)**  
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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 2020  
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 2023.

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 2023.

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) and inserting in place thereof the following subsection:-

24           (a) Not later than October 1 of every year, the commission shall hold public hearings  
25 based on the report submitted by the center under section 16 of chapter 12C comparing the  
26 growth in total health care expenditures to the health care cost growth benchmark for the  
27 previous calendar year and comparing the growth in actual aggregate behavioral health  
28 expenditures for the previous calendar year to the aggregate behavioral health expenditure target.  
29 The hearings shall examine health care provider, provider organization and private and public  
30 health care payer costs, prices and cost trends, with particular attention to factors that contribute

31 to cost growth within the commonwealth’s health care system and challenge the ability of the  
32 commonwealth’s health care system to meet the benchmark or the aggregate behavioral health  
33 expenditure target established under section 9A.

34 SECTION 4. Said section 8 of said chapter 6D, as so appearing, is hereby further  
35 amended by striking out, in line 94, the word “and” and inserting in place thereof the following  
36 words:- , including behavioral health expenditures, and.

37 SECTION 5. Said chapter 6D, as so appearing, is hereby further amended by inserting  
38 after section 9 the following section:-

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

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

43 (1) For the 3-year period ending with calendar year 2026, the aggregate behavioral health  
44 expenditure target in year 1, in year 2, and in year 3 shall be 30 per cent higher than aggregate  
45 behavioral health baseline expenditures, and the behavioral health expenditure target in year 1, in  
46 year 2, and in year 3 shall be 30 per cent higher than behavioral health baseline expenditures.

47 (2) For calendar years 2027 and beyond, the commission may modify the behavioral  
48 health expenditure target and aggregate behavioral health expenditure target, to be effective for  
49 each year of a 3-year period, provided that the behavioral health expenditure target and aggregate  
50 behavioral health expenditure target shall be approved by a two-thirds vote of the board not later  
51 than December 31 of the final calendar year of the preceding 3-year period. If the commission

52 does not act to establish an updated behavioral health expenditure target and aggregate  
53 behavioral health expenditure target pursuant to this subsection, the behavioral health  
54 expenditure target for each of the 3 years shall be 30 per cent higher than behavioral health  
55 baseline expenditures, and the aggregate behavioral health expenditure target for each of the 3  
56 years shall be 30 per cent higher than aggregate behavioral health baseline expenditures, until  
57 such time as the commission acts to modify the behavioral health expenditure target and  
58 aggregate behavioral health expenditure target. If the commission modifies the behavioral health  
59 expenditure target and aggregate behavioral health expenditure target, the modification shall not  
60 take effect until the 3-year period beginning with the next full calendar year.

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

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

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

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

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

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

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

94 (d) The health care entity may file any documentation or supporting evidence with the  
95 commission to support the health care entity’s application to waive or extend the requirement to

96 file a performance improvement plan. The commission shall require the health care entity to  
97 submit any other relevant information it deems necessary in considering the waiver or extension  
98 application; provided, however, that such information shall be made public at the discretion of  
99 the commission.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

179 SECTION 7. Section 16 of chapter 12C of the General Laws, as so appearing in the 2020  
180 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof  
181 the following subsection:-

182 (a) The center shall publish an annual report based on the information submitted under  
183 this chapter concerning health care provider, provider organization and private and public health

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

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

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

219 (d) The center shall publish the aggregate behavioral health baseline expenditures in its  
220 annual report, beginning in the center's 2024 annual report.

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

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

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

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

235 SECTION 10. Section 21A of said chapter 12C, as so appearing, is hereby amended by  
236 adding the following sentence:-

237 Said continuing program of investigation and study shall include developing and defining  
238 criteria for health care services to be categorized as behavioral health services, with  
239 subcategories including, but not limited to: (i) mental health; (ii) substance use disorder; (iii)  
240 outpatient; (iv) inpatient; (v) services for children; (vi) services for adults; and (vii) provider  
241 type.

242 SECTION 11. Notwithstanding any general or special law to the contrary, there shall be a  
243 special task force to develop guiding principles and practice specifications that will assist health  
244 care entities in meeting their annual behavioral health expenditure target, as established by  
245 section 9A of chapter 6D of the General Laws.

246 The task force shall consist of 21 individuals: the executive director of the health policy  
247 commission or a designee, who shall serve as chair; the secretary of health and human services  
248 or a designee; the executive director of the center for health information and analysis or a  
249 designee; the senate chair of the joint committee on health care financing or a designee; the  
250 house chair of the joint committee on health care financing or a designee; and 16 members to be

251 appointed by the chair, 1 of whom shall be a representative of the Association for Behavioral  
252 Healthcare, 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts,  
253 Inc., 1 of whom shall be a representative of the Children’s Mental Health Campaign, 1 of whom  
254 shall be a representative from Health Care For All, 1 of whom shall be a representative of the  
255 Massachusetts Association for Mental Health, Inc., 1 of whom shall be a representative of  
256 Massachusetts Association of Behavioral Health Systems, 1 of whom shall be a representative of  
257 the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of the  
258 Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the  
259 Massachusetts League of Community Health Centers, 1 of whom shall be from a healthcare  
260 consumer organization that advocates on behalf of adults who receive behavioral health care  
261 services, 1 of whom shall be from a healthcare consumer organization that advocates on behalf  
262 of children who receive behavioral health services, 1 of whom shall be a representative from a  
263 behavioral health provider group, 1 of whom shall have expertise in the behavioral health  
264 treatment of Black, Indigenous, and People of Color, 1 of whom shall have expertise in the  
265 behavioral health treatment of the lesbian, gay, bisexual, transgender, and queer community, 1 of  
266 whom shall have expertise in the treatment of individuals with a mental health condition, and 1  
267 of whom shall have expertise in the treatment of individuals with a substance use disorder.

268           The task force shall make recommendations on the guiding principles and practice  
269 specifications by which health care entities are required to meet their annual behavioral health  
270 expenditure target, as established by section 9A of chapter 6D of the General Laws. The guiding  
271 principles and practice specifications may include, but are not limited to: (i) the adoption and  
272 dissemination of practices that promote health; (ii) person-centered and whole person care  
273 delivery; (iii) early intervention and urgent care services that mitigate morbidity and mortality

274 risks; (iv) integrated behavioral health and primary care; (v) non-medical supports such a  
275 recovery coaches and peer specialists in care transformation efforts; and (vi) emphasis on  
276 ambulatory and community-based services.

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

281           SECTION 12. Subsection (e) of section 16 of chapter 12C of the General Laws shall take  
282 effect October 1, 2024.