Mandated Benefit Review of House Bill 5230 and Senate Bill 1390
Submitted to the 194th General Court:

An Act Relative to Access to Psychiatric Collaborative Care

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Prepared for Massachusetts Center for Health Information and Analysis
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CHIA

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Section 1.0 Executive Summary H.B. 5230 and S.B. 1390 "An Act relative to access to psychiatric collaborative care"

The Massachusetts Legislature's Committee on Financial Services referred House Bill (H.B.) 5230[1] and Senate Bill (S.B.) 1390,[2] both titled "An Act relative to psychiatric collaborative care," to the Massachusetts Center for Health Information and Analysis (CHIA) for review. This report references both bills H.B. 5230 and S.B. 1890 together and hereafter as "the bill."

As submitted to the 194th General Court of the Commonwealth of Massachusetts, the bill requires health insurers to ensure minimum payment rates for services delivered through the psychiatric collaborative care model (CoCM), an evidence-based approach that integrates behavioral health care into primary care. Reimbursement must include services billed under Current Procedural Terminology (CPT®) codes 99492, 99493, and 99494 and Healthcare Common Procedure Coding System (HCPCS) code G2214, which represent monthly collaborative care management activities performed by a primary care team in consultation with a psychiatric specialist. The bill requires that payment rates for these services be set at a minimum level equal to or greater than the current Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule and adjusted annually, if applicable.

The bill also specifies that reimbursement for CoCM shall include, but not be limited to, CPT® codes 99492, 99493, 99494 and HCPCS code G2214, and allows for the addition of billing codes and corresponding minimum payment rates through regulatory guidance. The bill specifies that these requirements apply to all contracts entered into, renewed, or amended on or after January 1, 2027.

1.1 What is Psychiatric Collaborative Care?

CoCM is an evidence-based, integrated care model for behavioral health care that treats common mental health conditions, such as depression and anxiety, in the primary care setting.[3,4] CoCM uses a collaborative team of providers that includes a primary care provider (PCP), behavioral health care manager (BHCM), and a consulting psychiatrist.[5,6] Under this model, the BHCM maintains a patient registry that enables the consulting psychiatrist to provide oversight of the patient caseload and deliver treatment guidance to the PCP without requiring direct patient contact, while also supporting ongoing patient follow-up, symptom monitoring using validated tools, care coordination, and communication across the care team. The PCP leads the delivery of care, with support from the BHCM and guidance from the consulting psychiatrist, to provide effective behavioral health treatment using clinical decision-making guided by validated measurement tools and evidence-based treatment protocols.[7] The PCP has frequent contact with the patient and oversees the entirety of the treatment plan, working closely with the BHCM. The BHCM maintains a patient registry that enables the consulting psychiatrist to provide systematic oversight of the caseload and deliver treatment guidance to the PCP, without requiring direct patient contact, while also supporting ongoing patient follow-up and care planning.[8] This structure helps ensure that psychiatric expertise flows back to the PCP, who integrates that guidance into the patient's treatment plan, rather than

requiring a separate referral or direct patient-psychiatrist encounter.[9,10] By integrating psychiatric expertise into the primary care environment, CoCM enables patients to receive evidence-based behavioral health care in a familiar and comfortable setting, connecting them to psychiatric-informed care through their existing primary care relationship and reducing barriers related to stigma, transportation, and limited provider availability.[11]

1.2 Current Coverage

Under the ACA, non-legacy individual and small group health plans are required to cover Essential Health Benefits (EHBs), including mental health and substance use disorder services.[12] The Massachusetts EHB benchmark plan, in effect for plan years 2025 – 2027, includes coverage for mental and behavioral health outpatient services with no quantitative benefit limit.[13,14] Massachusetts has also established an existing coverage mandate for CoCM through the Massachusetts General Laws (M.G.L.) c.175 §47QQ, c.176A §8RR, c.176B §4RR, c.176G §4JJ.[15] The proposed bill would build on this existing mandate by specifying the covered services and establishing a minimum reimbursement floor tied to the Medicare RBRVS physician fee schedule, updated annually, a provision that addresses not only coverage, but also the adequacy of reimbursement necessary to support provider participation in the model.[16,17] While the ACA does not expressly mandate coverage of CoCM as a standalone benefit, the overlap between the benchmark plan's mental and behavioral health outpatient services benefit and the existing statutory mandate provides relevant context for evaluating the scope of these coverage obligations.[18]

BerryDunn surveyed Massachusetts insurance carriers regarding current coverage of CoCM services and the potential impact of the proposed legislation. Respondent carriers indicated that CoCM services are currently covered, though approaches vary: one carrier maintains explicit subscriber-facing language, while other carriers cover services without formal payment policies or specific CoCM language and instead process claims as submitted. One carrier has established specific coverage criteria, including time-based thresholds for CoCM services and restrictions on billing CoCM alongside other care management codes. For example, CPT® codes 99492, 99493, 99494, and HCPCS code G2214 each require a minimum cumulative amount of time spent on qualifying collaborative care management activities within a calendar month before reimbursement is permitted. Views on the utilization impact of the proposed legislation were mixed. While most carriers did not anticipate a significant change, one carrier expects a meaningful increase in utilization, citing the need for uniform coverage across payers to support primary care adoption and noting that higher reimbursement rates might expand provider participation. One carrier noted that CoCM is currently underutilized and that broader, uniform coverage across payers might be necessary to support widespread primary care adoption.

Responses regarding procedure code limitations were mixed. Most carriers reported no diagnosis or frequency limitations for the applicable codes (99492, 99493, 99494, and G2214), while one carrier reported monthly frequency limits for select codes. Most carriers did not identify staffing or capacity constraints, although one cited administrative and operational complexity associated with the CoCM model

as a potential barrier to uptake; another indicated uncertainty regarding future capacity constraints. One carrier specifically identified child and adolescent behavioral health as an area of particular demand where workforce shortages might constrain utilization growth. One carrier also raised concerns regarding the bill's proposed reimbursement rate floor tied to Medicare, noting that such requirements might increase costs and limit flexibility in carrier-provider rate negotiations.

1.3 Analysis Overview

The legislative sponsors indicated that the intent of the bill is to ensure adequate reimbursement for medically necessary CoCM services delivered within primary care settings. The bill seeks to establish a minimum reimbursement floor tied to the Medicare RBRVS physician fee schedule for a defined set of CoCM billing codes, ensuring that payment rates are sufficient to support sustainable provider participation in the model across all commercial payers. The analysis evaluates the potential impact of this requirement on health insurance premiums by estimating the incremental cost of establishing the reimbursement floor given current utilization, as well as the incremental cost associated with anticipated increases in utilization resulting from improved reimbursement rates. The analysis focuses on individuals enrolled in fully insured commercial health plans in the Commonwealth under age 65.

1.4 Estimated Cost of Enactment

Requiring coverage for this benefit by fully insured health plans would result in an average annual increase to the typical member's health insurance premium of between $0.01 and $0.02 per member per month (PMPM) or between 0.001% and 0.003% of premium, over a projection period of five years.

1.5 Efficacy Impact

More than 90 randomized controlled trials (RCTs), representing one of the most rigorous and extensive evidence bases in behavioral health, have found that patients receiving care under CoCM experience notable and meaningful improvement in their symptoms related to anxiety and depression, and demonstrating consistently better outcomes than usual care.[19,20,21,22] Evidence shows the main drivers of the improved outcomes under CoCM to be the regular provider contact, systematic tracking of treatment progress against clinical benchmarks, and timely treatment adjustment. [23,24,25] Evidence also shows the implementation of CoCM has contributed to cost savings for the system, with savings being driven by reductions in use of costly services such as emergency department visits, inpatient admissions, and specialist referrals.[26] Analysis of CoCM in other states signals that stable, cross-payer funding of CoCM facilitates increased provider adoption of CoCM practices, as predictable funding supports providers in being able to invest in the resources and training required to implement CoCM effectively, ultimately expanding utilization and ensuring more individuals can access effective behavioral health care.[27]

Endnotes

[1] H.B. 5230. An Act relative to access to psychiatric collaborative care. https://malegislature.gov/Bills/194/H5230

[2] S.B. 1390. An Act relative to access to psychiatric collaborative care. https://malegislature.gov/Bills/194/S1390.

[3] AIMS Center. University of Washington. https://aims.uw.edu/collaborative-care/ Accessed March 12, 2026. https://aims.uw.edu/collaborative-care/.

[4] American Psychiatric Association. Learn About the Collaborative Care Model. 2026. Accessed March 12, 2026. https://www.psychiatry.org/psychiatrists/practice/professional-interests/collaborative-care/learn.

[5] *Op. cit.* AIMS Center. University of Washington.

[6] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[7] *Ibid.*

[8] *Op. cit.* AIMS Center. University of Washington.

[9] Massachusetts Acts of 2022, Chapter 177. An Act Addressing Barriers to Care for Mental Health. Approved April 7, 2022. Accessed March 13, 2026. https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177.

[10] *Ibid.*

[11] *Ibid.*

[12] Centers for Medicare & Medicaid Services. Information on Essential Health Benefits (EHB) Benchmark Plans. Last Modified 3/13/2026. Accessed March 31, 2026. https://www.cms.gov/marketplace/resources/data/essential-health-benefits

[13] CMS. MASSACHUSETTS EHB BENCHMARK PLAN (2025-2027). Accessed March 31, 2026. https://www.cms.gov/files/document/ma-bmp-summary-py2025-2027.pdf.

[14] Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. HMO Blue® New England $2,000 Deductible Plan Option, Schedule of Benefits. Accessed March 31, 2026. https://www.mass.gov/doc/ehbbp-hmoblue-2017pdf/download.

[15] M.G.L. c.175 §47QQ,. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47qq; M.G.L. c.176A §8RR https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176A/Section8rr; M.G.L. c.176B §4RR https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176b/Section4rr; M.G.L. c.176G §4JJ https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176G/Section4jj; M.GL. c.32A §22A

[16] *Op. cit.* H.B. 5230. An Act relative to access to psychiatric collaborative care.

[17] *Op. cit.* S.B. 1390. An Act relative to access to psychiatric collaborative care.

[18] *Op. cit.* Centers for Medicare & Medicaid Services. Information on Essential Health Benefits (EHB) Benchmark Plans.

[19] Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. JAMA. 2002;288(22):2836–2845. Accessed March 13, 2026. https://jamanetwork.com/journals/jama/fullarticle/195599

[20] Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews. 2012;(10):CD006525. doi:10.1002/14651858.CD006525.pub2. Accessed March 13, 2026. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006525.pub2/full

[21] Coventry PA, Hudson JL, Kontopantelis E, et al. Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials. PLoS ONE. 2014;9(9):e108114. Accessed March 13, 2026. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0108114

[22] Osilla KC, Dopp AR, Watkins KE, et al. Collaboration Leading to Addiction Treatment and Recovery from Other Stresses (CLARO): process of adapting collaborative care for co-occurring opioid use and mental disorders. Addict Sci Clin Pract. 2022;17(1):25. Accessed March 13, 2026. https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-022-00302-9

[23] *Op. cit.* Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems.

[24] *Op. cit.* Coventry PA, Hudson JL, Kontopantelis E, et al. Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials.

[25] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[26] Wolk CB, Wilkinson E, Livesey C, et al. Impact of the Collaborative Care Model on Medical Spending. Am J Manag Care. 2023;29(10):499–502. doi:10.37765/ajmc.2023.89438. Accessed March 13, 2026. https://www.ajmc.com/view/impact-of-the-collaborative-care-model-on-medical-spending

[27] Shatterproof; Mental Health Treatment and Research Institute (MHTARI). *Use of the Psychiatric Collaborative Care Model Increases Nationally, but Large State Disparities Persist.* Press release. February 4, 2026. Accessed March 24, 2026. https://filesmhtari.org/Press_Release__CoCM_Progress_Report.pdf.

An Act Relative to Access to Psychiatric Collaborative Care

MEDICAL EFFICACY ASSESSMENT

2.0 Medical Efficacy Assessment

The bill requires commercial health insurers to reimburse providers for services delivered through the psychiatric collaborative care model (CoCM), an evidence-based approach that integrates behavioral health care into primary care. Reimbursement must include services billed under Current Procedural Terminology (CPT®) codes 99492, 99493, and 99494 and Healthcare Common Procedure Coding System (HCPCS) code G2214, which represent monthly collaborative care management activities performed by a primary care team in consultation with a psychiatric specialist, and allows for additional codes to be added through regulatory guidance. The bill requires payers to ensure that payment rates for these services are equal to or greater than the Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule and adjusted annually, if applicable.[1, 2]

The bill sponsors indicated the bill's intent is to:

- Raise reimbursement rates for CoCM billing codes to at least Medicare levels for MassHealth, the Group Insurance Commission (GIC), and commercial carriers regulated by the MA Division of Insurance, enabling primary care practices to sustainably employ the BHCM and psychiatric consultant required by the model.
- Allow CoCM codes to be billed outside the MassHealth primary care sub-capitation payment because this payment was calculated on historical claims data that predates widespread CoCM adoption, meaning CoCM costs are structurally underrepresented in the formula.[i]
- Accelerate adoption of CoCM in primary care settings so more patients receive earlier mental health screening, faster access to initial treatment, and care coordination support.

This report proceeds in the following sections:

2.0 Medical Efficacy Assessment

- 2.1 Background
- 2.2 Applications of CoCM
- 2.3 Efficacy of CoCM
- 2.4 Current Barriers to CoCM Adoption

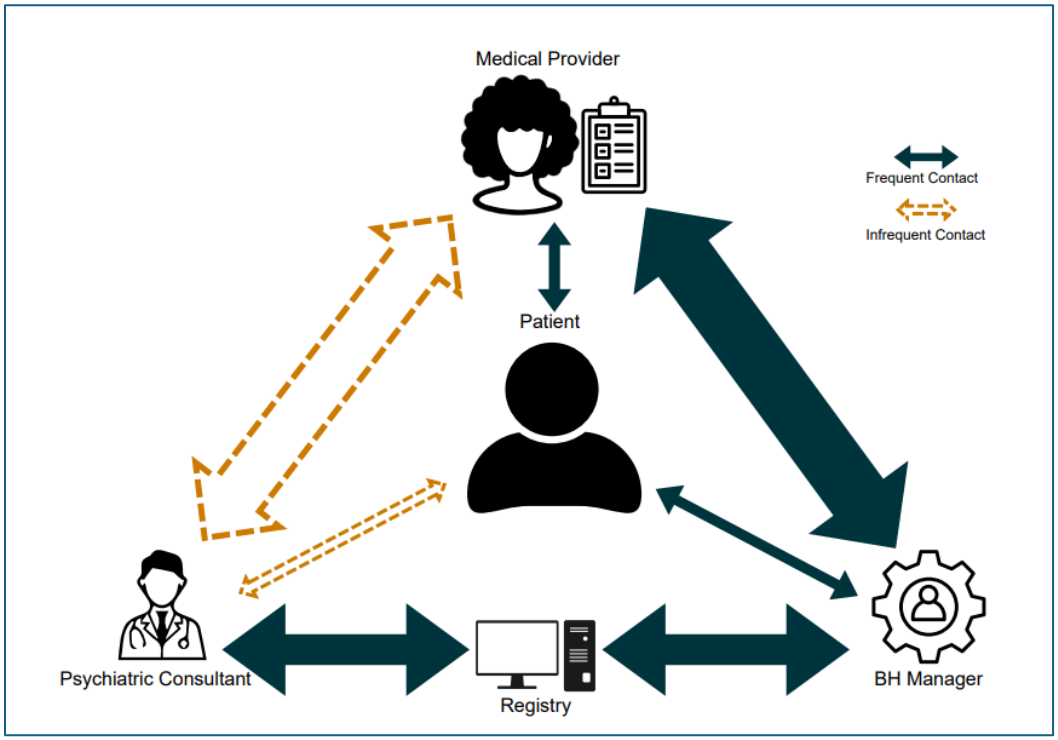
[i] While MassHealth is referenced in the bill's stated intent, it falls outside the scope of this analysis.

- 2.5 Anticipated Utilization Response to Reimbursement Rate Changes
- 2.6 Access and Health Equity

2.1 Background

Psychiatric collaborative care, commonly referred to as CoCM, is a structured, evidence-based model for delivering behavioral health services within primary care. Rather than requiring patients to navigate a separate behavioral health system, CoCM brings psychiatric expertise directly into the primary care setting through an integrated, team-based approach. The core team consists of three roles: a primary care provider (PCP), a BHCM, and a consulting psychiatrist, each of whom carries shared accountability for a defined panel of patients (see Figure 1). Clinical decisions are guided by validated measurement tools and evidence-based treatment protocols, with a population health orientation that flags patients who are not improving and helps ensure they receive timely follow-up.[3]

Figure 1 CoCM Structure[4,ii]



CoCM's origins date to landmark research in the late 1990s, most prominently the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) trial; a randomized controlled trial (RCT) enrolling 1,801 older adults with depression across 18 primary care sites. The trial found that patients in the CoCM

[ii] This Figure is based on University of Washington's original figure.

arm were more than twice as likely to achieve meaningful symptom improvement at one year relative to those in usual care. That foundational finding has since been replicated and extended across more than 90 RCTs, establishing CoCM as among the most rigorously tested integrated behavioral health models.[5]

The American Psychiatric Association (APA) has recognized CoCM as one of the most effective integrated care models available, designating it as a template for state legislative action based on its demonstrated record of improving clinical outcomes, lowering total cost of care, and increasing patient satisfaction across diverse settings, including in rural communities, urban safety-net systems, and veteran populations.[6]

Federal recognition followed. In 2017, the Centers for Medicare & Medicaid Services (CMS) established dedicated reimbursement codes for CoCM, acknowledging its distinct clinical structure and the administrative infrastructure it requires. The four codes applicable to the bill are described in Table 1.

Table 1. Bill Procedure Codes[7,iii,8]

Procedure Code	Description
99492	Initial month of CoCM; covers the first 70 minutes of BHCM time per calendar month (approximately $145 under 2026 Medicare rates).
99493	Subsequent months of CoCM; covers the first 60 minutes of BHCM time per calendar month (approximately $134 under 2026 Medicare rates).
99494	Add-on code; each additional 30 minutes of BHCM time beyond the initial or subsequent month threshold (approximately $56 per unit under 2026 Medicare rates). May be billed multiple times per month.
G2214	Initial or subsequent month CoCM; covers the first 30 minutes of BHCM time for shorter or lower-acuity engagements. Cannot be billed in the same calendar month as 99492, 99493, or 99494.

Massachusetts first required coverage of CoCM services under Chapter 177 of the Acts of 2022; however, the Acts did not establish minimum payment rates.[9]

2.2 Applications of CoCM

CoCM is designed to treat the behavioral health conditions most commonly presenting in primary care, i.e., depression and anxiety disorders, while increasingly demonstrating effectiveness for patients with substance use disorders (SUD) as well. This scope is particularly relevant in Massachusetts, where these conditions are both prevalent and undertreated: roughly one in five residents experiences a mental health condition each year, and SUD rates have placed significant strain on the Commonwealth's health system

[iii] The Centers for Medicare and Medicaid Services (CMS) eliminated G0512 for Medicare patients effective January 1, 2026, under the CY2026 Medicare Physician Fee Schedule Final Rule, requiring FQHCs to use the standard CoCM CPT® codes going forward.

(see Section 2.4 for additional detail on Massachusetts-specific prevalence data). The core facets of CoCM are:

- Care management, in which the BHCM, typically a licensed clinical social worker, nurse, psychologist, or other qualified behavioral health professional operating within their scope of practice, engages patients via phone or in-person visits, administers validated screening tools such as the Patient Health Questionnaire-9 (PHQ-9) for depression and the Generalized Anxiety Disorder-7 (GAD-7) for anxiety, maintains a real-time patient registry, and delivers brief evidence-based interventions;
- Psychiatric consultation, in which the consulting psychiatrist conducts regular caseload reviews, recommends treatment adjustments for patients who are not responding, and provides real-time guidance to both the PCP and BHCM. Under the CoCM model, psychiatrists typically provide indirect consultation across a panel of patients rather than ongoing direct patient treatment, with time generally dedicated through scheduled caseload review meetings and interprofessional consultation activities billed through monthly CoCM service codes; and
- Population monitoring, through which the care team systematically tracks patients against clinical benchmarks, identifies those falling short of targets, and escalates care before problems worsen.[10,11]

A defining feature of CoCM is that it does not require the consulting psychiatrist to be physically on-site. Remote consultation is standard practice, meaningfully extending the reach of psychiatric expertise beyond what traditional referral-based models can provide.[12] This design characteristic makes CoCM especially well-matched to Massachusetts' access landscape: the Commonwealth contains a significant number of federally designated Mental Health Professional Shortage Areas (HPSAs), concentrated in rural and lower-income communities, where waits for outpatient psychiatric appointments can stretch for months.[13] By embedding consultation within the primary care visit, CoCM allows patients to access evidence-based behavioral health care without a separate specialty referral, reducing barriers related to stigma, transportation, and availability.[14]

The model also supports the primary care workforce. A recent APA survey found that 85% of PCPs participating in CoCM reported reduced stress, and 81% reported greater job satisfaction, outcomes attributable in part to having a structured, team-based framework for managing behavioral health presentations rather than handling them alone.[15]

CoCM has been implemented across a range of Massachusetts settings. Health systems including Mass General Brigham and Beth Israel Lahey Health have integrated CoCM into their primary care networks, and several Massachusetts Federally Qualified Health Centers (FQHCs) have launched programs with state transformation grant support. Mass General Brigham has recently expanded its CoCM implementation across its primary care network in partnership with Concert Health, reaching over 6,500 patients since late

2023, with more than 1,600 actively receiving care and nearly 200 providers referring patients as of April 2025.[16] However, the Massachusetts Health Policy Forum documented persistent gaps in statewide adoption as recently as 2025, attributing them primarily to reimbursement rates that leave CoCM programs operating at a financial loss.[17]

The CY2026 Medicare Physician Fee Schedule Final Rule retired the former FQHC-specific code G0512, effective January 1, 2026, and now requires FQHCs to bill individual CoCM CPT® codes (99492, 99493, 99494, G2214) consistent with the broader billing framework that the bill would extend to all Massachusetts payers.[18]

2.3 Efficacy of CoCM

There is strong clinical evidence supporting the efficacy of CoCM. Across more than 90 RCTs, spanning diverse settings, populations, and health systems, the model has repeatedly produced meaningfully better outcomes than usual care.[19,20]

Effectiveness for Patients

The IMPACT trial, the foundational study of CoCM, established that patients enrolled in the model were more than twice as likely to experience meaningful depression symptom improvement at one year relative to patients receiving standard treatment.[21] Subsequent research has reinforced and extended these findings: a review spanning 79 clinical trials found persistent improvements in both depression and anxiety outcomes, while a complementary analysis of 74 trials identified the specific mechanisms driving effectiveness, i.e., regular patient contact, systematic tracking against clinical benchmarks, and prompt treatment adjustment when patients are not improving.[22,23]

CoCM's reach extends beyond mood disorders. Clinical trials have demonstrated that the model can be adapted to address alcohol use disorder and opioid use disorder within the primary care setting, broadening its application to the spectrum of behavioral health conditions driving unmet need in Massachusetts.[24,25] The bill language itself does not appear to restrict CoCM reimbursement to a specific primary diagnosis or condition category. Instead, it focuses on reimbursement of specified CoCM billing codes. However, actual coverage and reimbursement would still generally depend on payer medical necessity requirements, coding practices, and whether the underlying behavioral health condition is clinically appropriate for CoCM services.

CoCM has also demonstrated a meaningful impact on suicide risk reduction. A study of approximately 250,000 Kaiser Permanente health plan members found that patients enrolled in CoCM experienced a 25% reduction in completed suicides compared to those receiving standard care.[26] A separate study using data from the Penn Integrated Care program, a CoCM program, found a 52% reduction in suicide risk among CoCM patients.[27] These findings are reinforced by large real-world studies conducted in primary care settings, which have demonstrated reductions in suicide risk among more than half of at-risk patients and a

25% reduction in suicide attempts and deaths in large health system populations. This is particularly salient given that many individuals who die by suicide have had contact with a PCP in the year prior to death.[28]

The evidence base for CoCM is strongest at the individual patient level, where RCTs have consistently documented symptom improvement. Population-level evidence, measuring whether CoCM expansion translates into changes in community-wide behavioral health prevalence or aggregate utilization, remains an emerging area of research. The New York State Collaborative Care Medicaid Program, one of the largest state-led CoCM implementations in the country, documented that real-world uptake was limited and gradual under a funded, supported program, making population-level impact difficult to measure at early implementation stages.[29]This limitation reflects the methodological challenges inherent in attributing population health shifts to any single intervention. CoCM has the strongest evidence base for treatment of mild-to-moderate depression, anxiety, and increasingly SUD in the primary care setting. The evidence for its effectiveness in patients with serious mental illness, including schizophrenia spectrum disorders or treatment-resistant conditions requiring intensive specialty care, is less established. A 2025 qualitative synthesis found that CoCM effectiveness for serious mental illness specifically remains unknown, and that these patients may require care structures beyond what primary care-based CoCM can provide.[30]

System and PCP Benefits

The clinical case for CoCM is reinforced by system and provider benefits. Drawing on data from a large Pennsylvania health system, researchers found that total medical expenditures for CoCM patients dropped below those of a matched comparison group within seven months of enrollment, driven primarily by reductions in avoidable emergency department use, inpatient admissions, and specialist referrals.[31] The APA estimates the model returns approximately $6.50 for every dollar invested and characterizes CoCM reimbursement legislation as effectively budget-neutral for payers over time.[32] A Kaiser Permanente study found a 13% reduction in total healthcare costs on a per member per month (PMPM) basis for patients enrolled in CoCM compared to those receiving treatment as usual in primary care.[33] A study conducted by the University of Pennsylvania and Independence Blue Cross (Penn/IBX) found PMPM savings of $29.35 for CoCM patients; notably, those savings were attributable entirely to reductions in physical healthcare costs, even though CoCM patients received more mental health services, underscoring that behavioral health integration reduces downstream utilization of more expensive medical care.[34] A 2024 quasi-experimental study conducted in Texas (TX) found that a CoCM between Superior HealthPlan, TX's largest Medicaid MCO, and affordable housing provider Prospera Housing Community Services produced a 56% lower rate of emergency department and urgent care visits and over $2,000 in reduced prescription costs per participant compared to a matched control group.[35]

Providers working within CoCM programs report meaningful improvements in their working conditions. Multiple research reviews have documented lower rates of burnout and work-related stress among PCPs participating in the model,[36] a finding corroborated by APA survey data in which 85% of participating

providers described feeling less stressed, and 81% reported higher job satisfaction. Providers attribute this in part to the structured, consultative support CoCM provides for complex behavioral health presentations that would otherwise fall entirely on the PCP.[37]

The clinical outcomes documented in the CoCM evidence base are predicated on adherence to the model's core components: regular psychiatric case consultation, systematic patient registry tracking, and measurement-based care with active treatment adjustment. Real-world implementation studies indicate that outcomes vary when these elements are delivered inconsistently. A 2025 retrospective study of CoCM implementation at an urban academic medical center found that while patients experienced significant reductions in PHQ-9 and GAD-7 scores, less than half (40%) of enrolled cases received psychiatric case review as intended; a gap the authors identified as a potential constraint on outcomes, particularly in teaching settings where provider adoption was uneven across attending physicians and trainees.[38] A separate analysis of billing strategy implementation across multiple primary care sites found that staffing turnover among BHCMs created measurable variability in time spent on care coordination activities, with downstream effects on service delivery and revenue.[39] The University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center has identified fidelity to core model components, e.g., regular, planned psychiatric supervision of BHCMs, as a key driver of outcomes, noting that prior to 2017, programs failed primarily due to inadequate reimbursement and insufficient psychiatrist commitment.[40]

Trends Nationally and in Other States

CoCM adoption has accelerated in states with supportive reimbursement policies. As of early 2026, 36 states and the District of Columbia have established Medicaid coverage for CoCM, reflecting broad recognition of the model while also underscoring remaining gaps in statewide adoption.[41] Among commercially insured populations, CoCM use increased substantially between 2018 and 2024, with enrollment rising from 3,814 to 153,356 patients and utilization increasing 26-fold, from 12 to 317 patients per 100,000 individuals with a mental health or substance use diagnosis. Growth was particularly pronounced among children and adolescents under age 18, where utilization increased 148-fold over the same period.[42] Despite this growth, a 2026 national analysis found that states with limited Medicaid reimbursement tend to lag in commercial adoption as well, reflecting the importance of stable cross-payer revenue in supporting the infrastructure required for CoCM implementation.[43]

Several other states offer useful models. North Carolina (NC) paired Medicaid CoCM reimbursement set at 120% of the Medicare rate with a $5 million practice transformation fund.[44] Virginia established Medicaid CoCM coverage in 2024; California's Medi-Cal has covered the model since 2021; and Illinois enacted CoCM legislation that the APA has designated a national model.[45,46,47]

2.4 Current Barriers to CoCM Adoption

Massachusetts established a legal foundation for CoCM coverage through Chapter 177 of the Acts of 2022, which required commercial insurers and MassHealth managed care organizations to reimburse for CoCM services.[48] However, coverage authorization has not necessarily translated into meaningful utilization. The Massachusetts Health Policy Forum documented persistent statewide adoption gaps as recently as 2025, driven primarily by reimbursement rates that leave CoCM programs operating at a financial loss. The experience in Massachusetts is consistent with a well-documented national pattern: coverage without rate adequacy is often insufficient to produce robust uptake of a model that requires substantial and ongoing practice infrastructure investment.[49]

Reimbursement Inadequacy

One cited barrier to CoCM adoption nationally, and in Massachusetts specifically, is reimbursement below the threshold of financial sustainability. The Massachusetts Health Policy Forum's analysis of Massachusetts reimbursement rates concluded that commercial payers would need to reimburse CoCM at between 130% and 150% of Medicare rates to support financially self-sustaining programs, a level the current commercial market has not reached in the absence of a rate floor.[50]

The consequences of rate inadequacy are documented in studies from other states; however, much of this evidence is drawn from Medicaid populations, and there remains limited research on CoCM uptake in commercial markets. In NC, following Medicaid approval for CoCM billing codes in October 2018, researchers at Duke University School of Medicine found that only 915 of an estimated two million eligible Medicaid beneficiaries had at least one CoCM claim during the first 15 months of coverage availability, with a median of just two claims per patient. The authors concluded that reimbursement approval alone did not produce substantial utilization, and that a better understanding of implementation barriers would be necessary to expand uptake.[51] Findings from more recent implementation research in South Carolina (SC) further reinforce this conclusion, demonstrating that financial coverage is only one component of successful adoption. For example, a mixed-methods study of a telehealth-enabled CoCM model in rural primary care settings in SC identified persistent barriers including workforce shortages, limited behavioral health infrastructure, long referral wait times, provider time constraints, and challenges integrating new workflows into existing clinical practice. Even when providers expressed strong enthusiasm for CoCM, these operational and resource constraints limited uptake and scalability.[52]

Practice Transformation Costs and Workforce Constraints

Beyond reimbursement, CoCM requires considerable upfront investment and ongoing operational infrastructure that practices with limited capital cannot easily absorb. A 2020 study found that implementation of CoCM billing requires substantial clinical and administrative transformation, including redesigning workflows, developing systems to track cumulative time, and aligning billing processes with

team-based care delivery. Rather than functioning as a simple add-on service, CoCM billing necessitates new infrastructure to support patient registries, psychiatric case review, and ongoing care management activities. Early implementation experiences indicate that these requirements create meaningful operational barriers, contributing to slow and uneven uptake of the CoCM codes across health systems.[53] Sustaining CoCM programs over time will require addressing both workforce and reimbursement constraints. Massachusetts lost more than 1,200 mental health social workers and more than 1,100 community health workers between 2017 and 2023,[54] and federal projections anticipate ongoing shortages across behavioral health professions through at least 2038.[55] In addition to psychiatrist workforce shortages, implementation of CoCM may also depend on the availability of BHCMs, although the role may be staffed by several types of behavioral health professionals depending on the practice setting and scope of practice requirements.

2.5 Anticipated Utilization Response to Reimbursement Rate Changes

The evidence base on CoCM adoption indicates that reimbursement adequacy is a necessary precondition for expanding utilization, but that uptake typically occurs gradually rather than as an immediate step-change. Studies consistently find that while payment enables adoption, meaningful utilization depends on providers' ability to make upfront investments in staffing, workflow redesign, and data infrastructure. As a result, rate changes tend to produce a multiyear ramp in utilization.[56,57]

In response to low utilization of CoCM following coverage approval, NC implemented a multi-pronged strategy in 2022 that combined payment reform with implementation support. The state increased Medicaid reimbursement for CoCM to approximately 120% of Medicare rates, aligned coverage and billing requirements across payers, and launched a statewide Collaborative Care Consortium to provide training, registry infrastructure, and technical assistance to practices.[58] State reporting indicates that utilization among NC Medicaid PCPs nearly doubled between April 2023 and May 2024,[59] though the observed growth reflects the combined effects of reimbursement increases, technical assistance, and payer alignment rather than any single intervention in isolation.[60,61]

One finding across the literature is that CoCM adoption is highly sensitive to alignment across payers. Because the model requires fixed investments in care managers, registries used to track symptoms and treatment response across a patient caseload, and psychiatric consultation, providers make adoption decisions based on expected revenue across their full patient panel. CoCM requires substantial administrative and operational infrastructure,[62] while implementation guidance highlights the importance of sustainable, aligned financing mechanisms to support team-based care delivery.[63] The NC experience reinforces this dynamic. The state's 2022 reforms explicitly prioritized alignment across Medicaid, Medicare, and commercial payers, including standardizing billing requirements and reducing patient cost-sharing barriers.[64] This approach reflects broader evidence that payer alignment reduces administrative complexity and strengthens the business case for practice transformation.

The literature shows that CoCM adoption follows a multiyear trajectory. Practices must establish new workflows, implement time-tracking and billing systems, and integrate care management functions before they can reliably bill for CoCM services.[65] Implementation research further identifies workforce shortages, limited behavioral health infrastructure, and competing clinical demands as ongoing constraints on scaling the model.[66] The NC experience is consistent with this pattern. Despite initial coverage in 2018, meaningful uptake did not occur until after subsequent rate increases and infrastructure investments in 2022, underscoring the lag between policy change and utilization response.[67,68] This delayed response reflects the time required for practices to build staffing models, adopt registries, and integrate new workflows into routine care.

2.6 Access and Health Equity

Access to behavioral health care remains constrained by both longstanding engagement challenges and more immediate structural barriers. National research has consistently shown that individuals often delay seeking mental health treatment for extended periods; a 2004 seminal study using National Comorbidity Survey Replication data found a median delay of 11 years between onset of symptoms and first treatment contact, driven in part by low perceived need and attempts to manage symptoms independently.[69] In Massachusetts, these delays are compounded by financial and system-level barriers. Despite high rates of insurance coverage, the 2024 CHIA Behavioral Health Dashboard indicates that 8.8% of families and 5.1% of individuals reported unmet behavioral health needs due to cost, with Hispanic residents disproportionately affected.[70] In total, more than 600,000 Massachusetts residents reported an unmet behavioral health need in 2023.[71] Barriers extend beyond cost alone, as some individuals report paying fully out-of-pocket due to lack of provider insurance acceptance, and rising rates of emergency department boarding for behavioral health patients reflect broader system capacity constraints.[72,73]

Workforce capacity constraints compound the access issue. Findings from the Massachusetts Health Care and Human Services Workforce Survey (MHCW) highlight significant capacity constraints, including high vacancy rates among independently licensed clinicians (16%), non-independently licensed clinicians (15%), and case managers, as well as particularly high turnover among case managers (36%). Employers frequently cited a shortage of qualified applicants and non-competitive compensation as key recruitment challenges.[74] State analyses further indicate that compensation is a primary driver of workforce attrition, with clinicians in outpatient settings often earning less than their inpatient counterparts and facing financial pressures related to training, licensure, and low behavioral health provider reimbursement.[75] These dynamics, combined with constraints in the education and training pipeline, contribute to persistent shortages and limit the system's ability to meet growing demand. These capacity issues are reflected in broader access gaps: although roughly one in five Massachusetts residents experience a diagnosable mental health condition in any given year, only about half receive any care. This gap is especially pronounced among young people, with nearly one in four adults ages 18 to 24 reporting persistent poor

mental health and close to one-third of high school students describing their mental health as “not good most or all of the time.”[76]

Geographic disparities further exacerbate these challenges. Massachusetts has a substantial number of federally designated mental health HPSAs, concentrated in rural and lower-income communities, where outpatient psychiatric wait times frequently extend for months.[77] For many residents in these areas, the primary care office is the only regular touchpoint with the health care system, making it an indispensable gateway for behavioral health intervention.[78,79,80]

By integrating behavioral health services within primary care, CoCM reduces reliance on separate specialty systems and mitigates common obstacles such as distance, stigma, and fragmented referral pathways. Evidence also suggests the model is effective in improving outcomes across diverse populations; a systematic review found strong improvements in depression outcomes among Black, Hispanic/Latino, and Asian patients, with results comparable to or stronger than those observed in predominantly White populations. This may reflect the strength of the patient-PCP relationship, particularly in communities where structural barriers and historical mistrust have limited engagement with traditional mental health services.[81]

3.0 Conclusion

CoCM represents one of the most rigorously validated models in behavioral health, supported by more than 90 RCTs demonstrating consistent improvements in depression, anxiety, and increasingly, substance use disorder outcomes across diverse patient populations and care settings.[82,83] By embedding psychiatric expertise within primary care, CoCM removes barriers that have historically prevented patients from accessing behavioral health services, including stigma, fragmented referrals, transportation challenges, and specialist shortages.[84, 85] The model's documented capacity to reduce avoidable emergency department use, lower total medical expenditures, and improve PCP satisfaction strengthens the case for CoCM not only as a clinical intervention but as a system-level response to longstanding capacity and workforce challenges.[86,87]

Massachusetts has established early infrastructure for CoCM through health systems such as Mass General Brigham and Beth Israel Lahey Health, as well as FQHCs supported by state transformation grants. However, persistent adoption gaps have been documented, driven primarily by reimbursement rates that leave programs operating at a financial loss and by workforce and operational constraints. Evidence from Massachusetts and other states shows that coverage alone does not produce robust uptake; meaningful utilization typically occurs gradually following sustained investment in staffing, workflow redesign, and registry infrastructure.[88,89,90] The bill's requirement that commercial insurers reimburse CoCM at rates no less than the Medicare RBRVS fee schedule directly addresses this barrier, aligning commercial payment with the cross-payer revenue stability that health systems need to sustain the model's infrastructure.[91, 92]

Experience from states such as NC highlights that aligning reimbursement across Medicaid, Medicare, and commercial payers, combined with implementation support, accelerates adoption and strengthens the business case for practice transformation.[93,94] Multiyear adoption trajectories are expected, reflecting the time practices need to hire and train staff, integrate care management workflows, and implement registry and billing systems.[95,96]

The equity implications are noteworthy. CoCM's primary care foundation makes it particularly well-suited to reach residents in Massachusetts' federally designated mental health shortage areas, as well as racial and ethnic minority communities where structural barriers and historical mistrust have limited engagement with the traditional mental health system.[97] Evidence indicates that CoCM produces comparable or stronger depression outcomes among Black, Hispanic/Latino, and Asian patients relative to predominantly White study populations, suggesting the model may be an effective vehicle for narrowing the access and outcomes gaps that disproportionately affect underserved communities.[98] As national adoption continues and other states establish reimbursement frameworks paired with active implementation support,

establishing minimum commercial payment standards would position Massachusetts to build on its early CoCM investments and extend the model's reach to the populations with the greatest unmet need.[99,100]

Endnotes

[1] *Op. cit.* H.B. 5230. An Act relative to access to psychiatric collaborative care.

[2] *Op. cit.* S.B. 1390. An Act relative to access to psychiatric collaborative care.

[3] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[4] *Op. cit.* AIMS Center. University of Washington.

[5] *Op. cit.* Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial.

[6] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[7] *Op. cit.* Centers for Medicare and Medicaid Services. *Behavioral Health Integration Services*.

[8] Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F). Oct 31, 2025. Accessed April 6, 2026. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f.

[9] *Op. cit.* Massachusetts Acts of 2022, Chapter 177. An Act Addressing Barriers to Care for Mental Health.

[10] *Op cit*. American Psychiatric Association. Learn About the Collaborative Care Model.

[11] *Op. cit.* Massachusetts Acts of 2022, Chapter 177. An Act Addressing Barriers to Care for Mental Health.

[12] *Op cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[13] Health Resources and Services Administration (HRSA). Designated Health Professional Shortage Areas (HPSA) Statistics. As of December 31, 2025. Accessed March 13, 2026. https://data.hrsa.gov/default/generatehpsaquarterlyreport.

[14] *Op cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[15] *Ibid.*

[16] Yuhas, M., Mauch, D. Accelerating Adoption of the Collaborative Care Model (CoCM) in Massachusetts: Effectively Integrating Behavioral Health and Primary Care. Issue Brief. The Massachusetts Health Policy Forum. No. 55. 2025. Accessed April 6, 2026. https://heller.brandeis.edu/mass-health-policy-forum/categories/mental-health-substance-abuse/pdfs/collaborative-care-pdfs/collaborative-care-issue-brief-55.pdf.

[17] Massachusetts Health Policy Forum. Collaborative Care in Massachusetts: Opportunities and Barriers. Issue Brief 55. May 2025. Accessed March 13, 2026. https://heller.brandeis.edu/mass-health-policy-forum/categories/mental-health-substance-abuse/pdfs/collaborative-care-pdfs/collaborative-care-issue-brief-55.pdf.

[18] Centers for Medicare and Medicaid Services. CY2026 Medicare Physician Fee Schedule Final Rule. November 2025. Accessed March 13, 2026. https://www.cms.gov/medicare/payment/fee-schedules/physician.

[19] *Op. cit.* Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems.

[20] *Op. cit.* Coventry PA, Hudson JL, Kontopantelis E, et al. Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials.

[21] *Op. cit.* Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial.

[22] *Op. cit.* Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems.

[23] *Op. cit.* Coventry PA, Hudson JL, Kontopantelis E, et al. Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials.

[24] Watkins KE, Ober AJ, Lamp K, et al. Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care: The SUMMIT Randomized Clinical Trial. JAMA Intern Med. 2017;177(10):1480–1488. doi:10.1001/jamainternmed.2017.3947. Accessed March 13, 2026. https://pubmed.ncbi.nlm.nih.gov/28828487/.

[25] *Op. cit.* Osilla KC, Dopp AR, Watkins KE, et al. Collaboration Leading to Addiction Treatment and Recovery from Other Stresses (CLARO): process of adapting collaborative care for co-occurring opioid use and mental disorders.

[26] Angerhofer Richards, J., Cruz, M., Stewart, C., Lee, A. K., Ryan, T. C., Ahmedani, B. K., & Simon, G. E. (2024). Effectiveness of Integrating Suicide Care in Primary Care : Secondary Analysis of a Stepped-Wedge, Cluster Randomized Implementation Trial. *Annals of internal medicine*, *177*(11), 1471–1481. Accessed April 6, 2026. https://doi.org/10.7326/M24-0024.

[27] Khazanov, G.K., Wolk, C.B., Lorenc, E. *et al.* Change in suicidal ideation, depression, and anxiety following collaborative care in the community. *BMC Prim. Care* **25**, 241 (2024). Accessed April 6, 2026. https://doi.org/10.1186/s12875-024-02494-2.

[28] Large Reductions in Suicide Risk, Attempts and Deaths Demonstrated by Three "Real World" Studies in Primary Care. Bowman Family Foundation. Mental Health Treatment and Research Institute. April 2025. Accessed April 16, 2026. https://filesbff.org/CoCM_Suicide_Risk_Reduction.pdf.

[29] Bowen, D. J., Heald, A., LePoire, E., Jones, A., Gadbois, D., Russo, J., & Carruthers, J. (2021). Population-based implementation of behavioral health detection and treatment into primary care: early data from New York state. *BMC health services research*, *21*(1), 922. Accessed April 13th, 2026. https://doi.org/10.1186/s12913-021-06892-5.

[30] Abdulla, S., Kramer, S., Robertson, L. *et al.* Community-based Collaborative Care for Serious Mental Illness: A Rapid Qualitative Evidence Synthesis of Health Care Providers' Experiences and Perspectives. *Community Ment Health J* **61**, 1195–1207 (2025). Accessed April 13th, 2026. https://doi.org/10.1007/s10597-025-01459-8.

[31] *Op. cit.* Wolk CB, Wilkinson E, Livesey C, et al. Impact of the Collaborative Care Model on Medical Spending.

[32] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[33] *Op. cit.* Yuhas, M., Mauch, D. Accelerating Adoption of the Collaborative Care Model (CoCM) in Massachusetts: Effectively Integrating Behavioral Health and Primary Care.

[34] *Op. cit.* Wolk CB, Wilkinson E, Livesey C, et al. Impact of the Collaborative Care Model on Medical Spending.

[35] Tsai, J., Rajan, S., Truong, C., Schick, V., & Ganduglia Cazaban, C. (2024). Evaluation of a collaborative model between managed care and affordable housing on acute care costs. *The American journal of managed care*, *30*(3), 133–138. Accessed April 22, 2026. https://doi.org/10.37765/ajmc.2024.89514.

[36] Moll MF, et al. Effect of mental health collaborative care models on primary care provider outcomes: an integrative review. Fam Pract. 2022;39(5):964–970. doi:10.1093/fampra/cmac026. Accessed March 13, 2026. https://pubmed.ncbi.nlm.nih.gov/35357429/.

[37] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[38] Hahn, P. J., Johnson, D. Y., Wang, J., Lusk, C., Allen, S., Araújo, F. S., Yohanna, D., Staab, E. M., & Laiteerapong, N. (2025). Evaluating the Real-World Implementation and Effectiveness of a Collaborative Care Model for Adults with Depression and Anxiety at an Urban, Academic Hospital. *Journal of evaluation in clinical practice*, *31*(8), e70332. Accessed April 13th, 2026. https://doi.org/10.1111/jep.70332.

[39] Chang, D., Morrison, D. J., Bowen, D. J., Harris, H. M., Dusic, E. J., Velasquez, M. B., & Ratzliff, A. D. H. (2023). Making It to Sustainability: Evaluating Billing Strategies for Collaborative Care. *Psychiatric services (Washington, D.C.)*, *74*(11), 1192–1195. Accessed April 13th, 2026. https://doi.org/10.1176/appi.ps.20220596.

[40] Saldana, L., Bennett, I., Powers, D., Vredevoogd, M., Grover, T., Schaper, H., & Campbell, M. (2020). Scaling Implementation of Collaborative Care for Depression: Adaptation of the Stages of Implementation Completion (SIC). *Administration and policy in mental health*, *47*(2), 188–196. Accessed April 13th, 2026. https://doi.org/10.1007/s10488-019-00944-z.

[41] *Op. cit.* Shatterproof; Mental Health Treatment and Research Institute (MHTARI). *Use of the Psychiatric Collaborative Care Model Increases Nationally, but Large State Disparities Persist.*

[42] PROGRESS REPORT Psychiatric Collaborative Care Model (CoCM). Bowman Family Foundation. Mental Health Treatment and Research Institue. February 2026. Accessed April 16, 2026. https://filesmhtari.org/COCM_Progress_Report.pdf.

[43] *Op. cit.* Shatterproof; Mental Health Treatment and Research Institute (MHTARI). *Use of the Psychiatric Collaborative Care Model Increases Nationally, but Large State Disparities Persist.*

[44] North Carolina Department of Health and Human Services, Division of Health Benefits. Collaborative Care Model Program. January 2022. Accessed March 13, 2026. https://medicaid.ncdhhs.gov/providers/programs-and-services/collaborative-care-model.

[45] Virginia Department of Medical Assistance Services. Coverage of Collaborative Care Management (CoCM) Services. Effective January 1, 2024. Accessed March 13, 2026. https://vamedicaid.dmas.virginia.gov/bulletin/coverage-collaborative-care-management-cocm-services.

[46] California Health Care Foundation. Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care. 2021. Accessed March 13, 2026. https://www.chcf.org/resource/cracking-codes-state-medicaid-approaches-reimbursing-psychiatric-collaborative-care/.

[47] American Psychiatric Association. Model CoCM Legislation. Accessed March 13, 2026. https://www.psychiatry.org/psychiatrists/advocacy/state-affairs/model-cocm-legislation.

[48] *Op. cit.* Massachusetts Acts of 2022, Chapter 177. An Act Addressing Barriers to Care for Mental Health.

[49] *Op. cit.* Massachusetts Health Policy Forum. Collaborative Care in Massachusetts: Opportunities and Barriers.

[50] *Op. cit.* Massachusetts Acts of 2022, Chapter 177. An Act Addressing Barriers to Care for Mental Health.

[51] Copeland, J. N., Jones, K., Maslow, G. R., French, A., Davis, N., Greiner, M. A., Heilbron, N., & Pullen, S. J. (2022). Use of North Carolina Medicaid Collaborative Care Billing Codes After Statewide Approval for Reimbursement. *Psychiatric services (Washington, D.C.)*, *73*(12), 1420–1423. Accessed March 25, 2026. https://doi.org/10.1176/appi.ps.202200027.

[52] Kruis, R., Johnson, E., Guille, C. *et al.* Barriers and facilitators to implementing a technology-enhanced psychiatric collaborative care model among rural primary care sites: a mixed-methods implementation case study. *BMC Prim. Care* **26**, 177 (2025). Accessed March 25, 2026. https://doi.org/10.1186/s12875-025-02839-5.

[53] Carlo, A. D., Drake, L., Ratzliff, A. D. H., Chang, D., & Unützer, J. (2020). *Sustaining the collaborative care model (CoCM): Billing newly available CoCM CPT codes in an academic primary care system.* Psychiatric Services, 71(9), 972–974. Accessed March 25, 2026. https://doi.org/10.1176/appi.ps.201900581.

[54] Massachusetts Taxpayers Foundation. The Behavioral Health Workforce Challenge. December 2024. Accessed March 13, 2026. https://www.masstaxpayers.org/sites/default/files/publications/2024-12/MTF%20The%20Behavioral%20Health%20Workforce%20Challenge.pdf.

[55] Health Resources and Services Administration, Bureau of Health Workforce. State of the Behavioral Health Workforce, 2025. Accessed March 13, 2026. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf.

[56] *Op. cit.* Carlo, A. D., Drake, L., Ratzliff, A. D. H., Chang, D., & Unützer, J. (2020). *Sustaining the collaborative care model (CoCM): Billing newly available CoCM CPT codes in an academic primary care system.*

[57] *Op. cit.* Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial.

[58] North Carolina Department of Health and Human Services. (2023). The collaborative care model in North Carolina: A roadmap for statewide capacity building to integrate physical and behavioral health care. Accessed March 25, 2026. https://medicaid.ncdhhs.gov/collaborative-care-model-north-carolina-policy-paper/open.

[59] NCDHHS Press Release, October 30, 2024 — "$5 Million Investment to Expand Access to Behavioral Health Care in Primary Care Offices." Accessed March 27, 2026. https://www.ncdhhs.gov/news/press-releases/2024/10/30/5-million-investment-expand-access-behavioral-health-care-primary-care-offices.

[60] *Op. cit.* North Carolina Department of Health and Human Services. (2023). The collaborative care model in North Carolina: A roadmap for statewide capacity building to integrate physical and behavioral health care.

[61] North Carolina Department of Health and Human Services. (2022). *NC Medicaid enhancements to integrated physical and behavioral health.* Accessed March 25, 2026. https://medicaid.ncdhhs.gov/blog/2022/12/15/nc-medicaid-enhancements-integrated-physical-and-behavioral-health.

[62] *Op. cit.* Carlo, A. D., Drake, L., Ratzliff, A. D. H., Chang, D., & Unützer, J. (2020). *Sustaining the collaborative care model (CoCM): Billing newly available CoCM CPT codes in an academic primary care system.*

[63] *Op. cit.* Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial.

[64] *Op. cit.* North Carolina Department of Health and Human Services. (2023). The collaborative care model in North Carolina: A roadmap for statewide capacity building to integrate physical and behavioral health care.

[65] *Op. cit.* Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial.

[66] *Op. cit.* Kruis, R., Johnson, E., Guille, C. *et al.* Barriers and facilitators to implementing a technology-enhanced psychiatric collaborative care model among rural primary care sites: a mixed-methods implementation case study.

[67] *Op. cit.* Copeland, J. N., Jones, K., Maslow, G. R., French, A., Davis, N., Greiner, M. A., Heilbron, N., & Pullen, S. J. (2022). Use of North Carolina Medicaid Collaborative Care Billing Codes After Statewide Approval for Reimbursement.

[68] *Op. cit.* North Carolina Department of Health and Human Services. (2022). *NC Medicaid enhancements to integrated physical and behavioral health.*

[69] Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health services research*, *39*(2), 393–415. Accessed April 8th, 2026. https://doi.org/10.1111/j.1475-6773.2004.00234.x.

[70] Behavioral Health in Massachusetts. Massachusetts Center for Health Information and Analysis (CHIA). Publication Number 25-198-CHIA-01. Accessed April 8th, 2026. https://www.chiamass.gov/assets/docs/r/pubs/2025/Behavioral-Health-Care-Dashboard-2025.pdf.

[71] 2025 Massachusetts Health Insurance Survey (MHIS). Massachusetts Center for Health Information and Analysis (CHIA). Updated December 11, 2025. Accessed April 8th, 2026. https://www.chiamass.gov/massachusetts-health-insurance-survey/.

[72] *Op. cit.* Behavioral Health in Massachusetts. Massachusetts Center for Health Information and Analysis (CHIA).

[73] Doyle, A. Behavioral Health Workforce Center Overview & HPC Workforce Research. Massachusetts Health Policy Commission. November 13th, 2025. Accessed April 8th, 2026. https://www.mass.gov/doc/behavioral-health-workforce-center-overview-hpc-workforce-research-ma-health-policy-commission/download.

[74] Massachusetts Health Care Workforce Survey. Massachusetts Center for Health Information and Analysis (CHIA). Updated February 20, 2026. Accessed April 8th, 2026. https://www.chiamass.gov/massachusetts-healthcare-workforce-survey.

[75] *Op. cit.* Doyle, A. Behavioral Health Workforce Center Overview & HPC Workforce Research. Massachusetts Health Policy Commission.

[76] Massachusetts Executive Office of Health and Human Services. 2023 Community Health and Economic Needs Assessment: Mental Health Report. 2023. Accessed March 13, 2026. https://www.mass.gov/doc/2023-ches-mental-health-report/download.

[77] *Op. cit.* Health Resources and Services Administration (HRSA). Designated Health Professional Shortage Areas (HPSA) Statistics.

[78] Blue Cross Blue Shield of Massachusetts Foundation. *Access to Outpatient Mental Health Services in Massachusetts.* 2020. Accessed March 13, 2026. https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-09/Outpatient_MH_Access_SUMMARY_v05_final.pdf.

[79] Horstman C, Federman S, Williams RD. *Integrating Primary Care and Behavioral Health to Address the Behavioral Health Crisis.* Commonwealth Fund. September 2022. Accessed March 13, 2026. https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis.

[80] American Academy of Family Physicians. *Integrating Behavioral Health Into Primary Care.* Family Practice Management. May/June 2021. Accessed March 13, 2026. https://www.aafp.org/pubs/fpm/issues/2021/0500/p3.html

[81] Tanner-Smith EE, et al. Collaborative care for depression and anxiety in racial/ethnic minority populations: a PRISMA systematic review. Psychiatric Services. 2020. Accessed March 13, 2026. https://pmc.ncbi.nlm.nih.gov/articles/PMC7541409/.

[82] *Op. cit.* Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems.

[83] *Op. cit.* Coventry PA, Hudson JL, Kontopantelis E, et al. Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials.

[84] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[85] *Op. cit.* Health Resources and Services Administration (HRSA). Designated Health Professional Shortage Areas (HPSA) Statistics.

[86] *Op. cit.* Wolk CB, Wilkinson E, Livesey C, et al. Impact of the Collaborative Care Model on Medical Spending.

[87] *Op. cit.* American Psychiatric Association. Learn About the Collaborative Care Model.

[88] *Op. cit.* Massachusetts Health Policy Forum. Collaborative Care in Massachusetts: Opportunities and Barriers.

[89] *Op. cit.* North Carolina Department of Health and Human Services. (2023). The collaborative care model in North Carolina: A roadmap for statewide capacity building to integrate physical and behavioral health care.

[90] *Op. cit.* North Carolina Department of Health and Human Services. (2022). *NC Medicaid enhancements to integrated physical and behavioral health.*

[91] *Op. cit.* H.B. 5230. An Act relative to access to psychiatric collaborative care.

[92] *Op. cit.* S.B. 1390. An Act relative to access to psychiatric collaborative care.

[93] *Op. cit.* Massachusetts Health Policy Forum. Collaborative Care in Massachusetts: Opportunities and Barriers.

[94] *Op. cit.* North Carolina Department of Health and Human Services. (2023). The collaborative care model in North Carolina: A roadmap for statewide capacity building to integrate physical and behavioral health care.

[95] *Op. cit.* Carlo, A. D., Drake, L., Ratzliff, A. D. H., Chang, D., & Unützer, J. (2020). *Sustaining the collaborative care model (CoCM): Billing newly available CoCM CPT codes in an academic primary care system.*

[96] *Op. cit.* Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial.

[97] *Op. cit.* Health Resources and Services Administration (HRSA). Designated Health Professional Shortage Areas (HPSA) Statistics.

[98] *Op. cit.* Tanner-Smith EE, et al. Collaborative care for depression and anxiety in racial/ethnic minority populations: a PRISMA systematic review.

[99] *Op. cit.* Shatterproof; MHTARI. *Use of the Psychiatric Collaborative Care Model Increases Nationally, but Large State Disparities Persist.*

[100] *Op. cit.* Massachusetts Health Policy Forum. Collaborative Care in Massachusetts: Opportunities and Barriers.

An Act Relative to Access to Psychiatric Collaborative Care

ACTUARIAL ASSESSMENT

4.0 Actuarial Assessment

4.1 Background

The bill requires commercial health insurers to reimburse providers for services delivered through CoCM, an evidence-based approach that integrates behavioral health care into primary care settings. Covered services include monthly collaborative care management activities billed under Current Procedural Terminology (CPT®) codes 99492, 99493, and 99494 and Healthcare Common Procedure Coding System (HCPCS) code G2214, which encompass initial and subsequent month care management and additional clinical staff time performed by a primary care team in consultation with a psychiatric specialist. The bill requires that payment rates for these services be set at a minimum level equal to or greater than the current Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule and updated annually to reflect changes in Medicare payment rates.[1,2]

4.2 Plans Affected by the Proposed Mandate

The bill amends statutes that regulate commercial health care carriers in the Commonwealth. It includes the following sections, each of which addresses statutes dealing with a particular type of health insurance policy when issued or renewed in the Commonwealth:

- Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Chapter 175 – Commercial Health Insurance Companies
- Chapter 176A – Hospital Service Corporations
- Chapter 176B – Medical Service Corporations
- Chapter 176G – Health Maintenance Organizations (HMOs)

The bill includes MassHealth, although an analysis of the impact on its members is outside the scope of this review. This analysis includes members under 65 years of age who have fully insured commercial plans.

Plans Not Affected by the Proposed Benefit Mandate

Self-insured plans (i.e., where the employer or policyholder retains the risk for medical expenses and uses a third-party administrator or insurer to provide only administrative functions), except for those provided by the GIC, are not subject to state-level health insurance mandates. State mandates do not apply to Medicare, Medicare Advantage plans, or other federally funded plans, including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employees Health Benefit Plan, the benefits for which are determined by, or under the rules set by, the federal government.

Although the bill includes Chapter 118, this analysis does not estimate the bill's impact to MassHealth, nor does it address any potential effect on Medicare supplement plans—even to the extent they are regulated by state law.

The bill would require coverage for a benefit that may be beyond what is within the Division of Insurance (DOI)- designated Essential Health Benefits (EHBs), but further analysis is required. Any state benefit mandate that exceeds the state's definition of EHBs could require the defrayal of the additional cost incurred by enrollees in qualified health plans (QHPs) under federal law.

4.3 Existing Laws Affecting the Cost of the Mandate

Under the ACA, non-legacy individual and small group health plans are required to cover EHBs, which include mental health and substance use disorder services. This EHB category generally encompasses services intended to diagnose, treat, and manage behavioral health conditions, and may include outpatient therapy, psychiatric services, and care coordination activities delivered in primary care settings. CoCM services could be covered under this category when provided to treat conditions such as depression, anxiety, or SUD, as the model's care management activities align with the scope of mental health outpatient services. Such services are typically subject to medical necessity criteria and may be delivered through related covered benefits, including outpatient behavioral health visits and care management services. However, the ACA does not explicitly identify CoCM as a distinct or standalone covered benefit.[3]

In Massachusetts, EHB coverage for mental and behavioral health services is defined by the benchmark plan in effect for plan years 2025–2027, which includes coverage for mental and behavioral health outpatient services with no quantitative benefit limit. This provides a broad baseline for outpatient behavioral health coverage under which CoCM services may already be partially reimbursable, though the benchmark plan does not explicitly list CoCM CPT® or HCPCS codes as covered services.[4,5]

Massachusetts has further established a state-level coverage mandate for CoCM through M.G.L. c.175 §47QQ, c.176A §8RR, c.176B §4RR, and c.176G §4JJ.[6] The proposed bill would build on this existing mandate by specifying the covered CPT® and HCPCS codes, 99492, 99493, 99494, and G2214, and establishing a minimum reimbursement floor tied to the Medicare RBRVS physician fee schedule, updated annually. This reimbursement floor provision addresses not only the scope of covered services but the adequacy of payment rates necessary to support provider participation in the model, a gap that the existing mandate does not explicitly address.[7,8]

While the ACA does not expressly require coverage of CoCM as a standalone benefit, the Massachusetts Benchmark Plan's mental and behavioral health outpatient services benefit combined with the existing state statutory mandate, provides relevant context for understanding the breadth of current coverage obligations and the incremental impact of the proposed legislation.[9]

4.4 Current Coverage

BerryDunn surveyed Massachusetts insurance carriers in the Commonwealth, with respondents representing 86% of the Commonwealth's fully insured commercial membership.[iv] Key findings from this survey include:

- Carriers indicated that CoCM services are currently covered. One carrier referenced explicit subscriber handbook language describing CoCM as a covered evidence-based, integrated behavioral health service delivered by a primary care team in consultation with a psychiatric consultant. Other carriers indicated that CoCM services are covered; however, they do not maintain formal payment policies or explicit subscriber-facing language specific to CoCM and instead process claims for these services as submitted without medical management. One carrier has established specific coverage criteria, requiring that CoCM services be delivered to members with a continuous relationship with an integrated primary care team and that services meet minimum time thresholds; at least 70 minutes in the first month and at least 60 minutes in subsequent months. That carrier also noted that CoCM services may not be billed concurrently with chronic care management (CCM) or behavioral health integration (BHI) services.
- Views on anticipated utilization impact were mixed. Most carriers did not anticipate a significant change in utilization because of the proposed legislation, with some noting that CoCM services are already required to be covered. One carrier noted that CoCM is currently underutilized and that broader, uniform coverage across payers may be necessary to support widespread primary care adoption, as practices are unlikely to screen their full patient populations if coverage remains disparate across payers. One carrier anticipated a significant increase in utilization, citing the expectation that integrating behavioral health into primary care will expand screening, reduce structural barriers to care, and increase provider participation through improved reimbursement.
- On procedure code limitations, most carriers reported no diagnosis code requirements or frequency limitations for any of the four applicable codes (99492, 99493, 99494, and G2214). One carrier reported frequency limits of once per calendar month per provider for codes 99492 and 99493, with no limitations noted for 99494 or G2214.
- Most carriers did not identify staffing or capacity constraints. One carrier identified administrative complexity as a potential barrier to CoCM uptake, noting that the model requires coordination across multiple provider roles. One carrier specifically identified child and adolescent behavioral health as a high-demand area where workforce shortages may limit the pace of utilization growth. One carrier also characterized CoCM as a standard outpatient

[iv] BerryDunn surveyed 10 insurance carriers in the Commonwealth (although Tufts Health Plan and Harvard Pilgrim Health Care recently merged, they are accounted for separately); responses represent six carriers and 86% coverage of members.

service that is not subject to medical management, suggesting limited administrative oversight relative to other behavioral health services.

- One carrier expressed concerns regarding the bill's requirement to establish reimbursement rate floors tied to the Medicare fee schedule, noting that such provisions may increase costs and reduce flexibility in rate negotiations between carriers and providers.

5.0 Methodology

5.1 Overview

Estimating the impact of this mandate on premiums requires evaluating the cost and utilization of the mandated services relative to current coverage levels. These components were combined, with adjustments for carrier retention, to produce a baseline estimate of the proposed mandate's incremental effect on premiums. This impact was then projected over a five-year period beginning January 1, 2027, as the implementation date should the bill become law.

5.2 Data Sources

The primary data sources used in the analysis are as follows:

- Input from legislative sponsors regarding the intended effect of the bill
- Survey of commercial carriers in the Commonwealth regarding descriptions of current coverage
- Interviews with clinical and operational experts
- Massachusetts All Payers Claims Database (APCD) data
- Published scholarly literature, reports, and population data, cited as appropriate

5.3 Steps in the Analysis

1. Estimated the marginal costs for insurers for establishing a minimum reimbursement floor tied to the Medicare RBRVS physician fee schedule for CoCM.

A. Used APCD data to estimate the current fully insured commercial CoCM allowed reimbursement rates and utilization at the member claim-line level for the covered CPT® and HCPCS codes.

B. Estimated a paid to allowed factor based on APCD data to convert allowed costs to paid costs to insurers.

C. Estimated the reimbursement floor by using the maximum Medicare RBRVS physician fee schedule rates by Medicare locality and procedure code.

D. Calculated the annual incremental cost of establishing a reimbursement floor based on current utilization patterns. Estimated the incremental impact at the member claim-line level by multiplying current utilization by the difference between the estimated reimbursement floor by Medicare locality and procedure code from 1C, and the current fully insured commercial CoCM allowed cost per claim by member claim-line and procedure code. The paid to allowed factor estimated in 1B was then applied. The incremental cost was assumed to be zero if the current fully insured commercial allowed rates were higher than the maximum Medicare RBRVS physician fee schedule rates.

E. Estimated a range of rates of increased utilization for the first five years of mandated services under the proposed mandate. Developed low, medium, and high scenario estimates based on APCD data, literature research, and expert opinion.
F. Estimated a ramp-up factor for the first year under the proposed mandate based on expert clinical and operational input.
G. Calculated the annual incremental cost of increased utilization of mandated services under the proposed mandate by multiplying the estimated reimbursement floor by the range of incremental increased utilization. The paid to allowed factor estimated in 1B was then applied. For the first year, the ramp-up factor estimated in 1F was also applied. In instances where the current fully insured commercial allowed cost per claim was higher than the estimated reimbursement floor, the increase in utilization was assumed to be zero.
H. Calculated the range of incremental medical expense attributable to the mandate by summing: the estimated annual incremental cost of establishing a reimbursement floor given current utilization from step 1D and the estimated incremental cost of increased utilization from step 1G under each scenario for each year.
I. Divided the total dollar impact from step 1H by the total calendar year 2024 membership for all carriers to calculate the marginal cost PMPM associated with the mandate for each year.

2. Calculated the impact of the projected claim costs on insurance premiums.

A. Estimated the fully insured Commonwealth population under age 65 for the next five years (2027 – 2031).
B. Projected the incremental PMPM costs for 2027 through 2031 by applying an average annual medical inflation factor.
C. Multiplied the projected PMPM incremental net cost of the mandate from step 2B by the projected population estimate from step 2A to calculate the total estimated marginal claims cost of the bill.
D. Estimated insurer retention (i.e., administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in step 2C to calculate the effect of the bill on premiums.

5.4 Assumptions and Limitations

There are several important assumptions in this analysis that should be considered when interpreting the results.

To be more conservative, the maximum Medicare rates by locality were used to create the reimbursement floor, though the actual reimbursement rate floors will vary by provider setting. The base utilization and allowed costs per claim were also assumed to equal what is in the APCD for 2024, though there will likely be volatility year to year. Furthermore, it was assumed that the paid to allowed factor for 2027 through 2031 will be the same as 2024, though the actual paid to allowed factor will likely vary by year.

This study assumes that the observed base year difference between provider reimbursement rates and Medicare rates will trend forward with overall medical inflation, based on long-term average national projection for physician and clinical services. However, because the mandate would establish Medicare rates as a reimbursement floor, providers who are currently being reimbursed below Medicare rates would be required to receive at least the Medicare rate if the mandate is enacted. As a result, the current observed differential would no longer be observable under the mandate. If the mandate is not enacted, the differential may remain observable but could evolve differently than assumed due to changes in Medicare payment policy, provider contracting dynamics, market conditions, or other factors. These considerations introduce additional uncertainty in the projected cost impact.

This analysis is also subject to several limitations that should be considered.

Notably, cost offsets were not incorporated into this estimate. CoCM might reduce downstream utilization of higher-cost services, such as inpatient psychiatric admissions, emergency department visits, and overall physical health service use. To the extent these offsets are material, the estimates presented here might overstate the net cost of the mandate.

The true incremental increase in utilization resulting from the mandate is also uncertain. The utilization scenarios developed for this analysis draw on APCD data, published literature, and expert opinion, but actual utilization patterns might differ. Compounding this uncertainty is the relatively low current utilization of CoCM services, which introduces volatility into the baseline from which increased utilization rates are applied. A small or unstable base can amplify the sensitivity of relatively minor changes in assumptions compared to more established services.

It is also uncertain whether Medicare-level rates will be sufficient to meaningfully incentivize provider adoption of the CoCM model. If reimbursement at the Medicare floor does not adequately offset the administrative burden and operational complexity associated with CoCM, actual utilization increases might not be material. Similarly, implementation and scaling costs for provider practices, including care management staffing, training, and infrastructure, were not modeled and could vary considerably across practice settings, further influencing the pace and extent of CoCM uptake. It was also assumed in the five-year projection that utilization increases would ramp up in the first year and then stabilize at the assumed utilization scenarios for years two through five, though implementation might take longer than anticipated, causing a longer ramp-up period.

6.0 Analysis

This section describes the calculations outlined in the previous section in more detail. The analysis includes a best estimate middle-cost scenario, a low-cost scenario, and a high-cost scenario using more conservative assumptions. The analysis section proceeds as follows: Section 6.1 describes the steps used to calculate the incremental cost of the bill. Section 6.2 projects the fully insured population ages 0 – 64 in the Commonwealth over the years 2027 – 2031. Section 6.3 calculates the total marginal medical expense. Section 6.4 adjusts these projections for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

6.1 Incremental Cost of Mandate

BerryDunn first analyzed APCD data from 2020 to 2024 to estimate the current CoCM utilization and reimbursement rates. Data from 2024 was used as the base period. To estimate provider-level rates, analysis was done at the member claim-line level.

Medicare rates were pulled using APCD data for 2024 to align with the assumed base period, and the highest Medicare rate from the Medicare physician fee schedule pricing[10] by code and locality was used as the reimbursement floor. The impact of implementing a reimbursement floor given current utilization was calculated by multiplying 2024 fully insured commercial CoCM utilization by the difference between the reimbursement floor and the 2024 fully insured commercial CoCM allowed cost per claim by member claim line. A paid to allowed factor of 0.93 based on the 2024 overall fully insured commercial CoCM paid to allowed factor was then applied to convert allowed costs to paid costs to insurers. The impact was assumed to be zero for all claim lines where the 2024 fully insured commercial allowed rates were higher than the assumed reimbursement floor.

Based on APCD data, literature research, and input from experts, BerryDunn assumed that utilization of CoCM would increase if the reimbursement rates increased under the proposed mandate. A range of utilization increases was developed: a low scenario of no increase in utilization, a middle scenario of a 25% increase, and high scenario of a 50% increase. The mid-range best estimate of 25% increase in utilization was based on the cost increase if all claims with allowed costs currently below the proposed rate floor were instead reimbursed at the floor rate. The high scenario doubled the best estimate utilization increase to reflect the possibility of a stronger provider and member response to increased reimbursement levels. The low- and high-end estimates were developed by combining APCD data, literature research, and input from experts. It was assumed that utilization would only increase for member claim-level lines where allowed costs per claim were below the reimbursement floor for 2024 and would not increase if the allowed rates were already at, or above, the floor.

The estimated cost impact of implementing a reimbursement floor based on current utilization and projected utilization due to increased reimbursement rates was then summed, resulting in the total

incremental cost of the bill. An average medical inflation factor was used to project costs from the 2024 base to the five-year projection period.[11] Table 2 below shows the PMPM impact from calendar year 2027 to calendar year 2031.

Table 2. Projected PMPM Costs to Insurers for Implementation of CoCM Reimbursement Floor

	2027	2028	2029	2030	2031
Low Scenario	$0.01	$0.01	$0.01	$0.01	$0.01
Mid Scenario	$0.01	$0.01	$0.01	$0.01	$0.01
High Scenario	$0.02	$0.02	$0.02	$0.02	$0.02

6.2 Project Fully Insured Population in the Commonwealth

Table 3 shows the Commonwealth's fully insured population (ages 0 – 64) projected for the next five years. Appendix A describes the sources of these values.

Table 3. Projected Fully Insured Population in the Commonwealth, Ages 0 – 64

Year	2027	2028	2029	2030	2031
Total (0 – 64)	2,034,557	2,044,527	2,036,221	2,028,278	2,024,429

6.3 Total Marginal Medical Expense

The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2027. Based on input from experts, it was assumed that utilization increases would ramp up in the first year under the proposed mandate. An implementation period of 90 days was assumed, resulting in a ramp-up factor of 0.75, which was applied to the 2027 estimated increased utilization cost impact. Utilization was then assumed to hold flat for years 2028 through 2031.

Furthermore, based on an assumed renewal distribution by month, market segment, and the Commonwealth market segment composition, 72.1% of the member months exposed in 2027 will have the proposed mandate coverage in effect during calendar year 2027. The annual dollar impact of the mandate in 2027 was estimated using the estimated PMPM and applying it to 72.1% of the member months exposed.

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period results in the total cost (medical expense) associated with the proposed requirement, shown in Table 4.

Table 4. Estimated Marginal Claims Cost

	2027	2028	2029	2030	2031
Low Scenario	$87,467	$127,408	$132,617	$138,060	$144,017
Mid Scenario	$167,178	$282,224	$293,761	$305,819	$319,013
High Scenario	$246,889	$437,040	$454,905	$473,578	$494,009

6.4 Carrier Retention and Increase in Premium

Assuming an average retention rate of 11.3%—based on CHIA's analysis of administrative costs and profit in the Commonwealth[12]—the increase in medical expenses was adjusted upward to approximate the total impact on premiums. Table 5 displays the result.

Table 5. Estimate of Increase in Carrier Premium

	2027	2028	2029	2030	2031
Low Scenario	$98,561	$143,569	$149,438	$155,572	$162,284
Mid Scenario	$188,383	$318,022	$331,022	$344,610	$359,477
High Scenario	$278,205	$492,474	$512,606	$533,647	$556,670

7.0 Results

7.1 Five-Year Estimated Impact

For each year in the five-year analysis period, Table 6 displays the projected net impact of the proposed language on medical expenses and premiums using a projection of the Commonwealth's fully insured membership. Note that the relevant provisions are assumed to take effect on January 1, 2027.[v]

[v] With an assumed start date of January 1, 2027, dollars were estimated at 72.1% of the annual cost, based upon an assumed renewal distribution by month (Jan – Dec) by market segment and the Massachusetts market segment composition.

Table 6. Summary Results

	2027	2028	2029	2030	2031	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Average Members (000s)	2,035	2,045	2,036	2,028	2,024	N/A	N/A
Medical Expense Low ($000s)	$87	$127	$133	$138	$144	$133	$630
Medical Expense Mid ($000s)	$167	$282	$294	$306	$319	$290	$1,368
Medical Expense High ($000s)	$247	$437	$455	$474	$494	$446	$2,106
Additional Premium Low ($000s)	$99	$144	$149	$156	$162	$150	$709
Additional Premium Mid ($000s)	$188	$318	$331	$345	$359	$327	$1,542
Additional Premium High ($000s)	$278	$492	$513	$534	$557	$503	$2,374
PMPM Low	$0.01	$0.01	$0.01	$0.01	$0.01	$0.01	$0.01
PMPM Mid	$0.01	$0.01	$0.01	$0.01	$0.01	$0.01	$0.01
PMPM High	$0.02	$0.02	$0.02	$0.02	$0.02	$0.02	$0.02
Estimated Premium PMPM	$729	$761	$794	$829	$865	$796	$796
Premium % Rise Low	0.001%	0.001%	0.001%	0.001%	0.001%	0.001%	0.001%
Premium % Rise Mid	0.001%	0.002%	0.002%	0.002%	0.002%	0.002%	0.002%
Premium % Rise High	0.002%	0.003%	0.003%	0.003%	0.003%	0.003%	0.003%

7.2 Impact on GIC

The proposed mandate would apply to self-insured plans operating for state and local employees by the GIC. The benefit offerings of GIC plans are similar to most other commercial plans in Massachusetts. This section describes the results for the GIC.

Findings from BerryDunn's carrier survey indicate that benefit offerings for GIC and other commercial plans in the Commonwealth are similar. For this reason, the cost of the bill for GIC will likely be similar to the cost for other fully insured plans in the Commonwealth.

BerryDunn assumed the proposed legislative change will apply to self-insured plans that the GIC operates for state and local employees, with an effective date of July 1, 2027. Because of the July effective date, the results in 2027 are approximately one half of an annual value. Table 7 outlines the GIC's self-insured membership, as well as the corresponding incremental medical expense.

Table 7. GIC Summary Results

	2027	2028	2029	2030	2031	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	308	306	305	303	302	N/A	N/A
Medical Expense Low ($000s)	$9	$19	$20	$21	$22	$20	$90
Medical Expense Mid ($000s)	$18	$42	$44	$46	$48	$44	$197
Medical Expense High ($000s)	$26	$65	$68	$71	$74	$68	$304

Endnotes

[1] *Op. cit.* H.B. 5230. An Act relative to access to psychiatric collaborative care.

[2] *Op. cit.* S.B. 1390. An Act relative to access to psychiatric collaborative care.

[3] *Op. cit.* Centers for Medicare & Medicaid Services. Information on Essential Health Benefits (EHB) Benchmark Plans.

[4] *Op. cit.* CMS. MASSACHUSETTS EHB BENCHMARK PLAN (2025-2027).

[5] Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. HMO Blue® New England $2,000 Deductible Plan Option, Schedule of Benefits. Accessed March 29, 2026. https://www.mass.gov/doc/ehbbp-hmoblue-2017pdf/download.

[6] *Op. cit.* M.G.L. c.175 §47QQ; M.G.L. c.176A §8RR; M.G.L. c.176B §4RR; M.G.L. c.176G §4JJ.

[7] *Op. cit.* H.B. 5230. An Act relative to access to psychiatric collaborative care.

[8] S.B. 1390. An Act relative to access to psychiatric collaborative care. https://malegislature.gov/Bills/194/S1390.

[9] *Op. cit.* Centers for Medicare & Medicaid Services. Information on Essential Health Benefits (EHB) Benchmark Plans.

[10] National Government Services. Fee Schedule Lookup. Accessed May 1, 2026. https://www.ngsmedicare.com/fee-schedule-lookup?lob=93619&state=97310&rgion=93623

[11] Centers for Medicare & Medicaid Services. National Health Expenditure Data. Projected. Page Last Modified: 06/25/2025. Accessed May 19th, 2026. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

[12] Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System, March 2026. Accessed May 8, 2026. https://www.chiamass.gov/annual-report/.

Appendix A: Membership Affected by the Proposed Language

Membership potentially affected by the proposed mandated change includes Commonwealth residents with fully insured, employer sponsored health insurance (ESI) issued by a Commonwealth-licensed company (including through the GIC); nonresidents with fully insured, ESI issued in the Commonwealth; Commonwealth residents with individual (direct) health insurance coverage; and lives covered by GIC self-insured coverage. Other populations within the self-insured commercial sector are excluded from the state coverage mandate due to federal Employee Retirement Income Security Act (ERISA) protections of self-insured plans. The membership projections are used to determine the total dollar impact of the proposed mandate in question; however, variations in the membership forecast will not affect the general magnitude of the dollar estimates. To assess how recent volatility in commercial enrollment levels might affect these cost estimates, please note the PMPM and percentage of premium estimates are unaffected because they are per-person estimates, and the total dollar estimates will vary by the same percentage as any percentage change in enrollment levels.

CHIA-reported enrollment data formed the basis for membership projections. CHIA publishes a biannual enrollment trends report and supporting databook (enrollment-trends-Data Through September 2025 databook),[1] which provide enrollment data for Commonwealth residents by insurance carrier for most carriers, excluding some small carriers. CHIA uses supplemental information beyond the data in the APCD to develop its enrollment trends report and adjust the resident totals from the APCD. For the base year 2020 in the membership projection, the 2020 APCD and published 2020 membership reports available from the Massachusetts Division of Insurance (DOI) [2,3] were used to develop a factor to adjust the CHIA enrollment data for the few small carriers not present in the enrollment report. The adjustment was trended forward to 2025 and applied to CHIA enrollment data.

In 2021, commercial, fully insured membership was 5.6% less than in 2019, with a shift to both uninsured and MassHealth coverage. As part of the public health emergency (PHE), members were not disenrolled from MassHealth coverage even when they no longer passed eligibility criteria. Shortly before the PHE ended, redetermination efforts began in April 2023 and were anticipated to occur over a 12-month period. Many of the individuals subject to redetermination will no longer be eligible for MassHealth coverage. It is anticipated that a portion of individuals losing coverage will be eligible for coverage in individual ACA plans and ESI. MassHealth's monthly caseload reports[4] indicated coverage redeterminations were largely completed by June 2024. The Massachusetts Health Connector's monthly reports[5] showed membership growth stabilized through December 2024, likely due to disenrolled MassHealth members enrolling in individual plans. CHIA's quarterly enrollment trends report[6] showed stable total membership in private commercial group insurance, with a shift from fully insured to self-insured plans. Based on this information, BerryDunn estimated the final 2024 membership impacted by the proposed mandate.

The distribution of members by age and gender was estimated using APCD population distribution ratios, checked for reasonableness and validated against U.S. Census Bureau data.[7] Membership was projected from 2025 to 2050, with growth rate estimates by age and gender derived from a Massachusetts population projection from UMass Donahue Institute.[8]

Projections for the GIC self-insured lives were developed using the GIC base data for 2018, 2019, and 2025, which BerryDunn received directly from the GIC, as well as the same projected growth rates from the Census Bureau used for the Commonwealth population. BerryDunn accounted for municipalities that are expected to join GIC effective July 2026. This information was incorporated into the GIC membership projection. Breakdowns of the GIC self-insured lives by gender and age were based on U.S. Census Bureau distributions.

Endnotes

[1] Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed May 20, 2026. https://www.chiamass.gov/enrollment-in-health-insurance.

[2] Massachusetts Department of Insurance. HMO Group Membership and HMO Individual Membership. Accessed March 27, 2025. https://www.mass.gov/info-details/hmo-membership-reports.

[3] Massachusetts Department of Insurance. Membership in Insured Preferred Provider Plans. Accessed March 27, 2025. https://www.mass.gov/info-details/insured-preferred-provider-membership.

[4] MassHealth Enrollment and Caseload Metrics. Accessed March 27, 2025 https://www.mass.gov/lists/masshealth-enrollment-and-caseload-metrics#2025-masshealth-monthly-caseload-reports-.

[5] Massachusetts Health Connector. Membership During MassHealth Redeterminations. Accessed March 27, 2025. https://betterhealthconnector.com/wp-content/uploads/Health-Connector-MassHealth-Renewals-Dashboard-12-17-24.pdf.

[6] *Op. cit.* Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier.

[7] National Population by Characteristics: 2020-2024. Accessed March 27, 2025 https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html.

[8] Massachusetts Population Projections. Accessed March 27, 2025. https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-projections.