
MANDATED BENEFIT REVIEW OF HOUSE BILL 1276 AND SENATE BILL 703

SUBMITTED TO THE 194th GENERAL COURT:

AN ACT RELATIVE TO COMMUNITY BEHAVIORAL HEALTH CENTERS

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Mandated Benefit Review of House Bill (H.B.) 1276 and Senate Bill (S.B.) 703 Submitted to the 194th General Court

An Act Relative to Community Behavioral Health Centers

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1.0 Executive Summary: H.B. 1276 and S.B. 703; “An Act relative to community behavioral health centers”

The Massachusetts Legislature’s Committee on Financial Services referred House Bill (H.B.) 1276 and Senate Bill (S.B.) 703, both titled “An Act relative to community behavioral health centers,”^{1,2} to the Massachusetts Center for Health Information and Analysis (CHIA) for review. This report references H.B. 1276 and S.B. 703 together and hereafter as “the bill.”

As submitted to the 194th General Court of the Commonwealth of Massachusetts (the Commonwealth), the bill requires carriers to provide nondiscriminatory coverage for medically necessary behavioral health bundled services delivered through community behavioral health centers (CBHCs). The bill defines bundled services and CBHCs as follows:

- 1) “Behavioral health bundled services”, are services provided by a CBHC, as specified in title 101 CMR 305.00, for the evaluation, diagnosis, treatment, care coordination, management, or peer support of individuals with mental health, developmental or substance use disorders. These services are reimbursed through a flat rate per encounter rate.
- 2) “Community Behavioral Health Centers” are clinics licensed by the Department of Public Health (DPH) and regulated pursuant to title 130 CMR 448.00.”^{3,4}

This report focuses on the impact of requiring commercial carriers to reimburse CBHCs for the provision of coordinated and integrated behavioral health disorder treatment using the MassHealth behavioral health bundled services methodology which is based on a flat rate per encounter.^{i,5} The report also includes comparisons to the federal Certified Community Based Health Clinics^{ii,6} (CCBHCs) model, established in 2014 pursuant to the Protecting Access to Medicare Act.⁷ CCBHCs provide 24/7 crisis services, behavioral health support, and care coordination to assist patients in navigating behavioral and physical health care, social services, and other systems of care they receive.⁸

1.1 What Is a Community Behavioral Health Center?

The CCBHC model was established to strengthen access to comprehensive, coordinated behavioral health care through community-based outpatient facilities that serve local populations.⁹ Similar to CCBHCs, Massachusetts utilizes CBHCs^{iii,10} to help ensure access to coordinated behavioral healthcare. CBHCs are a key part of The

ⁱ As defined in 130 CMR 448.402, Behavioral Health Disorder means: “any disorder pertaining to mental health or substance use as defined by the current edition of the *Diagnostic and Statistical Manual of Mental Disorder*.”

ⁱⁱ The CCBHC initiative is operated through a Health and Human Services (HHS) partnership across the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Medicare & Medicaid Services (CMS), and the Office of Assistant Secretary for Planning and Evaluations.

ⁱⁱⁱ As defined in 130 CMR 448.402, CBHC means: “an entity that serves as a hub of coordinated and integrated behavioral health disorder treatment for individuals of all ages, including routine and urgent behavioral health outpatient services, mobile crisis services for adults and youth, and community crisis stabilization services for adults and youth.”

Behavioral Health Roadmap (Roadmap), a multiyear initiative introduced in 2021 and implemented in 2023. The Roadmap aims to enhance the effectiveness of treatment, expand access to behavioral health services, and promote health equity across the Commonwealth.^{11,12} As a result of the Roadmap, designated CHBCs now serve all areas of the Commonwealth as regional hubs of behavioral health treatment¹³ for individuals of all ages. CBHCs are licensed by the Department of Public Health (DPH) and certified by the DPH Bureau of Substance Addiction Services (BSAS).¹⁴ CBHCs provide urgent and ongoing person-centered mental health and addiction treatment.^{15,16} CBHCs serve as community-based alternatives to emergency departments for crisis intervention services, providing both routine and urgent outpatient services, as well as care coordination when needed.

1.2 Current Coverage

The Affordable Care Act (ACA) requires qualified health plans to cover essential health benefits (EHBs)^{iv} which include coverage for mental health, substance use disorder services, and behavioral health treatment.¹⁷ The Commonwealth's benchmark plan,^v HMO Blue New England, includes coverage for EHBs, which incorporate the behavioral health benefits required under the ACA, but does not specifically reference services delivered at CBHCs.^{18,19} State law requires commercial carriers to cover crisis services provided at CBHCs; however, it does not require coverage for outpatient behavioral services provided at these centers.

BerryDunn surveyed Massachusetts insurance carriers in the Commonwealth, with respondents representing 84% of the Commonwealth's fully insured commercial membership. The responding carriers reported that outpatient services provided at CBHCs are considered covered benefits; and two carriers indicated that they utilize the MassHealth bundled payment reimbursement methodology.

1.3 Analysis Overview

The bill's language stipulates that health insurers provide benefits on a nondiscriminatory basis for medically necessary behavioral health bundled services provided at CBHCs and further requires that reimbursement will be based through a flat rate per encounter.^{20,21} Currently, pursuant to Chapter 177 of the Acts of 2022,²² commercial carriers are required to contract for crisis services provided at CBHCs, which includes mobile crisis intervention (MCI) and crisis stabilization services (CSS);²³ however, the law does not set forth contractual obligations for commercial carriers related to the provision of outpatient services provided at CBHCs.

^{iv} EHBs are services that non-legacy insurers in individual and small group markets must cover in at least ten benefit categories, with limited cost-sharing.

^v HMO Blue New England \$2000 Deductible Plan (HMO Blue New England) offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

1.4 Estimated Cost of Enactment

The estimated cost of the mandate is driven by an All-Payer Claims Database (APCD) analysis of carriers that began covering the CBHC bundled payment in 2023 and subsequently experienced increased utilization of CBHC services. Additionally, the bill's requirement that commercial plans reimburse at the same rate as MassHealth contributes to the overall cost estimate.

The estimated impact on typical health insurance premiums is an increase of approximately \$0.43 and \$0.61 per member per month (PMPM) or between 0.05% and 0.07% of premium, over a projection period of five years.

1.5 Efficacy and Equity Impact

Behavioral health refers to both mental health and substance use disorders^{vi,24} and can impact physical health.²⁵ Recognizing the need to adequately address behavioral health, the Roadmap aims to expand coverage of behavioral healthcare services and increase community access.²⁶ The creation of a CBHC provider network throughout the Commonwealth provides access to 24/7 behavioral health services, resulting in increased access to outpatient and crisis services. Based on the Executive Office of Health and Human Services (EOHHS) MassHealth member claims data, CBHCs provided more than 643,000 bundled outpatient visits from January 2023 – January 2024 with an average of 12 visits per member, resulting in expanded access to urgent outpatient visits for adults and youth.²⁷ Further, in addition to providing access to outpatient behavioral health services, CBHCs have also increased access to crisis intervention services and have been shown to reduce hospital emergency department (ED) boarding as well as psychiatric admissions.^{28,29} However, despite these demonstrated improvements to behavioral health treatment access, a lack of sustainable funding for CBHCs to maintain staffing and facility services could jeopardize this access.³⁰ By mandating the use of a flat rate per encounter for behavioral health bundled services in the CBHC outpatient setting for commercial carriers, CBHCs would have a more predictable funding stream and would also allow them to market their services to the commercially insured population for whom not all of the comprehensive services provided at CBHCs are covered.³¹ Moreover, interviewed experts indicated that providers are more satisfied with the CBHC integrated and coordinated model of care because it allows them to provide a range of services to better address patients' often complex needs.^{vii} As reported by the experts interviewed, this increased satisfaction with team-based care also results in improved provider recruitment and retention at CBHCs.

^{vi} Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress related symptoms. Behavioral healthcare care refers to the diagnosis, prevention, and treatment of behavioral health conditions.

^{vii} BerryDunn interviewed CBHC representatives on January 15, 2025 and January 22, 2025.

Endnotes

¹ H.B. 1276. An Act relative to community behavioral health centers. Accessed May 17, 2025. <https://malegislature.gov/Bills/194/H1276>.

² S.B. 703. An Act relative to community behavioral health centers. Accessed May 17, 2025. <https://malegislature.gov/Bills/194/S703>.

³ *Op. cit.* H.B. 1276 An Act relative to community behavioral health centers.

⁴ *Op. cit.* S.B. 703 An Act relative to community behavioral health centers.

⁵ 130 CMR 448.000: Community Behavioral Health Services. Effective January 1, 2023. Accessed January 30, 2025. <https://www.mass.gov/doc/130-cmr-448-community-behavioral-health-center-services/download>.

⁶ Substance Abuse and Mental Health Services Administration (SAMHSA). CCBHCs. Last updated April 24, 2023. Accessed February 20, 2025. <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics>.

⁷ Substance Abuse and Mental Health Services Administration (SAMHSA). Certified Community Behavioral Health Clinics. History and Background. Last updated February 13, 2024. Accessed February 20, 2025. <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/history-background>.

⁸ *Op. cit.* CCBHCs.

⁹ Congressional Research Service. Certified Community Behavioral Health Clinics (CCBHCs). September 15, 2023. Congress.gov. Accessed February 13, 2025. <https://crsreports.congress.gov/product/pdf/IF/IF12494>.

¹⁰ *Op. cit.* 130 CMR 448.000.

¹¹ *Op. cit.* CCBHCs.

¹² Commonwealth of Massachusetts Executive Office of Health and Human Services. Background on the Behavioral Health Roadmap. Mass.gov. Accessed February 20, 2025. <https://www.mass.gov/info-details/background-on-the-behavioral-health-roadmap>.

¹³ Commonwealth of Massachusetts Executive Office of Economic Development. Division of Insurance. Bulletin 2023-11; Community-Based Emergency Behavioral Health Care; Mass.gov. Issued June 22, 2023. Accessed January 30, 2025 <https://www.mass.gov/doc/bulletin-2023-11-community-based-emergency-behavioral-health-care-issued-june-22-2023/download>.

¹⁴ *Op. cit.* 130 CMR 448.000.

¹⁵ Commonwealth of Massachusetts Executive Office of Health and Human Services. MassHealth. Community Behavioral Health Centers. Mass.gov. Accessed January 30, 2025. <https://www.mass.gov/community-behavioral-health-centers>.

¹⁶ Commonwealth of Massachusetts Executive Office of Health and Human Services. Roadmap for Behavioral Health Reforms: FAQs. Community Behavioral Health Centers (CBHCs). Mass.gov. Accessed January 9, 2025. Accessed January 30, 2025. [https://www.mass.gov/info-details/roadmap-for-behavioral-health-reform-faqs#community-behavioral-health-centers-\(cbhcs\)-](https://www.mass.gov/info-details/roadmap-for-behavioral-health-reform-faqs#community-behavioral-health-centers-(cbhcs)-).

¹⁷ 42 U.S.C. § 18022. Essential Health Benefits Requirements. Accessed January 17, 2025. <https://www.govinfo.gov/app/details/USCODE-2023-title42/USCODE-2023-title42-chap157-subchapIII-partA-sec18022>.

¹⁸ Commonwealth of Massachusetts Executive Office of Economic Development. Division of Insurance. Essential Health Benefit Benchmark Plan. Mass.gov. Accessed February 20, 2025. <https://www.mass.gov/doc/ehbbp-hmoblue-2017pdf/download>.

¹⁹ Commonwealth of Massachusetts Executive Office of Economic Development. Division of Insurance. Essential Health Benefit Benchmark Plan. 2017 and Years Thereafter. Mass.gov. Accessed April 16, 2025. <https://www.mass.gov/info-details/essential-health-benefit-benchmark-plan>.

²⁰ *Op. cit.* H.B. 1276.

²¹ *Op. cit.* S.B. 703.

²² An Act Addressing Barriers to Care for Mental Health. Chapter 177 of the Acts of 2022. The 194th General Court of the Commonwealth of Massachusetts. Accessed January 30, 2025. <https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177>.

²³ *Op. cit.* Bulletin 2023-11.

²⁴ American Medical Association. What is behavioral health? August 22, 2022. Accessed April 21, 2025. <https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health#>.

²⁵ Centers for Disease Control and Prevention (CDC). About Mental Health. Cdc.gov. Updated August 8, 2024. Accessed April 18, 2025. <https://www.cdc.gov/mental-health/about/index.html>.

²⁶ Blue Cross Blue Shield of Massachusetts Foundation & Manatt Health. Massachusetts Roadmap for Behavioral Health Reform: Overview and Implementation Update. Published 2024. Accessed February 21, 2025. https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2024-08/BH_Reform_Roadmap_Aug2024_final_0.pdf.

²⁷ *Ibid.*

²⁸ Commonwealth of Massachusetts Executive Office of Health and Human Services. Behavioral Health Roadmap Update: Exec Summary for May 2024. Mass.gov. Accessed February 21, 2025. https://www.mass.gov/doc/behavioral-health-roadmap-update-exec-summary-for-may-2024/download?_ga=2.43082341.1707382328.1740143037-1582405237.1680630415&_gl=1*8jku3v*_ga*MTU4MjQwNTIzNy4xNjgwNjMwNDE1*_ga_MCLPEG7WWM*MTc0MDE0MzA0NC43NC4xLjE3NDAxNDQ0MjguMC4wLjA.

²⁹ *Op. cit.* Massachusetts Roadmap for Behavioral Health Reform: Overview and Implementation Update.

³⁰ Cahan E. Community behavioral health centers have helped wase the ER boarding crisis. Now some are struggling financially. Boston Globe. January 4, 2025. Accessed February 21, 2025.

<https://www.bostonglobe.com/2025/01/04/metro/mental-health-boarding-urgent-care-massachusetts/>.

³¹ Jolicoeur L. Community behavioral health centers in Mass. see big demand for one-stop mental health care. WBUR. February 22, 2024. Accessed February 21, 2024. <https://www.wbur.org/news/2024/02/22/massachusetts-community-behavioral-health-centers>.

AN ACT RELATIVE TO COMMUNITY BEHAVIORAL HEALTH CENTERS

MEDICAL EFFICACY ASSESSMENT

2.0 Medical Efficacy Assessment

The bill requires health insurers to provide nondiscriminatory coverage for medically necessary behavioral health bundled services delivered by Community Behavioral Health Centers (CBHCs).^{viii} These services must be reimbursed at a flat (bundled) rate and may include evaluation, diagnosis, treatment, care coordination, and peer support for individuals with mental health conditions, substance use disorders, or developmental disabilities.^{1,2}

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

- Allow individuals access to the same set of services provided at CBHCs regardless of insurance coverage by requiring commercial carriers to provide coverage and reimburse the same bundled services available to MassHealth members at the prevailing MassHealth rate
- Enable CBHCs to build and maintain capacity to keep staff and facilities available given unpredictable patient flow

M.G.L. Chapter 3 §38C charges the Center for Health Information and Analysis (CHIA) with reviewing the medical efficacy of proposed mandated health insurance benefits. Medical efficacy reviews summarize current literature on the effectiveness and use of the treatment or service and describe the potential impact of a mandated benefit on the quality of patient care and health status of the population.

This report proceeds in the following sections:

2.0 Medical Efficacy Assessment

- 2.1 Evolution of the CBHC Model of Care
- 2.2 CBHC Utilization
- 2.3 Efficacy of Services Provided at a CBHC
- 2.4 CBHC Access and Health Equity

3.0 Conclusion

2.1 Evolution of CBHC Model of Care

Behavioral health—a key component of overall health and closely connected to physical health—is an umbrella term that includes mental health distress, mental health conditions,^{ix,3} suicidal thoughts and behaviors, and substance use.^{4,5} Mental health is a component of behavioral health and refers to emotional, psychological, and social well-being.⁶ Mental health conditions are among the most common health conditions in the United States, with a prevalence of nearly 25% among adults,⁷ and can affect a person's thinking, mood, and/or behavior.⁸

^{viii} See 130 CMR 448 (<https://www.mass.gov/doc/130-cmr-448-community-behavioral-health-center-services/download>)

^{ix} Mental health conditions are clusters of symptoms that are diagnosed as illnesses or disorders that affect thinking, feeling, behavior, or mood.

Federal involvement in community-based behavioral health service delivery has evolved through a series of legislative and programmatic developments. Congress authorized the first federal grants in the 1960s to establish outpatient mental health clinics to support states' provision of community-based behavioral health services.⁹ In 2014, the Community Based Behavioral Health Clinic (CCBHC) model of care was developed to further improve access to community behavioral health services.¹⁰ This model is centered on community-based outpatient facilities that provide coordinated, comprehensive behavioral healthcare. CCBHCs operate under a federally designed model of care and are supported through a Medicaid demonstration program^{x,11} and/or discretionary grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA).^{12,13} Among demonstration states, data indicates that CCBHC clients receive care that is comparable to or better than that received by the broader Medicaid population.^{xi,14}

Although Massachusetts received a CCBHC planning grant,¹⁵ the Commonwealth pursued a different approach to integrating behavioral health services. In 2016, MassHealth submitted a 1115 Waiver extension which provided the opportunity for Massachusetts to move from a fee-for-service model to a system based on accountable care organizations (ACOs).¹⁶ The system was intended to promote integration by fostering partnerships between ACOs and community-based organizations, with targeted investments in behavioral healthcare, long-term services, and supports as an alternative to adopting the federally defined CCBHC model.¹⁷

To address the statewide historic and structural challenges in accessing mental health and addiction treatment,¹⁸ EOHHS developed the Roadmap for Behavioral Health Reform (the Roadmap). The key components of the Roadmap include:^{19,20}

- Implementation of a statewide behavioral health crisis line
- Development of CBHCs which provide readily available outpatient evaluation and treatment, providing a convenient community-based alternative to emergency departments
- Expansion of inpatient psychiatric bed capacity

Effective January 3, 2023, EOHHS launched CBHCs²¹ as a centralized entry point for timely, high-quality behavioral health care for both urgent and ongoing needs across Massachusetts.²² As set forth in the Roadmap, the goal of CBHCs is to provide access to integrated, evidence-based, culturally competent behavioral healthcare that is seamless, predictable, and consistent for individuals and families across the state.²³ Pursuant to 130 CMR 448.00, in order to be enrolled by MassHealth, CBHCs must be:

- Physically located within the Commonwealth of Massachusetts
- Enrolled as a Medicare provider
- Enrolled with the MassHealth agency as a billing provider as evidenced by the issuance of a Provider Identification and Service Location (PIDSL) number for the provision of CBHC services

^x Authorized under Section 223 of the Protecting Access to Medicare Act (PAMA).

^{xi} Where Medicaid benchmark comparisons were possible. Some examples include antidepressant medication management (AMM) continuation, initiation of alcohol or other drug (AOD) Dependence Treatment, Engagement of AOD Dependence Treatment, follow-ups after ED visits and hospitalization for mental health conditions, follow-ups after ED visits for AOD dependence, and adherence to antipsychotic medications for individuals with schizophrenia.

- Licensed by DPH as (a) a clinic with a mental health service designation and a SUD service designation; or (b) a hospital or hospital satellite that provides outpatient mental health and SUD services
- Certified by the DPH BSAS through a Certificate of Approval for Substance Use Disorder services for outpatient counseling and outpatient withdrawal management
- Maintain a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver²⁴

Focused on quality and outcomes, CBHCs provide crisis stabilization, outpatient, and urgent care for mental health and addiction treatment in one location²⁵ to serve as a “one-stop shop” for behavioral healthcare.²⁶ CBHCs integrate crisis and community-based treatment, provide evidence-based integrated mental health and addiction treatment for all ages, and provide 24/7/365 community crisis response.²⁷ The three main components of CBHCs include:²⁸

- Urgent and crisis response capacity, including same-day crisis triage and evaluation,^{xii} and same or next day treatment and stabilization^{xiii}
- Mental health and addiction treatment, including same-day open access^{xiv} and individualized outpatient treatment^{xv}
- Care coordination^{xvi} and relationships with and/or referrals to community providers^{xvii}

In addition to mobile crisis intervention (MCI) and crisis stabilization services (CSS), CBHCs must offer youth^{xviii} and adult CBHC services including the following: intake, diagnostic evaluation, treatment planning, case and family consultation and therapy, and pharmacotherapy.²⁹ When provided on the same date of service, many of these non-crisis-related services are included in the behavioral healthcare services bundled rate as defined by MassHealth. Figure 1 below highlights the key similarities and differences between the requirements for the federal CCBHC model and the Massachusetts CBHC model.

^{xii} Crisis triage and evaluation includes triage, evaluation, and assessment, intervention and de-escalation, specialty consultation, and community-based mobile crisis intervention.

^{xiii} Same or next day treatment and stabilization includes evaluation and assessment, psychiatric consultation and/or psychopharmacology within 72 hours, individual and/or family crisis intervention and therapy, same-day Medication-Assisted Treatment (MAT) induction or linkage, adult and youth 24-hour Crisis Stabilization Services, peer/support services, medical screening, and facility capacity to receive ambulance and/or police drop-off.

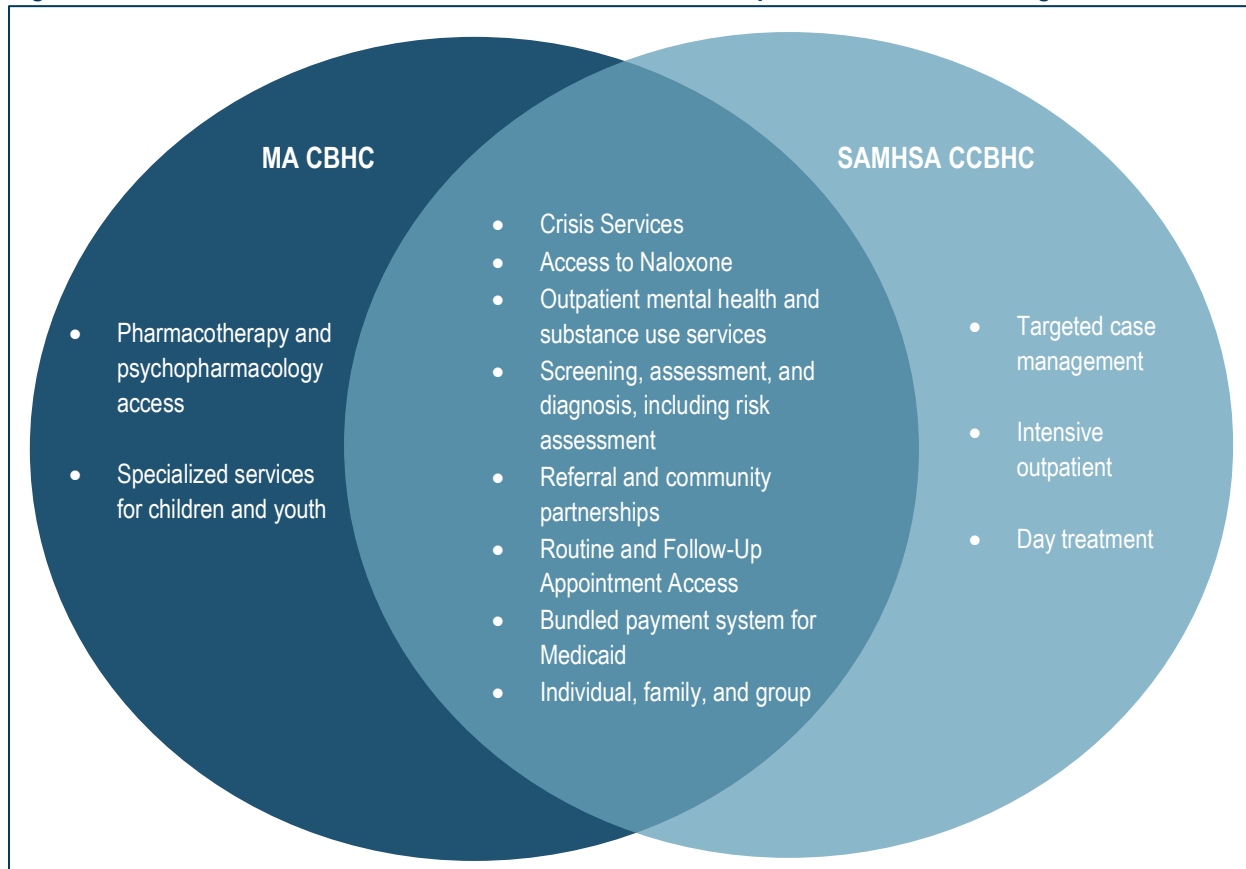
^{xiv} Same-day Open Access includes evaluation and assessment, topic-based group therapy, and peer/support services.

^{xv} Individualized outpatient treatment includes acute evidence-based therapy, maintenance therapy, prescribing MAT and/or psychiatric medication, specific treatment approaches for children, youth, families, and older adults, Community Support Program, and peer/support services.

^{xvi} Care coordination includes coordination with primary care providers, other behavioral health providers, SUD providers, insurance carriers, ACOs, Community Partners, state agencies, and schools.

^{xvii} Relationships with community providers includes referral relationships with other community providers.

^{xviii} Youth CBHC Services are services provided to children and youth younger than 21 years old.

Figure 1 Massachusetts CBHC^{30,31} and SAMHSA^{32,33,34} CCBHC Required Services Venn Diagram


2.2 CBHC Utilization

There are two broad categories which define mental health conditions: any mental illness (AMI)^{xix} and serious mental illness (SMI).^{xx,35} As of 2022, 23.1% of U.S. adults live with a mental health condition, and 6% of adults live with a SMI.³⁶ In Massachusetts, between 2021-2022, an estimated 1.3 million people over 18 reported having AMI, and an estimated 330,000 people over 18 reported having a SMI.³⁷ As of 2023, about 20% of adolescents (ages 12 – 17) were diagnosed with a current mental or behavioral health condition.³⁸ In 2023, an estimated 17% of people across the U.S. over the age of 12 had a substance use disorder (SUD);³⁹ and between 2022 - 2023, approximately 20% of people over the age of 12 in MA had an SUD diagnosis.⁴⁰

In 2023, according to CHIA, nearly 22% of MA residents had a visit related to behavioral healthcare within the past year, including almost 25% of children age 5 – 18 and 24% of adults age 19 – 64.⁴¹ In 2023, almost 10% of Massachusetts residents reported an unmet need for behavioral healthcare,^{xxi} about 21% of residents reported not knowing if insurance covered mental health visits, and almost 5% reported that their health insurance did not cover

^{xix} AMI is a mental, behavioral, or emotional disorder, with varying impact for an individual.

^{xx} SMI is a smaller and more severe subset of AMI that results in serious functional impairment for an individual.

^{xxi} 9.9% reported an unmet need for any behavioral health care, with 9.2% attributable to mental healthcare, and 2.2% attributable to substance use care or treatment.

mental health visits.⁴² The most commonly reported reason for paying entirely out-of-pocket for mental health care is that providers do not accept any insurance (36.6%), followed by providers not accepting specific insurance plans (26.8%).⁴³

In addition to the opioid epidemic,⁴⁴ the U.S. is currently experiencing a mental health crisis, resulting in increased levels of unmet behavioral health needs.⁴⁵ Many people are unable to access needed treatments, including access to mental health professionals.⁴⁶ The Health Resources and Services Administration (HRSA) projects significant shortages of mental and behavioral health providers over the next 10 years.⁴⁷ These shortages are due to a lack of supply of providers in the workforce, low reimbursement rates, restrictive and inconsistent scopes of practice and policies across states, large workloads and caseloads, workplace violence, a lack of organizational support, and provider burnout.^{xxii, 48}

A recent study found that utilization of behavioral health services has increased by 40% while utilization of other types of care has decreased since the COVID-19 pandemic.⁴⁹ Nationally, only about 21% of diagnosed individuals receive timely care,^{xxiii} with insufficient access to behavioral healthcare as a substantial barrier to effective treatment.⁵⁰ Researchers have identified structural barriers to accessing care—such as difficulty finding appropriate clinicians, limited appointment availability, and high costs—which may contribute to increased use of emergency departments and hospital services.⁵¹

In a 2024 Massachusetts survey conducted by CHIA, independently licensed clinicians were identified as the most challenging behavioral health providers^{xxiv} to recruit and retain over the past 12 months. Physicians providing behavioral health care were reported as the second most difficult to recruit, while non-independently licensed clinicians ranked as the second most difficult provider to retain.⁵² The main challenges for retaining behavioral health providers includes non-competitive salaries/benefits, burnout, and paperwork and regulatory burden.⁵³ As a result of staffing shortages, 63.3% of organizations providing behavioral health services reported limiting new intakes, and 68.9% of organizations reported an increase in people waiting for services over the last 12 months.⁵⁴ Among all health sectors surveyed, behavioral health had the greatest percentage of limited new intakes.⁵⁵

Data from January 2023, when the Roadmap was launched, through January 2024, found that CBHCs provided outpatient behavioral health bundled services to more than 16,000 youth members and 37,000 adult members, averaging 12 visits per member served.⁵⁶ In this same period, 85% of urgent appointments were completed in 48 hours, resulting in expanded access to urgent outpatient service for both the adult and youth populations.⁵⁷ From January to June of 2024, there were 344,559 behavioral health bundled claims reported by MassHealth and 603,543 for calendar year 2023, an indication that utilization might be even greater during the second year of the CBHC model implementation.^{xxv} As summarized in a 2024 Roadmap update, CBHCs have expanded access to urgent outpatient care and in-person community based crisis assessments for both youth and adults.⁵⁸

^{xxii} Burnout often occurs because of emotionally taxing positions, high stress environments, lack of career advancement, low salaries, and high caseloads.

^{xxiii} In the study, timely care was noted as receiving care from a behavioral specialist within a year.

^{xxiv} Includes physicians, advanced practice registered nurses, independently licensed clinicians, non--independently licensed clinicians, clinical directors, and clinical supervisors.

^{xxv} Data provided by the MassHealth Office of Accountable Care & Behavioral Health. February 11, 2025.

In 2023, emergency department (ED) boarding rates for MassHealth members decreased by 59% compared to 2022.⁵⁹ In that same year, 4.5% of Massachusetts residents reported that their most recent ED visits were related to mental health, a decline from 6% reported in 2021, and reported ED visits for SUD also declined from 2.1% in 2021 to 0.7% in 2023.⁶⁰ However, visits for mental health increased in 2023 to 21.4% from 17.5% in 2021, and for SUD, the reported visits were similar with 1.1% in 2023 and 1.5% in 2021.⁶¹

2.3 Efficacy of Services Provided at a CBHC

Mental health conditions, including substance use disorders (SUD), are among the most common health conditions in the U.S. with nearly one in four adults living with a mental health condition and one in seven children having a current diagnosed mental or behavioral health condition.⁶² In addition to sometimes interfering with daily functioning and affecting overall health, behavioral health and mental health conditions can be linked with increased medical spending,⁶³ especially for chronic physical conditions such as diabetes, cardiovascular disease, and chronic pain.⁶⁴ The CCBHC model is relatively new, and as a result, there is a limited but growing body of research evaluating its effectiveness as a care delivery and alternative payment model. Even less information is available on CBHCs, which were implemented in Massachusetts in 2023. Based on available research, patients and family representatives have credited CCBHCs with increasing access to behavioral healthcare.⁶⁵ Another study which examined the effect of the CCBHC demonstration in Missouri, Oklahoma (OK) and Pennsylvania (PA) reported that two states (OK and PA) had statistically significant reductions in the average number of behavioral health ED visits. Medicaid beneficiaries in OK and PA who received care in CCBHCs also had a greater reduction in behavioral health ED visits compared to those who received care from other behavioral health clinics.⁶⁶ An analysis of data collected from five CCBHCs in Colorado from January 2019 to September 2022 found the following improvements for patients involved:^{xxvi}

- Nearly 50% reduction in psychological distress
- Over 67% reduction in emergency department use
- Over 40% improvement in daily functioning
- Social connectedness, overall health, and quality of life improved by over 25%
- Close to 100% of clients reported stable housing after six months of care⁶⁷

By increasing community access to crisis and behavioral healthcare services, CCBHCs have decreased ED use, hospitalization rates, homelessness, and substance use among people served.^{68,69} For example, a case study of CCBHCs in Missouri found a 35% increase in patient access to care from 2017 to 2022, with a corresponding 16% decrease in ED visits and 27% decrease in hospitalizations.⁷⁰

Some states report cost savings from CCBHCs coordinating services.⁷¹ Research also demonstrates that individuals with mental health conditions or SUD often have higher rates of ED usage and hospitalizations which have been reduced by the CCBHC model.⁷² One CCBHC in Missouri indicated a 66% decrease in requests for crisis

^{xxvi} CCBHC funds have been used to purchase symptom of care measurement technology at Aurora Mental Health and Recovery, which allows patients and clinicians to connect more readily and has resulted in increased satisfaction for both clinicians and patients.

intervention services, while 85% of those referred for inpatient hospitalization were diverted to community care options. In a CCBHC partnership with a local jail, Oregon estimated \$2.5 million in reduced prison costs.⁷³

Pursuant to MassHealth regulations, CBHCs are required to coordinate behavioral health disorder treatment with medical care, both on-site and for needed services outside of the CBHC.⁷⁴ The community behavioral health model of CBHCs aims to improve quality and accessibility of behavioral healthcare by:

- Providing integrated, evidence-based, goal oriented, trauma-informed, and person-and-family-centered care
- Offering the full array of mental health and SUD services
- Establishing collaborative relationships with primary care and other specialty providers to ensure coordination of care^{xxvii,75,76}

Currently, MassHealth reimburses CBHCs for non-crisis services (e.g., therapy, medication consultation, peer support services, medication for addiction treatment)⁷⁷ as a bundled flat rate per encounter.^{xxviii,78,79} An encounter is only billable when a covered clinical service is provided^{xxix} and may only be billed once per member per day.⁸⁰ Providing a wide spectrum of comprehensive outpatient behavioral healthcare, the CBHC MassHealth bundled payment includes the following services:⁸¹

- Triage services
- Same-day access (within 24 hours of initial contact) to an intake and brief assessment for non-crisis services during business hours^{xxx}
- Urgent appointment access (within 48 hours of initial contact)^{xxxi} to a comprehensive diagnostic assessment and urgent outpatient crisis counseling/psychotherapy, group therapy, and peer/support services
- Urgent psychopharmacology access (within 72 hours of initial contact) to psychopharmacology appointments within 72 hours of the initial diagnostic evaluation and based on both assessment and member's statement of urgency

^{xxvii} These community behavioral health model goals mirror those of the CCBHCs.

^{xxviii} The managed care non-crisis per diem rate for members under the age of 21 is \$241.86, and for members 21 and over, the rate is \$233.90.

^{xxix} The bundled encounter rates incorporate service codes related to psychiatric evaluations, psychotherapy, interventions, evaluation and management, medical exams, preventive medicine counseling and/or risk factor reduction interventions, behavioral health counseling and therapy, alcohol, drug, and/or substance abuse services, and medication administration. See 101 CMR 305 for more detail (<https://www.mass.gov/doc/rates-for-behavioral-health-services-provided-in-community-behavioral-health-centers-effective-january-1-2023-0/download>).

^{xxx} Same-day access includes "same-day evaluation for initiation and bridging with Medications for the treatment of Opioid Use Disorder (MOUD) and access to medication no later than 24 hours after evaluation [as well as] timely referral to non-CBHC-provided services such as partial hospital program or medical services, etc."

^{xxxi} "Urgency is determined at time of same-day intake and triage and is additionally defined by the Member's statement of urgency."

- Non-urgent (routine) and follow-up appointment access (within 14 calendar days of initial contact) along with referral with a warm hand-off^{xxxii,82} to specialty providers if needed
- Assessment, including history of treatment episodes and efficacy of prior treatment^{xxxiii}
- Pharmacotherapy with basic evidence-based medical monitoring and medication reconciliation
- Individual and family therapy services^{xxxiv}

Providers must bill one code (T1040)^{xxxv,83} with the appropriate modifier, regardless of the number of services provided to the individual on that date.⁸⁴ The MassHealth managed care bundled rate was created using cost^{xxxvi} and volume^{xxxvii} estimates,⁸⁵ and is intended to financially support CBHCs with expanding hours, providing urgent access to crisis services, and care coordination.⁸⁶ Similarly, CCBHCs utilize four prospective payment systems (PPS) models that account for the expected cost of providing comprehensive behavioral health services to all individuals who seek care.^{xxxviii,87} Experts interviewed indicated that behavioral health bundled payment results in the provision of better care because it integrates health and wellness pursuant to the CBHC model and allows for some nurse interventions and multiple visits on the same-day that are typically not covered in fee-for-service contracts.^{xxxix}

^{xxxii} A warm-handoff is a transfer of care between providers through face-to-face, phone, or video interaction in the presence of the person being helped.

^{xxxiii} a. For adult Members: Assessment must include identification of current appropriate level of care needs, the use of standardized screening tools, history of overdose and risk of overdose, and determination of need for Behavioral Health Community Partner (BHCP) care coordination.

b. For youth Members: Assessment must include the Child and Adolescent Needs and Strength (CANS) Tool inclusive of the comprehensive clinical assessment and the use of standardized screening tools. Assessment must also include history of overdoses and risk of overdose and the need for BHCP care coordination.

^{xxxiv} Treatment modalities include: (1) In-house for all Members: i. Solution-focused crisis counseling; ii. Motivational Interviewing; iii. Dialectical Behavior Therapy (DBT) - skills portion; iv. Cognitive Behavioral Therapy (CBT) for Depression; and v. CBT for Anxiety. (2) In-house for adult Members: Relapse Prevention for Substance Use Disorders. (3) In-house for child and youth members: i. Family Crisis Intervention; ii. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); iii. Attachment, Regulation, and Competency (ARC); and iv. Child-Parent Psychotherapy (CPP).

^{xxxv} This is the same HCPCS code required for the SAMHSA CCBHCs bundled rate.

^{xxxvi} Cost estimates used data from Uniform Financial Report (UFR), Request for Information (RFI) responses, Bureau of Labor Statistics (BLS) benchmarks, and clinical input from the Office of Behavioral Health (OBH) and the Department of Mental Health (DMH) to project salaries, wage costs, fringe benefits, and staff levels needed.

^{xxxvii} Volume estimates were based on time-per-visit assumptions, volume assumptions of an average of 125 visits per day annually, and an average of 12 per day crisis service interventions annually.

^{xxxviii} The CCBHC Prospective Payment System (PPS) reimbursement model most similar to the CBHC bundled rate is the PPS-1, which is a cost-based, clinic specific rate that applies to all services rendered by a CCBHC. PPS-1 is a daily rate that is a fixed amount for services provided to a Medicaid beneficiary “regardless of the intensity of services or individual needs of persons utilizing services on that day.”

^{xxxix} BerryDunn interviewed CBHC representatives on January 15, 2025, and January 22, 2025.

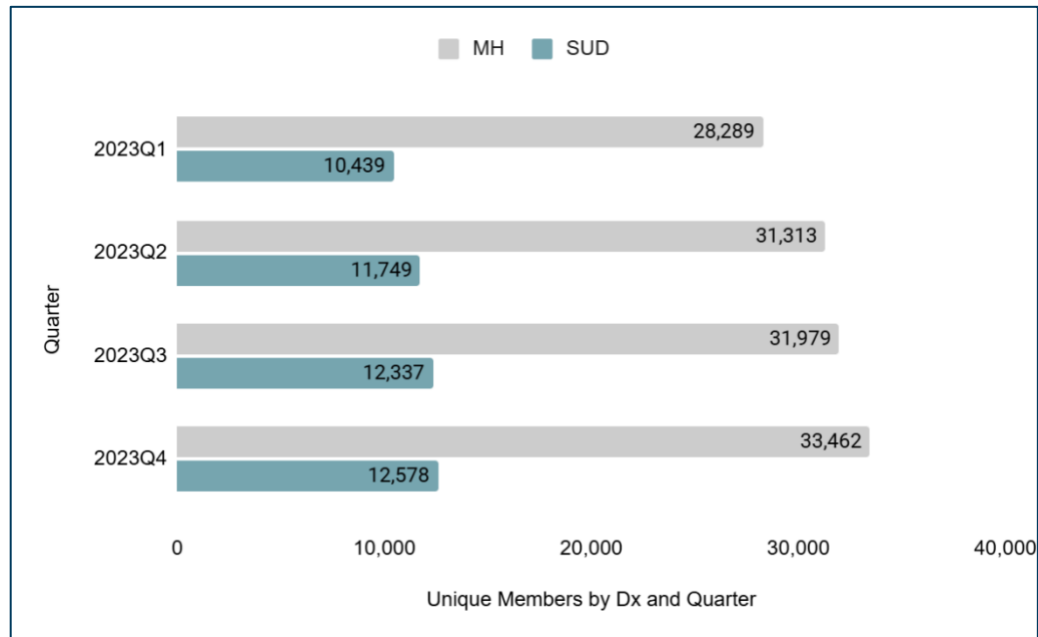
Expanding CBHC coverage to the commercially insured population could help also reduce both the frequency and duration of ED boarding.^{xi,88,89} Research conducted in 2018 by the Institute for Healthcare Improvement and the Well Being Trust found that nationally, one in eight patients in the ED are seeking care for a behavioral health-related need.^{90,91} In MA, over 38% of ED boarding visits from 2022 through May 2024 were attributable to BH-related visits, in comparison to over 9% ED boarding for overall visits during that same time period.⁹² In 2023, 47% of BH ED visits were covered by MassHealth, and 49% of residents who boarded during a BH ED visit were covered by MassHealth.⁹³ Further, a recent Roadmap overview and implementation update report highlighted that stakeholders^{xii} reported that they were seeing an increase in patients going to CBHCs for care rather than EDs since the initiation of the Roadmap reforms.⁹⁴

Since January 2023, CBHCs across the state have provided over 640,000 outpatient clinic visits to more than 53,000 members, with an average of 12 visits per member.⁹⁵ Figure 2 represents the count of unique MassHealth members by quarter and diagnostic category who received behavioral health bundled services in 2023.^{xiii}

^{xi} Chapter 177 of the Acts of 2022 (the ABC Mental Health Act) defines boarding as “waiting not less than 12 hours” to be placed in an appropriate therapeutic setting (e.g., inpatient, crisis stabilization, residential or community program) after the appropriate level of care is determined.”

^{xii} Stakeholders include state officials, community behavioral health providers, consumer advocacy groups, and other providers and provider associations with experience in behavioral health.

^{xiii} MassHealth provided BerryDunn with 2023 data by quarter with diagnosis and age bands for behavioral health bundled services.

Figure 2 All 2023 Mental Health-Related^{xliii} Claims and SUD^{xliv} Claims by Quarter


A 2025 CHIA report on primary care and behavioral health spending in Massachusetts for members enrolled in private commercial, MassHealth,^{xlv} and/or Medicare Advantage plans reported that behavioral health spending as a percentage of total spending for private commercial plans increased slightly in 2023 to 7.8%, compared to 2022.^{96,97} In contrast, MassHealth allocated 22.4% of its total healthcare spending to behavioral health, reflecting a 0.7 percentage point increase from the previous year. According to the report, the upward trend in MassHealth's behavioral health spending is due in part to a series of programmatic changes, including the establishment of CBHCs, a key component of the Roadmap initiative implemented in 2023.⁹⁸

^{xliii} Mental health diagnosis groups, in addition to all SUD diagnosis groups, include: ADHD, adjustment disorder, anxiety, autism spectrum disorder, bipolar disorder, conduct/oppositional defiant disorder, dementia, depressive disorder, developmental disorders of scholastic skills, developmental disorders of speech and language, dissociative disorder, eating disorder, fetal impact of maternal SUD, gender identity disorder, impulse disorders, intellectual disabilities, movement disorder, neglect, abuse, other trauma, other behavioral health conditions, other mood disorders, personality disorders, postpartum depression, psychosexual disorders, psychosis disorders, PTSD, suicidal/homicidal ideation, sleep disorders, somatoform disorder, suicide or self-harm, and traumatic brain injuries.

^{xliv} SUD diagnosis groups include alcohol related medical conditions, alcohol use disorder, benzodiazepines/sedative use disorder, cannabis use disorder, cocaine use disorder, hallucinogens use disorder, inhalant use disorder, maternal substance use disorder, opioid use disorder, other substance use disorder, overdose of a non-opiate, opiate overdose, other overdoses, stimulant use disorder, and tobacco use disorder.

^{xlv} MassHealth data includes programs administered by MassHealth directly, including ACO-Bs, and the PCC plan, and those administered by commercial plans such as ACO-As and MCOs. MassHealth members with FFS coverage are not included in the CHIA analysis.

On a per member per month (PMPM) basis, MassHealth had the highest behavioral health spending at \$144, compared to \$54 for commercially insured members.

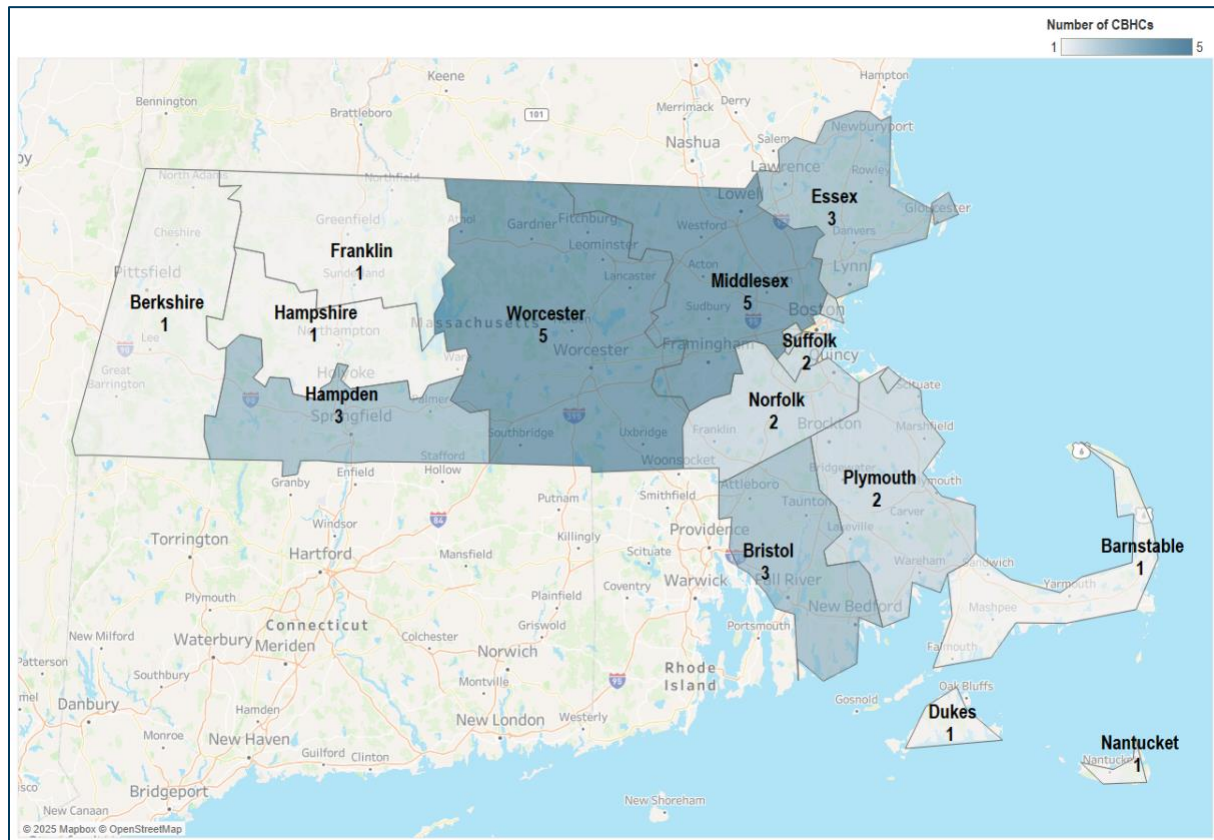
National data from 2023 indicates that Medicaid adult enrollees have higher rates of mental illness (35%) than those insured by private insurance (24%);⁹⁹ however, among adults diagnosed with a mental health illness, a slightly higher portion of Medicaid enrollees (59%) received treatment compared to those with private insurance (55%).¹⁰⁰ Given the comparable treatment rates for Medicaid enrollees and the privately insured, these findings suggest that with equal access to behavioral health bundled services coverage, commercially insured members in the Commonwealth might demonstrate similar increases in CBHC utilization and decreases in ED visits as reported for those enrolled in MassHealth.

Given that the CBHC model was adopted in January 2023 and few carriers currently utilize the MassHealth behavioral health bundled payment methodology, there is limited claims data for the commercial population. However, a recent study examining claims for patients with coverage other than Medicaid (commercial and Medicare) and a diagnosis of SMI found that CCBHCs were associated with a greater than 10% increase in outpatient mental health utilization by the patients' second year of CCBHC exposure, suggesting the innovative clinical redesign attributable to CCBHCs is likely to extend to all patients receiving treatment from them.¹⁰¹

2.4 CBHC Access and Health Equity

The identified need for high-quality behavioral health services and improved access, as outlined in the Roadmap, informed the development of the CBHC model of care in Massachusetts. Currently, there are CBHCs serving patients in 31 locations across Massachusetts providing comprehensive and coordinated outpatient behavioral health services seven days a week as well as crisis services 24 hours a day/7 days per week allowing for an alternative to receiving care in a hospital ED.^{xlvi,102} Bristol, Essex, Hampden, Middlesex and Worcester counties have three to five CBHCs while Norfolk, Plymouth, and Suffolk counties have two CBHCs; the remaining six counties each have one CBHC location, see Figure 3.

^{xlvi} Outpatient clinics are open from 8 a.m. to 8 p.m. on weekdays and from 9 a.m. to 5 p.m. on weekends.

Figure 3 Number of CBHCs per County in Massachusetts^{103, 104}


While CBHCs provide crisis services to all patients regardless of insurance coverage, only MassHealth is required to reimburse CBHCs for non-crisis behavioral health services using the bundled rate, resulting in variation for treatment options for commercially insured patients across the Commonwealth.¹⁰⁵ The Roadmap aims to advance health equity, reduce administrative and payment barriers, broaden behavioral health insurance coverage, and strengthen workforce diversity and competency.¹⁰⁶ The Roadmap also depends on commercial insurers committing to and investing in the proposed reforms.¹⁰⁷ Lack of coverage for ongoing outpatient treatment as well as continuation of fee-for-service (FFS) versus the bundled payment may hinder efficient care coordination, delay or prevent access to critical behavioral health services, and challenge the Roadmap's payer agnostic vision.¹⁰⁸ New York State recently implemented a reimbursement mandate effective January 1, 2025, whereby insurers are required to reimburse CCBHCs at negotiated rates for outpatient mental health and SUD treatment that are not less than the rates that would be paid for such treatment pursuant to the Medicaid rate.¹⁰⁹

The MassHealth CBHC Clinical Quality Incentive (CCQI) incentivizes CBHCs to improve timely access and follow-up to appropriate urgent care while reducing unnecessary readmissions for members experiencing a behavioral health crisis who need effective crisis stabilization. The CBHC Quality and Equity Incentive Program (CQEIP) component incentivizes MassHealth's CBHCs to pursue performance improvements in three domains: demographic and health-related social needs data; equitable quality and access; and capacity and collaboration. These incentives are part of larger efforts at EOHHS to center equity alongside quality as a pillar of value-based care and as a priority for the

state's healthcare system.^{xlvii,110} Similarly, CCBHCs require quality reporting including measuring access to care and timeliness of initial evaluation.^{xlviii,111} Across eight states^{xlix} that were part of the original SAMHSA demonstration, about 70% of new CCBHC patients received an initial evaluation within 10 days of contact, with greater variability for adult patients versus youth patients.¹¹²

The National Council for Mental Wellbeing^l has reported that CCBHCs, on average, serve 17% more people than prior to their implementation and sharply reduce waiting times with 50% of responding CCBHCs providing same-day access to care, 84% seeing clients for a first appointment within one week, and 93% seeing clients within 10 days.¹¹³

Individual states participating in the CCBHC demonstration have reported increases in access as well:

- Nevada – 250% increase in individuals served in the first three years
- New York – 212% increase in individuals served in the first year
- Oregon – 17% increase in number of individuals served with SMI¹¹⁴

Regarding health disparities, 100% of CCBHCs reported that their designation has enhanced their ability to serve people of color, improve access to care, and reduce health disparities within their communities. Notable impacts include:

- 75% increased screening for unmet social needs (e.g., housing, income, insurance status, transportation)
- 67% implemented organizational policies and protocols to improve diversity, equity, and inclusion
- 60% hired staff who reflect the demographic makeup of the populations their clinics serve
- 53% initiated or expanded translation and language access services¹¹⁵

In Massachusetts, comprehensive data is currently only available for the MassHealth population. Based on 2023 data presented in Figure 4, the majority of CBHC behavioral health bundled services were provided to individuals ages 21 to 64.

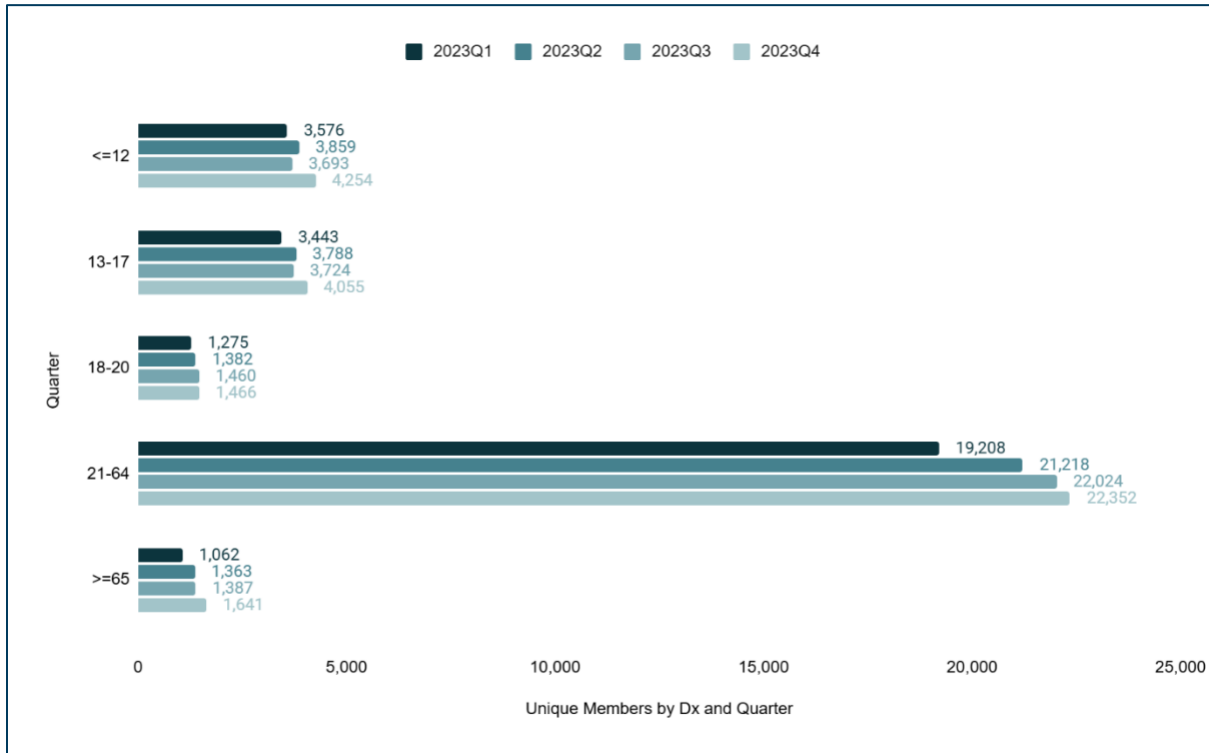
^{xlvii} The first performance year for the CCQI and CQEIP programs was CY 2024 and each CBHC in MA was required to submit a strategic plan on December 31, 2024, as well as other reports. The results of the CBHC reporting for program Year 1 will not be available until later in CY 2025, and, as a result, there is no data available from the CCQI and CQEIP to include in this report.

^{xlviii} Access to care/timeliness of initial evaluation is measured by reporting number/percent of new clients with initial evaluation provided within 10 business days and mean number of days until initial evaluation for new clients.

^{xlix} The eight states represented are part of the original SAMHSA demonstration and include Minnesota, Missouri, New Jersey, Nevada, New York, Oklahoma, Oregon, and Pennsylvania.

^l The National Council for Mental Wellbeing is the national technical assistance vendor that supports states in implementation and innovations for the CCBHC model. See <https://www.samhsa.gov/technical-assistance/ccbhc-s-tac>.

Figure 4 2023 Quarterly CBHC Utilization by Age Group



Requiring commercial carriers to adopt the MassHealth behavioral health bundled payment methodology would extend the same-day access to comprehensive and coordinated outpatient services at CBHCs to commercially insured members, aligning their coverage with that of MassHealth beneficiaries. According to the experts interviewed, the bundled payment model, as opposed to the FFS model, facilitates the delivery of outcomes-based, person-centered wraparound^{li,116} services, rather than limiting care to standard weekly one-hour therapy sessions.^{lii}

3.0 Conclusion

Behavioral and mental health impact both physical and overall health, and appropriate treatment for these conditions can lead to improved health outcomes. However, access to needed treatment remains a significant challenge, particularly when constrained by insurance coverage limitations. CBHCs were established to serve as an entry point to access behavioral health services, offering urgent and crisis services, outpatient treatment, and care coordination across the Commonwealth as part of an overall behavioral health improvement strategy.^{117,118} By increasing access to crisis and behavioral healthcare and providing care coordination and other supports in the community, CCBHCs

^{li} A wraparound model of care involves community and team-based principles to support individuals in meeting their goals.

^{lii} BerryDunn interviewed CBHC representatives on January 15, 2025, and January 22, 2025.

have been associated with reductions in substance use, homelessness, and reliance on emergency rooms and hospitalizations, among the patients they serve.^{119,120}

Currently, commercially insured individuals can access crisis services at CBHCs, as commercial carriers are required to contract for services such as mobile crisis intervention (MCI) and community support services (CSS).¹²¹ While these individuals may also access certain outpatient services at CBHCs reimbursed on a FFS basis, they often encounter barriers to the more comprehensive outpatient care provided through CBHCs due to lack of coverage for the behavioral health bundled services provided at CBHCs, high out-of-pocket costs, or both. Further, FFS reimbursement—often restricted to direct care services—is frequently cited as a barrier to team-based behavioral healthcare, which commonly involves activities beyond direct patient care.¹²²

By requiring coverage of the behavioral health bundled services delivered at CBHCs, this bill has the potential to significantly improve access to outpatient care for commercially insured individuals and enhance the continuum of services already supported through crisis coverage. Further, this bill's requirement to provide coverage for the behavioral health bundled services delivered through community CBHCs has the potential to improve access for commercially insured patients with behavioral health needs to the full array of services provided at CBHCs during an encounter instead of the potential limitations resulting from a FFS payment model. Bundled payments help support staff retention, expanded hours, and care coordination—key components of delivering comprehensive behavioral health services at CBHCs. The literature suggests that increased access to needed behavioral health services, especially when integrated with primary care, can improve health outcomes.^{123,124}

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AN ACT RELATIVE TO COMMUNITY BEHAVIORAL HEALTH CENTERS

ACTUARIAL ASSESSMENT

4.0 Actuarial Assessment

4.1 Background

H.B. 1276 and S.B. 703 (collectively, “the bill”) require health insurers to provide nondiscriminatory coverage for medically necessary behavioral health services delivered as bundled payments at community behavioral health centers. While Massachusetts carriers report covering outpatient services at CBHCs, most do not currently employ the bundled payment methodology outlined in the bill. From All-Payer Claims Database (APCD) data, 28% of the commercial members had bundled payment coverage in 2023.

4.2 Plans Affected by the Proposed Mandate

The bill amends statutes that regulate commercial healthcare 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)

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.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of Commonwealth defrayal under the ACA, nor is it intended to assist with Commonwealth defrayal calculations if it is determined to be a health insurance mandate requiring Commonwealth defrayal.

4.3 Existing Laws Affecting the Cost of the Bill

State law requires commercial carriers to contract for crisis services delivered at CBHCs, including Mobile Crisis Intervention (MCI) and Crisis Stabilization Services (CSS). However, there is no corresponding requirement for outpatient behavioral health services.^{1,2} No existing laws were identified that would impact the cost associated with the bill.

4.4 Current Coverage

Massachusetts carriers report covering outpatient services provided at CBHCs; however, payment methodology varies.ⁱⁱⁱⁱ Two carriers indicated they use an FFS payment methodology, while others reported reimbursing CBHCs based on the MassHealth bundled payment approach for outpatient services (CBHC bundle).

5.0 Methodology

5.1 Overview

To estimate the marginal PMPM cost for insurers to cover the CBHC bundle, BerryDunn analyzed APCD data from carriers currently using the CBHC bundle pricing model. The analysis examined observed cost trends before and after implementation to identify incremental impact. Cost increases for carriers not currently covering the CBHC bundle were estimated using observed trends from carriers that do provide coverage. Then, BerryDunn calculated the overall financial impact of the mandate from the total incremental cost of non-covering carriers.

Estimation of incremental cost, and accounting for carrier retention, results in an estimate of the bill's incremental effect on premiums, which is projected over five years beginning with January 1, 2026, 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 medical experts
- Massachusetts APCD
- Published scholarly literature, reports, and population data, cited as appropriate

5.3 Steps in the Analysis

This section summarizes the analytic steps used to estimate the bill's impact on premiums.

1. **Estimated the marginal costs for insurers to cover the CBHC bundle.**
 - A. Used APCD data to compare the rate difference of CBHC bundled claims among commercial and MassHealth and calculated the dollar impact to bring commercial rates to prevailing MassHealth rates for commercial carriers that began covering CBHC bundled claims in 2023
 - B. Calculated quarterly PMPM percentage changes for CBHC services from calendar year 2022 to calendar year 2023 for commercial carriers that began covering CBHC bundle claims in 2023 including the impact from step A

ⁱⁱⁱⁱ BerryDunn surveyed Massachusetts insurance carriers in the Commonwealth, with respondents representing 84% of the Commonwealth's fully insured commercial membership.

- C. Developed a range of the percentage increases to PMPMs for the services included in the bundle from Step B to apply to commercial carriers that are currently not covering the CBHC bundled claims
- D. Applied the percentage PMPM increase assumptions from Step C to the calendar year 2023 values for CBHC services to estimate the PMPM increase for commercial carriers not covering the CBHC bundle
- E. For each commercial carrier not currently covering CBHC bundle services, multiplied the estimated percentage PMPM increase from Step D by their calendar year 2023 membership to calculate the projected dollar impact of covering CBHC services
- F. Summed the dollar impacts from Step E across all commercial carriers not covering the CBHC bundle
- G. For each commercial carrier currently covering CBHC bundle services, estimated the incremental claim impact under each scenario from step C as some of the providers ramped up their CBHC bundled services throughout 2023. Added this incremental impact to 2023 bundled service claim experience to calculate the estimated stabilized CBHC bundled service cost
- H. Applied the rate difference from Step A to the estimated stabilized CBHC bundled service cost from step G for each commercial carrier currently covering CBHC bundle services
- I. Summed the dollar impacts from Step H across all commercial carriers covering the CBHC bundle to bring bundled service rates up to the prevailing MassHealth rates
- J. Summed the dollar impacts from Step F and Step I to calculate the total dollar impact for the mandate
- K. Divided the total dollar impact from Step J by the total calendar year 2023 membership for all carriers to calculate the marginal cost PMPM associated with the mandate

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 (2026 – 2030).
- B. Multiplied the PMPM incremental net cost of the mandate by the projected population estimate to calculate the total estimated marginal claims cost of the bill.
- C. Estimated insurer retention (administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in Step 1K.

5.4 Assumptions and Limitations

BerryDunn analyzed APCD data to estimate the impact of the mandate by examining changes in utilization among commercial carriers that began covering the CBHC bundled payment in 2023. The analysis also compared the reimbursement rates paid by these carriers to the MassHealth rates required by the bill. From 2022 to 2023, the overall PMPM cost remained stable for commercial carriers that did *not* cover bundled services. In contrast, carriers that did cover the CBHC bundle experienced a substantial increase in PMPM costs. Notably, these carriers represented a critical mass of the market—accounting for approximately 28% of the membership and 52% of CBHC-related services in 2022, prior to the implementation of bundled services—making them a meaningful and representative population for estimating mandate impact. Because health profiles and service needs differ across populations, it is challenging to fully isolate the effects of CBHC service coverage from underlying year-over-year utilization trends. Additionally, service needs vary between carriers, further complicating the analysis. BerryDunn addressed these challenges by developing a range of assumptions based on quarterly cost trends among carriers covering the bundle. These trends were used to estimate the PMPM cost increases expected from the mandate.

Following the unwinding of the Medicaid continuous enrollment coverage in Massachusetts, which began in April 2023, some individuals who lost Medicaid coverage transitioned to private insurance plans. These members are expected to have a higher demand for CBHC services compared to the general commercially insured population. To monitor shifts in utilization patterns more effectively, BerryDunn analyzed quarterly PMPM trends rather than relying solely on annual data. However, the inclusion of these newly insured members introduced additional volatility into observed utilization patterns. Moreover, since APCD data is currently only available through 2023, the analysis is based on a limited observation period. To address this uncertainty, BerryDunn assumed the greatest utilization impact seen across carriers currently covering bundled service as its middle-cost scenario and was conservative in its high-cost scenario.

With the mandate in effect, the number of commercially insured individuals utilizing CBHC services is expected to increase. This growth may put pressure on CBHC providers' ability to deliver services in a timely manner, particularly given the variability in staffing levels across providers and broader economic factors that influence workforce availability. BerryDunn did not incorporate assumptions regarding potential impacts of provider capacity constraints into the analysis, given the uncertainty and variability surrounding these factors.

Improved access to timely, coordinated care may help prevent the escalation of untreated conditions and reduce reliance on higher-cost interventions, such as emergency department visits and hospital admissions. However, these potential benefits are likely to emerge gradually over time. As such, BerryDunn's cost analysis does not include estimates of potential cost offsets resulting from improved health outcomes.

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 age 0 – 64 in the Commonwealth over the years 2026 – 2030. 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 CBHC Bundled Rate

To estimate the impact of covering the CBHC bundle, BerryDunn analyzed APCD data from 2019 to 2023, focusing on commercial carriers that began covering the CBHC bundle in 2023. BerryDunn evaluated quarter-over-quarter changes in the per member per month (PMPM) costs for services provided in the CBHC bundle among these carriers. Quarterly trends for the largest carrier covering the CBHC bundled rate remained stable in the second-, third-, and fourth quarter of 2023. For the remaining carriers covering CBHC bundled rate, quarterly trends increased throughout 2023.

BerryDunn also analyzed the rate difference for bundled service costs between commercial carriers and MassHealth. The estimated dollar impact of adjusting commercial rates up to MassHealth levels was incorporated into the quarterly trend analysis. Based on these observed patterns—consistent with observations detailed in the efficacy section of this report—BerryDunn developed a range of percentage PMPM increase assumptions.

Using these assumptions, BerryDunn then applied the estimated percentage PMPM increases to the 2023 CBHC service PMPMs of commercial carriers that had not yet implemented CBHC bundle coverage. The dollar impact was calculated by multiplying the incremental PMPM increase by each carrier's 2023 membership. BerryDunn aggregated the dollar impacts across all applicable carriers to determine the total financial impact.

For commercial carriers already covering the CBHC bundles, BerryDunn estimated stabilized payments and applied the rate differences to project the impact of aligning rates with MassHealth levels under the developed assumptions.

Finally, the total dollar impact was divided by the combined commercial membership to calculate the overall PMPM impact of the mandate.

Table 1 summarizes the CBHC percentage PMPM increase assumptions and presents the resulting incremental PMPM costs associated with the mandate under each scenario.

Table 1. Marginal Costs to Insurers for Coverage of CBHC Bundle

	PERCENTAGE PMPM INCREASE ASSUMPTIONS	INCREMENTAL PMPM COST FOR CARRIERS NOT COVERING CBHC BUNDLES	INCREMENTAL PMPM COST FOR CARRIERS COVERING CBHC BUNDLES	TOTAL INCREMENTAL CBHC PMPM COST UNDER MANDATE
Low Scenario	200%	\$0.21	\$0.10	\$0.30
Mid Scenario	250%	\$0.24	\$0.12	\$0.36
High Scenario	300%	\$0.27	\$0.15	\$0.43

BerryDunn trended the PMPM impact from Table 1 from calendar year 2023 to calendar year 2030 and forward using the long-term average national projection for cost increases to physician and clinical services (calculated at 4.4%³).

Table 2. Projected PMPM

	2025	2026	2027	2028	2029	2030
Low Scenario	\$0.33	\$0.34	\$0.36	\$0.37	\$0.39	\$0.41
Mid Scenario	\$0.40	\$0.41	\$0.43	\$0.45	\$0.47	\$0.49
High Scenario	\$0.46	\$0.49	\$0.51	\$0.53	\$0.55	\$0.58

6.2 Projected 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	2026	2027	2028	2029	2030
Total (0 – 64)	2,069,210	2,061,977	2,055,073	2,048,499	2,042,252

6.3 Total Marginal Medical Expense

The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2026. Based on an assumed renewal distribution by month, by market segment, and by the Commonwealth market segment composition, 72.1% of the member months exposed in 2026 will have the proposed mandate coverage in effect during calendar year 2026. The annual dollar impact of the mandate in 2026 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

	2026	2027	2028	2029	2030
Low Scenario	\$6,111,883	\$8,816,588	\$9,171,191	\$9,541,480	\$9,928,210
Mid Scenario	\$7,392,217	\$10,663,510	\$11,092,397	\$11,540,255	\$12,007,999
High Scenario	\$8,686,451	\$12,530,486	\$13,034,462	\$13,560,731	\$14,110,368

6.4 Carrier Retention and Increase in Premium

Assuming an average retention rate of 13.1%—based on CHIA’s analysis of administrative costs and profit in the Commonwealth⁴—the increase in medical expense was adjusted upward to approximate the total impact on premiums. Table 5 displays the result.

Table 5. Estimate of Increase in Carrier Premium Expense

	2026	2027	2028	2029	2030
Low Scenario	\$7,030,308	\$10,141,445	\$10,549,334	\$10,975,266	\$11,420,110
Mid Scenario	\$8,503,036	\$12,265,903	\$12,759,237	\$13,274,395	\$13,812,426
High Scenario	\$9,991,753	\$14,413,426	\$14,993,134	\$15,598,486	\$16,230,715

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 effective January 1, 2026.^{liv}

^{liv} With an assumed start date of January 1, 2026, 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 displays projected membership based on a population projection. A 72.1% adjustment factor to the first year (2026) is also applied to account for ramp up in implementation.

Finally, the impact of the proposed law on any one individual, employer group, or carrier may vary from the overall results, depending on the current level of benefits each receives or provides and on how the benefits will change under the proposed language.

Table 6. Summary Results

	2026	2027	2028	2029	2030	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Average Members (000s)	2,069	2,062	2,055	2,048	2,042		
Medical Expense Low (\$000s)	\$6,112	\$8,817	\$9,171	\$9,541	\$9,928	\$9,233	\$43,569
Medical Expense Mid (\$000s)	\$7,392	\$10,664	\$11,092	\$11,540	\$12,008	\$11,167	\$52,696
Medical Expense High (\$000s)	\$8,686	\$12,530	\$13,034	\$13,561	\$14,110	\$13,122	\$61,922
Premium Low (\$000s)	\$7,030	\$10,141	\$10,549	\$10,975	\$11,420	\$10,620	\$50,116
Premium Mid (\$000s)	\$8,503	\$12,266	\$12,759	\$13,274	\$13,812	\$12,845	\$60,615
Premium High (\$000s)	\$9,992	\$14,413	\$14,993	\$15,598	\$16,231	\$15,093	\$71,228
PMPM Low	\$0.39	\$0.41	\$0.43	\$0.45	\$0.47	\$0.43	\$0.43
PMPM Mid	\$0.47	\$0.50	\$0.52	\$0.54	\$0.56	\$0.52	\$0.52
PMPM High	\$0.56	\$0.58	\$0.61	\$0.63	\$0.66	\$0.61	\$0.61
Estimated Monthly Premium	\$737	\$780	\$825	\$872	\$923	\$827	\$827
Premium % Rise Low	0.05%	0.05%	0.05%	0.05%	0.05%	0.05%	0.05%
Premium % Rise Mid	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%
Premium % Rise High	0.08%	0.07%	0.07%	0.07%	0.07%	0.07%	0.07%

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, 2026. Because of the July effective date, the results in 2026 are

approximately one half of an annual value. Table 7 breaks out the GIC's self-insured membership, as well as the corresponding incremental medical expense.

Table 7. GIC Summary Results

	2026	2027	2028	2029	2030	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
GIC Self-Insured							
Average Members (000s)	309	308	306	305	304		
Medical Expense Low (\$000s)	\$634	\$1,316	\$1,367	\$1,421	\$1,476	\$1,382	\$6,215
Medical Expense Mid (\$000s)	\$766	\$1,592	\$1,654	\$1,718	\$1,786	\$1,672	\$7,516
Medical Expense High (\$000s)	\$901	\$1,871	\$1,943	\$2,019	\$2,098	\$1,965	\$8,832

Endnotes

¹ An Act Addressing Barriers to Care for Mental Health. Chapter 177 of the Acts of 2022. The 194th General Court of the Commonwealth of Massachusetts. Accessed January 30, 2025. <https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177>.

² Mass.gov. Executive Office of Economic Development. Division of Insurance. Bulletin 2023-11; Community-Based emergency Behavioral Health Care; Issued June 22, 2023. Accessed January 30, 2025. <https://www.mass.gov/doc/bulletin-2023-11-community-based-emergency-behavioral-health-care-issued-june-22-2023/download>.

³ U.S. Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Projections. “Table 8, Physician and Clinical Services Expenditures; Levels, Percent Change, and Percent Distribution, ; Private Insurance.” Accessed April 25, 2025. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>.

⁴ Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System, March 2025. Accessed April 25, 2025. <https://www.chiamass.gov/annual-report/>.

Appendix A: Membership Affected by the Proposed Language

Membership potentially affected by 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 the 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 that 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.

Membership projections were based on enrollment data reported by CHIA. CHIA publishes a biannual Enrollment Trends Report and accompanying data book (Enrollment Trends – Data Through September 2024), which provide enrollment figures for most insurance carriers serving Commonwealth residents, with the exception of certain small carriers. CHIA uses supplemental information beyond the data in the Massachusetts APCD to develop its enrollment trends report and adjust the resident totals from the Massachusetts APCD. For the 2020 base year membership projection, data from the 2020 Massachusetts APCD and published 2020 membership reports from the Massachusetts Division of Insurance (DOI)^{1,2} were used to develop an adjustment factor to account for the few small carriers not included in the CHIA enrollment report. The adjustment was trended forward to 2024 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 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 reports³ indicated that coverage redeterminations were largely completed by June 2024. The Massachusetts Health Connector's monthly reports⁴ indicate that membership growth stabilized through December 2024, likely due to disenrolled MassHealth members enrolling in individual plans. CHIA's quarterly enrollment trends report⁵ demonstrate 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 Massachusetts APCD population distribution ratios and was checked for reasonableness and validated against U.S. Census Bureau data.⁶ Membership was projected from 2025 – 2050 with growth rate estimates by age and gender derived from a Massachusetts population projection from UMass Donahue Institute.⁷

Projections for the GIC self-insured lives were developed using the GIC base data for 2018 and 2019, which BerryDunn received directly from the GIC, as well as the same projected growth rates from the Census Bureau used for the Commonwealth population. Breakdowns of the GIC self-insured lives by gender and age were based on Census Bureau distributions.

Endnotes

¹ Massachusetts Department of Insurance. HMO Group Membership and HMO Individual Membership. Accessed March 27, 2025. <https://www.mass.gov/info-details/hmo-membership-reports>.

² Massachusetts Department of Insurance. Membership in Insured Preferred Provider Plans. Accessed March 27, 2025. <https://www.mass.gov/info-details/insured-preferred-provider-membership>.

³ MassHealth Enrollment and Caseload Metrics. Accessed March 27, 2025 <https://www.mass.gov/lists/masshealth-enrollment-and-caseload-metrics#2025-masshealth-monthly-caseload-reports->.

⁴ Massachusetts Health Connector publishes report on monthly membership during MassHealth redeterminations. Accessed March 27, 2025. <https://betterhealthconnector.com/wp-content/uploads/Health-Connector-MassHealth-Renewals-Dashboard-12-17-24.pdf>.

⁵ Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed March 27, 2025. <https://www.chiamass.gov/enrollment-in-health-insurance/>.

⁶ National Population by Characteristics: 2020-2024 Accessed March 27, 2025. <https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html>.

⁷ Massachusetts Population Projections. Accessed March 27, 2025. <https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-projections>.