MIND THE GAP: EXAMINING THE DIFFERENCE IN REIMBURSEMENT FOR PRIMARY CARE, BEHAVIORAL HEALTH, AND SPECIALTY SERVICES IN MASSACHUSETTS

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INTRODUCTION

High-quality, accessible primary care is foundational to an effective and efficient health care system, and access to behavioral health care has been shown to both reduce health care spending and improve physical health outcomes, including chronic disease management. However, Massachusetts, as elsewhere, has faced challenges recruiting and retaining provider supply to match patient demand and residents report persistent difficulties accessing both primary and behavioral health care (PCBH).[1]

Prior Massachusetts Health Policy Commission (HPC) research on primary care found that Massachusetts has high and growing rates of residents reporting difficulty accessing care, an aging primary care physician workforce, and among the smallest shares of new physicians entering primary care across states.[2] Similar concerns about the current and future supply of behavioral health providers led to the establishment of the HPC's Behavioral Health Workforce Center, tasked with conducting research and making recommendations to strengthen the behavioral health workforce in Massachusetts.

One of the root causes of PCBH workforce challenges is a payment structure that favors specialty procedures and undervalues the cognitive services at the core of PCBH, including care coordination and chronic condition management. This underpayment has been cited as a driver of shortages in the PCBH workforce as it can discourage new trainees from entering these fields. For example, Medicare, which serves as the model for commercial insurers, reimburses physicians three to five times more for common procedures than for cognitive services, and as a result, these procedures can generate more revenue in a few hours than a primary care physician receives for a whole day of patient care.[3] This analysis aims to quantify this difference using claims reimbursed by commercial insurers in Massachusetts.

OBJECTIVES

Due to ongoing concerns with payments of PCBH services relative to more highly paid specialty services in Massachusetts, this study uses commercial claims data to understand the difference in payment levels and the growth of these payments for behavioral health, primary care, and specialty services. This analysis compares rates for provider "work time" for psychotherapy, primary care visits, and select specialty services (a "specialty basket").

STUDY DESIGN

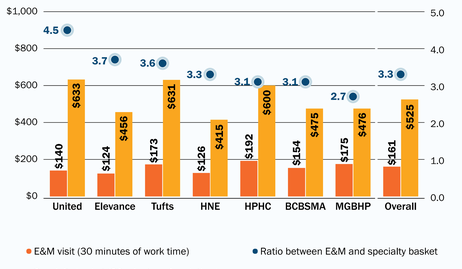
A price index was constructed to compare the average price for a basket of common specialty procedures to the average price for 30 minutes of primary or behavioral health care delivered in ambulatory settings, using the Center for Health Information and Analysis (CHIA) Massachusetts All-Payer Claims Database version 2023 (APCD v.2023) for 2019-2023. For these analyses, the HPC included commercially-insured Massachusetts residents covered by one of six large payers included in the Massachusetts APCD, representing approximately 38 percent of the commercial market (Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Care, Health New England, United Health, and Elevance).

The specialty basket was constructed by first identifying the 15 most common physician specialty types by volume, excluding general practitioners, family practitioners, and pediatricians, among services performed in ambulatory settings. For each specialty, the ten most common procedures that can be safely performed in either an office or hospital outpatient department (commonly referred to as "crossover services") were included, and procedures with fewer than 300 claims across specialty types were excluded. After exclusions, 77 distinct procedures were included. The median immediate pre-service, intra-service, and post-service work times for each service were identified using CMS work time estimates from the 2025 Physician Fee Schedule Final Rule, and the average price for each service was adjusted to a 30-minute equivalent. The specialty index was compared to the average price of a 20-minute evaluation and management (E&M) visit (equivalent to 30 minutes of total work time) and 30 minutes of psychotherapy. For all calculations, the HPC excluded allowed amounts that were more than 10 times the statewide median or less than 20% of the statewide median for a given procedure code and site of service.

RESULTS

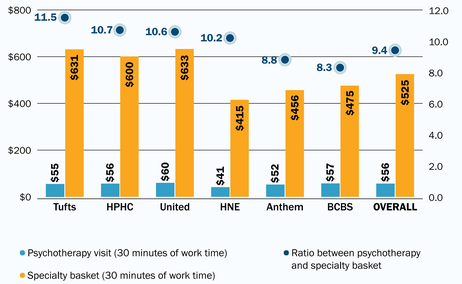
The average reimbursement for 30 minutes of specialty services ($525) was 3.3 times greater than the average reimbursement for an E&M visit requiring 30 minutes of work time ($161), and 9.4 times greater than 30 minutes of psychotherapy ($56) (**Exhibit 1 & 2**). This means that, on average, the specialty procedures can generate more revenue in three hours than a primary care physician receives for a whole day of patient care. The specialty procedures generate more revenue in one hour than a behavioral health clinician receives for 8 hours of psychotherapy. While the average reimbursement for all services increased between 2019 and 2023, the primary care rates grew the fastest over this time period (23%) and behavioral health psychotherapy rates grew the slowest (9%) (**Exhibit 3**). The ratios of primary care or psychotherapy payment rates to specialty services also varied by commercial payer. These ratios ranged from 2.7 to 4.5 for the E&M visit and from 8.3 to 11.5 for psychotherapy (**Exhibit 1 & 2**).

EXHIBIT 1. Commercial Price ratio for 30 minutes of work time for select specialty services to prices for primary care E&M visits, 2023



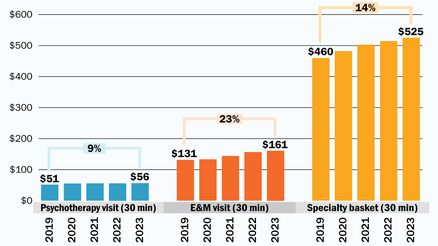
Notes: E&M = evaluation & management visit. "E&M visit" reflects average allowed amount for a 20-minute E&M visit with an established patient (CPT 99213) (30 minutes of work). "Specialty basket" reflects average of average prices paid for select specialty procedures performed in an ambulatory setting (30 minutes of work).
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2023

EXHIBIT 2. Commercial Price ratio for 30 minutes of work time for select specialty services to prices for psychotherapy visit, 2023



Notes: "Psychotherapy visit" reflects average allowed amount for a 60-minute psychotherapy visit (CPT 90837) (75 minutes of work) scaled to 30 minutes of work time. "Specialty basket" reflects average of average prices paid for select specialty procedures performed in an ambulatory setting (30 minutes of work).
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2023

EXHIBIT 3. Trends in Commercial Price for 30 minutes of work time for psychotherapy, primary care visits, and select specialty services, 2019–2023



Notes: E&M = evaluation & management visit. "E&M visit" reflects average allowed amount for a 20-minute E&M visit with an established patient (CPT 99213) (30 minutes of work). "Psychotherapy visit" reflects average allowed amount for a 60-minute psychotherapy visit (CPT 90837) (75 minutes of work) scaled to 30 minutes of work time. "Specialty basket" reflects average of average prices paid for select specialty procedures performed in an ambulatory setting (30 minutes of work). Excludes claims from MGBHP.
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2023

CONCLUSIONS

Services commonly provided by PCBH providers were reimbursed at lower rates than services commonly provided by specialists. While primary care prices grew faster than specialty services, as of 2023, specialty services were still paid 3.3 times more for the same amount of work time than a primary care evaluation and management visit. Behavioral health psychotherapy prices grew more slowly than either specialty or primary care visits. Despite overall price increases in reimbursement for all service types examined, large differences in prices for similar amounts of work time remain.

POLICY IMPLICATIONS

The considerable difference in prices paid for primary and behavioral health care services compared to common specialty procedures has implications for the stability of the PCBH workforce, access to PCBH services, and the delivery system in Massachusetts and nationally. Lower payments do not reflect the value of preventive and longitudinal care and can limit access to these types of care that deliver better health outcomes, reduce hospitalizations, and lower costs.[4,5]

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2. Massachusetts Health Policy Commission, "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action." January 2025. Accessed at: https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and
3. The Centers for Medicare and Medicaid Services (CMS) and many private insurers use relative value units (RVUs) in their Resource-Based Relative Value Scale (RBRVS) payment methodologies to determine the value of a service or procedure based on the extent of physician work, clinical and nonclinical resources, and expertise required to provide such services. This methodology assigns a lower value to common, primary care services and procedures compared to services and procedures performed by specialists, which results in lower payments to primary care providers than specialty providers.
4. Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. Health Affairs. 2010 May 1;29(5):766-72.
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Explore further in the 2025 Cost Trends Report Chartpack, PCBH

Explore an interactive version of this research on the HPC's website.

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