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ABH Survey Analysis and Recommendations: Behavioral Health for Children and Adolescents (BHCA) Implementation

February 2020

ABH is a statewide association representing more than eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people.

Our members represent all 32 of the state-contracted Community Service Agencies (CSAs) which provide Intensive Care Coordination (ICC) and Family Support and Training (FS & T) and operate numerous additional Children's Behavioral Health Initiative (CBHI) programs including In-home Therapy, In-home Behavioral Services, Therapeutic Mentoring (TM), Mobile Crisis Intervention (MCI), Community Based Acute Treatment (CBAT) and Intensive Community Based Treatment (ICBAT).

Background

The Executive Office of Health and Human Services, the Division of Insurance, and the Department of Mental Health have partnered with numerous stakeholders, including ABH, on the implementation of intermediate behavioral health services for children and adolescents by commercial insurance carriers, as mandated by Division of Insurance/Department of Mental Health Joint Bulletin 2018-07: Access to Services to Treat Child-Adolescent Mental Health Disorders. This initiative is often referred to as Behavioral Health for Children and Adolescents (BHCA) implementation.

This implementation includes a transition to a new coordination of benefits process whereby CBHI providers must bill primary insurance for BHCA services before billing the Massachusetts Behavioral Health Partnership (MBHP) for cost sharing or for services delivered to children and youth whose plans are not required to cover these services.

In order to facilitate a smooth transition to commercial coverage for intermediate services for youth, MassHealth members with third party liability insurance (TPL) and to promote continuity of care, the Executive Office of Health and Human Services (EOHHS) extended the transition period end date to March 31, 2020. Effective April 1, 2020, all MBHP-contracted CBHI providers will be required to provide a primary insurance explanation of benefits for TPL members when submitting claims to MBHP.

As safety-net provider behavioral health provider organizations, ABH members join other stakeholders in seeking to ensure that BHCA implementation is successful and to understand the impact on children who have commercial insurance as their primary insurer and MassHealth as their secondary insurance as well as any impact on the Children's Behavioral Health Initiative

system of care. ABH surveyed our member organizations on implementation and our recommendations based on those findings are as follows.

ABH Recommendations

1. **Delay Coordination of Benefits Implementation**. Because of the length of time it has taken for plan contracts to be executed and the continued evolution of plan benefits and coding information,[1] ABH recommends an additional extension of at least three months before implementing the coordination of benefits protocols for providers.

2. **Behavioral Health for Children and Adolescents Ombudsman**. This initiative crosses the authority of multiple governmental agencies in ways that are currently challenging to navigate from the family and from providers. ABH recommends the creation of an ombudsman that could triage and resolve family and provider concerns during the implementation period. The ombudsman should remain in place through the implementation of the Family Partner and Therapeutic Mentor benefit in the commercial market.

3. **Consider Making Permanent the Centralized Management of the Coordination of Benefits Process**. ABH recommends that the Commonwealth consider whether there is an economy of scale and efficiency in having the Massachusetts Behavioral Health Partnership (MBHP) permanently continue its coordination of benefits role for all BHCA-CBHI services.

4. **Clarify Coverage of Collateral and Case Consultation through MassHealth**. In order to minimize disruption and effectively engage youth and families utilizing in-home services, providers rely on the ability to consult with relevant collaterals to support the implementation of the treatment plan. Clarification is still needed regarding the extent to which collateral and case consultation is covered under BHCA IHT. If not, carriers should adopt a uniform standard that recognizes collateral contacts as integral to the service, or MBHP should reimburse for case consultation and collateral contacts.

5. **Offer Additional Coordination of Benefits Training and Technical Assistance**. Providers that offer only or primarily CBHI services have limited experience with coordination of benefits. ABH recommends that the Commonwealth work with MBHP to offer additional coordination of benefits training with additional opportunities for questions and answers. Providers report that it would be helpful to have a complete set of coding cross-walks and a step-by-step walkthrough of claims submissions, including screen grabs of applicable use of MBHP platforms.

6. **Work with Carriers to Simplify Coordination of Benefits Processes.** ABH recommends that the Division of Insurance partner with carriers that offer both plans on that are subject to Bulletin 2018-07 *and* those that are not subject to the bulletin to create or streamline processes to secure EOBs or alternate documentation. This is particularly important where

[1] Despite significant assistance from the Division of Insurance in coordinating with carriers, providers still do not have complete BHCA information from at least one carrier.

a carrier has authority over plans that are not subject to the bulletin but from which the provider must secure documentation that the benefit is not covered.

7. **Require Commercial Carriers to Publish BHCA Network.** ABH recommends that DOI require that the carriers publish and maintain publicly available directories of their BHCA network for the benefit of consumers and providers alike.

Survey Background

ABH surveyed its member organizations that deliver CBHI services to gain insights into the implementation from the perspective of safety-net providers. Survey responses were collected from January 10, 2020 through January 31, 2020. Thirty-two (32) unique provider agencies that collectively operate at least 124 CBHI programs (including Family Partner and Therapeutic Mentoring) responded and provided feedback as to contracting status, barriers to contracting, anticipated impact on clients with MassHealth secondary, and various operational challenges. The following analysis broadly presents the survey's findings, highlights emerging themes, and makes specific recommendations as implementation proceeds.

Ongoing State Agency Support and Partnership

The Division of Insurance partnered with ABH over the past two months to complete benefit service grids to help providers understand the new BHCA benefits and requirements. Grids have been completed for almost all carriers. They are available here for reference: https://abh.memberclicks.net/child-and-adolescent-commercial-behavioral-health.

In early-to-mid-February 2020, the Division of Insurance partnered with commercial carriers to coordinate webinars targeted toward their CBHI/BHCA provider networks. These webinars have recently concluded and likely resolved some of the outstanding questions highlighted in the survey findings below.

Considerations Relative to Primary Insurance Contracting

Survey respondents reported that barriers to contracting still exist, with some carriers being highlighted as more challenging to contract with than others. Survey respondents reported the following:

- A significant number of responding ABH members are not contracting with Cigna (81.3%; 26 respondents), Aetna (75.0%; 24 respondents), and ConnectiCare (65.6%; 21 respondents), in any capacity regardless of service. The primary reasons identified were:
    - insufficient rate;
    - lack of communication with plan;
    - lack of needed documentation; and
    - other unspecified barriers impacting contracting.

- Respondents' decision to contract with a plan is heavily influenced by geographical and payer mix considerations e.g. not contracting due to distance from covered members, or low or minimal referrals/engagement with Aetna and Cigna members.

- BMC HealthNet/Beacon Health Options, Fallon Health/Beacon Health Options, and Blue Cross Blue Shield of Massachusetts (BCBSMA) are the plans with the highest percentage of providers intending to contract for one or more BHCA services. By this metric, 93.8% of respondents (30 providers) are contracted with BMC HealthNet, 90.6% (29 providers) with Fallon Health, and 81.3% (26 providers) with BCBSMA. Please see Appendix A for additional data regarding contracting status by carrier. Please see Appendix B for contract status by carrier and service.

- The reasons respondents are not or have not yet contracted with a given carrier varied widely and depends heavily on the various parameters on each BHCA service. As a result, many providers have chosen to contract with a carrier for one service, but not for the other BHCA services.

Considerations Relative to Impact on Children/Youth with MassHealth Secondary

The survey responses indicate that a strong majority of providers are deeply concerned about the impact implementation will have on children, youth, and families who have primary insurance with a commercial carrier and have MassHealth as a secondary insurance coverage.

Providers report concerns about access to services and the financial burden of cost-sharing. While providers are still determining the full extent these financial implications will have on families, survey respondents reported the following:

- 71.9% of survey respondents (23 providers representing 56 programs) report that they will continue to serve clients with MassHealth secondary with some potential for impact relative to intensity of care as a result of either the rate structure or service definition.
- 15.6% of survey respondents (5 respondents representing 12 programs) will serve existing clients with MassHealth but may not be able to serve new clients with MassHealth secondary.
- 12.5% of survey respondents (4 respondents representing 20 programs) may not be able to serve any clients (existing or new) with MassHealth secondary.[2]

<u>Disparate Impact on Families Depending on Primary Insurer</u>

Survey respondents who reported that they would continue to serve clients (both new and existing) with MassHealth secondary with some potential for impact relative to intensity of care were asked which members may be impacted most greatly:

Blue Cross Blue Shield of Massachusetts

- A total of 60% of respondents identified clients with BCBSMA as a primary insurance as being most impacted. Providers explain this is due to:
    - High volume of children and adolescents covered by BCBSMA;

[2] ABH members operate at least 36 Family Partner (FP) and Therapeutic Mentoring (TM) programs. As FP and TM are not yet BHCA-covered benefits, these services were excluded from this survey.

- Adoption by this payer of procedure codes or units that are different than MassHealth for similar service under CBHI;
    - CBHI providers are accustomed to a standardized system of codes and corresponding units, as specified by MassHealth rate regulation. Some commercial carriers have adopted MassHealth's billing codes and units for BHCA services, while others have created new codes and/or are operationalizing units differently i.e. electing to use a day rate for IHT where MassHealth uses a 15-minute unit. These discrepancies pose new administrative and operational challenges for providers.
- Confusion around clinician licensure requirements;
    - At the time of this survey, responses suggested that providers erroneously believe that BCBSMA requires an independently licensed clinician to render BHCA services. This survey was administered prior to the February carrier webinars, and its findings indicate that providers may need additional information and training around individual plans' licensure requirements and supervisory protocols as it pertains to non-independently licensed staff ability to bill for services.
- Rate and service definitions differ significantly from current practice, e.g., BCBSMA approach assumes collateral contacts and consultations are covered within scope of a single code and rate. Please see Appendix C for more information.

Optum/UBH

- A total of 39% of respondents identified Optum/UBH members as being most impacted. Providers indicated that this is due to following reasons:
    - High volume of children and adolescents covered by Optum;
    - Intensive Care Coordination (ICC) service being offered directly by Optum
        - At the time of this survey, respondents reported that Optum's ICC benefit would be disruptive to families, and would hinder community-based ICC programs' ability to serve youth in need;[3]
    - Perception that rate and service definitions differ significantly from current practice; and,
    - Confusion around clinician licensure requirements
        - As with BCBSMA, at the time of this survey, responses indicate that providers erroneously believed that Optum/UBH requires a licensed clinician render the services under BHCA. This survey was administered prior to the February carrier webinars, and its findings indicate that providers may need additional information and training around individual plans' licensure requirements and supervisory protocol as it pertains to non-independently licensed staff ability to bill for services

[3] Optum since clarified on a webinar that single case agreements would be available for children with TPL who are already enrolled in ICC through a CSA. Please see Appendix D for more information.

Other Carriers

- To a lesser extent, Aetna and Cigna were similarly identified as carriers with numerous barriers to engagement such as lack of readily available information, differing service definitions, and restrictive licensure requirements for In-Home Therapy.

Services Impacted by BHCA Implementation and Impact on Clients with MassHealth Secondary

Survey respondents reported that certain services accessed by children/youth with MassHealth secondary will be more greatly impacted than others. Respondents anticipated that greatest impact will be on In-Home Therapy (IHT) clients (68.7%, 22 respondents), followed by Intensive Care Coordination (ICC) (53.1%, 17 respondents). In the case of BCBSMA and Optum, respondents perceive that IHT is a different, more limited service under these plans' BHCA construct. As one respondent explained, due to the variations in service definition across carriers, "we will be expected to provide one service to MassHealth and another to straight commercially insured youth, and it is unclear which service those with secondary MassHealth would require."

Operational Challenges

Survey respondents identified a number of operational challenges to serving children and youth with MassHealth secondary, including:

- Plan documentation around service delivery is unclear or has not been consistently provided;
- Rate or rate structure substantively changes the care delivery model for a subset of each provider's client population in ways that may make service delivery operationally difficult;
- Erroneous perception that licensure requirements may make BHCA services difficult to staff;[4]

  Note: Carriers' webinars and updating of documentation should correct these perceptions where erroneous.
- Designing a clinical model with multiple billing unit types may be unworkable for clinical staff and administrative infrastructure, i.e. provider organizations may not have the capacity to operationalize one clinical model of In-Home Therapy predicated on a 15-minute rate (most carriers) vs. one predicated on a day rate (two carriers), particularly where they serve few children/youth insured by the latter carriers; and,
- Billing for services rendered will be challenging due to plans adoption of different codes, unit structures, as well as EHR/billing system limitations.

[4] In the case of BCBSMA and Optum, providers' perceptions regarding the clinician licensure requirement is erroneous. Where Aetna is concerned, licensed clinicians are required for the provision of IHT.

Considerations Relative to Upcoming Enforcement of Provider-Led Coordination of Benefits Process

As the secondary payer for children/youth who have MassHealth as their secondary insurance, MBHP covers eligible charges not covered by primary insurance, such as member cost sharing and denied services in certain circumstances. As of April 1st, providers will face a significant increase in administrative work in order to be paid for services delivered to children/youth who are entitled to them through MassHealth secondary coverage.

Operational Challenges

MassHealth has always been the payer of last resort for significant public policy reasons. However, survey respondents reported a number of concerns around the additional administrative and billing resources that will be required to continue to serve children/youth who have MassHealth as their secondary insurance.

Dual Authorization
In order to be paid for member cost sharing and certain denied services delivered to children/youth with MassHealth secondary, the provider will need to obtain authorizations from the primary insurer and from MBHP. Providers have raised this as one of many operational barriers to successful implementation.

Obtaining EOBs from Primary Insurer
In order to have eligible charges covered by MBHP, the provider will need to obtain an Explanation of Benefits (EOB) from the primary insurer and attach it to the provider's MBHP claim. This process is not something many CBHI programs are currently equipped to manage.

Survey respondents indicated that they have had varied experience in obtaining EOBs for BHCA services. A large percentage of respondents (44%) did not have experience obtaining an EOB as of the time they responded to the survey. Of those who have attempted to obtain an EOB, respondents have had mixed experiences with 28% reporting no issue, 21% reporting extreme difficulty, and a very small minority reporting that they are unable to accept commercial referrals due to the difficulty in obtaining an EOB.

Trying to secure an EOB from a plan with which they provider is not contracted, i.e., self-insured or out-of-state plans not subject to the bulletin, is extremely difficult and time consuming.[5] Additionally, it is our understanding that 55% of the Massachusetts insurance market is not subject to Bulletin 2018-07, so providers will be spending a significant amount of time attempting to obtain information from plans that have no incentive to assist the provider.

[5] The Massachusetts Behavioral Health Partnership traditionally has been willing to work with providers on alternatives to the EOB with prior approval. Examples include a letter generate by the primary insurer to the member/provider stating the billed services are non-covered or information from the member benefit handbook stating the billed services are not covered. However, in the provider experience, most insurers are unwilling to generate these letters. Where insurers are willing to generate these letters, they are typically generated after timely filing deadlines. Further, providers report that insureds often lack member benefit handbooks or that this documentation does not include the level of specificity required.

Finally, most ABH members bill insurers electronically. However, electronic coordination of benefits is not possible where units are different. Thus, providers must either submit paper claims with EOBs attached or upload claims and related scanned EOBs into MBHP's provider portal.[6] This is a resource-intensive process particularly for high-frequency services such as ICC and IHT.

Service Code Cross-Walking

Providers who are seeing clients with MassHealth Secondary must bill the primary insurance using that carrier's service unit definition and service code, then transpose the codes to MBHP/MassHealth service units and code.[7] This is a manual process for providers and is subject to continued confusion.

Providers continue to have questions around how this cross-walking will work. As there is variation in units and codes across insurers for these services, billing systems are not currently set up to do this. This will require either a manual cross-walking process for every claim or will require investing in EHR and billing systems to have vendors develop this capability. Survey respondents also anticipate a higher volume of appeals and more errors due to the manual nature of this work.

[6] Recommended billing instructions around coordination of benefits include circling relevant charge information on the EOB and changing EOB file names to associate paperwork with related claims. While this is helpful advice, it creates resource needs that providers cannot meet.

[7] E.g., For In-Home Behavioral Health Services (IHBS), BCBSMA adopted a day rate using code H0040 HK. MassHealth/MBHP adopted a 15-minutes unit using code H2014 HO/HN. For a child with BCBSMA and MassHealth secondary, the provider would need to continue to track service delivery in 15-minute units solely for billing purposes. If the provider delivered two hours of IHBS, the provider first bills BCBSMA with H0040 HK for a day of service and then receives the EOB. The provider then looks to their records for the amount of MassHealth-reimbursable service, here 8 units (120 minutes/15-min units = 8 units) and bills MBHP for family cost sharing utilizing 8 units with code H2014 and attaching the EOB.

Appendix A: Reported Contracting Status by Carrier (as of 2/1/2020)

Respondents: 32 Member Agencies		
Carrier	**# of ABH Members Who Are Contracted**	**% of Respondents Who Are Contracted/Intend to Contract**
Aetna	8	25%
AllWays Health Partners	23	72%
Blue Cross Blue Shield of Massachusetts	26	81%
BMC HealthNet	30	94%
Cigna	6	19%
ConnectiCare	11	34%
Fallon Health	29	91%
Harvard Pilgrim Health Care	23	72%
Health New England	18	59%
Tufts Health Plan	25	78%
United Behavioral Healthcare	22	69%

Appendix B: Reported Contracting Status by Carrier and Service

Q3. For the purposes of reporting back to DOI/DMH, for which commercial health plans and which BHCA services is your agency contracted?

Question Respondents: 32 Member Agencies

Carrier	Executed/Intended		ICC		IHBS		IHT		FST		MCI		CBAT		ICBAT	
	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
Aetna	**25.00%**	**8**	9.38%	3	9.38%	3	21.88%	7	3.13%	1	6.25%	2	3.13%	1	0.00%	0
AllWays Health Partners	**71.87%**	**23**	37.50%	12	25.00%	8	65.63%	21	21.88%	7	21.88%	7	12.50%	4	9.38%	3
Blue Cross Blue Shield of MA	**81.25%**	**26**	40.63%	13	25.00%	8	71.88%	23	28.13%	9	21.88%	7	12.50%	4	9.38%	3
BMC HealthNet	**93.75%**	**30**	53.13%	17	34.38%	11	78.13%	25	28.13%	9	25.00%	8	21.88%	7	9.38%	3
Cigna	**18.75%**	**6**	6.25%	2	6.25%	2	9.38%	3	3.13%	1	9.38%	3	6.25%	2	3.13%	1
ConnectiCare	**34.37%**	**11**	15.63%	5	15.63%	5	31.25%	10	12.50%	4	9.38%	3	3.13%	1	0.00%	0
Fallon Health	**90.62%**	**29**	43.75%	14	37.50%	12	75.00%	24	31.25%	10	18.75%	6	21.88%	7	9.38%	3
Harvard Pilgrim Health Care	**71.87%**	**23**	37.50%	12	28.13%	9	68.75%	22	21.88%	7	18.75%	6	12.50%	4	9.38%	3
Health New England	**59.37%**	**19**	25.00%	8	28.13%	9	43.75%	14	21.88%	7	21.88%	7	12.50%	4	0.00%	0
Tufts Health Plan	**78.12%**	**25**	50.00%	16	34.38%	11	71.88%	23	18.75%	6	21.88%	7	18.75%	6	9.38%	3
United Behavioral Healthcare	**68.75%**	**22**	34.38%	11	25.00%	8	65.63%	21	21.88%	7	15.63%	5	12.50%	4	9.38%	3

Appendix C: In-Home Therapy and Case Consultations/Collateral Services

Under the CBHI payment and care construct, providers are reimbursed for each 15-minutes of in-home therapy. Vital to the care model are collateral and case consultations, often independent of the delivery of a given in-home therapy intervention. The Commonwealth has recognized the significant value of collateral and case consultations for families with children with serious emotional disturbance by pricing these services at the same rate as psychotherapy.

Survey respondents perceive the BCBSMA payment construct for IHT as leading to a substantively different care model from the CBHI benefit. BCBMSA structures its IHT reimbursement as a day rate that can be generated when an in-home therapeutic intervention occurs with the family.

The BCBSMA payment construct has been messaged two ways:

1. The rate presumes that any related collateral contacts and consultations are covered through its rate. Thus collateral and case consultations are directly related to the delivery of a specific therapeutic intervention in the home; or,
2. Collateral contact and case consultations can be addressed by obtaining an authorization for ICC and utilizing those units.

The challenges with these approaches are as follows:

1. The first construct presumes that not only is the rate sufficient to cover collateral and case consultation service delivery but that these services are always directly tied to an in-home therapy encounter.[8] ABH cannot collect individually negotiated rate information due to antitrust considerations, but implicit in provider feedback is concern that the day rate does not cover the costs of service delivery; and
2. There are numerous concerns relating to utilizing ICC units for the purposes of IHT collateral contacts, including how providers who do not offer ICC should operate and how authorizations would work in situations would where another agency is the ICC provider.

In addition, the adoption of daily rate by two carriers (BCBSMA and Optum) requires providers to set up a completely different clinical and administrative infrastructure for service delivery to families covered by those carriers. As a result, the fundamental question for providers is whether this commercial payment model translates into the same service, particularly for children with MassHealth secondary.

[8] This is in contrast to Optum/UBH adoption of a day rate for IHT, but allowing providers to bill the unit whenever family or case consultation occurs.

Appendix D: Intensive Care Coordination

Relative to Intensive Care Coordination (ICC), respondents cited Optum's decision to offer ICC directly as the reason for the potential impact. Under the Children's Behavioral Health Initiative, Intensive Care Coordination services are delivered exclusively through contracted Community Service Agencies (CSAs) that serve designated service areas. Depending on the number of children involved for a particular Community Service Agency (CSA), the transition of a large number of children who are Optum members to internally-delivered ICC on an ongoing basis is potentially destabilizing. ABH understands that Optum has clarified on its recent webinar that ICC providers can pursue single case agreements with Optum in order to continue serving current families and avoid disrupting care. However, the post-transition concern remains as new children seek services.