REPORT ON BEHAVIORAL HEALTH MANAGERS IN THE COMMONWEALTH

Report to the Massachusetts Legislature

NOVEMBER 2024

INTRODUCTION

Behavioral health managers, entities that contract with a health plan to provide or arrange for behavioral health services for plan members, are used for a significant number of Massachusetts residents with commercial health plans and the majority of residents with Medicaid coverage. Chapter 177 of the Acts of 2022, *An Act Addressing Barriers to Care for Mental Health*, directed the Health Policy Commission (HPC), in consultation with the Division of Insurance (DOI), to conduct an analysis of the behavioral health managers in the Commonwealth. Specifically, the HPC was asked to analyze the services that behavioral health managers provide; the effect of behavioral health managers on accessibility, quality and cost of behavioral health services, including an analysis of their impact on patient outcomes; the oversight practices by other states on behavioral health managers, and the effects of state licensure, regulation or registration on access to behavioral health services; and any other issues pertaining to behavioral health managers as deemed relevant by the HPC.

To conduct this study, the HPC reviewed laws and regulations in Massachusetts and other states, reviewed research literature, and analyzed available data, including National Committee for Quality Assurance (NCQA) Health care Effectiveness Data and Information set (HEDIS®)[1] measures. In addition, the HPC conducted interviews with payers, behavioral health managers, providers, and patient advocates.

In the following report, the HPC describes the use of behavioral health managers by commercial health plans and Medicaid plans in the Commonwealth, summarizes the regulatory landscape in Massachusetts and other states, describes perspectives on the advantages and disadvantages of using behavioral health managers, and reviews comparative health plan quality measures. The report concludes with recommendations about ways to improve the provision of behavioral health care services when behavioral health managers are involved.

BACKGROUND

A behavioral health manager (BHM) is a company that contracts with a public or commercial health plan to "provide for or arrange for the provision of behavioral, substance use disorder, or mental health services" for health plan members.[2] Through this contractual relationship, the BHM fulfills some or all of the insurer's functions of managing behavioral health services for health plan members, including duties required by statute or regulation of the health plan related to their coverage of behavioral health care.[3] A health plan may choose to use a BHM for all or substantially all of the functions regarding behavioral health services or for select functions. BHMs are used by fully-insured health plans, subject to regulation by DOI as "carriers"; the state's Medicaid program, MassHealth; and commercial health plans contracting with MassHealth as Medicaid Managed Care Organizations (MCO) or Accountable Care Organizations (ACO). In addition, self-insured plans offered by employers, which are not regulated by DOI, may contract with BHMs to manage behavioral health services in addition to another third-party administrator for medical/surgical services.

USE OF BEHAVIORAL HEALTH MANAGERS IN MASSACHUSETTS

MASSACHUSETTS LANDSCAPE

BHMs have been used by health plans in Massachusetts for many years and continue to be used across the Massachusetts health care landscape. Most commercial health plans in Massachusetts use a BHM for at least some services, and the use of specific BHM vendors has remained relatively consistent over time.[4] Three national BHM companies operate in Massachusetts and serve the commercial and MassHealth

1 HEDIS® The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

2 Mass. Gen. Laws. Ch. 176O, § 1, defines "behavioral health manager" as "a company, organized under the law of the commonwealth or organized under the laws of another state and qualified to do business in the commonwealth, that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled member of the carrier." Behavioral Health Managers are sometimes referred to as managed behavioral health organizations (MBHOs), behavioral health vendors or behavioral health carve-outs.

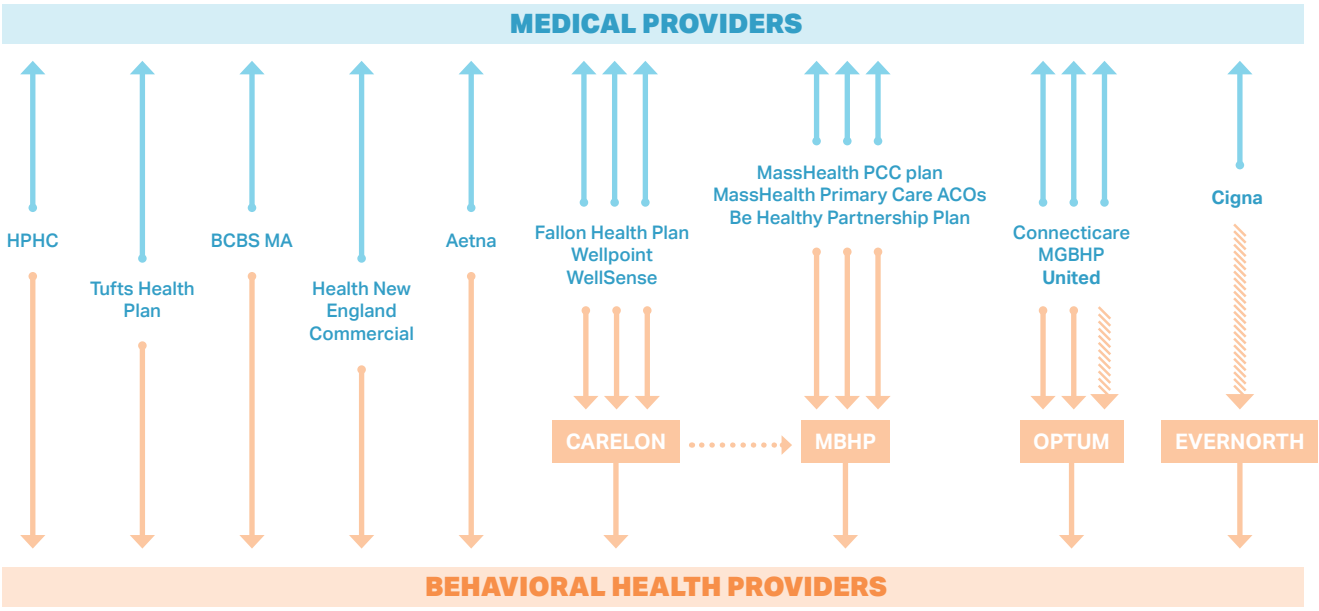
3 For purposes of this report, the HPC uses the term "behavioral health services" or "behavioral health care" to encompass services for individuals experiencing mental health, substance use and emotional disorders. Association for Behavioral Health care, Issue Brief, Kids Are Waiting, Children's Behavioral Health Services Crisis and Collapse, December 2023. https://www.abhmass.org/images/CBHI_Brief/ABH_Brief_Children_Are_Waiting_FINAL_121423_R.pdf.

4 See Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D §8, The Office of the Attorney General's 2015 report stated that MBHP, Optum, and Beacon (now Carelon) provided behavioral health management services in the state at that time as well. Optum served HPHC, Beacon served GIC's Tufts Health Plan, GIC Unicare, Neighborhood Health Plan, BMC Health Net, and Fallon, and MBHP served MassHealth and HNE.

managed care market: United Behavioral Health dba Optum (Optum), Carelon Behavioral Health Strategies, LLC (formerly Beacon Health Options) (Carelon), and Evernorth Behavioral Health, Inc. (Evernorth). Optum contracts with ConnectiCare of Massachusetts, Inc. (ConnectiCare)[5], Mass General Brigham Health Plan, Inc. (MGBHP)[6], and UnitedHealthcare Insurance Company (United)[7] to manage all or substantially all behavioral health services for those health plans. Carelon contracts with Wellpoint Life and Health Insurance Company (formerly GIC Unicare) (Wellpoint), Fallon Community Health Plan, Inc. (Fallon)[8] and Boston Medical Center Health Plan, Inc. dba WellSense (WellSense)[9] to manage all or substantially all the behavioral health services for those health plans. Evernorth contracts with Cigna Health and Life Insurance Company (Cigna) to manage all or substantially all of its behavioral health services.[10]

Tufts Associated Health Maintenance Organization, Inc. and Tufts Health Public Plans, Inc. (Tufts Health Plan), Harvard Pilgrim Health Care, Inc. (HPHC)[11], and Aetna Life Insurance Company and Aetna Health, Inc. (Aetna) manage all of their behavioral health services without the use of a BHM. Blue Cross Blue Shield of Massachusetts[12] and Health New England[13] manage substantially all of their behavioral health services without the use of a BHM. The Massachusetts Medicaid program, MassHealth, and many MassHealth MCOs and ACOs use BHMs. The Massachusetts Behavioral Health Partnership (MBHP) serves as the BHM for most

Relationships between health plans and behavioral health managers in Massachusetts, 2024



Notes: This infographic is an updated version of an infographic displayed in the Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D §8, Office of the Attorney General, June 30, 2015.

5 ConnectiCare has notified DOI that it is not renewing its Massachusetts insured health plan as it prepares to exist the Massachusetts market.

6 MGBHP operates one member-facing call center for all services, including behavioral health, and does not contract with Optum for its member-facing call center.

7 Optum and United Health Care are corporate affiliates.

8 Fallon performs case management of behavioral health services and does not contract with Carelon for case management.

9 WellSense performs case management of behavioral health services and does not contract with Carelon for case management.

10 Evernorth and Cigna are corporate affiliates. Evernorth also acts as a behavioral health manager for health plans other than Cigna nationally.

11 Optum previously contracted with Harvard Pilgrim Health Care, Inc. to manage substantially all behavioral health services through October 31, 2023. The data in this report reflects calendar year 2022. Since Harvard Pilgrim Health Care contracted with Optum for the entirety of 2022 for behavioral health management, this report categorizes Havard Pilgrim Health Care as using a behavioral health manager for enrollment and quality analysis.

12 BCBSMA contracts with Carelon for its REACH program for adults and children who have significant and persistent mental health difficulties or substance use disorders after discharge from a facility.

13 Health New England contracts with MBHP for its MassHealth population.

MassHealth members.[14] MBHP is a division within Carelon operating exclusively in Massachusetts. MBHP contracts with MassHealth to provide behavioral health services for its Primary Care Clinician (PCC) plan and Primary Care ACOs, Community Care Cooperative and Revere Health Choice. Health New England contracts with MBHP for its MassHealth population through its ACO, Be Healthy Partnership Plan with Baystate Health Care Alliance.[15]

Behavioral Health Manager	Plans	Estimated Members Enrolled*
Optum	Connecticare, MGBHP, HPHC**, United	Commercial: 887,006 MassHealth: 45,651
Carelon	Fallon, WellSense, WellPoint	Commercial: 171,904 MassHealth: 388,219
MBHP	MassHealth PCC plan; MassHealth Primary Care ACOs: Community Care Cooperative, Revere Health Choice; Be Healthy Partnership (HNE)	MassHealth FFS, PCC, Primary Care ACOs and HNE: 759,862
Evernorth	Cigna	Commercial: 217,726

*Members enrolled estimated by CHIA Enrollment Data for December 15, 2022.

** HPHC contracted with Optum for the entirety of 2022 for behavioral health management.

SERVICES PROVIDED BY BEHAVIORAL HEALTH MANAGERS

BHMs offer a wide range of services to health plans in Massachusetts. Health plans contract for a specific set of services, which may change over time based on the needs of the health plan. For services that are not managed by the BHM, the health plan manages and provides those services itself or "in-house." BHMs may provide some or all of the following services:

- Clinical Services: utilization management, including developing and using medical necessity criteria, and case management, through communicating directly with patients and providers, for either all or a specific subset of services such as community behavioral health services and applied behavioral analysis.
- Network Management: developing and maintaining a network of behavioral health providers (including individual behavioral health providers, hospitals, facilities, residential and outpatient treatment centers) sufficient to meet applicable network adequacy requirements through recruiting, credentialing, and contracting with those providers as well as ongoing management of those provider relationships.
- Quality of Care: reporting and working to improve performance on HEDIS quality measures and working with providers to identify best practices.
- Appeals and Grievances: facilitating appeals and grievances for members challenging denials or complaining about quality of care.
- Parity Compliance: assisting health plans in meeting their responsibilities under state and federal parity requirements including preparing comparative analysis of non-quantitative treatment limitations.[16]
- Fraud, Waste, and Abuse Services: detecting and investigating potential fraud, waste, and abuse, assisting with recovery when applicable, and performing analytics and compliance activities related to fraud, waste and abuse.
- Claims: processing claims for behavioral health services, which may include pricing, adjudication, and payment.
- Reporting: performing a variety of reporting functions as required by the contract with the health plan, including reporting to the health plan at the end of claim period, state and federal-mandated reporting, and analytics to support performance under value-based contracting.
- Call centers: staffing and management of call centers for both member-facing and provider-facing hotlines.[17]

CONTRACTS WITH BEHAVIORAL HEALTH MANAGERS

As noted above, many health plans in Massachusetts have maintained long-term relationships with their chosen BHM vendors. Health plans typically contract with BHMs for multi-year terms. The contracts outline what services the BHM will provide and how the responsibilities for management of behavioral health services will be delineated between the health plan and the BHM. The contracts vary by how the BHM is paid by the health plan as well as what other service level agreements or performance requirements the BHM must meet.[18]

14 MBHP is owned by Carelon but operates as a separate entity.

15 Massachusetts Behavioral Health Partnership, https://www.masspartnership.com/ (last visited February 2024); 130 Mass. Code Regs. 450.105 (2022).

16 Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51589 (August 3, 2023).

17 MBHP contracts with the Commonwealth to staff and manage the Massachusetts Behavioral Health Helpline launched in 2023.

18 See Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D §8, Office of the Attorney General, June 30, 2015 at 8.

The payment structures in BHM contracts can generally be categorized into two models: an administrative services only model or a risk arrangement model. Under an administrative services only model, the health plan pays a set fee per member per month to the BHM. The BHM processes and adjudicates claims and either the BHM pays the providers on the health plan's behalf, or the health plan pays the providers directly. If the BHM pays claims on behalf of the health plan, the BHM invoices the health plan for all claims paid and receives these payments in addition to the per member per month administrative service fee. Currently, the administrative services only model is the most common payment arrangement between Massachusetts health plans and BHMs.

Risk-based payment models are also used, but are becoming less common in Massachusetts.[19] Under some risk management models, BHMs are paid a capitated premium per member per month. The BHM then holds the risk for paying the claims for those members often within a specified risk corridor. Other risk payment structures are limited to a specific type of service. For example, the BHM may be paid a set amount for a residential program, or a set of services, like substance use disorder services, and hold some risk if claims paid exceed the set amount for that service.

Health plan contracts with BHMs specify which state and federal regulatory responsibilities are delegated to the BHM. For example, BHMs may be held responsible by the health plan for meeting MassHealth network adequacy requirements, or BHMs may be required by the health plan to directly submit any state or federal reporting on a timely basis.[20] The health plan remains responsible for compliance regarding any delegated functions.

In addition to specifying the specific health plan functions that are delegated to the BHM, the contracts typically include performance requirements for each service known as service level agreements. Health plans may also require service level agreements to ensure that the BHM is meeting certain standards. For example, contracts may require claims processing within a certain amount of time and only allow a certain percentage of inaccurate claims. Likewise, health plans may require that hotline calls be answered within a certain amount of time and below an agreed upon call abandonment rate. Health plans may also require that the BHM perform on quality statistics within a certain percentile.

19 The Attorney General's 2015 report on health care cost trends reported that risk-based payment models, including capitation payments for claims, were common at the time of the report. Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D §8, Office of the Attorney General, June 30, 2015 at 15-16.

20 Requirements Related to the Mental Health Parity and Addiction Equity Act, 88 Fed. Reg. 51589 (August 3, 2023).

STATE OVERSIGHT OF BEHAVIORAL HEALTH MANAGERS

MASSACHUSETTS

State oversight of Behavioral Health Managers (BHMs) is largely achieved indirectly through carrier licensure by the DOI.[21] In Massachusetts, BHMs are considered Third-Party Administrators (TPAs), which are registered with the DOI.[22] DOI's TPA regulation is limited to registration and reporting, and the reporting is largely limited to information on self-insured customers of the TPA only.[23]

Massachusetts law provides that carriers contracting with BHMs maintain the ultimate responsibility for the actions of BHMs.[24] If a carrier contracts with a BHM to perform some or all behavioral health functions, it is the carrier's responsibility to ensure that the BHM is in compliance with statutory and regulatory managed care consumer protections, accreditation, and utilization review requirements.[25] Contracts between BHMs and carriers provide that BHMs providing services for carriers must adhere to requirements applicable to carriers, such as accreditation requirements, utilization review standards, quality management standards, credentialing requirements, provider contracts requirements, and network adequacy requirements.[26]

In addition, DOI requires disclosures by carriers regarding the use of BHMs. Carriers must provide to each household certain information about the use of a BHM, including: a summary of the process by which clinical guidelines and

21 A "carrier" is a fully-insured health plan licensed in Massachusetts and subject to Massachusetts insurance regulation. See 211 Mass. Code Regs. 52.03. Massachusetts insurance regulation does not apply to self-insured health plans. This report refers to carriers when specifically referencing this definition in state law.

22 Third-party Administrator is defined as "A[n] … entity … who, on behalf of a health insurer, "receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the Commonwealth." 211 Mass. Code Regs. 148.02.

23 The annual reports include information on TPAs' self-insured customers, including the number of customers, aggregate number of subscribers enrolled in the benefits plans, and details on claims information for the TPAs' self-insured customers. 211 Mass. Code Regs. 148.03-.04.

24 211 Mass. Code Regs. 52.14 (15). 211 Mass. Code Regs. 52.01.

25 Id.

26 211 Mass. Code Regs. 52.07-.13

utilization review criteria are developed; information on emergency mental health services, either through the carriers' evidence of coverage or through a separate document; and the name and number of the BHM must be included on the enrollment card.[27] Pursuant to DOI's managed care regulations, as amended in November 2023, carriers must submit all contracts with vendors, including BHMs, who perform utilization review and member services with their accreditation application.[28] Carriers are also required to submit an explanation of how the carrier or its BHM utilizes a base fee schedule for Behavioral Health Providers that is not less than the base fee schedule used for Primary Care Providers and how the carrier has established such a base fee schedule for Behavioral Health Providers while not lowering its base fee schedule for Primary Care Providers.[29] Lastly, DOI has updated its provider directory requirements in the managed care regulations to include new audit requirements for accuracy of behavioral health provider directories.[30]

MASSHEALTH OVERSIGHT OF BEHAVIORAL HEALTH MANAGERS

Certain MassHealth plans are required by regulation to use the designated Behavioral Health Contractor, Massachusetts Behavioral Health Partnership (MBHP). MBHP provides behavioral health management services for: MassHealth's Primary Care Clinician (PCC) plan; MassHealth's Primary Care ACOs, Community Care Cooperative and Revere Health Choice. MassHealth directly oversees and monitors MBHP through regulatory and contractual requirements, for example:

Regulatory Requirements for Behavioral Health Contractor:

- All behavioral health services are authorized, provided and paid for by the behavioral health contractor
- Members must receive behavioral health services from a provider contracted with the behavioral health contractor, except for emergency behavioral health services

Contractual Requirements in MassHealth's contract with MBHP:

- MBHP must have a process for investigating and resolving any MassHealth dissatisfaction with MBHP's performance and for improvements in its internal system
- Contract management and responsiveness standards
- Network adequacy and access standards

MassHealth Managed Care Organizations (MCOs) and Accountable Care Partnership Plans are not required to use the Behavioral Health Contractor, MBHP. MCOs and ACOs can choose to contract with a behavioral health manager or keep behavioral health in-house. Tufts Health Plan manages its MassHealth members' behavioral health services in-house. Carelon contracts with Fallon and WellSense. Optum contracts with MGBHP. HNE contracts with MBHP for it MassHealth ACO, Healthy Partnership Plan with Baystate Health Care Alliance.

Similar to the commercial insurance landscape, MassHealth primarily oversees the BHMs indirectly through requirements of the MCO or ACOs. However, BHMs are considered Behavioral Health Subcontractors under MassHealth regulation and Material Subcontractors under MassHealth's contracts with the MCOs and ACOs, and therefore must directly meet certain requirements, including:

Regulatory Requirement for Behavioral Health Subcontractor:

- Behavioral Health Subcontractors must comply with federal mental health parity

Contractual Requirements for Material Subcontractor:

- Material Subcontractors must be approved by MassHealth.
- The MCO or ACO must submit an organizational chart of the behavioral health Material Subcontractor which "clearly demonstrates the relationship with the Material Subcontractor and the [MCO or ACO]'s oversight of the Material Subcontractor."

Sources: 130 CMR 450; 130 CMR 508; MassHealth Managed Behavioral Health Vendor Contract, effective January 1, 2023; The Sixth Amended and Restated Managed Care Organization Contract; First Amended and Restated Accountable Care Partnership Plan Contract.

27 211 Mass. Code Regs. 52.14.

28 211 Mass. Code Regs. 52.05(3)(k); 211 Mass. Code Regs. 52.05(4)(e).

29 211 Mass. Code Regs. 52.05(3)(u); 211 Mass. Code Regs. 52.05(4)(n).

30 211 Mass. Code Regs. 52.15.

OTHER STATES

Like Massachusetts, states generally regulate BHMs indirectly through health plan licensing and/or utilization review regulations. BHMs are subject to utilization review regulatory requirements, either through the health plan they contract with and/or directly as a utilization review organization in states that license utilization review organizations. While the framework for health plan licensing and utilization review rules varies across states, the content of those requirements is generally similar to those in Massachusetts. Also, like Massachusetts, many states directly register or license BHMs as TPAs and require the BHM to annually report limited information to the state insurance division.

A small number of states have regulations specifically requiring health plans to notify their members that their plan utilizes a BHM. For example, in Maryland, health plans are required to report the use of BHMs to the state,[31] and in at least two states, Maryland and New Jersey, the BHM is required to report data directly to the state.[32]

A number of states have managed care regulatory schemes that may apply to BHMs, especially if the BHM assumes financial risk under the contract. These laws are not specific to BHMs, but they may apply to the BHM as a managed care organization and create a more direct touchpoint between state regulatory bodies and BHMs. Of note, even in states where the BHM is separately licensed as a managed care entity, the laws generally provide that the health plan maintains responsibility for the actions of the BHM.

One example is Washington's health care benefits manager license, which requires that health care benefits managers, which includes BHMs, register with the state.[33] The health care benefits manager must have a written contract with the health plan of which it is acting on behalf, and those contracts must be filed with the state.[34] The health care benefits manager law creates a mechanism for inquiries and complaints regarding health care benefits managers and outlines actions to be taken against health care benefits managers by the state.[35]

Another example is New Jersey's organized care delivery system law. This law applies to organizations including BHMs, which act on behalf of health plans to "to provide, or arrange to provide, limited health care services that the [health plan] elects to subcontract for as a separate category of benefits and services apart from its delivery of benefits under its comprehensive benefits plan, which limited services are provided on a separate contractual basis and under different terms and conditions than those governing the delivery of benefits and services under the [health plan's] comprehensive benefits plan."[36] Under the law, an organized delivery system (ODS) assuming financial risk is required to be licensed. A licensed ODS is then directly subject to New Jersey's Health Care Quality Act.[37] An ODS that does not take on risk is not required to become certified.[38]

Oversight Practice	Requirements	Massachusetts Requirement?	Common Nationally?	States
Through Health Plan Licensing	Health Plan is responsible for BHM compliance with law	Yes	Yes	
Utilization Review Regulations	Registration or Licensure as Utilization Review Organization	No	Yes	
	Utilization review standards	Yes	Yes	
Third Party Administrator Regulations	Registration and reporting with state	Yes	Yes	
Additional Consumer Notification Requirements for BHMs	Health Plan must inform members that they and under a BHM, explain services	Yes	No	MD, NJ, WA
BHM Specific Data Reporting Requirements	Health plan must report data on BHM services to state	No	No	MD
	BHM must report data on services directly to state	No	No	MD, NJ
Specific Managed Care License applicable to BHMs	Depends on state	No	No	CA, CT, NJ, VT, WA

Notes: While Massachusetts does not have any BHM-specific data reporting requirements, DOI regulations do require carriers to submit BHM contracts and information on BHM behavioral health fee schedules to DOI. See supra 26-27.

31 Md. Code Ann., Ins. § 15-127 (West); Md. Code. Regs. 31.10.31.01, et. seq.

32 Md. Code. Regs 10.25.06.01 et seq; N.J. Stat. Ann. § 26:2S-15.1 (West).

33 Wash. Rev. Code Ann. § 48.200.010 (West).

34 Wash. Rev. Code Ann. § 48.200.040 (West).

35 Washington Rev. Code 48.200.040 (West).

36 N.J. Admin. Code § 11:22-4.2.

37 N.J. Admin. Code § 11:22-4.3.

38 Id.

Notably, no state has a licensing scheme or oversight structure that is specific to BHMs. HPC did not identify data or studies on the effects of state licensure, regulation or registration of BHMs on access to behavioral health services.

STAKEHOLDER PERSPECTIVES ON BEHAVIORAL HEALTH MANAGERS

The HPC conducted a series of stakeholder interviews to solicit input on the use of Behavioral Health Managers (BHM) in the Commonwealth. The HPC met with BHMs Optum and Carelon, as well as commercial health plans, MassHealth, providers, and patient advocacy organizations. Experiences with BHMs varied from stakeholder to stakeholder. The following section presents findings on recurrent themes from these conversations.[39]

BEHAVIORAL HEALTH PROVIDER NETWORK

Health plans that contract with BHMs stated that a major benefit of working with a BHM is using the BHMs' provider network. Maintaining a provider network requires experience in and resources devoted over time to recruiting and credentialling networks of contracted behavioral health providers that meet the necessary standards.[40] Health plans using BHMs stated that, since those organizations are focused solely on behavioral health, BHMs have better connections with behavioral health providers and are better able to attract providers to their networks than the health plans. Beyond the initial approval to join the network through the credentialling process, BHMs also monitor the network to make sure requirements are being met and maintain the network through provider relationship departments and investigating provider complaints.

Health plans that use a BHM said it would be enormously difficult to invest the time and resources into developing their own networks. Specifically, at least one health plan emphasized its reliance on the BHM's national coverage. Depending on the member population of a health plan, the national reach of a BHM is valuable. BHMs highlighted their ability to contract with national telehealth providers to supplement the local network and specifically allow for members to access behavioral health providers that match their racial, ethnic, or sexual identities.

Health plans serving MassHealth members said that they rely on their BHM to meet the network adequacy requirements of MassHealth and expressed skepticism that they would be able to meet those requirements without a BHM. Health plans contracting with MassHealth to deliver services to its enrollees must meet federal network adequacy standards for Medicaid programs.[41] MassHealth, through its contracts with health plans, enforces comprehensive network adequacy requirements that include geographic access and PCP to enrollee ratio requirements.[42] MassHealth has additional provider network requirements for behavioral health services, including that the network has expertise in twelve subpopulations and conditions, for example serious and persistent mental illness, fire-setting behaviors, and post-adoption issues.[43] MassHealth also requires that health plans contract with certain types of providers for services that are specific to the MassHealth population, for example, community services, family support and training services, in-home behavioral services, and youth mobile crisis services.[44] In addition to these requirements, health plans must also report changes to the provider directory and changes that may impact member access to care, relative to contract standards for geographic access and appointment wait times.[45]

39 The themes discussed in this section are consistent with the limited available literature on BHMs. See, Research Report, RAND Corporation. Carve-In Models for Specialty Behavioral Health Services in Medicaid, Lessons for the State of California (2022); Richard G Frank. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Debate-Commentary, Health Services Research 56(5) (2021); Christina J Charlesworth. Use of behavioral health care in Medicaid managed care carve-out versus carve in arrangements. Research Report Health Services Research 56(5) (2021).

40 See 211 Mass. Code Regs. 52.12. 42 CFR §438.68 (2024); 42 CFR §438.206 (2024).

41 42 CFR §438.68 (2024); 42 CFR §438.206 (2024).

42 The Sixth Amended and Restated Managed Care Organization Contract, Section 2.8(A)-(C), pp 167-189; First Amended and Restated Accountable Care Partnership Plan Contract, Section 2.8(A)-(C), pp 174-198. MassHealth contracts are available at https://www.mass.gov/masshealth-health-plan-contracts.

43 The Sixth Amended and Restated Managed Care Organization Contract, Section 2.8(A), pp 171-178; First Amended and Restated Accountable Care Partnership Plan Contract, Section 2.8(A), pp 179-186.

44 The Sixth Amended and Restated Managed Care Organization Contract, Section 2.8(A), pp 173-177; First Amended and Restated Accountable Care Partnership Plan Contract, Section 2.8(A), pp 181-185.

45 The Sixth Amended and Restated Managed Care Organization Contract, Appendix A; First Amended and Restated Accountable Care Partnership Plan Contract, Appendix A; MassHealth Network Adequacy and Assurances Report.

Many patients in the Commonwealth struggle to access behavioral health providers that accept insurance.[46] Stakeholders indicated that, even with the network developed and maintained by a BHM, it is difficult to find providers who are accepting new patients. BHMs, like health plans, are challenged to maintain up to date provider rosters that take into consideration whether the providers are active or accepting patients.[47,48] The difficulties accessing behavioral health providers, which have been mitigated somewhat by the increased accessibility to behavioral health providers through telehealth and new state insurance policy, are not unique for BHMs.

Some providers said that a BHM's credentialing process can be difficult and take a long time. Credentialling, the process by which health plans and BHMs ensure that providers meet the health plan's criteria for participation in the network, is resource-intensive on both sides. Each health plan or BHM sets its own requirements and has a process through which providers can supply information to prove that they meet the requirements, sometimes using a common application. There are general requirements for all providers and there may be additional requirements for certain professions. Undergoing different credentialing processes for multiple health plans and their contracted BHMs may be administratively burdensome for behavioral health professionals, especially those in solo or small practices.

BEHAVIORAL HEALTH EXPERTISE

Health plans using BHMs report that behavioral health expertise is a major strength of using a BHM. They state that BHMs' sole focus on behavioral health means that BHMs have the resources and expertise to meet the needs of the health plans' members. One health plan said it switched from an in-house model to using a BHM several years ago based on its assessment that it lacked the in-house expertise to address what was becoming an important part of the business. In particular, BHMs and health plans stated that BHMs have extensive experience in severe mental illness that is not possible to match at a health plan where only a small fraction of the member population has severe mental illness. Also, the national reach of the larger BHMs contributes to their level of expertise, stakeholders said, allowing them to take advantage of trends and innovations across the country to the benefit of members locally.

Specific to MassHealth, many health plans that use BHMs stated that BHMs were very helpful in meeting MassHealth-specific requirements and providing expertise around MassHealth-specific services, like the children's behavioral health initiative. At least one health plan uses a BHM just for its MassHealth population.

But some stakeholders, primarily providers, stated that the BHMs did not have superior expertise.[49] In some cases, providers stated that BHMs do not know or understand Massachusetts state laws and that local entities are able to be more nimble and innovative in response to the specific needs of their members.

INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

Health plans that choose to manage behavioral health care in-house cited the importance of the integration of physical and behavioral health as a major reason for that decision. Stakeholders stated that aligning behavioral and medical providers and coverage for patients under one entity helps in the effort to provide "whole person care." Health plans said that the lack of transparency into a BHM's claims system

46 Press Release, Office of the Attorney General, AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More than One Million Residents. July 27, 2020, https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents?_gl=1*1us5bwy*_ga*MTE0ND-QzMjcyLjE2ODMwNDc2NjQ.*_ga_MCLPEGW7WM*MTcwOD-k1MTY4Ni43LjEuMTcwODk1MjA0NS4wLjAuMA.

47 Massachusetts Division of Insurance, Summary Report, Market Conduct Exam, Reviewing Health Insurance Carriers' Provider Directory Information. Gary D. Anderson, Commissioner of Insurance, June 2018, https://www.mass.gov/doc/provider-information-report-6-12-2018/download; Senate Committee on Finance, Major Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks, May 3, 2023 https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf; Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid, Jane M Zhu et al, July 2022, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052.

48 After the stakeholder interviews were conducted, the Division of Insurance promulgated new provider directory regulations to address accuracy of provider directories for both medical and behavioral health providers. 211 Mass. Code Regs. 52.15.

49 For example, "the Massachusetts Medical Society (MMS) is opposed to mental health carve-outs for the provision of behavioral health services because of concerns regarding the impact of carve-out arrangements on patient access to high quality health care. These concerns include lack of parity in payment and processes, fragmentation of the medical and mental health care systems; management techniques which limit provider networks; adherence to patient confidentiality; and the disruption of communication, collaboration, and continuity of care for patients with mental health and substance use disorders." MMS Policy Compendium (1978-2023), p.55.

and/or delays in receiving data from the BHM makes it impossible to calculate the total cost of care when using a BHM, and keeping behavioral health management in-house gives health plans the ability to calculate and analyze the total cost of care for members. Separation of medical and behavioral health management may prevent health plans from enlisting care management and other methods to work with providers to properly care for that patient's needs. A health plan with in-house behavioral health care management emphasized the need to "destigmatize behavioral health." As an example, the health plan mentioned combining the behavioral health hotline and general hotline as an action toward this goal.

However, health plans that use BHMs and the BHMs themselves discussed the importance of integrating behavioral and physical health and their strategies to advance integration. Some health plans with BHMs have chosen to keep or bring care management in-house in an effort to integrate care management for those patients who have both physical and behavioral health needs. Stakeholders stated that BHMs collaborate on clinical care by regularly discussing individual patient care plans with the health plan and sharing data on high cost/high need members with the health plans.

OPERATIONAL ISSUES

The BHMs and health plans that use BHMs in Massachusetts work together closely to manage behavioral health for their member populations. Health plans and BHMs reported that staff from the two entities meet anywhere from daily to weekly. Health plans also described oversight meetings with larger groups of staff at both entities monthly. Health plans and BHMs confirmed that there is no direct health plan access to the claims system, but the health plans are given downloads at intervals determined by the contract. For example, health plans reported receiving lists of patients boarding in emergency departments daily from their contracted BHM.

Some health plans that use BHMs reported that they do not have a behavioral health medical director at the health plan, but use operational, and in some cases clinical, staff to manage the contract. Several health plans in Massachusetts who use BHMs still provide the case management in-house. In those instances, care management staff at the health plan meet often with utilization review staff at the BHM to share information and clinical strategies for high needs patients. One health plan that outsources behavioral health care management reported that staff at the BHM attend the health plan's medical surgical care management meetings to coordinate care for those members with dual needs.

Despite this coordination, providers and patient advocates stated that operational challenges remain. Many of the described operational challenges with using a BHM stem from the inherent issues with having two large entities coordinate with each other. First, BHM staff often manage multiple health plan accounts, and providers stated that BHM staff do not always understand the rules or systems specific to each health plan. Second, providers noted that BHMs and health plans use separate IT systems, and these separate systems do not always interface well. For example, providers stated that there can be delays in updating the BHMs' systems such that BHM staff may not have up-to-date eligibility, appeals, or other member information.

Some stakeholders highlighted difficulties that can arise when dealing with two separate entities from an operational perspective. Providers stated that there is sometimes confusion as to where to submit claims for services that fall in the grey area between behavioral health and physical health or for services that implicate both, like billing for a psychiatric stay within an acute care hospital. Providers and patient advocates stated that patients can get confused by having to deal with two separate entities, including who they should contact for assistance. When issues arise, providers and patient advocates stated that it can be burdensome to reach a solution as the issue gets bounced between two different entities. Providers and patient advocates stated that issues that need escalation often get "stuck" without resolution. For this reason, some stakeholders expressed a desire for direct state oversight of BHMs.

ANALYSIS

To examine the effect of Behavioral Health Managers (BHM) on accessibility and quality of behavioral health services, the HPC examined NCQA Health Effectiveness and Data Information Set (HEDIS) behavioral health measures for both commercial and MassHealth lines of business. NCQA HEDIS allows health plans, consumers, and providers to evaluate health care plan performance. Health plans wishing to be NCQA accredited must annually submit data attesting to a slate of HEDIS measures. This report focuses on measures that reflect behavioral health quality and access to care. These measures are often used by health plans in contracts with BHMs as a way of evaluating effectiveness in providing behavioral health care to their membership.

Health plans may require that BHMs meet certain targets for a set of HEDIS behavioral health measures as part of their contracts.

HPC focused on two domains of HEDIS behavioral health measures: Effectiveness of Care and Access/Availability of Care. Most HEDIS behavioral health measures fall under the Effectiveness of Care domain and evaluate if patients are receiving appropriate follow-up care or monitoring for their conditions (e.g., having a follow-up appointment for a mental health disorder within 7 days of having an emergency department visit for a mental health disorder). The Access/Availability of Care domain includes an assessment of access to initial care (e.g., engaging children and adolescents in psychosocial care prior to a new prescription for antipsychotic medication). A complete list of measures examined with a brief description can be found in Appendix A. Results with measures specific to children's behavioral health care can be found in Appendix C.

NCQA BEHAVIORAL HEALTH QUALITY MEASURE ANALYSIS

As noted above, commercial health plans engage BHMs in a variety of ways, ranging from no use of BHMs, use of BHMs for specific populations, and use of BHMs for a range of activities (that may or may not include case management). HPC categorized commercial health plans as having outsourced a substantial amount of behavioral health management to a BHM ("yes") or as having none to very few members covered by a BHM ("no").

For the MassHealth population, HPC was able to obtain HEDIS rates for five health plans that seek accreditation for their MassHealth line of business. MassHealth requires health plans participating as a MassHealth ACO or MCO to be NCQA accredited. In addition, MassHealth reports out select behavioral health measures for their ACOs, MCOs, One Care plans, Senior Care Option plans, MBHP, and their Primary Care Clinician program.[50] Four out of the five health plans that have a MassHealth line of business have their behavioral health services managed by Optum, Carelon or MBHP.

Due to licensing agreements, this report shows behavioral health HEDIS measures in relationship to national percentiles for that measure (e.g., did a given Massachusetts health plan do worse, similar, or better than the 75th percentile score for the nation for patients receiving behavioral health follow-up care within seven days after an emergency room visit for mental health). Both MassHealth and commercial measures are evaluated against the same benchmark values (e.g., national 75th percentile). These measures factored in NCQA reported 95% confidence intervals. If a measure value's 95% confidence interval contained the national benchmark value (e.g., the 75th percentile), that measure was noted as being "near" the 75th percentile.

COMMERCIAL ANALYSIS OF HEDIS MEASURES

Overall, Massachusetts commercial health plans perform quite well compared to national standards especially for mental illness related measures. For follow-up after emergency department and follow-up after hospital stays for mental illness, all plans were above or near the 75th percentile nationally (**Table 1**).

For the ED and high intensity stay follow-up measures for substance use related visits and stays, Massachusetts commercial health plans continued to perform better or near the 75th percentile for ED visits but did not perform as well for follow-up after high-intensity care for SUD. Three of the eleven plans evaluated scored below the 50th percentile for follow-up after high intensity care for SUD after both 7 days and 30 days. This indicates that these plans were doing less well than half the NCQA accredited health plans in the U.S. for connecting patients to care after inpatient treatment. All three of these plans do not use a BHM (two BCBS plans and one HNE plan).

50 For more information on the MassHealth performance measures and quality measure reports see: https://www.mass.gov/info-details/masshealth-quality-reports-and-resources#masshealth-performance-measure-reports/quality-reports-.

Table 1. NCQA HEDIS Follow-up after Emergency Department and Hospitalization Effectiveness of Care Measures for Mental Illness Measures for Massachusetts Commercial Health Plans, 2022

Plan	BHM	Follow-Up After ED Visit for MI - 7 days	Follow-Up After ED Visit for MI - 30 days	Follow-Up After Hospitalization For MI - 7 days	Follow-Up After Hospitalization For MI - 30 days
Cigna HMO/POS/PPO/EPO	Yes - Evernorth	1	1	1	1
Harvard Pilgrim Health Care HMO/POS	Yes - Optum	1	1	1	1
Harvard Pilgrim Health Care PPO	Yes - Optum	1	1	1	1
Mass General Brigham Health HMO	Yes- Optum	1	1	1	1
United POS/PPO	Yes - Optum	1	1	1	1
Aetna PPO/EPO Combined	No	1	1	1	1
BCBSMA HMO Blue HMO/POS	No	1	1	1	1
BCBSMA PPO	No	1	1	1	1
Health New England HMO/POS	No	1	1	1	1
Tufts Benefits Admin PPO	No	1	1	1	1
Tufts Health Plan HMO/POS/EPO	No	1	1	1	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: The BHM category (yes/no) is based on stakeholder's response to questions during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but the actual contracts and services do vary across payers and plans. Likewise, for the "no" category, some plans may have a small portion of members whose care is managed by a BHM. For example, some payers may act as a third-party administrator to self-insured employers who use a BHM separately from the third-party administrator contract for medical/surgical coverage. United Health Group and Cigna were both characterized as using a BHM because they engage a corporate subsidiary for their BHM. Although Tufts Health Plan (THP) and Harvard Pilgrim Health Care (HPHC) have merged and now are Point32 Health–for this HEDIS reporting year they reported as separate entities. HPHC is listed as using a BHM because HPHC was contracted with Optum for the entirety of 2022.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Table 2. NCQA HEDIS Follow-up after Emergency Department and Hospitalization Effectiveness of Care Measures for Substance Use Measures for Massachusetts Commercial Health Plans, 2022

Plan	BHM	Follow-Up After ED Visit for Substance Use - 7 days	Follow-Up After ED Visit for Substance Use - 30 days	Follow-Up After High-Intensity Care for SUD - 7 Days	Follow-Up After High-Intensity Care for SUD - 30 Days
Cigna HMO/POS/PPO/EPO	Yes - Evernorth	1	1	1	1
Harvard Pilgrim Health Care HMO/POS	Yes - Optum	1	1	3	2
Harvard Pilgrim Health Care PPO	Yes - Optum	1	1	1	1
Mass General Brigham Health HMO	Yes - Optum	1	1	1	2
United POS/PPO	Yes - Optum	1	1	1	1
Aetna PPO/EPO Combined	No	1	1	1	1
BCBSMA HMO Blue HMO/POS	No	1	1	3	3
BCBSMA PPO	No	1	1	3	3
Health New England HMO/POS	No	1	1	3	3
Tufts Benefits Admin PPO	No	1	1	1	1
Tufts Health Plan HMO/POS/EPO	No	1	1	2	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: The BHM category (yes/no) is based on stakeholder's response to questions during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but the actual contracts and services do vary across payers and plans. Likewise, for the "no" category, some plans may have a small portion of members whose care is managed by a BHM. For example, some payers may act as a third-party administrator to self-insured employers who use a BHM separately from the third-party administrator contract for medical/surgical coverage. United Health Group and Cigna were both characterized as using a BHM because they engage a corporate subsidiary for their BHM. Although Tufts Health Plan (THP) and Harvard Pilgrim Health Care (HPHC) have merged and now are Point32 Health–for this HEDIS reporting year they reported as separate entities. HPHC is listed as using a BHM because HPHC was contracted with Optum for the entirety of 2022.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Overall, only five of the eleven commercial health plans scored near or above the 75th percentile for initiation and engagement for substance use disorder treatment. Four of five plans with a BHM scored near or above the 75th percentile for engagement in substance use disorder treatment. With two exceptions, Massachusetts commercial health plans scored near or above the 75th percentile nationally for pharmacotherapy for opioid use disorder.

HEDIS has several measures that relate to appropriate psychotropic medicine prescribing and follow-up. Table 4 examines several of these measures including measures related to appropriate follow-up care for children. Overall, most Massachusetts commercial health plans score near or above the 75th percentile for all measures examined. However, several measures did not have a rating, due to insufficient volume of members for a reporting score.

Table 3. NCQA HEDIS Substance Use Disorder Treatment Quality Measures for Massachusetts Commercial Health Plans, 2022

Plan	BHM	Initiation of SUD Treatment	Engagement of SUD Treatment	Pharmacotherapy for OUD
Cigna HMO/POS/PPO/EPO	Yes - Evernorth	1	1	2
Harvard Pilgrim Health Care HMO/POS	Yes - Optum	2	1	1
Harvard Pilgrim Health Care PPO	Yes - Optum	1	1	-
Mass General Brigham Health HMO	Yes - Optum	2	1	1
United POS/PPO	Yes - Optum	2	2	1
Aetna PPO/EPO Combined	No	2	2	1
BCBSMA HMO Blue HMO/POS	No	1	2	1
BCBSMA PPO	No	1	2	2
Health New England HMO/POS	No	3	2	1
Tufts Benefits Admin PPO	No	1	1	-
Tufts Health Plan HMO/POS/EPO	No	2	2	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: '-' means that no rate was reported. The BHM category (yes/no) is based on stakeholder's response to questions during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but the actual contracts and services do vary across payers and plans. Likewise, for the "no" category, some plans may have a small portion of members whose care is managed by a BHM. For example, some payers may act as a third-party administrator to self-insured employers who use a BHM separately from the third-party administrator contract for medical/surgical coverage. United Health Group and Cigna were both characterized as using a BHM because they engage a corporate subsidiary for their BHM. Although Tufts Health Plan (THP) and Harvard Pilgrim Health Care (HPHC) have merged and now are Point32 Health–for this HEDIS reporting year they reported as separate entities. HPHC is listed as using a BHM because HPHC was contracted with Optum for the entirety of 2022.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Table 4. NCQA HEDIS Medication Adherence and Medication Management Measures for Massachusetts Commercial Health Plans, 2022

Plan	BHM	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Antidepressant Medication Management - Effective Acute Phase Treatment	Antidepressant Medication Management - Effective Continuation Phase Treatment
Cigna HMO/POS/PPO/EPO	Yes - Evernorth	2	1	1
Harvard Pilgrim Health Care HMO/POS	Yes - Optum	1	1	1
Harvard Pilgrim Health Care PPO	Yes - Optum	-	1	1
Mass General Brigham Health HMO	Yes - Optum	-	1	1
United POS/PPO	Yes - Optum	1	2	1
Aetna PPO/EPO Combined	No	1	1	1
BCBSMA HMO Blue HMO/POS	No	1	2	2
BCBSMA PPO	No	1	2	1
Health New England HMO/POS	No	-	1	1
Tufts Benefits Admin PPO	No	-	1	1
Tufts Health Plan HMO/POS/EPO	No	1	1	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: '-' means that no rate was reported. The BHM category (yes/no) is based on stakeholder's response to questions during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but the actual contracts and services do vary across payers and plans. Likewise, for the "no" category, some plans may have a small portion of members whose care is managed by a BHM. For example, some payers may act as a third-party administrator to self-insured employers who use a BHM separately from the third-party administrator contract for medical/surgical coverage. United Health Group and Cigna were both characterized as using a BHM because they engage a corporate subsidiary for their BHM. Although Tufts Health Plan (THP) and Harvard Pilgrim Health Care (HPHC) have merged and now are Point32 Health - for this HEDIS reporting year they reported as separate entities. HPHC is listed as using a BHM because HPHC was contracted with Optum for the entirety of 2022. See Appendix for pediatric measures.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Overall, plans with BHMs and plans without BHMs seem to perform highly compared to national benchmarks, with Massachusetts commercial plans often performing near or above the 75th percentile. However, BHMs may do a better job of engaging people with substance use disorder in care as they performed better on follow-up after high-intensity care for SUD and for engagement of SUD treatment than health plans without BHMs.

MASSHEALTH ANALYSIS OF HEDIS MEASURES

Because four of the five plans with MassHealth lines of business use a BHM for most BHM-related services, it is challenging to evaluate the impact of behavioral health managers on access to and use of behavioral health services as there is only one plan that does not engage a BHM. Overall, health plans did well on follow-up after ED visits for mental illness, with all plans performing above the 75th percentile nationally. However, only two plans – Fallon and Tufts Health Plan were near or above the 75th percentile for follow-up after hospitalization measures. The remaining plans are near the 50th percentile or higher.

For follow-up after an emergency visit for substance use, MassHealth plans scored above or near the 75th percentile nationally for follow-up for substance use for both ED and high intensity treatment settings. The only exception was that MGBHP scored near the 50th percentile for follow-up within 7 days of a high intensity treatment.

Table 5. NCQA HEDIS Follow-up After Emergency Department Visits and Hospitalization for Mental Illness Measures for MassHealth Plans, 2022

Plan	BHM	Follow-Up After ED Visit for MI - 7 days	Follow-Up After ED Visit for MI - 30 days	Follow-Up After Hospitalization For MI - 7 days	Follow-Up After Hospitalization For MI - 30 days
Fallon Health	Yes - Carelon	1	1	1	1
Health New England	Yes - MBHP	1	1	2	2
Mass General Brigham Health	Yes - Optum	1	1	2	2
WellSense Health Plan MA	Yes - Carelon	1	1	2	2
Tufts Health Plan	No	1	1	1	1

1 **Near or above 75th percentile** 2 **Near or above 50th percentile** 3 **Below 50th percentile**

Notes: The BHM category (yes/no) is based on what had been conveyed to MA HPC during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but that the actual contracts and services do vary across payers and plans.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Table 6. NCQA HEDIS Substance Use Disorder Treatment Quality Measures for MassHealth Plans, 2022

Plan	BHM	Follow-Up After ED Visit for Substance Use - 7 days	Follow-Up After ED Visit for Substance Use - 30 days	Follow-Up After High-Intensity Care for SUD - 7 Days	Follow-Up After High-Intensity Care for SUD - 30 Days
Fallon Health	Yes - Carelon	1	1	1	1
Health New England	Yes - MBHP	1	1	1	1
Mass General Brigham Health	Yes - Optum	1	1	2	1
WellSense Health Plan MA	Yes - Carelon	1	1	1	1
Tufts Health Plan	No	1	1	1	1

1 **Near or above 75th percentile** 2 **Near or above 50th percentile** 3 **Below 50th percentile**

Notes: The BHM category (yes/no) is based on what had been conveyed to MA HPC during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but that the actual contracts and services do vary across payers and plans.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Table 7. NCQA HEDIS Medication Adherence and Medication Management Measures for MassHealth Plans, 2022

Plan	BHM	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Antidepressant Medication Management - Effective Acute Phase Treatment	Antidepressant Medication Management - Effective Continuation Phase Treatment	Pharmacotherapy for OUD
Fallon Health	Yes - Carelon	1	2	1	1
Health New England	Yes- MBHP	1	3	3	1
Mass General Brigham Health	Yes- Optum	2	3	3	3
WellSense Health Plan MA	Yes- Carelon	2	2	2	2
Tufts Health Plan	No	1	1	1	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: The BHM category (yes/no) is based on what had been conveyed to MA HPC during stakeholder meetings. The "yes" category just indicates that there is a substantial reliance on the BHM but that the actual contracts and services do vary across payers and plans. See Appendix for pediatric measures.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Finally, the medication adherence and follow-up measures for MassHealth plans were more mixed in terms of performance against national benchmarks. Most plans did well for initiating pharmacotherapy for opioid use disorder (above or near 75th percentile). Only Tufts Health Plan, the only plan not managed by a BHM, had scores near or above the 75th percentile for all six measures examined.

Overall, Tufts Health Plan was uniformly above or near the 75th percentile for every HEDIS metric evaluated for their MassHealth line of business. The remaining health plans with MassHealth lines of business that used BHMs mostly performed near or above the 50th percentile for all metrics except for medication adherence measures. However, there was also variability in performance within the health plans that engage a BHM (e.g. Fallon was only below the 75th percentile for 2 measures). Since only one health plan did not use a BHM for their MassHealth line of business and since there was some variability within BHM performance for the remaining MassHealth lines of business, there is not a clear conclusion on the influence of BHMs on behavioral health access and outcomes for MassHealth members in the Commonwealth.

SUMMARY

Overall, Massachusetts health plans perform highly for HEDIS behavioral health quality measures compared to national benchmarks for both commercial and MassHealth lines of business. The areas with the greatest variation among plans were for follow-up after high intensity care for substance use treatment and medication adherence metrics. There was no significant data to indicate that plans that engaged BHMs provided better (or worse) quality care to their members.

SUMMARY AND POLICY RECOMMENDATIONS

Behavioral Health Managers (BHM) continue to be used by both commercial and MassHealth plans and are integrated into the Commonwealth's health care delivery landscape. While the specific functions and services provided by BHMs vary, most Massachusetts commercial and MassHealth plans utilize BHMs for some or all functions regarding the provision of behavioral health care to their members.

Consistent with other states, BHMs are subject to regulatory oversight in Massachusetts primarily through their relationship with health plans. The contractual arrangements between health plans and BHMs outline the relationship between the entities and the responsibilities of the BHM. Health plans remain responsible for compliance with all regulatory requirements, including any contractually delegated to the BHM.

Massachusetts health plans that use BHMs and those that do not both perform well on behavioral health HEDIS quality measures. The HPC's analysis did not identify evidence of other quality, access, cost or outcome differences for members.

Stakeholder interviews highlighted the reliance of health plans in Massachusetts on the services offered by BHMs, particularly on existing behavioral health provider networks and specific expertise which such companies may provide. However, stakeholder interviews also revealed operational issues that can occur when BHMs are used which can create challenges for providers, patients, and regulators in communicating with BHMs and enforcing health plan compliance. Future policymaking on BHMs could address these operational challenges. In accordance with Chapter 177 of the Acts of 2022, the HPC makes the following recommendations to the legislature regarding BHMs.

GREATER TRANSPARENCY FOR STATE REGULATORS AND CONSUMERS

BHMs are used to manage behavioral health care services for both public and commercial health plan members across Massachusetts. There are opportunities to enhance transparency about the relationship between the health plan and the BHM and for regulators, consumers, and providers. The Commonwealth should:

- Establish requirements for health plans to report information on use of BHMs to DOI.
- Require that health plan contracts with BHMs identify a contact person from the BHM authorized to give information to DOI to resolve complaints.
- Ensure that new DOI requirements for provider directories apply to BHM networks.

IMPROVED HEALTH PLAN INTEGRATION

Health plans that manage behavioral health in-house and those that utilize BHMs agree on the importance of integration of physical and behavioral health care. Some stakeholders using BHMs reported integration challenges, including challenges arising out of communication between the organizations. Contracts between health plans and BHMs can address the challenges and ease integration. The HPC recommends requiring the following contractual terms to improve integration between health plans and BHMs:

- Require that contracts between health plans and BHMs identify a state or account specific contact person from the BHM for communication and case escalation.
- Require that contracts between health plans and BHMs establish a plan for integration of behavioral and physical health care services/management.
- Require that contracts between health plans and BHMs establish a process for investigating and resolving any issues with integration.

AREAS FOR FUTURE RESEARCH AND MONITORING

To continue understanding the impact and role of BHMs in the Commonwealth, the HPC highlights the following areas for future research and monitoring:

- Continued monitoring BHM use in the Commonwealth's health care market.
- Review of contracts between health plans and BHM contracts with health plans submitted to the DOI.

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Coleen Elstermeyer
Deputy Executive Director

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The HPC received valuable input and assistance from other state agencies, including the Division of Insurance, MassHealth, and the Group Insurance Commission.

APPENDIX A.
SELECT BEHAVIORAL HEALTH HEDIS MEASURES AND BRIEF DESCRIPTIONS

Measure Name	Measure Description
Follow-Up After Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.
Follow-Up After Emergency Department Visit for Mental Illness	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After High-Intensity Care for Substance Use Disorder	The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After High-Intensity Care for Substance Use Disorder	The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported: 1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge. 2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.
Initiation and Engagement of Substance Use Disorder Treatment	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Pharmacotherapy for Opioid Use Disorder	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of OUD.
Antidepressant Medication Management	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Follow-Up Care for Children Prescribed ADHD Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Source: Description found at https://www.ncqa.org/wp-content/uploads/2021/12/HEDIS-MY-2022-Measure-Descriptions.pdf

APPENDIX B.
HEDIS METHODOLOGY

For this report, the HPC procured behavioral health HEDIS measures in order to compare health plans' relative performance on the quality measures found in Appendix A.[51] The HPC assessed each plan's measure rate 95th confidence interval relative to the NCQA-specified national benchmark percentile for each measure. If the plan's measure rate confidence interval values were above or near the 75th percentile for all health plans that submitted to NCQA (e.g. the plan confidence interval included the 75th percentile for the nation), the plan measure was marked as "near or above the 75th percentile." If the plan's measure rate confidence intervals were above or near the 50th percentile for the nation, but not above the or near the 75th percentile for the nation, the plan measure was marked as "Near or above the 50th percentile". Finally, if a plan's measure rate confidence intervals were below the 50th percentile, then the plan measure was marked as below the 50th percentile. For example, if a plan had a rate of 60% (95% confidence interval 55%-65%) and the 75th percentile for the nation was 56%, the plan measure would be marked as "Near or above the 75th percentile". For more information on how NCQA derives HEDIS measure rates, confidence intervals, and national percentiles please see: https://www.ncqa.org/wp-content/uploads/2021/04/20210426_2022_HPR_Methodology.pdf

51 The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the Data") is Quality Compass® 2023 and is used with the permission of the National Committee for Quality Assurance ("NCQA"). Any analysis, interpretation or conclusion based on the Data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA. The Data comprises audited performance rates and associated benchmarks for Healthcare Effectiveness Data and Information Set measures ("HEDIS®") and HEDIS CAHPS® survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or clinician that uses or reports performance measures or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in Quality Compass and the Data, or NCQA has obtained the necessary rights in the Data, and can rescind or alter the Data at any time. The Data may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the Data without modification for an internal, noncommercial purpose may do so without obtaining approval from NCQA. All other uses, including a commercial use and/or external reproduction, distribution or publication, must be approved by NCQA and are subject to a license at the discretion of NCQA. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

APPENDIX C.
ADDITIONAL NCQA HEDIS BEHAVIORAL HEALTH MEASURES FOR CHILDREN

Table 4. Cont.

Plan	BHM	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Cigna HMO/POS/PPO/EPO	Yes - Evernorth	1	1	1
Harvard Pilgrim Health Care HMO/POS	Yes - Optum	1	1	1
Harvard Pilgrim Health Care PPO	Yes - Optum	1	1	-
Mass General Brigham Health HMO	Yes - Optum	1	-	-
United POS/PPO	Yes - Optum	1	1	-
Aetna PPO/EPO Combined	No	1	1	1
BCBSMA HMO Blue HMO/POS	No	1	1	1
BCBSMA PPO	No	1	1	1
Health New England HMO/POS	No	1	-	-
Tufts Benefits Admin PPO	No	1	-	-
Tufts Health Plan HMO/POS/EPO	No	1	1	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: '-' means that no rate was reported. The BHM category (yes/no) is based on stakeholder's response to questions during stakeholder meetings. The "yes" category indicates that there is a substantial reliance on the BHM but the actual contracts and services do vary across payers and plans. Likewise, for the "no" category, some plans may have a small portion of members whose care is managed by a BHM. For example, some payers may act as a third-party administrator to self-insured employers who use a BHM separately from the third-party administrator contract for medical/surgical coverage. United Health Group and Cigna were both characterized as using a BHM because they engage a corporate subsidiary for their BHM. Although Tufts Health Plan (THP) and Harvard Pilgrim Health Care (HPHC) have merged and now are Point32 Health - for this HEDIS reporting year they reported as separate entities. HPHC is listed as using a BHM because HPHC was contracted with Optum for the entirety of 2022.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

Table 7. Cont.

Plan	BHM	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase
Fallon Health	Yes - Carelon	2	1
Health New England	Yes- MBHP	3	1
Mass General Brigham Health	Yes- Optum	3	-
WellSense Health Plan MA	Yes- Carelon	3	2
Tufts Health Plan	No	1	1

1 Near or above 75th percentile 2 Near or above 50th percentile 3 Below 50th percentile

Notes: The BHM category (yes/no) is based on what had been conveyed to MA HPC during stakeholder meetings. The "yes" category just indicates that there is a substantial reliance on the BHM but that the actual contracts and services do vary across payers and plans.

Source: HPC analysis of NCQA HEDIS Quality Reporting, RY2022

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEALTH POLICY COMMISSION
50 Milk Street, 8th Floor
Boston, MA 02109
MassHPC.gov