Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending

By Vinayak Sinha and Janice Bourgault

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Introduction

Background

States are facing an unprecedented rise in the rates of behavioral health conditions. To address this health crisis, state policymakers are increasingly focused on identifying ways to improve access to high-quality behavioral health care, including defining and tracking how much payers spend to treat behavioral health conditions. Understanding how much is spent and on what services is the first step to knowing if spending is sufficient to support a growing need. Several states plan to use the data to set targets for how much payers should spend on behavioral health clinical services.

Purpose

In April 2024, the Milbank Memorial Fund (Milbank) in collaboration with Freedman HealthCare (FHC) published Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. These recommendations were developed with input from an Advisory Group of state behavioral health leaders and subject matter experts. The FHC and Milbank teams used the Advisory Group recommendations to develop a code set (Appendix A) to support more standardized measurement of behavioral health spending across states.

This document provides technical specifications to support states in implementing the code set. Informed by stakeholder feedback, the specifications provide a base for

implementation that states can modify to reflect their measurement priorities and stakeholder needs.

Methodology Overview

The standardized methodology focuses on clinical behavioral health spending paid by health care payers (Appendix C). It includes approaches to measuring claims and non-claims spending and separates all behavioral health clinical spending into mental health (MH) spending and substance use disorder (SUD) spending.

Claims: Spending paid via claims is organized into subcategories that allow for more granular analysis by states and can be rolled up into higher level categories for reporting (Table 1). A decision tree (Figure 1) and code-level specifications (Appendix A: Service Category Specifications) guide allocating spending to these subcategories.

Table 1. Organizing Behavioral Health Clinical Spending Paid via Claims

Service Category	Subcategories
Inpatient	▯ Inpatient – Facility ▯ Long-Term Care ▯ Residential Care*
Outpatient	▯ Emergency Department/Observation – Facility ▯ Outpatient Facility Non-Primary Care ▯ Mobile Services
Professional	▯ Inpatient – Professional ▯ Emergency Department/Observation – Professional ▯ Outpatient Professional Primary Care ▯ Outpatient Professional Non-Primary Care
Other	▯ Other Behavioral Health Services
Prescription Drugs	▯ SUD Prescription Drug Treatments ▯ MH Prescription Drug Treatments

*Residential care may be included in the inpatient or outpatient category to align with state measurement use cases and priorities.

Non-Claims: The standardized methodology categorizes non-claims behavioral health spending using the Expanded Non-Claims Payment Framework (Expanded Framework), (Appendix B). The California Department of Health Care Access and Information and Freedman HealthCare developed the Expanded Framework to categorize non-claims payments by health care payers to provider organizations. The Expanded Framework offers the ability to understand both the intent of the payment and the level of financial risk assumed by providers. These technical specifications define

non-claims behavioral health spending using a subset of the Expanded Framework categories.

Reporting Spending: The methodology supports reporting behavioral health spending across several dimensions including claims and non-claims spending, by service category and subcategory. Similar to reporting primary care and other types of spending, behavioral health spending may be reported as a total; a per member, per month amount; and as a percentage of total spending. Behavioral health spending is also sometimes reported as a portion of total spending only for individuals with a behavioral health diagnosis. States may choose to report any of these figures in total, by payer, by geography, by provider organization, or by demographic factors.

Allowing for Flexibility: The standardized methodology also allows states flexibility to reflect priorities and stakeholder needs. These options are discussed throughout the technical specifications and include the following:

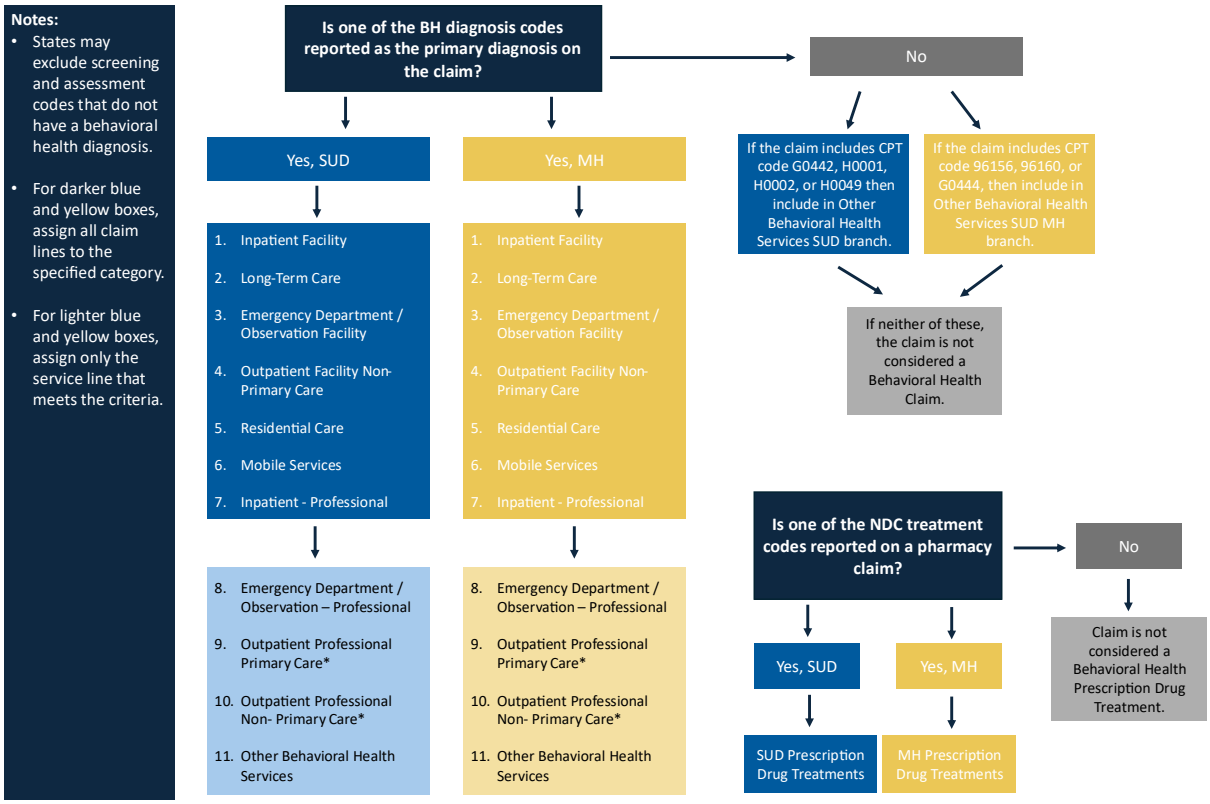
- Isolating spending on behavioral health in primary care
- Including spending when the behavioral health diagnosis is not the primary diagnosis
- Using type of bill codes instead of revenue codes to categorize spending in certain care settings
- Aggregating certain categories of non-claims payment, such as capitation

Claims-Based Clinical Spending

The standardized methodology uses a decision tree (Figure 1) to identify behavioral health clinical spending paid via claims. The decision tree provides a hierarchical order to identify and aggregate claims based on: Diagnosis, Service, Care Setting, and Treatment. The methodology does not require services to be delivered by providers with specific taxonomies. The only exception is an optional component to isolate behavioral health spending in primary care. This is discussed more in Identifying Behavioral Health Spending in Primary Care.

As noted above, the methodology separates behavioral health clinical spending into MH spending and SUD spending. Data submitters should report allowed amounts as they are more likely to capture the full payment.

Figure 1. Measurement Decision Tree



***Note**: States may choose to collect Outpatient Professional Primary Care and Outpatient Professional Non-Primary Care separately or as a single Outpatient Professional subcategory.

Categorizing Claims-Based Spending

Step 1: Diagnoses — Identify all medical claims for patients with a behavioral health primary diagnosis based on the list of International Classification of Diseases, Tenth Revision, (ICD-10) codes provided in the code set. The code set indicates whether spending associated with each diagnosis code should be classified as SUD or MH spending. Put this population aside until Step 2.

Step 1a: Screening and Assessment — Individuals receiving screening and assessment for behavioral health conditions may not have a primary behavioral health diagnosis but spending for these services should be included. For patients without a behavioral health primary diagnosis, identify medical claims with Current Procedural Terminology (CPT) codes G042, H0001, H0002, and H0049. Classify these claims as SUD spending in the "Other Behavioral Health Services" subcategory regardless of the patient's diagnosis. Similarly, identify medical claims with CPT codes 96156, 96160, or G0444 and classify these claims as MH spending in the "Other Behavioral Health

Services" subcategory. Note that these services are also included in service categories for patients with a behavioral health diagnosis.

Step 2: Services and Care Settings — For patients with a behavioral health condition, use the list of codes and the decision tree to categorize medical spending into discrete, mutually exclusive service subcategories. Service subcategories are defined by either care setting codes, such as place of service or revenue codes, or by a combination of services and care settings. Note that each service category is mutually exclusive, and its spending will be included in SUD or MH spending as identified in the Measurement Decision Tree based on the specific ICD-10 diagnosis code.

Optional: The recommended methodology to identify spending in certain care settings is to use revenue codes. An alternative approach could be to use type of bill codes. States should consider working with data submitters or claims database administrators to do sensitivity testing to see which fields are populated with high quality, reliable data.

Detailed information on the methodology and specific codes for each subcategory is provided in Appendix A: Service Category Specifications. As shown in Table 1 above, service subcategories can be rolled up into more aggregate categories to support reporting.

For some subcategories, data submitters should include all claim lines associated with the identified care setting codes. For other subcategories, data submitters should include only claims with the combination of specific Current Procedural Terminology and Healthcare Common Procedure Coding System codes (CPT/HCPCS codes) and care setting codes. The Service Category Specifications specify the approach for each subcategory.

Claims with a primary behavioral health diagnosis that do not fall into any other service categories should be included in the "Other Behavioral Health Services" category.

Step 4: Treatments — Next, data submitters should identify pharmacy claims with a prescription drug National Drug Code (NDC) in the code set. Spending on these treatments should be classified as SUD prescription drug treatments or MH prescription drug treatments, according to the guidance in the code set.

Note that pharmacy claims are often missing diagnosis codes. Therefore, the standardized methodology does not require a primary behavioral health diagnosis on the pharmacy claim and there may be instances when the drug is prescribed to treat non-behavioral health conditions. While prescription drug spending to treat behavioral

health conditions may be inflated, it is important to understand trends over time and include this indicator of behavioral health spending.

Non-Claims Clinical Spending

The Expanded Non-Claims Payments Framework categorizes non-claims payments from health care payers to provider organizations. The framework gives states the ability to understand both the intent of the payment and the level of financial risk borne by providers. Expanded Framework categories and their associated Health Care Payment Learning & Action Network (HCP-LAN) categories are included in Appendix B. These technical specifications identify all spending in two non-claims payments categories as behavioral health clinical spending: Integrated Behavioral Health and Behavioral Health Capitation. The methodology also includes an approach to allocate portions of the following categories to behavioral health clinical spending: Professional Capitation, Global Capitation, Payments to Integrated Payment and Delivery Systems, and Other Non-Claims Payments.

Note: States in which health care payer organizations do not have significant capitation and full risk payments may choose not to require data submitters to calculate the portion of the payments to treat patients with behavioral health conditions. Therefore, not including portions of capitation toward behavioral health spending.

Categorizing Non-Claims Spending

Step 1: **Allocate all Integrated Behavioral Health and Behavioral Health Capitation Payments** — All payments for integrated behavioral health in primary care and behavioral health capitation should be included as behavioral health clinical spending. These payments should each be tracked as a distinct service category.

Step 2: Allocate a portion of Professional and Global Capitation Payments — To apportion professional capitation payments to behavioral health, data submitters should identify all behavioral health encounters using the code set. Services must meet all requirements to be counted as behavioral health.

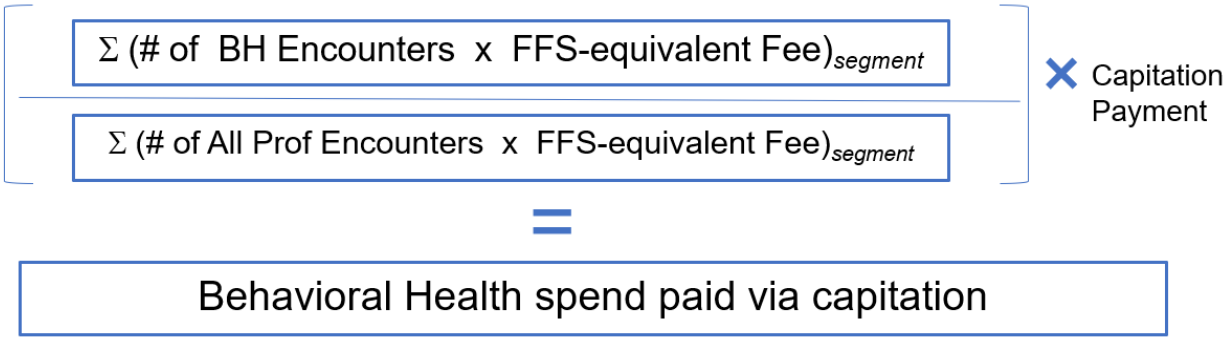
Then, data submitters should multiply each behavioral health encounter by its fee-for-service (FFS) equivalent fee. Next, data submitters should multiply all other encounters covered under the professional capitation by their FFS equivalent fees. Fee schedules used should represent the payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate. Each combination of these elements is a different “segment.”

Data submitters should then divide the behavioral health FFS equivalent payments by the sum of all other FFS equivalent payments paid under the capitation. This ratio is the

percent of all encounter payments that went to behavioral health services. Finally, that ratio is multiplied by the distinct capitation payment to the provider organization. The result is the portion of the capitation payment allocated to behavioral health. Professional capitation payments apportioned to behavioral health for each provider organization are then summed to arrive at a total for the category.

The steps above are then repeated for Global Capitation.

Figure 2: Calculating the Behavioral Health Portion of Professional or Global Capitation



Note: The above formula should applied to each type of payment (i.e., professional, global, integrated) separately.

Step 3: Allocate a portion of payments to Integrated Payment and Delivery Systems —Data submitters should follow the same approach as used for professional and global capitation categories. Payments apportioned to behavioral health for each integrated system should be added together to arrive at a total.

If behavioral health services are carved out of the contract with the integrated system, the behavioral health spending should be included in another appropriate category, such as behavioral health capitation or through the claims-based behavioral health clinical spending measurement.

Step 4: Allocate a portion of Other Non-Claims Payments — Data submitters should include payments made to third-party providers to support patients with behavioral health conditions, as data is available. Data submitters should identify the organization receiving the payment and describe the relevant services provided.

Patients with behavioral health conditions often may receive additional services and care management from payers themselves. States should consider whether a portion of payers' internal investments should be included in their measurement of behavioral health clinical spending. States that include this spending should modify the definition of the "Other Non-Claims Payments" category to accommodate.

These payments have not been included in behavioral health clinical spending to date but may continue to increase as behavioral health investment increases. Some states, such as Delaware, include indirect payer spending in their calculations of primary care spending. These states typically limit the amount of this internal payer investment that can count toward primary care spending.

Common Data Elements and Reporting

While developing this methodology, Advisory Group members expressed interest in including a set of standard fields to support measurement use cases. Fields to capture year, payer type (i.e. Commercial, Medicaid fee-for-service, Medicaid Managed Care, Medicare fee-for-service, Medicare Advantage), product code (i.e. HMO, PPO, Medicare Advantage, Managed Care Organization), payer and member months will support granular analyses of the spending data as a percentage of total medical expense or a per member, per month payment. States should also collect spending by MH and SUD and by the service categories and subcategories discussed in these specifications to allow for the greatest reporting flexibility. States, in consultation with stakeholders, should decide whether the behavioral health spending data is collected and reported at the state, payer, payer and market, or provider organization level. This will inform the level of accountability payers and providers have in achieving the use case, such as a meeting behavioral health investment benchmark.

Appendix A: Service Category Specifications

Service Category Specifications

Inpatient - Facility

Spending for the inpatient facility service category can be identified through the following methodology:

Service Category	Specifications
Inpatient - Facility (Using revenue codes)	**Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has one or more of the following Revenue codes:** (0100, 0101, 0110-0119, 0120-0129, 0130-0139, 0141-0149, 0150-0159, 0160, 0161, 0164, 0167, 0169, 0170-0174, 0179, 0180-0183, 0189, 0200-0204, 0206-0209, 0210-0214, 0219)

Long-Term Care

Spending for the long-term care service category can be identified through the following methodology:

Service Category	Specifications
Long-term Care	**Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has one or more of the following Revenue codes:** (0022, 0024, 0185, 0190, 0191, 0192, 0193, 0194, 0199, 0660)

Emergency Department/Observation Facility

Spending for the emergency department/observation facility service category can be identified through the following methodology:

Service Category	Specifications
Emergency Department / Observation - Facility (no inpatient admission)	**Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has one or more of the following Revenue codes:** (0450-0452, 0456, 0459, 0762, 0769, 0981)

Outpatient Facility Non-Primary Care

Spending for the outpatient facility non-primary care service category can be identified through the following methodology:

Service Category	Specifications

Outpatient Facility Non-Primary Care	**Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has Revenue codes:** (0500, 0509, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0780, 0790, 0900, 0901, 0902, 0903, 0904, 0905, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0918, 0919, 0940, 0941, 0942, 0943, 0944, 0945, 0946, 0947, 0948, 0949, 0951, 0952, 0953, 0960, 0961, 0962, 0963, 0964, 0969, 0982, 0983, 0984, 0985, 0986, 0987, 0988, 0989, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2109, 3101, 3102, 3103, 3104, 3105, 3106)

Residential Care

Spending for the residential care service category can be identified through the following methodology:

Service Category	Specifications
Residential Care	**Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has one or more of the following Revenue codes:** (1001, 1002, 1003, 1004, 1005, 1006) ***or*** one of the following Place of Service codes on a Professional claim: (55, 56) ***or*** **CPT/HCPCS codes:** (H0010 - H0013, H0017 - H0019, H2034)

Mobile Services

Spending for the mobile services service category can be identified through the following methodology:

Service Category	Specifications
Mobile Services	**Report payer paid and member cost-share amounts across all medical claim lines for Professional claims with the following Place of Service code:** (15) ***or*** HCPCS code H2011 ***or*** HCPCS codes S9484 and S9485 only when modifiers HA, HB, HE, UI are present.

Inpatient - Professional

Spending for the inpatient - professional service category can be identified through the following methodology:

Service Category	Specifications
Inpatient - Professional (Using	**Report payer paid and member cost-share amounts across all medical claim lines for Professional claims with the following Place of Service codes** (02, 21, 31, 32, 34, 51,

Place of Service codes [POS])	54, 56, 61) ***and*** **CPT codes: (**99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291, 99292, 99304-99310, 99315, 99316, 99318, 99356, 99357, 99418, 99468-99472, 99475-99480, G0425, G0426, G0427, G0459)

Emergency Department/Observation - Professional

Spending for the emergency department/observation - professional service category can be identified through the following methodology:

Service Category	Specifications
Emergency Department / Observation - Professional (no inpatient admission)	**Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has a Place of Service code of** 23 ***and*** **CPT codes:** (99217-99220, 99224-99226, 99234-99236, 99281-99285, 99288, 99285, 99291, 99292, 99356, 99357, 99418, G0378-G0384, G0425-G0427, G2213).

Outpatient Professional Primary Care

Spending for the outpatient professional primary care service category can be identified through the following methodology:

Service Category	Specifications
Outpatient Professional Primary Care	**Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has Place of Service (POS) codes and, CPT/HCPCS codes with a primary care provider Taxonomy code. Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has POS codes:** (02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 22, 24, 25, 26, 27, 33, 49, 50, 52, 53, 57, 58, 62, 71, 72, 99) ***and,*** **CPT/HCPCS codes:** (90785, 90791, 90792, 90832-90840, 90845-90847, 90849, 90853, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90885, 90887, 90899, 90901, 90912, 90913, 96105, 96116, 96121, 96125, 96127, 96130-96133, 96136-96139, 96146, 96156, 96158, 96159, 96160, 96161, 96164, 96165, 96167, 96168, 96170, 96171, 97110, 97112, 97129, 97130, 97151-97158, 97530, 97535, 97537, 97802-97804, 97810, 97811, 97813, 97814, 98960-98962, 98966-98972, 99050, 99051, 99053, 99056, 99058, 99060, 99078, 99199, 99201-99205, 99211-99215, 99241-99245, 99324-99328, 99334-99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99358, 99359, 99366-99368, 99374, 99375, 99377-99387, 99391-99397, 99401-99404, 99406-99409,

	99411, 99412, 99415-99417, 99421-99423, 99439, 99441-99444, 99446-99449, 99451, 99452, 99483, 99484, 99487, 99489, 99490, 99491, 99492-99494, 99495, 99496, 99510, 99605- 99607, 0362T, 0373T, C9154, G0032, G0033, G0071, G0076-G0087, G0155, G0156, G0162, G0176, G0177, G0270, G0271, G0299, G0300, G0396, G0397, G0406-G0408, G0409-G0411, G0442- G0444, G0451, G0463, G0468-G0470, G0473, G0480-G0483, G0490, G0506, G0511, G0512, G0513, G0514, G2001-G2015, G2021, G2058, G2061-G2065, G2067-G2080, G2082, G2083, G2086-G2088, G2211, G2212, G2214, G2250-G2252, G8427, G9001-G9012, G9016, G9475, G9477, G9478, G9685, G9903, G9978-G9986, H0001-H0029, H0031, H0032, H0033, H0034, H0035, H0036, H0037, H0038-H0040, H0046, H0047, H0048, H0049, H0050, H1000, H1001, H1002, H1003, H1004, H1005, H2000, H2001, H2010, H2012, H2013, H2014-H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2024, H2025, H2026, H2027, H2028, H2029, H2030, H2031, H2032,H2033, H2034, H2035, H2036, J0570, J0571, J0572, J0573, J0574, J0575, J0576, J0592, J1230, J2315, J3490, S0109 , S0201, S9117, S9475, S9480, S9482, S9484, T1000, T1001, T1002, T1003, T1004, T1005, T1006, T1007, T1012, T1015, T1016, T1017, T1018, T1019, T1020, T1021, T1023, T1024, T1025, T1026, T1027, T1028, T1040, T1041, T1502, T1503, T2024, T2048, Q9991, Q9992) ***<u>with</u>*** **a primary care provider Taxonomy code:** (207QA0000X, 207RA0000X, 364SA2200X, 363LA2200X, 207QA0505X, 367A00000X, 261QB0400X, 364S00000X, 261QC1500X, 363LC1500X, 163WC1500X, 364SC1501X, 282NC0060X, 261QC0050X, 207Q00000X, 363LF0000X, 261QP0904X, 261QF0400X, 208D00000X, 163WG0000X, 207QG0300X, 207RG0300X, 363LG0600X, 207VG0400X, 207R00000X, 363AM0700X, 176B00000X, 363L00000X, 363LX0001X, 207V00000X, 207VX, 0000X, 2080A0000X, 364SP0200X, 363LP0200X, 208000000X, 261QP2300X, 363LP2300X, 163W00000X, 282NR1301X, 261QR1300X, 261QP0905X, 364SW0102X, 363LW0102X, 163WP0200X, 175F00000X, 364SF0001X, 363A00000X, 364SG0600X, 163WG0600X)

Outpatient Professional Non-Primary Care

Spending for the outpatient professional non-primary care service category can be identified through the following methodology:

Service Category	Specifications

Outpatient Non-Primary Care	**Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has Place of Service codes:** (02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 22, 24, 25, 26, 27, 33, 49, 50, 52, 53, 57, 58, 62, 71, 72, 99) ***and*** **CPT/HCPCS codes:** (90785, 90791, 90792, 90832-90840, 90845-90847, 90849, 90853, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90885, 90887, 90899, 90901, 90912, 90913, 96105, 96116, 96121, 96125, 96127, 96130-96133, 96136-96139, 96146, 96156, 96158, 96159, 96160, 96161, 96164, 96165, 96167, 96168, 96170, 96171, 97110, 97112, 97129, 97130, 97151-97158, 97530, 97535, 97537, 97802-97804, 97810, 97811, 97813, 97814, 98960-98962, 98966-98972, 99050, 99051, 99053, 99056, 99058, 99060, 99078, 99199, 99201-99205, 99211-99215, 99241-99245, 99324-99328, 99334-99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99358, 99359, 99366-99368, 99374, 99375, 99377-99387, 99391-99397, 99401-99404, 99406-99409, 99411, 99412, 99415-99417, 99421-99423, 99439, 99441-99444, 99446-99449, 99451, 99452, 99483, 99484, 99487, 99489, 99490, 99491, 99492-99494, 99495, 99496, 99510, 99605- 99607, 0362T, 0373T, C9154, G0032, G0033, G0071, G0076-G0087, G0155, G0156, G0162, G0176, G0177, G0270, G0271, G0299, G0300, G0396, G0397, G0406-G0408, G0409-G0411, G0442-G0444, G0451, G0463, G0468-G0470, G0473, G0480-G0483, G0490, G0506, G0511, G0512, G0513, G0514, G2001-G2015, G2021, G2058, G2061-G2065, G2067-G2080, G2082, G2083, G2086-G2088, G2211, G2212, G2214, G2250-G2252, G8427,G9001-G9012, G9016, G9475, G9477, G9478, G9685, G9903, G9978-G9986, H0001-H0029, H0031, H0032, H0033, H0034, H0035, H0036, H0037, H0038-H0040, H0046, H0047, H0048, H0049, H0050, H1000, H1001, H1002, H1003, H1004, H1005, H2000, H2001, H2010, H2012, H2013, H2014-H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2024, H2025, H2026, H2027, H2028, H2029, H2030, H2031, H2032, H2033, H2034, H2035, H2036, J0570, J0571, J0572, J0573, J0574, J0575, J0576, J0592, J1230, J2315, J3490, S0109, S0201, S9117, S9475, S9480, S9482, S9484, T1000, T1001, T1002, T1003, T1004, T1005, T1006, T1007, T1012, T1015, T1016, T1017, T1018, T1019, T1020, T1021, T1023, T1024, T1025, T1026, T1027, T1028, T1040, T1041, T1502, T1503, T2024, T2048, Q9991, Q9992)

Other Behavioral Health Services

Claims with a primary behavioral health diagnosis that do not fall into any other service categories should be included in the "Other Behavioral Health Services" category.

Optional: The Advisory Group expressed an interest in understanding behavioral health clinical spending by primary care providers. Therefore, the Outpatient Professional Primary Care and Non-Primary Care service subcategories are included. States may replace these subcategories with an aggregated Outpatient Professional service category by removing the primary care provider worksheet in the code set and adjusting these specifications.

Identifying Behavioral Health Spending in Primary Care

If a state chooses to identify behavioral health spending in primary care using the Outpatient Professional Primary Care subcategory, submitters must include only claims with a National Uniform Claim Committee (NUCC) provider taxonomy code identified in the list of primary care provider taxonomy codes included in the code set. Calculations of Behavioral Health Spending in Primary Care also should include non-claims payments classified as Integrated Behavioral Health.

Appendix B: Expanded Non-Claims Payment Framework

The Expanded Non-Claims Payment Framework was developed by California's Department of Health Care Access and Information in collaboration with Freedman HealthCare. The framework builds upon two models of categorizing alternative payment models and measuring non-claims spending, the Health Care Payment Learning and Action Network (HCP-LAN) and Milbank Memorial Fund - Bailit models.

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
1	**Population Health and Practice Infrastructure Payments** Prospective non-claims payments paid to health care providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.	
a	Care management/care coordination/population health/medication reconciliation Prospective non-claims payments paid to health care providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A
b	Primary care and behavioral health integration Prospective non-claims payments paid to health care providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A
c	Social care integration Prospective non-claims payments paid to health care providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A
d	Practice transformation payments	2A

	Prospective non-claims payments paid to health care providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	
e	EHR/HIT infrastructure and other data analytics payments Prospective non-claims payments paid to health care providers or organizations to support providers in adopting and utilizing health information technology (HIT), such as electronic medical records (EHR) and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	2A
2	**Performance Payments** Non-claims bonus payments paid to health care providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.	
a	Retrospective/prospective incentive payments: pay-for-reporting Non-claims bonus payments paid to health care providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B
b	Retrospective/prospective incentive payments: pay-for-performance Non-claims bonus payments paid to health care providers or organizations for achieving specific predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C
3	**Payments with Shared Savings and Recoupments** Non-claims payments to health care providers or organizations (or recouped from health care providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category are considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality."	
a	Procedure-related, episode-based payments with shared savings Non-claims payments to health care providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A

b	Procedure-related, episode-based payments with risk of recoupments Non-claims payments to health care providers or organizations (or recouped from health care providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
c	Condition-related, episode-based payments with shared savings Non-claims payments to health care providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A
d	Condition-related, episode-based payments with risk of recoupments Non-claims payments to health care providers or organizations (or recouped from health care providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B
e	Risk for total cost of care (e.g., ACO) with shared savings Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	3A
f	Risk for total cost of care (e.g., ACO) with risk of recoupments Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers	3B

	a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as "Performance Payments." Providers that would be classified by CMS as "low revenue" may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as "Risk for total cost of care with shared savings."	
4	**Capitation and Full Risk Payments** Per capita non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category are considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality."	
a	Primary Care capitation Per capita non-claims payments paid to health care organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A
b	Professional capitation Per capita non-claims payments paid to health care organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A
c	Facility capitation Per capita non-claims payments paid to health care organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A
d	Behavioral Health capitation Per capita non-claims payments paid to health care organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A
e	Global capitation Per capita non-claims payments paid to health care organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B
f	Payments to Integrated, Comprehensive Payment and Delivery Systems Per capita non-claims payments paid to health care organizations and providers to provide a comprehensive set of services to a designated patient population over a	4C

	defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	
5	**Other Non-Claims Payments** Any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments).	
6	**Pharmacy Rebates** Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.	

Note: Categories shaded in orange should be fully allocated to behavioral health spend. Categories shaded in green should be partially allocated to behavioral health spend.

Appendix C: Components of Behavioral Health Spending