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California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

# Webinar: Measuring Behavioral Health

Rachel Block

April 24, 2023

## The California Health Care Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. CHCF focuses especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. CHCF partners with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

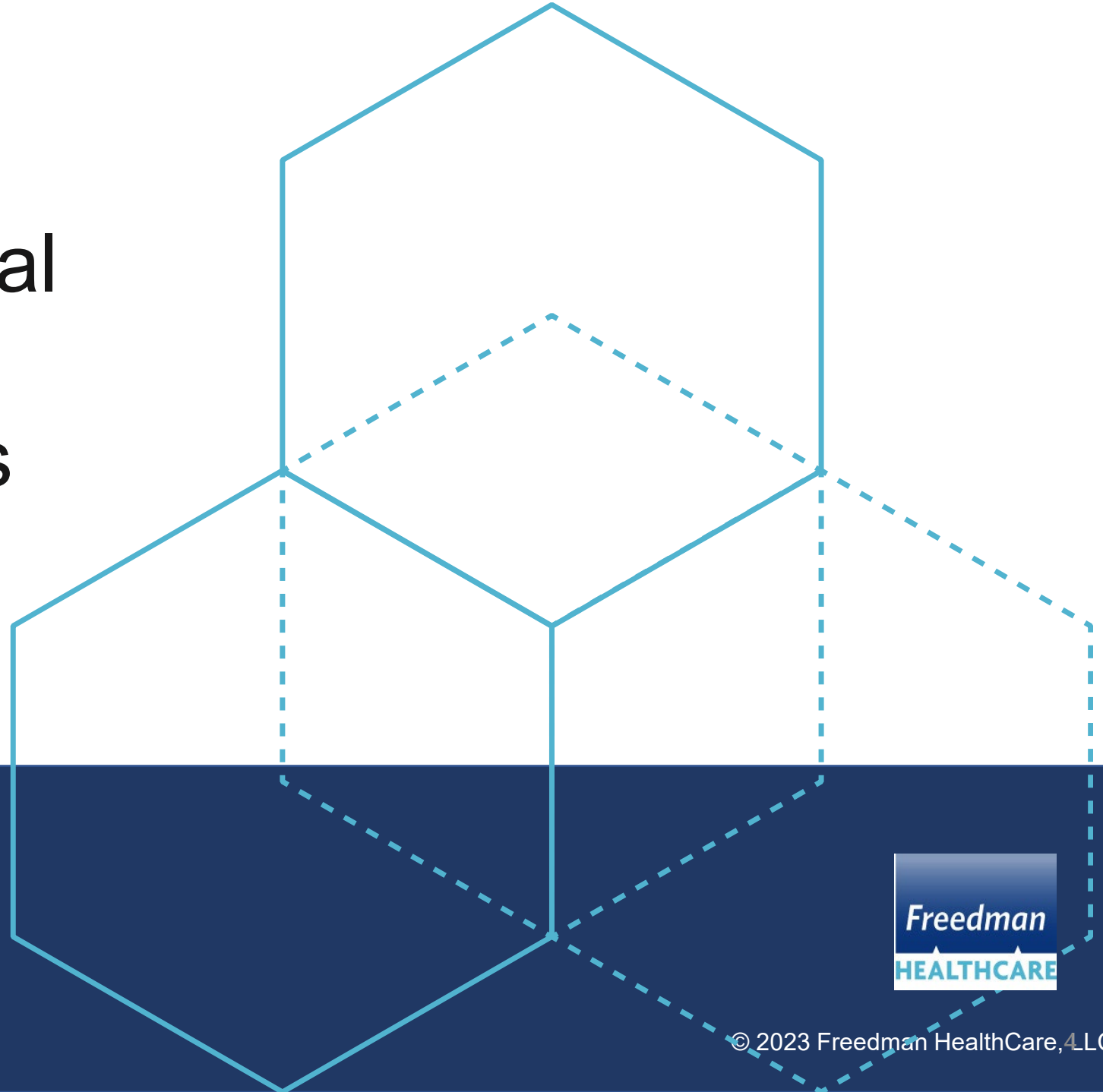
## The Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health and health equity by collaborating with leaders and decision-makers and connecting them with experience and sound evidence.

# Panelists

- **Mary Jo Condon**, Principal Consultant, Freedman HealthCare
- **Vinayak Sinha**, Consultant, Freedman HealthCare
- **Caitlyn B. Sullivan**, Deputy Executive Director, Health Informatics and Reporting, Massachusetts Center for Health Information and Analysis
- **Rick Rowley**, Chief Data Officer, Colorado Behavioral Health Administration

# Identifying and Measuring Behavioral Health Services and Related Investments



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April 24, 2022

Freedman HEALTHCARE

# Meet the Team

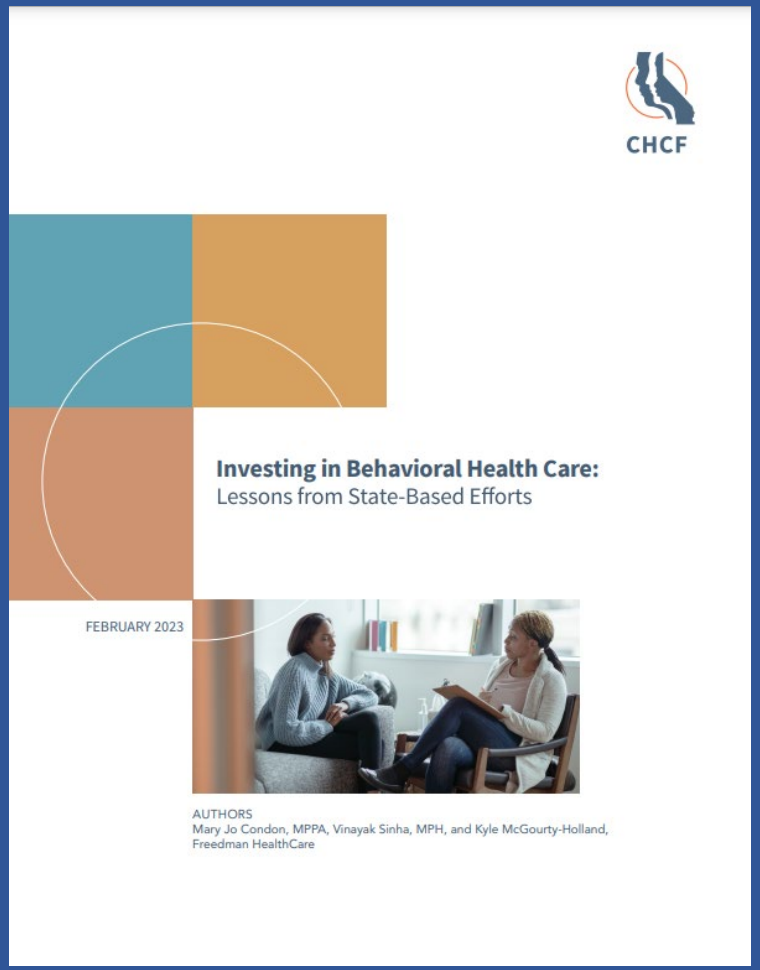
**Mary Jo Condon, *MPPA, Principal Consultant,*** has supported multiple states in the development of care delivery and payment models that put primary care and behavioral health at the center. Recent projects include leading the Delaware Department of Insurance Office of Value-Based Health Care Delivery, designing a primary care payment model for Connecticut, and guiding Rhode Island systems of care through a collaborative process to identify care delivery requirements to support comprehensive primary care capitation. Ms. Condon was the lead author of “Identifying and Measuring Behavioral Health Services and Related Investments,” a 2023 report detailing the early efforts of states to monitor spending on expenses related to behavioral health.

**Vinayak Sinha, *MPH, CSM, Consultant*,** has analyzed primary care and behavioral health delivery and payment models, designed and implemented data collection on healthcare claims and nonclaims payments, and developed reports and presentations for multi-stakeholder audiences. Mr. Sinha serves as project manager for Delaware’s Office of Value Based Health Care Delivery. Mr. Sinha managed the development of a primary care delivery and payment model in Connecticut and was a co-author of “Investing in Primary Care: Lessons from State-Based Efforts,” a 2022 report detailing the efforts of 17 states to increase primary care investment and orientation.

# Goals for Today

1. Provide an overview of state approaches to measuring behavioral health spending
2. Share lessons learned from early state efforts to measure behavioral health spending
3. Discuss how the differences in states' approaches reflect differences in use cases

# Key Findings




- Only two states were measuring behavioral health investment across all clinical services
- At least two other states were measuring state behavioral health expenditures
- Nine states were including some behavioral health services in their primary care investment definitions
- APCDs can be a powerful source for measuring certain behavioral health expenditures, but its often not a complete picture
- Best practices are emerging regarding what diagnoses, services and providers should be included

# The Process

***Identified 13 states meeting at least one of these criteria***:

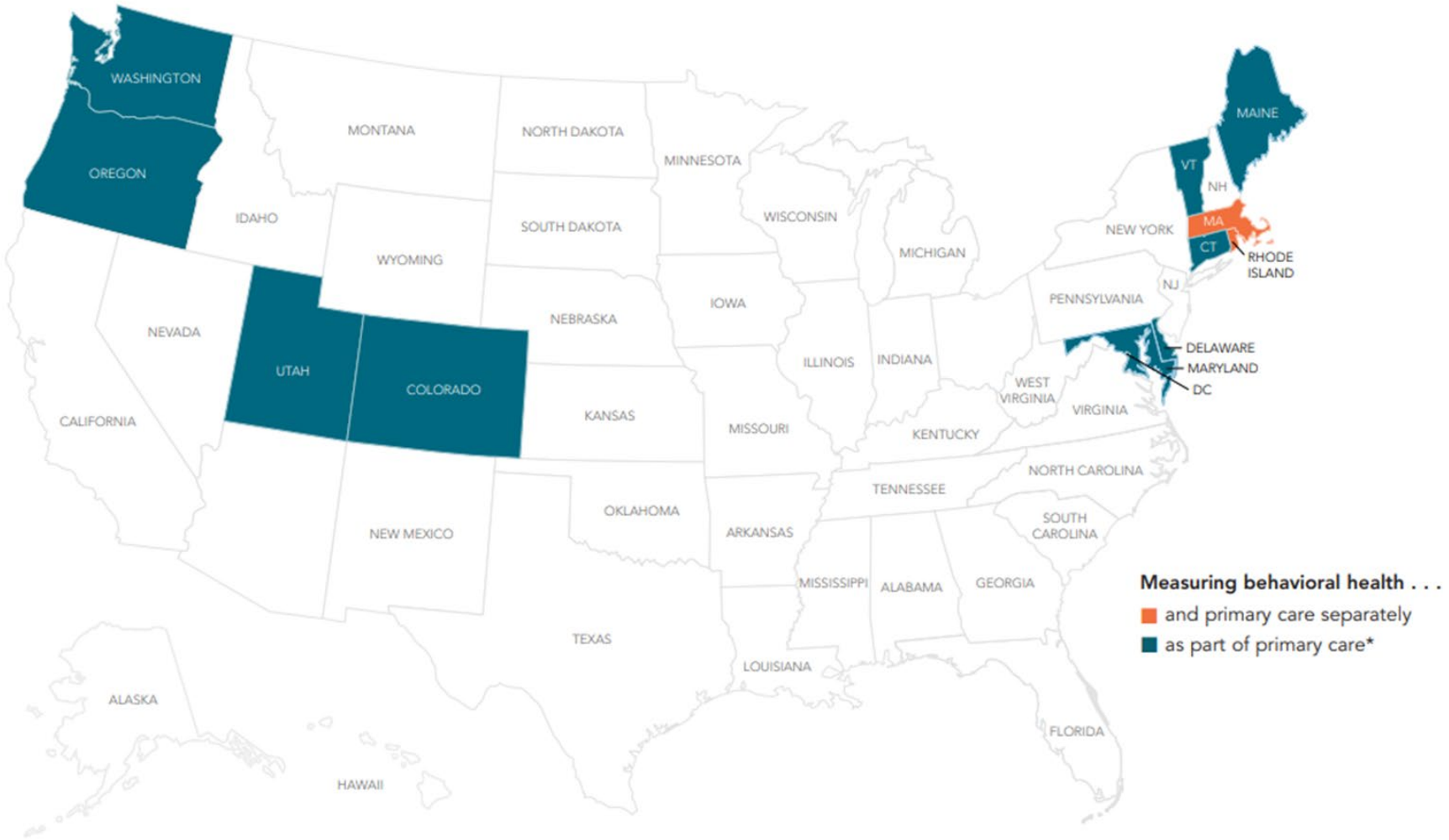
- Measuring behavioral health investment across clinical settings
- Measuring behavioral health investment as part of primary care measurement activities
- Early adopter of best practices in behavioral health systems change (e.g., care delivery, financing)

***For each of these states, reviewed:***

- Technical specifications to support behavioral health investment measurement
- Benefit summaries and other plan documentation
- Budget documents outlining behavioral health services provided under Medicaid waivers and the general fund

***Interviewed agency leaders and experts from key states***

# States Measuring Behavioral Health Investment



# Key Decision #1: Defining Investment Categories

Should states focus behavioral health investment measurement on clinical services, or should it also include social supports and/ or other behavioral health initiatives such as workforce expansion?

| CLINICAL CARE | SOCIAL SUPPORTS | OTHER |
|---|---|---|
| ▸ Assessment, screening, and other diagnostic services | ▸ Housing assistance | ▸ Workforce |
| ▸ Mobile crisis response | ▸ Nonemergency transportation | ▸ Agency/department/ division operations |
| ▸ Medication | ▸ Employment | ▸ Infrastructure and analytics |
| ▸ Therapeutic procedures | ▸ Peer support | |
| ▸ Inpatient/residential treatment | ▸ Respite services | |
| ▸ Psychotherapy and counseling | | |

# Key Decision #2: Choosing Data Sources

## APCDs

Offer a solid starting place for measuring most investment in clinical behavioral health services.

## Other Data Sources

A non-claims data collection template can serve many use cases, including measuring non-claims payments to support behavioral health.

Over time, states may want to expand data collection to include other state investments in workforce and infrastructure.

# Key Decision #3: Incorporating best practices into measurement and reporting

## Diagnoses

States measuring behavioral health investment develop a list of diagnosis codes to define behavioral health.

## Providers & Places of Service

Some states' measurement specifications require services to be rendered by providers with specific specialties or provided in specific care settings to be included as behavioral health.

## Services & Medications

Massachusetts and Rhode Island measure behavioral health investment across all clinical services.

Nine states that measure primary care investment include certain behavioral health services in their primary care definitions.

# Behavioral Health Investment Equation


Source: Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti, ***Measuring Non-Claims-Based Primary Care Spending***, Milbank Memorial Fund, April 16, 2021.

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# MEASURING BEHAVIORAL HEALTH EXPENDITURES: THE MASSACHUSETTS EXPERIENCE

April 24, 2023

CENTER FOR HEALTH INFORMATION AND ANALYSIS

CHIA.

# Background

- The Center for Health Information and Analysis (CHIA) is an independent state agency that serves as the primary hub for Massachusetts health care data and analytics and is charged with objectively reporting on annual performance against the state's health care cost growth benchmark as well as other key metrics including costs, quality, and access.

- In recent years, Massachusetts has embarked on a Roadmap for Behavioral Health Reform, implementing new policies to create community behavioral health centers for urgent care, a 24/7 behavioral health help line, and to require private insurance coverage for pediatric and adolescent intermediate care in the community.

- In 2019, Massachusetts policymakers proposed enacting a target for increasing investment in primary care and behavioral health services, which in concert with the cost growth benchmark, aimed to "rebalance" health care expenditure growth.

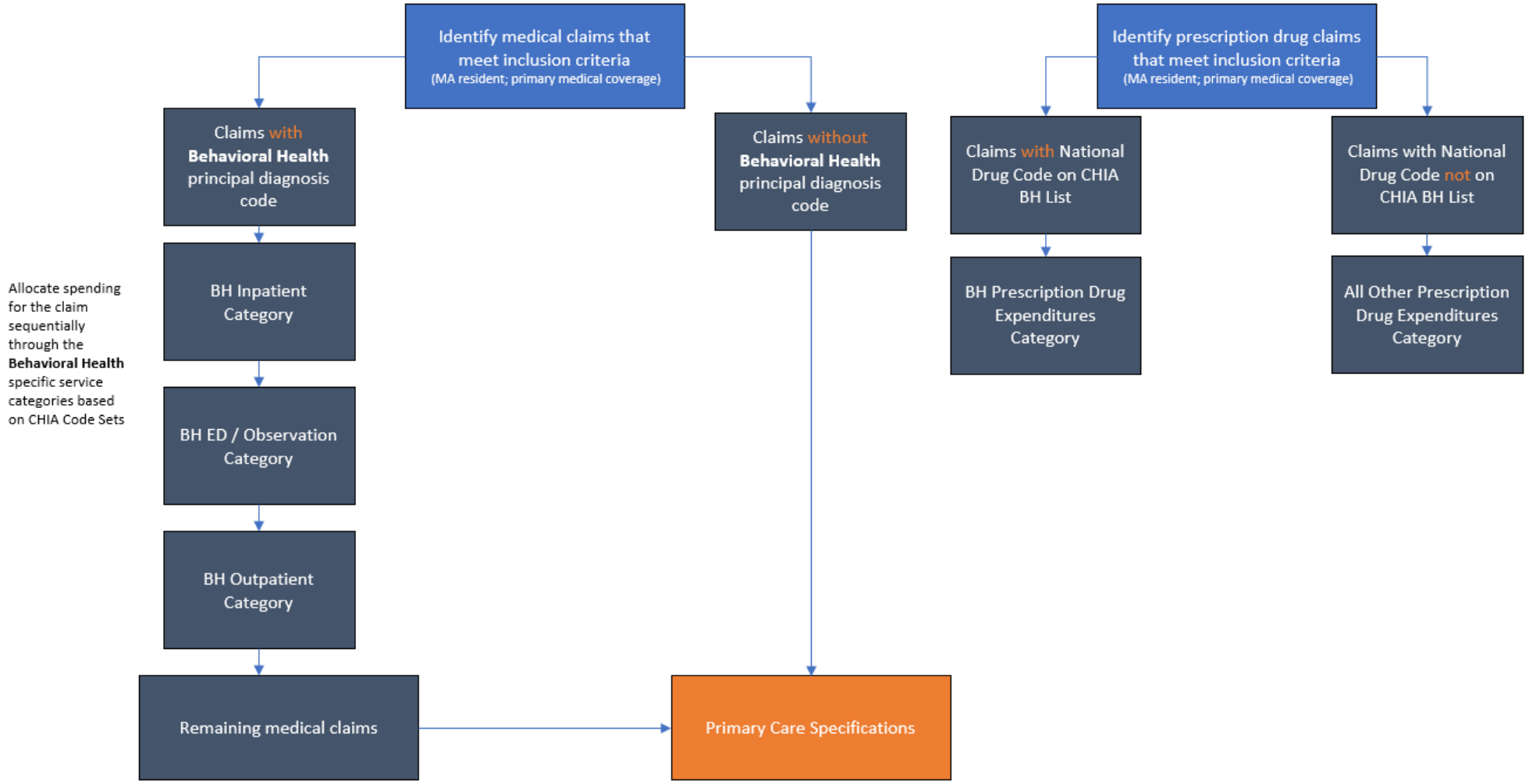
- To inform this policy proposal, CHIA collaborated with health care industry stakeholders and organizational partners to develop a specification for collecting claims and non-claims payments for primary care and behavioral health services.

# Data Specification Development

- Data strategy was informed by the specific policy proposal

| Data Requirement | Solution | Limitations |
|---|---|---|
| Data about services must be **readily available** for measurement | Include services covered by insurance that would result from a claim or a non-claims-based payment explicitly outlined in payer-provider contract | • Does not account for services delivered outside of the health insurance system, e.g., fully self-pay services and some social and community supports<br>• Submitters have difficulty identifying BH non-claims |
| Expenditure data needed to capture the **total private commercially-insured population** (both self and fully-insured Massachusetts residents) | Leverage existing framework for cost growth reporting and collect summary level data directly from health plans | • Administrative burden on data submitters<br>• Use of APCD would enable more drill-down and control over data specification updates |
| Primary care and behavioral health service categories needed to **be mutually-exclusive** | Create hierarchy for data submitters to allocate spending, first to behavioral health, then primary care, then all other services | • Where to place primary care/behavioral health integration services? |
| Spending data needed to be **stratified by standard service categories** so that any accountability program could flexibly include or exclude service types (e.g., prescription drugs) | Build code sets using existing methodologies (e.g., CMS substance use disorder filter, NCQA standards, Medicaid formulary list) | • Implementation challenging for health plans as any updates require coding revisions and testing<br>• Drug list includes drugs for multiple indications and therefore overcount BH spending |

# Data Specifications Overview



# Next Steps

- CY2021 behavioral health expenditure results available in CHIA's March 2023 Annual Report on the Performance of the Massachusetts Health Care System; CY2022 data to be collected in Fall 2023
- Collaborate with data submitters to improve non-claims-based payments that support behavioral health care
- Use the Massachusetts All Payer Claims Database to drill into trends observed in summary level data and incorporate demographic data to provide equity lens
- Field survey of behavioral health providers to collect data on workforce and capacity
- Collaborate with other states measuring behavioral health to assess alignment of definitions and approach to enable state level comparisons

# Contact

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Chief Data Officer

Colorado Behavioral Health Administration

**Question:** Who should receive behavioral health care coordination services connecting state social supports with payer coordination teams?

**Outside consultant answer**: Anyone with a behavioral health diagnosis. There should be three levels of increasing support based on the complexity of the diagnosis.

**What do you think?**

**Problem: The proposed model doesn't work:**

Care coordination is designed to improve care AND reduce expenses. As proposed, the fiscal analysis had it costing Colorado just short of $100 million annually.

**Question:** What are some of the fundamental flaws of taking this Medicare approach to care coordination and applying it to behavioral health state services?

**Answer:** Enrollment based on an uncurable diagnosis like many of those common in behavioral health means more people will be enrolled year after year with no chance of ever being released.

**Answer (personal experience):** Behavioral health providers work backward more often than physical medicine specialties. Practitioners understand the support their patients need and sometimes select the diagnosis that allows for the needed support over another that may more accurately reflect objective findings.

**Answer:** People with severe diagnoses already have care coordination through their medical team. Much of the cost savings associated with care coordination are obtained with the initial coordination team. Distilling it a second time with state oversight has a significantly less return on investment.

**Question:** What criteria for enrollment and unenrollment would you or your organization suggest?

Leaning toward using the utilization of services over a diagnosis for inclusion and exclusion of care coordination.

**Example:** A person with a mild behavioral diagnosis who utilizes emergency room and justice system services regularly due to mental health needs would be enrolled for a high level of care coordination.

**Example**: A person with severe physical and mental disabilities who does not require the use of crisis and emergency services may not be enrolled at all.

What allows Colorado to take this approach is the Behavioral Health Administration, which collects data and coordinates behavioral care with over 17 different government agencies providing various types of services affecting behavioral needs.

# Data Sources

Multiple data sources are needed to understand behavioral health need and services as no one data source can present a complete picture. Examples include:

## Demographics and Social Determinants of Health

American Community Survey

ArcGIS Community Analyst

## Disease or Injury Surveillance Data

Colorado Violent Death Reporting System

Opioid Overdose Prevention Program

## Population Health Surveys

The Behavioral Risk Factor Surveillance System

National Survey on Drug Use and Health

Healthy Kids Colorado Survey

Colorado Health Access Survey

## Services Directory

OBH Licensing and Designation Database and Electronic Records System

SAMHSA Behavioral Health Treatment Services Locator

Colorado Health Services Directory

## Primary Data Collection

Key informant interview

Focus groups

Surveys

## Health Care Utilization

OBH Encounter

Health First Colorado (Medicaid) Claims

Colorado Hospital Association

Drug Alcohol Coordinated Data System

# The Next Phase

1. Convene an advisory group of representatives from leading states
2. Work collaboratively with them to identify priority use cases for measuring and reporting behavioral health spending
3. Develop an issue brief documenting current use cases and the key steps in implementing those of most interest to states.