Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending

BY VINAYAK SINHA, EMMA ROURKE, MARY JO CONDON, WILLIAM BRANDEL, FREEDMAN HEALTHCARE

REPORT | April 2024

Milbank Memorial Fund

About the Milbank Memorial Fund

The Milbank Memorial Fund works to improve population health and health equity by collaborating with leaders and decision makers and connecting them with experience and sound evidence. Founded in 1905, the Milbank Memorial Fund advances its mission by identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness; convening and supporting state health policy decision makers to advance strong primary care and sustainable health care costs; and publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy. For more information, visit **www.milbank.org**.

About Freedman HealthCare

Established in 2005, Freedman HealthCare (FHC) is a focused, independent consulting firm that helps states put health data to work to solve complex problems. FHC's team of seasoned experts support clients in using data to identify opportunities to improve healthcare quality, affordability and equity and measure the impact of meaningful policy change.

FHC's work to develop and implement health policy initiatives, including measuring progress toward quality and cost growth, primary care and behavioral health investment targets, in more than 15 states and several national non-profit organizations provides us with a broad and deep understanding of various healthcare data sources, and how to make meaningful connections.

CONTENTS

Executive Summary 4

Introduction 6

Capturing Claims Spending by Payers 9

- Behavioral Health Diagnoses 10
- Behavioral Health Services and Treatments 12
- Behavioral Health Providers 13
- Behavioral Health Care Settings 14

Capturing Behavioral Health Non-Claims Spending 16

Conclusion 18

About the Authors 21

Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org

EXECUTIVE SUMMARY

States are facing an unprecedented rise in the rates of behavioral health conditions. To address this health crisis, state officials are increasingly focused on identifying ways to improve access to high-quality behavioral health care, including by 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 workforce need. Several states plan to use the data to set targets for how much payers should spend on behavioral health clinical services. Other use cases include monitoring compliance with laws and regulations such as mental health parity, improving service delivery, and informing state budgeting.

Behavioral health spending includes payments from public and private payers to providers, state funds to support behavioral health service delivery, and payments from patients to providers. Today, 12 states measure how much payers spend on clinical care to treat behavioral health conditions, including three—Maine, Massachusetts, and Rhode Island—that measure across the clinical care continuum, from outpatient therapist visits to inpatient day programs. The three states' approaches to measurement are largely similar. They typically define spending to treat behavioral health conditions using a combination of diagnosis codes, procedure codes, and provider taxonomy codes. Yet, there is variation across the states' code sets—for example, the services and care settings included, the categories of non-claims payments used, and the technical specifications for the data. (Non-claims payments, such as prospective, per-patient payments, are not based on individual claims for services.)

Now, several states are calling for a more consistent approach to measurement. A shared definition implemented via a standardized methodology will support comparability, streamline measurement decision-making and implementation, and reduce administrative burden on data submitters. This brief offers recommendations for a definition and standardized methodology supported by a detailed code set to measure how much payers spend on behavioral health clinical services, which includes claims and non-claims spending. The methodology was designed with input from an Advisory Group of state behavioral health leaders and subject matter experts convened by Milbank Memorial Fund and Freedman HealthCare.

Advisory Group Recommendations for a Standardized Definition of Clinical Behavioral Health Spending

Claims Spending

Diagnosis

- Include a specific set of diagnosis codes to identify patients with a primary diagnosis of a behavioral health condition.
- Include all diagnosis codes for mental health and substance use disorders consistently used in state definitions, as well as dementia, developmental disorders, and poisoning related to self-harm.
- Assign diagnoses and associated spending to mental health and substance use disorder categories.

Services and Treatments

- Include a specific set of procedure codes to define behavioral health services.
- Use a standardized code set to identify and categorize services into inpatient, emergency department/observation, outpatient primary care, and outpatient non–primary care. Include additional categories of long-term care, residential care, and mobile services.
- Separate spending in each service category into mental health and substance use disorder based on the patient's primary behavioral health diagnosis.
- Include services typically covered by Medicaid only.
- Define behavioral health treatments for those with behavioral health conditions using the National Drug Codes in place in Massachusetts and Rhode Island.

Provider

- Do not restrict by provider type.
- Track behavioral health services delivered by primary care providers in the primary care setting.

Care Setting

- Assign services to specific care settings based on place of service and revenue codes.

Non-Claims Spending

- Measure non-claims clinical spending using a standardized approach.
- Include only non-claims payments to support behavioral health needs, such as integrated behavioral health, as behavioral health spending.
- Do not classify non-claims payments to support services with broader impact, such as care coordination and management, as behavioral health spending.

INTRODUCTION

This brief provides a standardized definition and methodology for measuring behavioral health spending on clinical services funded via claims and non-claims payments from commercial, Medicaid, and Medicare payers.

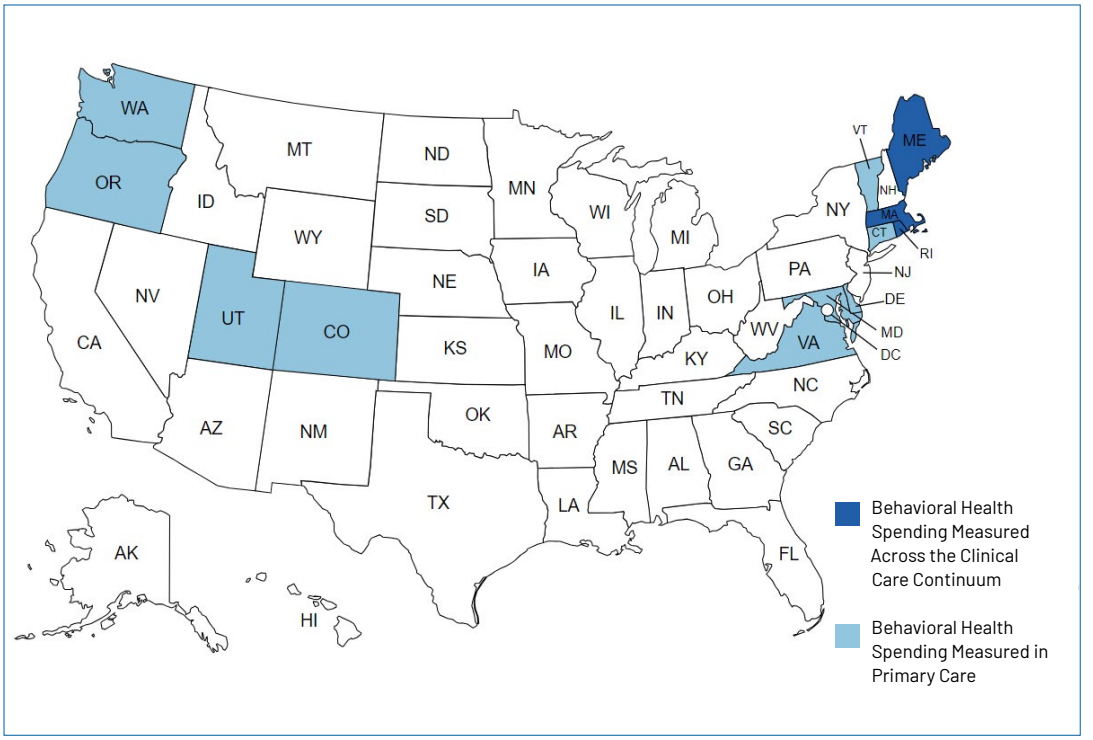
Rates of anxiety, depression, substance use disorders, and other behavioral health conditions have been rising in recent years, particularly among youth and teens.[1] Against this backdrop, a growing number of states are considering ways to expand access to treatment of behavioral health conditions, improve the effectiveness of services, and identify appropriate levels of statewide spending. For example, defining behavioral health care provision and measuring spending can help determine whether state goals related to access are being met and inform how to fill any gaps.

Today, three states measure behavioral health spending across the clinical care continuum: Maine, Massachusetts, and Rhode Island. Nine other states measure behavioral health spending as part of efforts to measure primary care spending (see Figure 1). Each state measuring behavioral health spending across the clinical care continuum has its own use case:

- The Maine Health Data Organization is required to collect behavioral health spending data to support the Maine Quality Forum in developing an annual report.
- In Rhode Island, the Office of the Health Insurance Commissioner measures behavioral health spending to inform state policy.
- In Massachusetts, the Center for Health Information and Analysis (CHIA) oversees the state's all-payer claims database and separately collects data on behavioral health, primary care, and total health care expenditures.

Their approaches to measurement are largely similar; states typically define spending to treat behavioral health conditions using a combination of diagnosis codes, procedure codes, and provider taxonomy codes.[2] Some states also measure spending paid through non-claims payments. However, the state code sets used to define claims spending, including categories of non-claims payments and technical specifications, vary. Several states share an interest in developing a more standardized methodology that supports greater comparability, utilizes best practices, and reduces data submitter burden.

Figure 1. States Measuring Behavioral Health Clinical Spending



To support this goal, the Milbank Memorial Fund partnered with Freedman HealthCare to convene an Advisory Group of state leaders and subject matter experts to consider ways to standardize behavioral health spending measurement.

State efforts to measure primary care investment offer important lessons learned, such as strategies for developing a standardized measurement definition and presenting results. These efforts draw attention to the need for tailored technical assistance for data submitters, discussions on data submitters' abilities to identify primary care providers using taxonomy codes, and how to estimate the portion of non-claims payments that goes toward primary care.

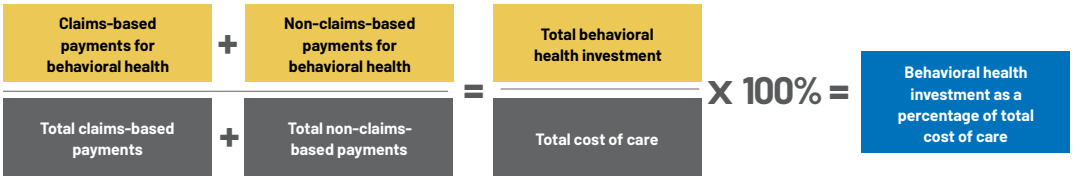
However, measuring how much payers spend to treat behavioral health conditions raises additional considerations, including the following:

- Spending on behavioral health conditions spans a broad care continuum, including specialty and inpatient hospital care, and often straddles clinical and social care.
- Measurement of spending on behavioral health conditions goes beyond behavioral health services measurement. It identifies patients with behavioral health conditions and includes the services and treatments, via National Drug Codes, associated with treating the condition. The spending is attributed to the patient with the condition, not the providers.
- Payments to treat behavioral health conditions are more likely to include non-claims payments, particularly for social supports, than other types of care delivery.

- Payment sources for behavioral health conditions include traditional payers (e.g., Medicaid, Medicare, commercial) as well as federal grants, state and local programs, and a larger proportion of self-pay than other conditions.
- Self-pay, or out-of-pocket spending, in behavioral health makes up a greater portion of payments when compared to other care delivery. It includes patient cost sharing, patient costs associated with a lack of coverage for certain services, and costs related to a lack of available in-network providers.
- Behavioral health coverage is more likely to be "carved out" from typical health insurance coverage than other care delivery.
- Medicaid pays for roughly one-quarter of behavioral health spending nationally.[3] Medicaid demonstration programs, such as Section 1115 waivers, provide states additional flexibility to design, test, and improve behavioral health programs, including expanded services and treatments for conditions. These payments and programs span the care continuum and include both clinical and social supports.

The Advisory Group focused on standardizing measurement of spending on clinical services by commercial, Medicaid, and Medicare payers to treat behavioral health conditions. The equation to calculate this spending, which includes claims and non-claims payments, is similar to the approach that typically has been taken for primary care spend measurement (see Figure 2).

Figure 2. Payer-Funded, Clinical Behavioral Health Investment Equation



Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring non-claims-based primary care spending. Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_8.pdf. Published April 2021. Accessed February 21, 2024.

To calculate payer-funded clinical behavioral health investment, states would likely use an all-payer claims database (APCD), a supplemental template completed by payers, or both. An APCD can serve as a ready source of information on behavioral health spending paid via claims. APCDs typically include spending and utilization data for Medicare, Medicaid, and fully insured commercial payers. However, APCDs often lack information on spending paid outside the claims system, such as capitation payments. APCDs also typically have limited data on self-insured commercial spending. A supplemental template can overcome these gaps.

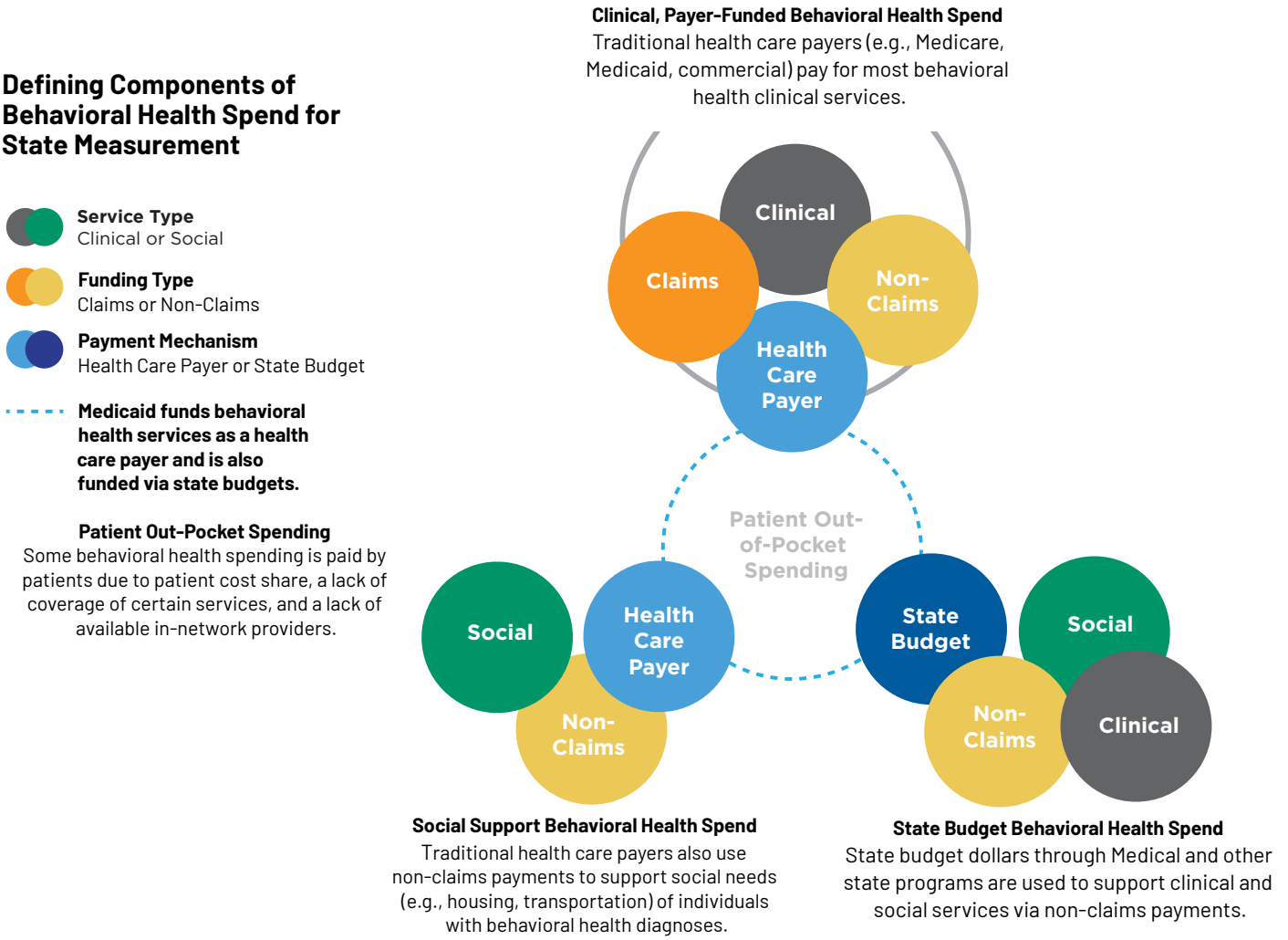
The definition for spending on clinical services by payers to treat behavioral health conditions and its accompanying code set will need to be assessed for operational feasibility. In the next phase of work, the potential implementation of these recommendations will be discussed with states and public and private payers. The Advisory Group also identified other key areas of behavioral health spending (see Figure 3).

Considerations for Evaluating Potential Data Sources

The following factors can affect data quality and use:

- The populations included, i.e., payer types and market
- Whether non-claims data are present or how they may be included
- Time frame for analysis and results, i.e., data lags
- Data submitter burden and quality of submissions

Figure 3. Components of Behavioral Health Spending



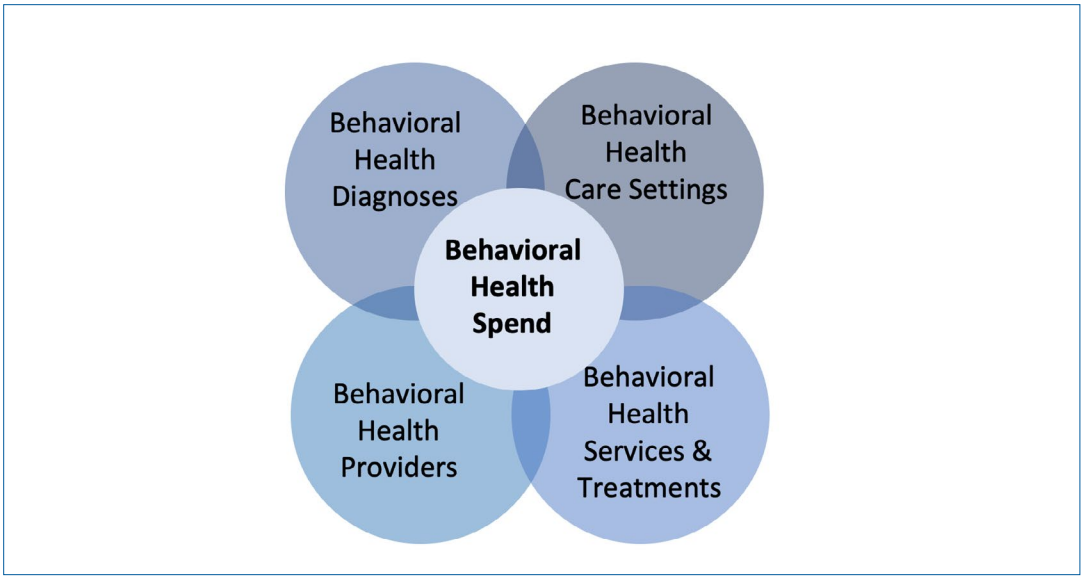
CAPTURING CLAIMS SPENDING BY PAYERS

Definitions of behavioral health spending paid through claims typically include behavioral health diagnoses, services and treatments, providers, and care settings (see Figure 4). The Advisory Group discussed approaches to collecting data on these components. They used the three behavioral health spending definitions currently in use by Maine, Massachusetts, and Rhode Island:

- Maine's definition includes all services delivered to patients with a list of specified primary behavioral health diagnoses administered by a specified set of providers at certain places of service.
- Massachusetts' definition includes a specific set of services and treatments delivered to patients with a list of specified primary behavioral health diagnoses administered by a specified set of providers in specific care settings.
- Rhode Island's definition includes all services and specified treatments delivered to patients with a list of specified primary behavioral health diagnoses administered by any provider at any place of service.

Each state definition is implemented via a code set to guide payers in submitting data. These code sets include lists of relevant diagnoses, services and treatments, providers, and care settings. The group used these code sets as "anchor definitions" to develop a recommended definition for payer-funded, clinical behavioral health spending. The recommended definition is supported by a code set included in Appendix A. The following sections discuss the decisions considered, the influence of the anchor definitions, benefits and drawbacks identified, and Advisory Group recommendations.

Figure 4. Defining Behavioral Health Spending Paid Through Claims



Behavioral Health Diagnoses

The anchor definitions include an extensive list of International Classification of Diseases, Tenth Revision (ICD-10), diagnosis codes and cover most behavioral health conditions, such as anxiety, depression, and schizophrenia. All anchor definitions also require a behavioral health diagnosis as the primary diagnosis on the patient's claim. Although there is considerable overlap among the codes in use by the states, the recommended Advisory Group definition addresses four areas of divergence.

The anchor definitions differ on whether to include dementia, developmental disorders, downstream diagnoses impacted by alcohol, and/or substance use disorders (SUD), which include gastritis, hepatitis, complicated pregnancy or childbirth, and adverse effects of poisoning related to intentional self-harm. Advisory Group members prioritized diagnoses most directly related to behavioral health instead of those that were the result or effect of previous health conditions. They also discussed what portion of care for the condition would likely be classified as a behavioral health service. An overview of the benefits and drawbacks of including or excluding each of these conditions in the definition is presented in Table 1. Whether to categorize diagnoses was an additional consideration. Massachusetts identifies a list of primary behavioral health diagnoses and categorizes each diagnosis as mental health or SUD. Separating care related to mental health diagnoses from care related to SUD diagnoses in data collection enables states to analyze each of these categories of spend separately.

Measurement Decision: Diagnoses

The standardized definition of behavioral health spending includes the ICD-10 codes identified in all three of the state anchor definitions. It also includes diagnoses for dementia, developmental disorders, and poisoning related to intentional self-harm.

Table 1. Behavioral Health Diagnoses Decisions

Decision	Included in State Definition			Benefits	Drawbacks	Recommendation
	ME	MA	RI			
Include dementia		X	X	• Some treatment for dementia is behavioral; other treatment is medical. • Enables accounting for behavioral health services and treatments by providers that treat the condition. • Certain codes related to dementia were included in all three anchor definitions.	• In Maine's 2023 report, the Substance Abuse and Mental Health Services Administration (SAMHSA) discussed dementia as a medical, not behavioral, condition.[4]	Include
Include developmental disorders, including autism		X		• Treatment for developmental disorders is largely behavioral. • Promotes increased investment, which may improve access to needed services.	• If not accurately categorized, medical costs could artificially inflate behavioral health cost.	Include
Include adverse effects of poisoning related to intentional self-harm	X		X	• Poisoning related to intentional self-harm is a serious behavioral health event. • The immediate effects of poisoning are directly related to the behavioral health event.	• The services to treat these adverse effects may be predominantly medical. • States may want to reduce and disincentivize this spending through investment in upstream, preventive care delivery.	Include
Include diagnoses impacted by alcohol use and/or SUD (e.g., alcoholic gastritis, hepatitis)	X			• Understanding the impact of alcohol and other substance use disorders on physical health care needs is important to understanding behavioral health spend.	• This spending may be the result of other co-occurring conditions unrelated to behavioral health diagnosis. • Most services are not considered behavioral health and are performed by providers without a behavioral health focus.	Exclude

Recommendations: The recommended definition, provided in Appendix A, includes most diagnoses currently included in the three anchor definitions, as well as dementia, developmental disorders, and the effects of poisoning related to self-harm. It excludes downstream diagnoses impacted by alcohol and/or SUD, which are included in Maine's definition. For example, pregnancy complications due to alcohol use are excluded from the definition. Like all three anchor definitions, the recommendation requires that the patients' behavioral health diagnosis be the primary diagnosis and be coded as such on the claim. Like Massachusetts, the recommended definition categorizes the list of diagnoses as either mental health or SUD to better understand changes in spending for each category of diagnoses. The group recognized that behavioral health diagnoses in the secondary diagnosis position on a claim also result in spending to treat individuals with behavioral health conditions. This may be explored further with stakeholders to understand data submitter burden while calculating clinical, payer-funded behavioral health spending. The Advisory Group also recommends updating the definition annually to ensure it captures new codes and maintains codes no longer in use to aid in the consistency of multiyear comparisons.

Behavioral Health Services and Treatments

Advisory Group members considered whether to include all services at a visit with a primary behavioral health diagnosis or to restrict the definition to include only certain services. The group also discussed which services and treatments to include if services were restricted and how to categorize them. Behavioral health services and treatments for patients with a behavioral health condition are defined by Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS), and National Drug Codes (NDCs).

The Massachusetts definition is the only anchor definition to restrict by service. Advisory Group members said such service restrictions may be helpful, particularly considering the broader recommended definition of diagnosis (i.e., including dementia, developmental disorders, and effect of poisoning related to self-harm). Restricting by service would limit the spending related to medical services to treat these conditions. Massachusetts bases its service list on Healthcare Effectiveness Data and Information Set (HEDIS) value sets for defining Diagnosed Mental Health Disorders and Diagnosed Substance Use Disorders. Massachusetts and Rhode Island aim to measure how much it costs to treat behavioral health conditions, which is slightly broader than measuring spending on behavioral health services. Massachusetts also includes spending on behavioral health treatments such as prescription drugs to treat behavioral health conditions. Their treatment list is based on a list of NDCs developed by MassHealth, Massachusetts' state Medicaid agency. Massachusetts also assigns services to categories (e.g., inpatient, outpatient) based on the HEDIS methodology to support more refined analyses. The benefits and drawbacks of these and other decision points are outlined in Table 2.

Measurement Decision: Services and Treatments

The recommended definition of behavioral health spending includes a set of services defined via CPT, HCPCS, and NDCs, and an approach for categorizing services to support monitoring spending by service type.

State Use Case: Regulatory

Mental health parity—determining whether mental health services are paid at the same rate as similar physical health services—is an important state use case. This recommended definition provides a framework for defining mental health services, a first step to evaluating parity.

Table 2. Behavioral Health Services Decisions

Decision	Included in State Definition			Benefits	Drawbacks	Recommendation
	ME	MA	RI			
Restricting by service		X	X (NDCs only)	• Offers a more focused view of behavioral health spending. • Helps ensure care not related to behavioral health is excluded, therefore preventing an inaccurate inflation of behavioral health spending, which may limit data credibility and result in less increased investment.	• May limit capturing new, innovative treatments for behavioral health conditions. • May undercount current spending for behavioral health conditions.	Limit services
Defining the list of services and treatments		X		• Will likely receive broad stakeholder buy-in. • NDC codes used in Massachusetts were developed with stakeholder input; these codes are also used in Rhode Island.	• The narrower the list of services, the more likely some behavioral health spending will be excluded.	Leverage HEDIS value sets and NDC list used in Massachusetts.

Categorizing services and treatments		X		• Provides greater insight into delivery and supports monitoring changes in spending. • Enables states with different priorities for behavioral health investment to include or exclude categories when setting investment targets.	• Requires more work for the data submitter and/or analyst.	Categorize and include the following categories: inpatient, emergency department/observation, outpatient primary care, outpatient non-primary care, long-term care, residential care, and mobile services.

Recommendations: The recommended definition includes the list of services and treatments currently used in Massachusetts. The Advisory Group also supported categorizing services and treatments into modules like the Massachusetts approach, which uses place of service and revenue codes to support a better understanding of care delivery. This allows states to conduct more nuanced analyses and modify the definition for certain purposes, such as target setting. The Advisory Group reviewed categories used in CHIA's data collection (see Figure 5), and recommended additional service categories of mobile services, long-term care, and residential care. Members pointed out that additional categories would enable states to understand the impact of recent funding to expand mobile services and downstream impact on long-term care and residential care. (The American Rescue Plan Act included additional funding for home and community-based services, particularly for Medicaid members.[5]) The group also discussed potentially including diversionary care—support provided to patients returning to the community after hospitalization—as an additional category. Due to additional data submitter burden, the services within this category have been included in inpatient and outpatient categories. The code set also includes an optional set of behavioral health related preventive screenings that do not require a behavioral health diagnosis. This list is optional to avoid double counting, as these services are often included in state calculations of primary care spend. The list of services, their corresponding care settings, and associated service categories are provided in Appendix A.

Figure 5. Center for Health Information and Analysis Mental Health and SUD Service Categories

Abbreviations: MH=mental health, ED =emergency department, PC=primary care, and SUD=substance use disorder.

Behavioral Health Providers

Another decision point is whether to limit behavioral health spending to services performed by certain types of providers and, if so, whether to categorize them. Massachusetts previously limited spending to certain providers, as defined by taxonomy code. It now only distinguishes behavioral health provided by primary care providers versus other types of providers to understand this service provision. The other anchor definitions do not restrict by provider or categorize care by provider type.

Limiting the definition to include only certain providers, as is done in Maine, may support a more focused understanding of how services are provided within the behavioral health delivery system. However, primary care providers, emergency department physicians, and other clinicians routinely provide behavioral health services. Excluding these providers may

create an incomplete picture of behavioral health service delivery. Twelve states already measure spending on certain behavioral health services as part of primary care. For states that measure both behavioral health and primary care spending, it is important to understand the overlap in spending and ensure spending is not double counted. Therefore, creating a module of behavioral health service delivery in primary care by identifying behavioral health care delivered by primary care providers allows states to allocate that spending to either analysis depending on the use case. Massachusetts provides a list of primary care provider taxonomy codes to support data submitters in identifying these services and reporting them distinctly from other behavioral health services.

Collecting spending data by categories of providers, such as primary care, adds to data submitter burden if the state is requesting a supplemental template to capture this information. It also adds analytic complexity, especially if the state is utilizing an internal data source for measurement, such as an APCD. However, Advisory Group members noted that focused analyses of spending and utilization of behavioral health services by provider type could provide insight into access gaps and behavioral health workforce needs. These and other key benefits and drawbacks are presented in Table 3.

Measurement Decision: Provider Type

The recommended definition of behavioral health spending does not restrict provider type. It does provide a list of primary care taxonomies to track behavioral health services delivered in the primary care setting.

Table 3. Behavioral Health Providers Decisions

Decision	Included in State Definition			Benefits	Drawbacks	Recommendation
	ME	MA	RI			
Restrict by provider type (e.g., psychologist, social worker, therapist, peer specialist)	X			• Only includes services delivered by providers most commonly considered behavioral health by stakeholders and the state.	• Likely to miss a broad array of behavioral health spending. • Does not reflect how care is delivered. • Increases data submitter burden.	Do not restrict.
Categorize spending by provider type	X	X		• Provides greater insight into service delivery trends.	• Increases submitter burden; the more detailed/ exhaustive the list of categories, the greater the burden.	Include primary care taxonomy list for categorization.

Recommendations: The recommended definition does not restrict by provider type. It does include a list of primary care taxonomies to define and better understand behavioral health delivery in primary care settings. Implementing this list of primary care taxonomies, such as family medicine, internal medicine, or pediatrics, is an optional component of the recommended definition. The Advisory Group also noted that deeper insight into behavioral health service provision by provider type could be attained via analyses using APCDs.

Behavioral Health Care Settings

For the purposes of measuring spending, states may define behavioral health as care delivered only in specific care settings. The aim of these restrictions may be to promote care delivery in specific settings, increase continuity of care, or align with current standards of care. However, treatments for patients with behavioral health conditions are increasingly delivered in varied and evolving settings to meet patients' needs in the most convenient way.

State Use Case: Improvement

Spending on behavioral health services is increasing. Measuring service use and spending by service category will enable states to better understand whether upstream investments are addressing patients' conditions earlier and reducing the need for higher-intensity care.

Behavioral health care is increasingly shifting to nontraditional care settings such as via telehealth, mobile units, and schools. Not having a restriction on care settings would help states capture a wider array of spending, particularly for these evolving delivery settings. Massachusetts requires specific place of service and revenue codes. The benefits and drawbacks of limiting by place of service for professional services and revenue codes for facility services are outlined in Table 4. Advisory Group members highlighted how analyses by care setting for certain diagnoses—such as care for dementia in nursing homes—could inform whether those diagnoses should be included in future iterations of the definition by offering insight into how often these services are provided and the associated spend. A state APCD also could support these behavioral health spending analyses.

Table 4. Behavioral Health Care Settings Decisions

Decision	Included in State Definition			Benefits	Drawbacks	Recommendation
	ME	MA	RI			
Restrict by care setting	X	X		• Only includes care settings most commonly considered behavioral health by stakeholders and the state (e.g., community mental health centers, offices, federally qualified health centers).	• Standard of care may require delivery of care in certain settings for continuity of care and coordination. Restricting by care setting may exclude some of this spending. • Innovation in behavioral health delivery will result in service delivery in diverse settings, which is important to track. Restricting by care setting may exclude some of this spending.	• Restrict; categorize services consistent with the Massachusetts definition using place of service and revenue codes.
Track care by setting to understand change in delivery	X	X		• Supports various analyses, such as whether increased investment in preventive care decreases care delivered in downstream settings, such as residential places of service.	• Adds to data submitter burden and analytic complexity.	Consider opportunities to track care delivered via telehealth and in mobile units, schools, and residential settings, through an APCD.

Recommendations: The recommended definition's code set, in Appendix A, includes place-of-service codes and revenue codes to assign services to care settings, consistent with the Massachusetts definition. States should consider opportunities to monitor and report on care delivery in care settings of interest, such as telehealth, schools, mobile units, and residential settings, to better understand care delivery in these settings.

Measurement Decision: Care Setting

The recommended definition of behavioral health spending restricts by care setting to enable categorization of services. The recommended definition also assigns care and spending to service categories based on revenue and place of service codes.

CAPTURING BEHAVIORAL HEALTH NON-CLAIMS SPENDING

Medicare and Medicaid pay for about 58% of all behavioral health services.[6] These payer types are more likely to pay for this care using non-claims payments than commercial carriers. Non-claims payments are payments for services not covered by a fee-for-service claim, such as performance bonuses or penalties and capitation, or for services provided in non-clinical settings such as housing or social supports.

As states increase investments in behavioral health, the volume of these non-claims payments is increasing.[7] Federal programs, such as the AHEAD model supported by the Center for Medicare and Medicaid Innovation, stress the importance of increasing non-claims payments when working toward investment targets, as these payments offer providers more flexibility to meet a wide range of patient needs.[8] Advisory Group members agreed the standardized methodology should include an approach to measuring non-claims payments to support behavioral health, which is incorporated into two of the three anchor definitions.

Non-claims payments often support care coordination, connections to social supports, and other services to address medical, behavioral, and social needs. The Advisory Group discussed whether to include non-claims payments only when directly linked to a behavioral health need or add those that may address behavioral health needs indirectly. For example, non-claims payments to fund care coordination and connections to social supports for individuals with a behavioral health diagnosis may meet behavioral health needs. Apportioning these payments to behavioral health requires further discussion with payers and providers on the distribution of the funds within provider organizations. Further, no method to define and assign non-claims payments to categories works perfectly, as payers often have little insight into how certain non-claims payments are deployed by provider organizations. In Massachusetts, payers report difficulty allocating non-claims payments such as capitation, risk settlements, and care management to behavioral health. Maine collects behavioral health non-claims with primary care non-claims payments due to these difficulties. The state has recently recommended collecting non-claims payments in more discrete categories to understand the portions truly going to behavioral health.

The Advisory Group reviewed an approach for categorizing non-claims payments being piloted by California. This approach, known as the Expanded Framework, was developed by the California Office of Health Care Affordability and Freedman HealthCare. It builds on previous efforts by the Milbank Memorial Fund and Bailit Health to categorize non-claims payments for primary care.[9] The Expanded Framework, included in Appendix B, allows states to categorize non-claims into discrete buckets to reflect a broad array of purposes, including payments to support integrated behavioral health (behavioral health care provided in collaboration with primary care) and behavioral health capitation payments (predefined, typically prospective payments to support providing behavioral health services for a population over a defined period of time) (see Figure 6). These discrete, descriptive categories enable payers to differentiate behavioral health non-claims payments based on the purpose of the payment, allowing states to better understand the dollars flowing to support various care delivery goals.

Measurement Decision: Non-Claims Spending

The methodology includes using the Expanded Framework approach to collect non-claims spending via payers to support behavioral health clinical services.

Figure 6. Expanded Framework Behavioral Health Categories

*Payers would be instructed to calculate the behavioral health component based on fee-for-service equivalents for services outlined in Appendix A adjusted for geography and payer type and their associated utilization.

A summary of the benefits and drawbacks of these decision points is included in Table 5.

Advisory Group members highlighted that non-claims payments for behavioral health services, particularly those made by Medicaid, will continue to evolve as states innovate through Section 1115 waiver programs. For example, Massachusetts' Section 1115 waiver now includes support for members with behavioral health needs who are experiencing or are at risk for homelessness. The group expects that other payers will follow suit in increasing and evolving these types of payments.

State Use Case: State Budgeting

Comparing spending for populations engaged in different programs can help identify programs with the greatest impact. State leaders may use this information to inform future budget decisions.

Table 5. Non-Claims Spending Decisions

Decision	Included in State Definition			Benefits	Drawbacks	Recommendation
	ME	MA	RI			
Measure behavioral health non-claims payments in one non-claims category	X			• Most aligned with current payer understanding of non-claims behavioral health payments.	• Does not provide granularity into what non-claims payments are used for.	Multiple discrete categories, such as those in the Expanded Framework.
Separate behavioral health non-claims payments into discrete categories		X		• Payers are likely to continue to develop targeted non-claims payments to support behavioral health delivery.	• Separating non-claims payments into discrete categories will add to submitter burden. • Payers lack detail on the portion of non-claims payments providers use to support behavioral health.	Multiple discrete categories, such as those in the Expanded Framework.
Exclude payments that may only indirectly support behavioral health (e.g., care coordination, risk settlements)	X	X	X	• These types of services may benefit those with behavioral health conditions.	• Difficult to quantify and apportion. • Could promote gaming in states with a spending target.	Exclude payments that indirectly support behavioral health.

Recommendation: The recommended definition includes collecting non-claims spending by service categories aligned with the Expanded Framework. For the purposes of behavioral health spending measurement, include all payments to support integrated behavioral health and behavioral health capitation. If other capitation payments include behavioral health services, payers should calculate the behavioral health component, such as by using a fee-for-service equivalent multiplied by the number of encounters for behavioral health services. California is piloting using the Expanded Framework to identify non-claims payments to support behavioral health and then allocate these payments to distinct categories (see Figure 6). States should consider inclusion of payments that indirectly support behavioral health, such as risk settlements, in the future based on further discussion with payers and providers.

CONCLUSION

Measuring behavioral health spending can help identify access and quality issues. It can also support mental health payment parity analyses and increase understanding of whether certain upstream investments accrue downstream savings. As investments in preventive services and treatments for behavioral health conditions expand, understanding the impact on spending on downstream treatment interventions, such as residential treatment, will support states in focusing spending. Our Advisory Group of state leaders and subject matter experts' recommendations for the definition of payer-funded clinical behavioral health, as well as other methodology considerations, are provided in the following box. These recommendations will benefit states in understanding the historic underinvestment in behavioral health, provide context for developing investment targets, and enable comparisons across states while reducing data submitter burden. A standardized definition and methodology for calculating this behavioral health spending is included in Appendix A.

Advisory Group Recommendations for a Standardized Definition of Clinical Behavioral Health Spending

Claims Spending

Diagnosis

- Include a specific set of diagnosis codes to identify patients with a primary diagnosis of a behavioral health condition.
- Include all diagnosis codes for mental health and substance use disorders consistently used in state definitions, as well as dementia, developmental disorders, and poisoning related to self-harm.
- Assign diagnoses and associated spending to mental health and substance use disorder categories.

Services and Treatments

- Include a specific set of procedure codes to define behavioral health services.
- Use a standardized code set to identify and categorize services into inpatient, emergency department/observation, outpatient primary care, and outpatient non–primary care. Include additional categories of long-term care, residential care, and mobile services.
- Separate spending in each service category into mental health and substance use disorder based on the patient's primary behavioral health diagnosis.
- Include services typically covered by Medicaid only.
- Define behavioral health treatments for those with behavioral health conditions using the National Drug Codes in place in Massachusetts and Rhode Island.

Provider

- Do not restrict by provider type.
- Track behavioral health services delivered by primary care providers in the primary care setting.

Care Setting

- Assign services to specific care settings based on place of service and revenue codes.

Non-Claims Spending

- Measure non-claims clinical spending using a standardized approach.
- Include only non-claims payments to support behavioral health needs, such as integrated behavioral health, as behavioral health spending.
- Do not classify non-claims payments to support services with broader impact, such as care coordination and management, as behavioral health spending.

While this methodology focuses on clinical spending by payers, the Advisory Group also identified other areas of behavioral health spending measurement, such as capturing clinical spending funded via state budgets; more consistently tracking investments in workforce, infrastructure, and other social supports; and identifying patient out-of-pocket spending. Standardizing measurement of these areas will capture additional clinical care and social supports spending.

Future efforts should focus on additional opportunities for standardization and optimizing uses of the proposed measures. Our next phase of work will address concerns expressed about the details of measurement, such as:

- Is the methodology feasible for state analysts and payer data submitters to implement?
- What guidance should be included in technical specifications to support consistent application of the definition, particularly for measuring non-claims spending?
- How would states use the behavioral health spending data to advance policy goals?

ABOUT THE REPORT

This study builds on the 2023 Freedman HealthCare, LLC (FHC) report *Investing in Behavioral Health Care: Lessons from State-Based Efforts,* which marked the progress by states to measure behavioral health spend.

Decisions noted throughout the report are based on research by FHC, two discussions with an Advisory Group, and additional discussions with state leaders and subject matter experts.

Advisory Group Members

State/ Organization	Participant Name	Job Title
California Office of Health Care Affordability	Margareta Brandt, MPH	Assistant Deputy Director, Health System Performance
California Office of Health Care Affordability	Jill Yegian, Ph.D.	Consultant
Maine Health Data Organization	Karynlee Harrington	Executive Director
Massachusetts Center for Health Information and Analysis	Lauren Peters, JD	Executive Director
Massachusetts Center for Health Information and Analysis	Caitlin Sullivan, MPH	Deputy Executive Director, Health Informatics & Reporting
National Association of State Mental Health Program Directors	Brian Hepburn, M.D.	Executive Director
National Association of State Mental Health Program Directors	Ted Lutterman	Senior Director, Government and Commercial Research
National Association of State Mental Health Program Directors	Jessica Pollard, Ph.D.	Senior Behavioral Health Advisor
Rhode Island Office of the Health Insurance Commissioner	Cory King, MPP	Acting Health Insurance Commissioner
SJA Health Solutions	Sarah Arnquist, MPH	Principal Consultant
Texas Health and Human Services	Courtney Harvey, Ph.D.	Associate Commissioner – Office of Mental Health Coordination, Behavioral Health Services Department

ABOUT THE AUTHORS

Vinayak Sinha, MPH, a senior consultant for Freedman HealthCare, supports teams focused on measuring and improving the value of health care across several states. Mr. Sinha coauthored the California Health Care Foundation report Investing in Behavioral Health Care: Lessons from State-Based Efforts on how states capture behavioral health spending. He currently supports the Massachusetts Center for Health Information and Analysis on collecting and reporting on behavioral health costs, cost trends, and price. While at Freedman HealthCare, Mr. Sinha has analyzed primary care delivery and payment models, designed and implemented data collection on health care claims and non-claims payments, developed and delivered reports and presentations for multistakeholder audiences, and managed projects to provide FHC clients with unique insights into measuring and improving health care quality, access, and cost.

Emma Rourke, CSPO, a project manager for Freedman HealthCare, brings her project management knowledge, stakeholder engagement experience, and writing and report development skills to form well-crafted deliverables and responsive project support. While at Freedman HealthCare, Ms. Rourke has led project management and report development exploring health plan compliance and potential expansion of essential health benefits, managed state APCD data governance and release processes, and supported state efforts to measure primary care spend. Ms. Rourke is also FHC's expert on communications, shaping and implementing social media and communications strategy for both internal and client use.

Mary Jo Condon, MPPA, a principal consultant for Freedman HealthCare, has supported multiple states in the development of care delivery and payment models that put primary care at the center, expand care teams, integrate community resources, and utilize data to address the medical, behavioral, and social needs of patients and caregivers. While at Freedman HealthCare, Ms. Condon has led multilayered, data-driven health policy projects requiring extensive stakeholder engagement, complex analytic methodologies, and clear, concise presentation of cost and quality outputs. Recent projects include leading the Delaware Department of Insurance Office of Value-Based Health Care Delivery, developing an environmental scan of state approaches to behavioral health investment, and

supporting the states of Massachusetts, California, and Maryland in efforts such as measuring investment in primary care and behavioral health and uptake of alternative payment models.

William Brandel, PhD, a health policy analyst and researcher/writer, uses his experience in research, analysis, and communication to help organizations shape policy decisions. As a policy analyst, Dr. Brandel helps develop creative solutions to complex problems by identifying data sources, evaluating policy, and communicating trade-offs and other considerations for implementation. Dr. Brandel has conducted numerous research efforts involving various methods and subjects to provide guidance to stakeholders in health care, government, business, and academia. Most recently, he has participated in analytical efforts that include total health care expenditures reporting for the Center for Health Information and Analysis in Massachusetts, developing essential health benefits for Delaware, and conducting cost and market impact review for the Office of Health Strategy in Connecticut.

NOTES

[1] Wilson S, Dumornay NM. Rising rates of adolescent depression in the United States: challenges and opportunities in the 2020s. *J Adolesc Health.* 2022. doi:10.1016/j.jadohealth.2021.12.003.

[2] Condon M, Sinha V, McGourty-Holland K. Investing in behavioral health care: lessons from state-based efforts. California Health Care Foundation. https://www.chcf.org/publication/investing-in-behavioral-health-care-lessons-from-state-based-efforts/. Published 2023. Accessed February 21, 2024.

[3] Substance Abuse and Mental Health Services Administration. Behavioral health spending & use accounts 2006—2015. HHS Pub. No. (SMA) 19-5095. https://store.samhsa.gov/sites/default/files/bhsua-2006-2015-508.pdf. Published 2019. Accessed February 21, 2024.

[4] Maine Quality Forum. Public Law 2021, Chapter 603, 2023 Annual Report: Behavioral Health Spending. https://mhdo.maine.gov/_pdf/MQF%20Annual%20BH%20Spending%20Report%20230323.pdf. Published March 2023. Accessed February 23, 2024.

[5] Antezzo M. Investments in behavioral health service systems: top three emerging themes from state home and community-based services spending plans. National Academy for State Health Policy. https://nashp.org/investments-in-behavioral-health-service-systems-top-three-emerging-themes-from-state-home-and-community-based-services-spending-plans/. Published October 18, 2021. Accessed February 21, 2024.

[6] Nathaniel Counts, Behavioral health care in the United States: how it works and where it falls short. Commonwealth Fund. Published September 7, 2022. doi:10.26099/txpy-va34.

[7] Massachusetts Medicaid 1115 waiver approval. Centers for Medicare and Medicaid Services website. https://www.medicaid.gov/sites/default/files/2023-09/ma-masshealth-apprvl-08312023.pdf. Accessed November 2, 2023.

[8] States advancing All-Payer Health Equity Approaches and Development (AHEAD) model. Centers for Medicare and Medicaid Services website. https://www.cms.gov/priorities/innovation/innovation-models/ahead. Accessed November 2, 2023.

[9] Taylor E, Bailit M, Kanneganti D. Measuring non-claims-based primary care spending. Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_8.pdf. Published April 2021. Accessed February 21, 2024.

[10] California Department of Health Care Access and Information. Health Care Affordability Board Meeting. https://hcai.ca.gov/wp-content/uploads/2024/02/February-2024-Board-Meeting-Presentation.pdf. Published February 28, 2024.