CHCF

Investing in Behavioral Health Care:
Lessons from State-Based Efforts

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Executive Summary

Over the last decade, at least a dozen states and regions have taken steps to measure primary care investment as part of larger efforts to increase investment in primary care. Some states have similar requirements for behavioral health care measurement (i.e., care related to mental health and substance use disorders). California's Senate Bill 184, for example, requires the Department of Health Care Access and Information (HCAI) to calculate the percentage of total health care expenditures allocated to behavioral health.

In this paper, Freedman HealthCare (FHC) examines national best practices in behavioral health investment data collection and reporting. Based on a set of criteria, FHC identified 13 states and reviewed specifications and methodologies used to measure behavioral health investment within each state. In its analysis, FHC identified three categories of investment — clinical care, social supports, and "other," including workforce development and other administrative costs. This paper discusses the ways in which these states have measured and reported on these three categories, as well as the data sources used to document and measure investments. By taking the state examples into account, as well as input from subject matter experts, FHC outlines the key decisions and trade-offs to take into consideration when developing measurement and reporting methodologies:

- 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?
- What data sources should be used to supplement the all-payer claims database (APCD)?
- What best practices should states consider incorporating into measurement and reporting of behavioral health investment?

While this paper is focused on California implementation, the analysis and recommendations should also be valuable to agencies, planners, and policymakers in other states that are working toward measuring and reporting behavioral health investment.

Purpose and Context

Over the last decade, at least a dozen states and regions have taken steps to measure primary care investment as part of larger efforts to increase investment in primary care. Some states have similar requirements for behavioral health care measurement (i.e., care related to mental health and substance use disorders). For instance, California's Senate Bill 184, which was signed into law in June 2022, requires the Department of Health Care Access and Information (HCAI) to calculate the percentage of total health care expenditures allocated to primary care and behavioral health.[1] In this paper, Freedman HealthCare (FHC) examines national best practices in behavioral health investment data collection and reporting. In its previous report, ***Investing in Primary Care: Lessons from State-Based Efforts***, FHC provided similar guidance related to primary care.

This paper aims to support HCAI in completing required activities outlined in the statute, including defining the following:

- Categories of payments to behavioral health care providers and practices, including non-claims-based payments, such as alternative payment model payments, which should be included when determining the total amount spent on behavioral health
- Data sources necessary for measurement, using the Health Care Payments Data (HPD) Program to the greatest extent possible to minimize reporting burdens

- Categories of health care professionals who should be considered behavioral health providers
- Specific procedure codes that should be considered behavioral health services

While this paper is focused on California implementation, the analysis and recommendations should also be valuable to agencies, planners, and policymakers in other states that are working toward measuring and reporting behavioral health investment.

Key Decisions Discussed in this Paper

- 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?
- What data sources should be used to supplement the all-payer claims database (APCD)?
- What best practices should states consider incorporating into measurement and reporting of behavioral health investment?

Process

To begin this work, FHC identified 13 states (CO, CT, DE, ME, MD, MA, NY, OR, RI, TX, UT, VT, and WA) that met one or more of the following 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, FHC reviewed the following:

- Technical specifications to support behavioral health investment measurement
- Benefit summaries and other documentation of covered services
- Budget documents outlining behavioral health services provided under Medicaid waivers and through general fund expenditures
- Other documentation of behavioral health expenditures, as available

FHC also interviewed experts in leading states, listed in Appendix A, to better understand the rationale and trade-offs of key measurement decisions. Findings from across the states were then analyzed in the context of California.

Behavioral Health Investment Categories

In its analysis, FHC identified three categories of behavioral health investment — clinical care, social supports, and "other," including workforce development and other administrative costs. Table 1 shows examples of expenses FHC included in each category.

No state measures behavioral health expenditures across all three categories.

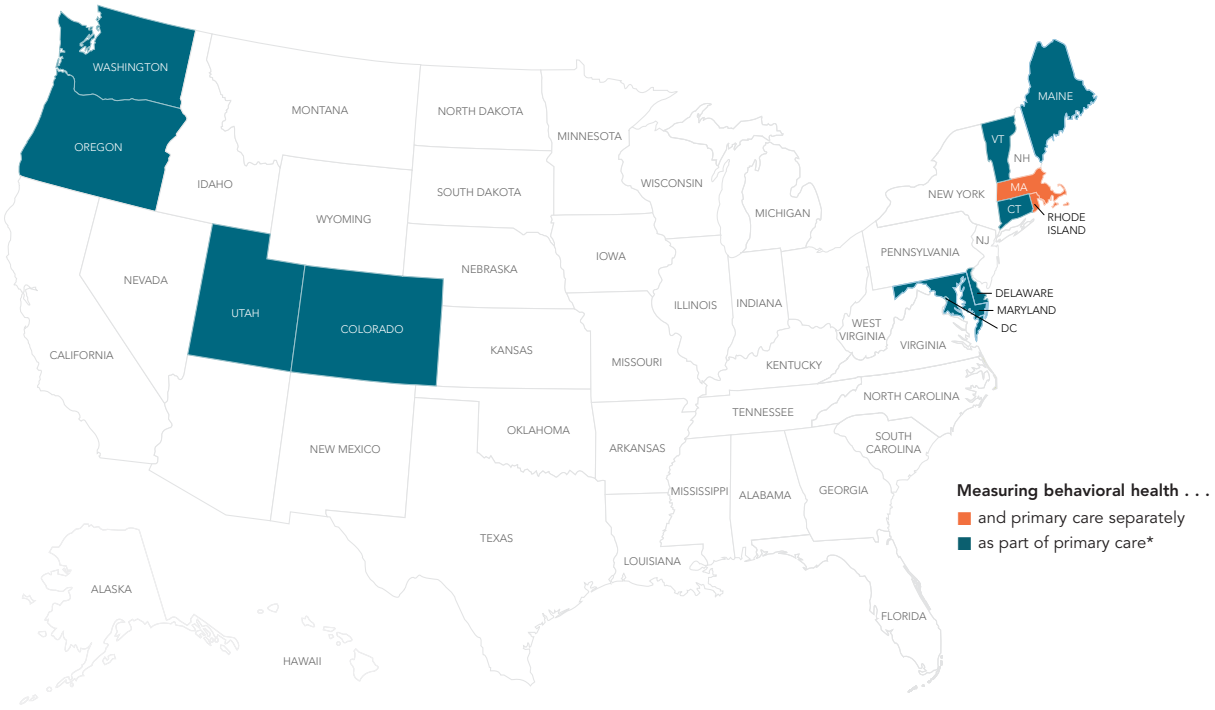
Table 1. Examples of Expenses in Behavioral Health Investment Categories

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		

Source: Author analysis of state Essential Health Benefit Benchmark Plans and state Medicaid benefit documentation.

Clinical care. Most states measuring behavioral health investment today do so on a limited basis as part of efforts to measure primary care investment. Of the dozen states reporting primary care investment, nine include a limited number of behavioral health services. These services typically include assessment, screening and counseling, and, in some states, select treatments. Massachusetts and Rhode Island are the only states measuring behavioral health investment across all clinical services, as shown in Figure 1.

Figure 1. States Measuring Behavioral Health Investment



*States measuring behavioral health services as part of primary care investment use different definitions. For example, some include individual and group psychological therapy while others limit the definition to behavioral health services more commonly performed in a primary care setting such as behavioral health-related assessments, screenings, and collaborative care services.

Source: Author analysis of state primary care investment definitions.

State behavioral health definitions for measurement and reporting. Appendix B documents the Current Procedural Terminology (CPT), Place of Service (POS) and taxonomy, and International Statistical Classification of Diseases and Related Health Problems (ICD) codes each state uses to define behavioral health care for measurement and reporting.

Social supports. Support services — which are an important component of behavioral health care — are often reimbursed outside the claims system and therefore are more difficult to capture. No state captures these expenses specific to behavioral health in a meaningful way today. Several states interviewed for this paper expressed interest in expanding their behavioral health investment definitions and refining their approaches. Massachusetts and Rhode Island would like to include more expenses related to social supports, such as connections to housing, transportation, and employment assistance for individuals with a behavioral health diagnosis. Medicaid tends to cover these services more frequently than commercial payers do, as shown in Table 2 (see page 7). More discussion on the difficulty of capturing these payments is provided in the sidebar to the right.

Other. Faced with growing need and workforce shortages, many states are investing more in statewide programs to better organize and fund behavioral health.[2] This investment may support workforce recruitment and retention programs, new departments and divisions focused on behavioral health, and analytics to understand need and prioritize resources. To capture trends in these expenses, Colorado and Oregon document state spending on them, as shown in Appendix C.

KEY DECISION

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?

- States might begin by measuring investments in behavioral health clinical services.
- Medicaid covers behavioral health services not typically covered by commercial payers. Medicaid programs could help states identify services — particularly those paid on a fee-for-service basis — that should be included in this initial measurement definition.
- Social services play an important role in achieving strong behavioral health outcomes. These services are often reimbursed outside the fee-for-service claims system. To fully capture these services, a state would need to collect data on alternative payment models (APMs). More information on challenges related to APM data collection specific to this use case is provided in the sidebar on page 8.

Medicaid plans typically cover more behavioral health services than commercial plans. Many states noted their definitions of behavioral health were developed to align with commercial coverage. Therefore, their definitions tend to exclude some Medicaid expenditures. Table 2 shows services covered by each state's Medicaid plan, services covered by its commercial essential health benefits plan, and services included in its measurement and reporting of behavioral health.

Table 2. Overview of Coverage for Behavioral Health Services and Reporting Definitions

KEY: ● Publicly reported investment ● Medicaid ● Commercial
○ Specified populations ◇ Specified procedures □ Specified providers

CLINICAL CARE	MA	RI*	CO	OR	DE	MD	WA†	UT	ME	CT	VT	TX‡	NY‡
Assessment, screening, and other diagnostic services	●●●	●●●	●□●	○●●	●●●	○●●	○●●	○●●	○●●	○●●	○●●	●●	●●
Case management	●□□	●●	○□	●●●	○●	●	○●	●	○	●○	○	●	●
In-home services	●□□	●□	●	●●				□		○○			
Inpatient/residential MH treatment	●●●	●●●	●●	●●	●●	○●	●●	●●	●●	○●	○□	●○	●●
Inpatient/residential SUD treatment	●●	●●●	●●	●□	●●	●●	●●	●●	○●	●●	●□	●●	●●
Medication-assisted treatment (MAT)	●●●	●●	●●	○●	●	●●	●●	●	●●	●●	●	●	●
Medication	●●●	●●●	●●	●●	●●	●●	●●	●●	●●	●●	●●	●●	●●
Medication management	●●	●●□	●●	○●	○	●●	●	●●	●	●●	●	●●	●
Mobile crisis response	□□	●●	□	●				●	□	●	○		●
Partial hospitalization program (PHP)/ intensive outpatient program (IOP)	●●●	●●●	□●	●□		●●	●●	●	○	●●	○●	●●	●□
Psychotherapy and counseling	●●●	●●●	●□●	○●●	○●●	○□●	○●●	○●●	○●●	○●●	○●●	●●	●●
Therapeutic procedures	●◇	●◇	●□	◇●	●	◇●		◇◇	●	◇●		◇◇	□●

*Rhode Island did not restrict by service but rather required a primary behavioral health diagnosis.
† Washington has narrow and broad services definitions, and the broad definitions are reflected in the table. See Appendix B for further detail.
‡ Texas and New York do not report on primary care spending.

Notes: *MH* is mental health. *SUD* is substance use disorder.

Source: Author analysis of state Essential Health Benefit Benchmark Plans and state Medicaid benefit documentation. See Appendix D for a full source list.

Data Sources

Identifying data sources is an important early step in developing a measurement approach. As discussed above, most states measuring behavioral health investment focus on clinical services reimbursed through fee-for-service payments. For data sources, these states use a template completed by payers, the state's all-payer claims database (APCD), or both.

Massachusetts and Rhode Island — the two states measuring behavioral health investment across all clinical services — demonstrate the variation in approaches. Massachusetts leverages its Total Health Care Expenditures (THCE) data collection process, an Excel template that captures data from the state's fully insured and self-insured populations as well as its Medicaid plans.[3] Massachusetts chose the THCE supplemental data reporting instead of its APCD because the THCE data collection includes self-insured populations and non-claims data, which the APCD lacks. The Center for Health Information and Analysis (CHIA), which oversees the APCD, the THCE data collection process, and the state's primary care and behavioral health investment measurement, also finds the THCE data more timely and more efficient for coding and analysis than the APCD data.

However, although THCE reporting collects data on non-claims-based payments, CHIA finds the data to be of limited value for measuring non-claims investment in behavioral health services specifically. Payers contributing data found it challenging to identify the portion of non-claims payments that should be classified as behavioral health versus primary care or "other." Therefore, they classified most non-claims payments as "other." Massachusetts is considering ways to collect better data from providers directly or through payers.

Rhode Island uses its APCD as its data source for measuring behavioral health investment. The Rhode Island APCD includes fee-for-service spending for fully insured commercial enrollees and Medicaid and Medicare beneficiaries. Though Medicaid and Medicare analyses of behavioral health investment were developed by the Office of the Health Insurance Commissioner (OHIC), the state is currently focused on measuring behavioral health investment across the commercially insured population. Rhode Island would like to use these data to inform development of a minimum behavioral health investment requirement for commercial carriers, beginning with children or adolescents. To capture non-fee-for-service spending, Rhode Island plans to transition its measurement to a template format similar to the one used by Massachusetts.

Challenges Measuring Investment from Non-Claims Payments

Non-claims payments typically lack a defined diagnosis, making it difficult to identify whether the service was related to a behavioral health condition.

Further, these payments often are intentionally structured to support care coordination, connections to social supports, and other services that aim to address needs that span across medical, behavioral health, and social services.

Therefore, quantifying the portion of this spending that should be assigned to behavioral health can feel like a false choice. Payers, not providers, are typically the reporting entity. Payers lack sufficient detail on how non-claims payments were spent, further complicating whether any of the dollars should be classified as behavioral health.

To accurately measure non-fee-for-service payments to support behavioral health, states will need a data collection process that recognizes this specific use case and encourages payers and providers to develop a payment mechanism that differentiates non-claims payments to support behavioral health from other non-claims payments.

For many states, primary care measurement offers the best model for behavioral health measurement. As noted above, many states begin by including some behavioral health services in their primary care investment definition. Of the nine states that include certain behavioral health services in their primary care investment definitions, four collect these data from the APCD. Connecticut uses a carrier template. Colorado, Oregon, Vermont, and Delaware collect data through both methods.[4] APCDs offer several benefits. Payers do not have to submit any additional data. APCDs' "in-house measurement" helps ensure that technical specifications are followed in a consistent way. Templates, however, may include data from members of self-insured plans and non-claims payments that are typically not included in APCDs.

Regardless of whether states use a template or an APCD, some investments in behavioral health may be missing, including the following:

- Employer investments made through behavioral health carve-outs, employee assistance programs, and digital behavioral health platforms
- Medicaid dollars flowing to providers through federal waivers or from the general fund outside of the claims system and not captured in template non-claims reporting
- Certain clinical services and social supports commonly covered by Medicaid plans but less commonly covered by commercial payers
- State agency investments in community-based care delivery, workforce development, administrative supports, and other public programs
- Self-pay portions of services, including services not covered by a payer or in which the provider is out of network and a claim is not submitted to the carrier. Missing self-pay data is a more significant problem when measuring behavioral health investment because of the high proportion of out-of-network providers. A recent JAMA Psychiatry article found that 22% of psychiatrist visits were self-paid by patients, compared with less than 4% of primary care clinician visits.[5]

KEY DECISION

What data sources should states use to supplement their APCDs?

- An APCD will offer states a solid starting place for measuring most investment in clinical behavioral health services.
- In developing its initial technical specifications, a state may find it beneficial to connect with its Medicaid agency to ensure that all appropriate claims-based behavioral health services are included.
- Some payers may carve out behavioral health services to networks of behavioral health providers that are responsible for providing this care in exchange for a per-member per-month payment. States will need a way to capture this spending either through encounters with a behavioral health diagnosis reported to the APCD or through a non-claims data collection process that includes capitated payments.
- Over time, state APCDs or other state agencies may develop a non-claims data collection template that can serve many use cases, including measuring non-claims payments to support behavioral health. It will be helpful to reconnect with states already collecting these data. Massachusetts and other states may have overcome current challenges and offer new lessons learned.
- Over time, states may want to expand data collection to include other state investments in workforce and infrastructure. States such as Colorado and Oregon, whose approaches to this type of data collection are shown in Appendix C, may offer important insights and lessons learned.

Key Investment Measurement Decisions and Trade-Offs

Similar to primary care investment, states measuring behavioral health investment plan to express it as a per-member per-month dollar amount or as a percentage of total medical expense as shown in Figure 2. The per-member per-month dollar amount serves as the numerator in the percentage calculation. States calculate this figure by summing total spending on services related to behavioral health. This definition may include a combination of the following:

- Diagnoses as defined by a set of International Classification of Diseases, Tenth Revision (ICD-10) codes
- Services as defined by a set of Current Procedural Terminology (CPT) codes
- Providers as defined by taxonomy codes
- Care settings as defined by place of service (POS) codes on professional claims and revenue codes or bill type codes on facility claims
- Medications as defined by National Drug Codes (NDC)

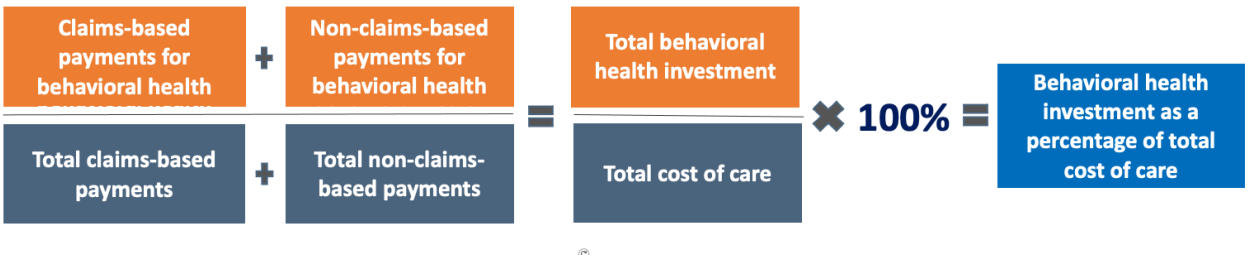
The denominator may include the full population or only individuals with a behavioral health diagnosis. Including the full population in the denominator provides an understanding of total dollars flowing to behavioral health and how it compares to total spending. Including only individuals with a behavioral health diagnosis shows whether spending is increasing among the population using these services. Interviewees for this paper suggested calculating spending both ways to avoid increases in prevalence masking stagnant or decreasing investment among those using services.

States measuring behavioral health treat each component of the numerator in different ways. Behavioral health investment varies by the defined list of diagnoses, services, providers, and places of service included in each state's measurement specifications.

Diagnoses

States measuring behavioral health investment must develop a list of diagnosis codes to define behavioral health. Massachusetts chose two commonly used Healthcare Effectiveness Data and Information Set (HEDIS) measures as the basis for the ICD-10 diagnosis codes included in its definition. The HEDIS value sets used in 2022 were Mental Health Utilization (MPT) renamed to Diagnosed

Figure 2. 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.

Mental Health Disorders (DMH), and Identification of Alcohol and Other Drug Services (IAD) renamed to Diagnosed Substance Use Disorders (DSU). Stakeholders then refined these lists of diagnosis codes. CHIA expects its list of diagnosis codes will be further refined in future specifications. In Rhode Island, OHIC worked with the state Department of Behavioral Healthcare, Developmental Disabilities & Hospitals to define the diagnoses included in its behavioral health investment definition. A list of diagnosis codes used in both states can be found in Appendix B.

California stakeholders interviewed for this paper suggested that the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) would provide another potential starting point. Medi-Cal (California's Medicaid program) has used it as the basis for other behavioral health definitions.

Stakeholders in Massachusetts and Rhode Island focused on whether to include autism spectrum disorders, dementia, and tobacco and alcohol use disorders in their states' definitions. Massachusetts decided to include certain tobacco and alcohol use disorders, dementia, and disorders of psychological development, such as autism. Rhode Island decided to include dementia and tobacco and alcohol use disorders, including alcohol poisoning, which Massachusetts excluded. Rhode Island excludes autism and other disorders of psychological development.

Note that APCDs have varying approaches to addressing federal privacy laws that restrict the sharing of substance use disorder diagnosis information. Nationally, data submitters have varying levels of comfort with including this diagnosis information as part of APCD submissions. In some states, the data are submitted but held to more restrictive data release policies.

Services

As discussed above, only Massachusetts and Rhode Island measure behavioral health investment across all clinical services. These two states are often among the first to explore new health care policies, data analytics, and measurement strategies. Both states were pioneers in measuring primary care investment and collecting non-fee-for-service payments. Both states also maintain active, mature APCDs.

Massachusetts defined its list of services using the same HEDIS value sets it used to define its list of diagnosis codes. Stakeholders then refined the service list to include medication-assisted treatment (MAT). MassHealth, the state's Medicaid and Children's Health Insurance Program (CHIP) agency, helped CHIA develop a list of NDC codes to define medications to treat behavioral health conditions. Though certain medications could be used to treat other conditions, CHIA includes them for patients with a behavioral health diagnosis.

Rhode Island included all services provided to a patient with a primary behavioral health diagnosis and separated those services into one of three care settings — facility, as defined by institutional claim type; community, as defined by professional claim type; and pharmacy. Rhode Island borrowed Massachusetts' NDC list.

Nine states that measure primary care investment include behavioral health services in their primary care definitions, as shown in Figure 1. All include assessments and screenings as well as psychotherapy and counseling services. Four of the nine states include case management services to support patients' navigation of health care and social support systems. Colorado, a national leader in integrated behavioral health, also includes payments for therapeutic procedures and group and family interventions as part of its primary care definition.

Medicaid typically covers a broader array of behavioral health services than commercial health plans. Examples of these services include MAT, mobile crisis response services, medication management, and social services and supports. As shown in Table 2, many behavioral health services covered by Medicaid payers are not covered by commercial payers or captured in current reporting on behavioral health investment.

Providers

Some states' measurement specifications require services rendered by providers with specific specialties to be included as behavioral health. These states develop a list of taxonomy codes to define those specialties. Massachusetts, for example, developed an extensive list of specialties to define behavioral health providers, including physicians, counselors, organizations, and agencies as well as peer recovery specialists. Rhode Island does not restrict by provider type.

All states including behavioral health services in primary care measurement limit by provider type. All of these states include traditional primary care specialties (e.g., general internal medicine, family medicine). Four of these states include some behavioral health providers. Among these states, Colorado and Washington include the most extensive list of behavioral health specialties. A comparison of the specialties included in each state's definition can be found in Table 3.

Providers included in measurement range from traditional clinical roles, such as social workers, psychiatrists, and psychologists, to nonclinical members of the care team, including community health workers and peer specialists. Medicaid plans are more likely to reimburse for nontraditional providers and often do so through non-claims payments. Services provided at Federally Qualified Health Centers (FQHCs), more frequently covered by Medicaid than commercial plans, are often paid for via a lump sum payment for the services rendered by other providers, such as peers or community health workers.

Places of Service

Professional services included in behavioral health measurement may be restricted by the place of service. Massachusetts developed a comprehensive list of POS codes based on stakeholder conversations. Its specifications detail a hierarchical sequence for categorizing payments associated with behavioral health, then primary care, and finally a bucket designated "other." A comparison of POS codes included in each state's definition can be found in Table 3. The Massachusetts list excludes only hospice care. Massachusetts also includes a list of revenue codes for facility services. Rhode Island does not restrict by place of service. Among states measuring behavioral health services related to primary care, only Colorado, Oregon, Delaware, and Connecticut restrict by place of service.

Table 3. Overview of Behavioral Health Investment Definitions, by Approach

KEY: ● One or more provider types within the category were included in the state definition.*

	FULL CARE CONTINUUM		PRIMARY CARE FOCUSED								
	MA	RI	CO	OR	DE	VT	MD	WA	UT	ME	CT
Provider Specialties†											
Agencies	●	●									
Clinical nurse specialists		●	●	●				●	●	●	
Counselors	●	●	●					●		●	
Health centers/clinics	●	●	●	●	●	●		●	●		●
Nurse practitioners and physician assistants	●	●	●	●	●	●	●	●	●	●	●
Psychiatrists	●	●	●	●				●		●	
Psychologists	●	●	●					●		●	
Social workers	●	●	●		●			●		●	
Therapists	●	●	●					●		●	
Other physicians	●	●	●	●	●	●	●	●	●		●
Others	●	●	●	●		●		●		●	●
Places of Service‡											
School/work	●	●	●								
Places of residence	●	●	●		●						
Telehealth	●	●	●		●						●
Health centers/clinics	●	●	●	●	●						●
Inpatient/residential settings	●	●									
Correctional facilities	●	●									
Outpatient settings	●	●	●		●						●

† Rhode Island did not restrict by provider type.

‡ Vermont, Maryland, Washington, Utah, and Maine did not restrict by place of service. Rhode Island did not restrict by place of service and categorized care as either facility, as defined by institutional claim; community, as defined by professional claim; or pharmacy.

Table 3. Overview of Behavioral Health Investment Definitions, by Approach, *continued*

	FULL CARE CONTINUUM		PRIMARY CARE FOCUSED								
	MA	RI	CO	OR	DE	VT	MD	WA	UT	ME	CT
Data Source											
All-payer claims database (APCD)		●	●	●	●	●	●	●	●	●	
Payer submits Excel template to state	●		●	●	●	●					●
Non-Claims Payments											
Non-claims payments not specific to behavioral health (BH) services			●	●	●	●					●
Non-claims payments specific to BH services	●										

* For more details about specific taxonomy codes, please see Appendix B.

Source: Author analysis of state Essential Health Benefit Benchmark Plans and state Medicaid benefit documentation. See Appendix D for a full source list.

KEY DECISION

What best practices should states consider incorporating into their definition of behavioral health investment?

- **Diagnoses.** Identify a standardized list of diagnosis codes, such as from relevant HEDIS value sets or the DSM. Seek stakeholder input to refine the list.
- **Services.** Identify a standardized set of services, such as those from relevant HEDIS value sets. Collaborate with the state Medicaid agency and other stakeholders to ensure as many behavioral health services as possible are captured.
- **Providers.** Develop a list of the provider specialties that typically perform the services included in the definition. Given the variation in service delivery and across payer types, either using an extensive list of provider specialties or not restricting by specialty would support the most robust measurement.
- **Places of service** included in the measurement definition should align with the types of services and provider types included in it. Casting a broad net will allow states to understand where services are provided and increases in investment may be warranted.
- **Denominator.** As states develop measurement specifications, it will be important to collect total medical expenses for both the total population and those receiving behavioral health services.

Reporting

Rhode Island, one of the two states examining behavioral health investment across clinical care delivery, has yet to publish its analysis. Massachusetts (the other state) released its **first report** in September 2022, with data for 2018, 2019, and 2020.[6]

The Massachusetts report and interactive dashboards cover both primary care and behavioral health spending and is designed to inform a broad set of stakeholders, including providers, payers, and consumer advocates. Key findings from this first report include:

- In 2020, spending on primary care and behavioral health services represented 14.3% of total spending for commercial members, 27.4% for Medicaid members covered by health plans, and 6.5% for members enrolled Medicare Advantage plans.
- Across all major insurance categories, spending on behavioral health services increased from 2019 to 2020, while primary care spending was flat or declined.
- Changes in delivery systems—particularly the increased use of telehealth—impacted trends in behavioral health spending, while trends in primary care spending were impacted by decreased utilization in 2020.

In Rhode Island, the initial use case is more policy focused. The Rhode Island OHIC would like to explore whether the state should require payers to spend a defined percentage of total medical expense on behavioral health services, similar to the state's primary care investment requirements. OHIC anticipates sharing the information as a presentation to key stakeholders and refining its data collection and reporting process over time. Rhode Island is seeking data from Vermont, Virginia, and Massachusetts to provide additional context to its state-specific results.

Most states measuring behavioral health investment include a limited number of behavioral health services and types of behavioral health providers in their primary care investment definitions. They do not report this investment separately but as a component of primary care investment. Most states

report primary care investment in a static document with text and informational graphics. Oregon uses interactive graphics to allow users to create the views of most interest to them.[7]

Regardless of the format, these reports typically show primary care investment as a per-member per-month dollar amount and as a percentage of total medical expense. Some states have developed both a narrow definition of primary care with a more limited set of providers and services, and a broad definition with an expanded set of providers and services. Dimensions or filters may include age band, geography, payer type, or service category, such as "office visits." Some states provide investment information by commercial health plan and Medicaid managed care organization.

There are several approaches to primary care investment reporting that can also be applied to behavioral health investment reporting:

- **Narrow and broad definitions**
  - **Benefit:** If the behavioral health investment definition includes certain services covered by Medicaid but not included in most states' definitions, an additional, narrower definition could be developed to better support cross-state comparisons.
- **Results by various dimensions or filters, such as age band, geography, payer type, or service category**
  - **Benefit:** There is little consensus on how to define or identify sufficient investment in behavioral health services. Comparing investment across subgroups and analyses of prevalence and utilization may help inform policy development. For example, if one county has higher rates of self-reported behavioral health needs but low investment, this may point to a maldistribution of services. Similarly, if another county is spending more on outpatient treatment and less on hospitalization, this highlights a need to talk with stakeholders in that county to determine if outpatient services are addressing issues early or if there is an unmet need for more intensive services.
- **Results by commercial health plan or Medicaid managed care organization**
  - **Benefit:** Primary care investment reporting in other states shows dramatic variation by carrier and managed care organization. In Oregon, for example, primary care investment ranged from less than 9% of total medical expense to 23% depending on the Medicaid managed care plan.[8] Similar variations in spending were reported among the state's commercial plans.

KEY DECISION

What best practices from other states should states consider incorporating into reporting of behavioral health investment?

- Develop a static report to highlight key findings and interactive graphics to encourage stakeholders to explore trends of interest.
- Report spending for the total population and for those with a behavioral health diagnosis to avoid distortions caused by increasing prevalence.
- Consider developing broad and narrow definitions to serve multiple use cases.
- Analyze data across multiple dimensions or filters and combine with analyses of prevalence and utilization to inform policy development.
- Over time, explore public reporting by plan for increased transparency and accountability.

Target Development

Targets for behavioral health investment should express a vision of behavioral health care delivery and sufficient payments to support those behavioral health services. Targets should also recognize differences in covered populations — including the average total medical expense and the percentage of population with a behavioral health diagnosis. As displayed in Table 2, coverage of behavioral health services across commercial payers and Medicaid varies. With this in mind, states may want to consider different behavioral health investment targets for different payer types or may want to hold all payer types to a similar standard to encourage commercial carriers to expand coverage for behavioral health services.

Conclusion

Investment in behavioral health spans clinical services, social supports, and workforce development and other administrative expenses. Developing an approach to measure investment in these services will support a better understanding of existing service delivery and future needs. Behavioral health services and related investments are more expansive and diversified than primary care. Therefore, measuring investment in behavioral health requires a wider net to capture associated investments. There is also more variation in covered services between commercial payers and Medicaid. This variation may require data collection approaches and targets specific to each payer type.

Only two states currently measure behavioral health investment across the care continuum. Building on lessons learned from these states, other states may want to begin with a measurement approach focused on clinical services paid through the claims system. Over time, states may want to expand behavioral health investment measurement to account for services provided outside of the claims system and expenditures beyond traditional care delivery. Initial measurement efforts can inform next steps, including whether to set a target for behavioral health investment.

Appendix A. Behavioral Health Experts Interviewed

Massachusetts Center for Health Information and Analysis (CHIA)

- Caitlin Sullivan, MPH, Deputy Executive Director of Health Informatics & Reporting
- Erin Bonney, MA, Director of Health Informatics & Reporting
- Lauren Coakley Sears, MPP, Manager of Health Informatics & Reporting

Eugene S. Farley, Jr. Health Policy Center, University of Colorado Anschutz Medical Campus

- Emma Gilchrist, MPH, Deputy Director
- Lauren Hughes, MD, MPH, MsC, FAAFP, State Policy Director
- Stephanie Gold, MD, Scholar (family physician)
- Stephanie Kirchner, MSPH, RD, Scholar (practice transformation specialist)
- Larry A. Green, MD, Senior Advisor

Rhode Island Office of the Health Insurance Commissioner (OHIC)

- Cory King, Acting Commissioner

Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy

- JoAnn Volk, MA

Integrated Healthcare Association

- Dolores Yanagihara, MPH, VP of Strategic Initiatives

UpHealth, Inc.

- Sarah Arnquist, MPH, SVP of Integrated Care Solutions (California behavioral health coverage expert)

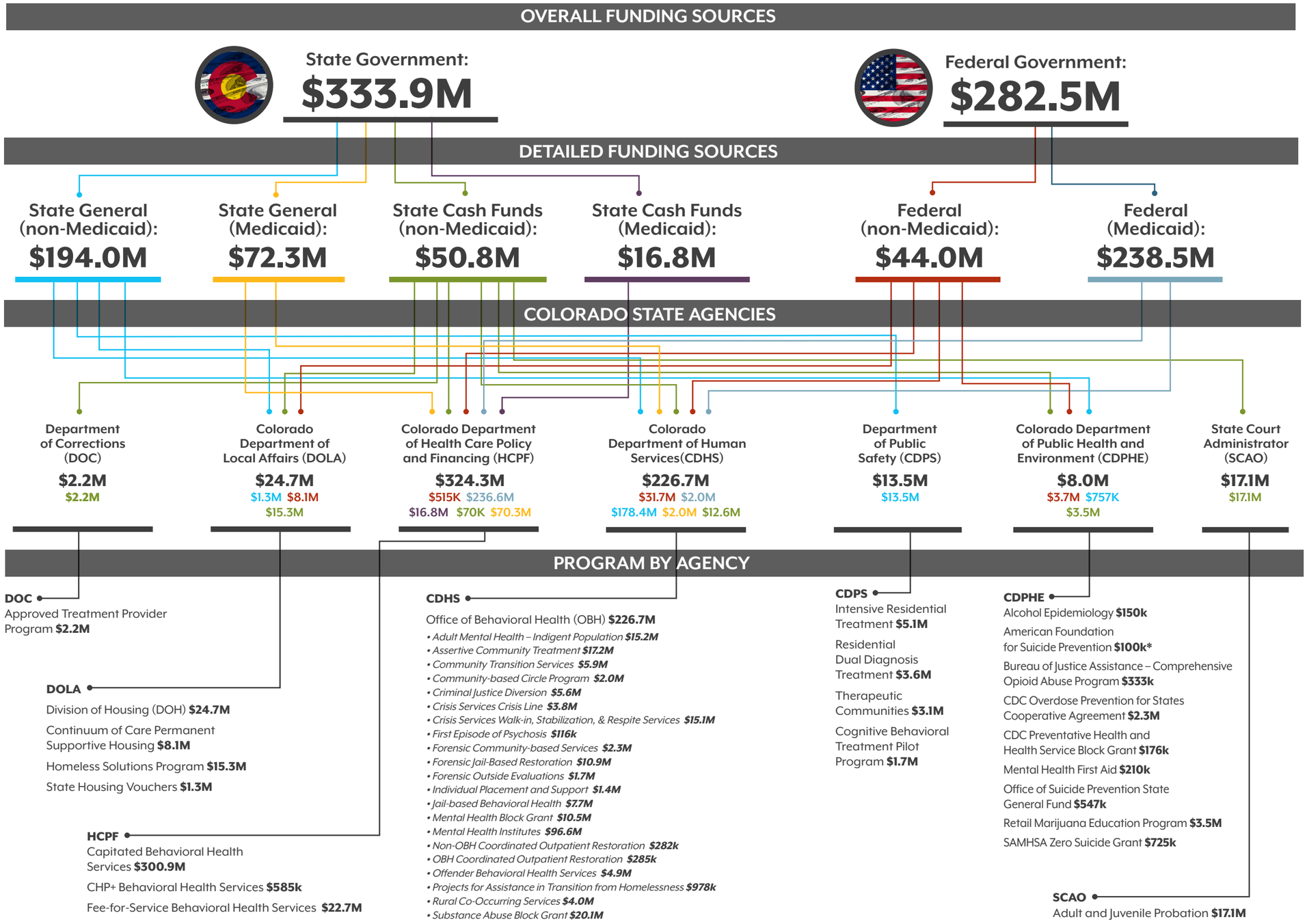
Appendix B. State Behavioral Health Definitions for Measurement and Reporting

Behavioral health investment is typically defined as spending for a behavioral health service, as denoted by a Current Procedural Terminology (CPT) code, when it is performed by a specific provider, as specified by the provider's taxonomy code. Some definitions also restrict by place of service or include non-claims payments for behavioral health services. Spending associated with certain diagnoses, as denoted by an International Statistical Classification of Diseases and Related Health Problems (ICD) code, may also be included.

A crosswalk of the code sets used by the two states measuring behavioral health and the nine states including behavioral health services as part of their primary care measurement is available for download at **www.chcf.org/investinginbh.**

Appendix C. Adult Behavioral Health Financial Map Layers and Amounts

This financial map of behavioral health spending prepared by the Colorado Health Institute for the Colorado Behavioral Health Task Force illustrates one method of documenting the disbursement of investments in Colorado's behavioral health system.



How to Read the Financial Map

Top Level:
OVERALL FUNDING SOURCES

Funding comes from two overall sources: the federal government and the state government. These are represented in the top level of the financial map.

Second Level:
DETAILED FUNDING SOURCES

The second level specifies six sub-sources: the federal government (non-Medicaid); federal Medicaid; state general funds (non-Medicaid); state Medicaid general funds; state cash funds; and state medicaid cash funds.

Third Level:
COLORADO STATE AGENCIES

This section shows the state agencies that receive these funds. Agencies then distribute funding to programs.

Bottom Level:
PROGRAM BY AGENCY

The seven agencies distribute their funds for behavioral health across 42 distinct programs ranging from direct services to adults in need of behavioral health treatment to targeted training programs aimed at improving services and prevention efforts.

*CDPHE reported receiving $100k in philanthropic funds. This funding is only listed in the fourth level of this financial map.

Table C1 was developed by the Oregon Health Authority and included in Key Behavioral Health Investments (21-23 biennium) Expected to Increase Resources and Improve Outcomes for the Population Needing Intensive Services, which was published in September 2022. It provides an additional example of how states may document and present behavioral health investments.

Table C1. Grant and Funding Timeline of Key Behavioral Health Investments

			$ awarded / initiated									$ funding period (if finite)
			Prior Biennium		21 - 23 Biennium							
			2021		2021		2022				2023	
Investment	**Grant/Funding Focus**	**Funds ($)**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Aid & Assist / Intensive Services	Supportive Housing NWRRC	$5.4M										
	3 County Housing/Restoration	$3.5M										
	CMHP CFAA Stopgap	$2.3M										
	CMHP Community Restoration RFA	$15.0M										
BH Crisis / 988	Mobile Crisis CFAA amendment	$10.0M										
	988 Call Center	$5.0M										
	Mobile Response and Crisis Stabilization	$6.5M										
Ballot Measure 110	Access to Care	$39.9M										
	Behavioral Health Resource Networks (BHRNs)	$265.0M										
BH Housing / SDOH	Planning Grants	$5.0M										
	Licensed Residential* (current infrastructure)	$10.0M										
	Licensed Residential/Adult and Youth*	$112.9M										
	Supportive Housing*											
	Housing one-time funds (counties)	$100.0M										
BH Workforce	Clinical Supervision*	$20.0M										
	Scholarships, Loan Repayment, Housing Incentives, and Childcare Incentives*	$60.0M										
	Workforce Stability	$132.3M										
Investment / Innovation	BH Rate Increase/FFS (ongoing)**	$80.0M										
	BH Rate Increase/CCO (contract)**	$74.5M										

* Timing and total funds allocated to future grant solicitation and award dispersement is dependent on the outcome of earlier rounds, including number and type of applications received and subtotal of dollars awarded.

** Total fund dollars; general fund is $42.5 across FFS and CCO and requires Emergency Board Special Purpose Appropriation.

Notes: *BH* is behavioral health. *CCO* is coordinated care organization. *CFAA* is County Financial Assistance Agreement. *CMHP* is Community Mental Health Program. *FFS* is fee-for-service. *NWRRC* is Northwest Regional Re-entry Center. *RFA* is request for application. *SDOH* is social determinants of health.

Source: ***Key Behavioral Health Investments (21-23 biennium) Expected to Increase Resources and Improve Outcomes for the Population Needing Intensive Services*** (PDF), Oregon Health Authority, September 19, 2022.

Appendix D. Full Source List for Tables 2 and 3

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