Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Proposed Behavioral Health Spending Definition and Measurement Methodology
September 19, 2025
Public Comments

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox. Public comments related to the proposed behavioral health spending definition and measurement methodology were accepted until September 3, 2025.

| Date | Name | Written Comment |
|---|---|---|
| 09/03/2025 | Bay Area Regional Pacific Islander Task Force, California Pan-Ethnic Health Network, Health Access California, National Health Law Program and Pacific Asian Counseling Services | See Attachment #1. |
| 09/03/2025 | California Academy of Family Physicians | See Attachment #2. |
| 09/03/2025 | California Medical Association | See Attachment #3. |
| 09/03/2025 | National Union of Health Care Workers | See Attachment #4. |
| 09/03/2025 | Purchaser Business Group on Health's California Quality Collaborative | See Attachment #5. |
| 09/03/2025 | California Hospital Association | See Attachment #6. |
| 09/03/2025 | California Association of Health Plans | See Attachment #7. |

September 3, 2025

Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
2020 W. El Camino Ave, Ste. 800
Sacramento, CA 95833

Via email: OHCA@HCAI.CA.GOV

***Re: Proposed Behavioral Health Spending Definition and Measurement Methodology***

Dear Ms. Johnson, Ms. Landsberg and Mr. Vishaal –

On behalf of the undersigned consumer advocacy organizations, we appreciate the opportunity to comment on the Office of Health Care Affordability's (OHCA) Proposed Behavioral Health Spending Definition and Measurement Methodology and associated code set.

***Behavioral health care costs are a significant barrier to accessing care, across all payer systems:*** Fifteen percent of all mental health spending nationally is paid directly out-of-pocket by individuals and families, amounting to over $15 billion annually.[1] ***This burden is particularly high for communities of color in California*****;** 47% of adults report difficulty affording healthcare costs, with the burden

[1] Anita Soni, PhD, MBA, "Healthcare Expenditures for Treatment of Mental Disorders: Estimates for Adults Ages 18 and Older, U.S. Civilian Noninstitutionalized Populations, 2019," Agency for Healthcare Research and Quality, Statistical Brief #539, February 2022: https://meps.ahrq.gov/data_files/publications/st539/stat539.pdf

disproportionately falling on Black (60%) and Latine (65%) adults.[2] These same disparities exist within Asian American and Pacific Islander communities. For example, 80% of Cambodians suggested that cost was a barrier to seeking mental health services, according to a 2019 study.[3] A survey of more than 900 Native Hawaiians and Pacific Islander adults in California, found that cost was a commonly cited reason for NHPI adults who reported avoiding or delaying needed mental health care.[4] For American Indian/Alaska Natives (AI/AN), chronic underfunding of Indian Health Services (IHS) and other health programs has resulted in affordability challenges and increased medical debt.[5] Furthermore, in the commercial insurance market, individuals seeking mental health services are six times more likely to have to go out-of-network for care compared to other services, and in one-third of these cases, they bear the full cost themselves.[6] Similarly, despite efforts to ensure insurance coverage of behavioral health services, nationally individuals with substance use disorders (SUD) often face difficulties accessing treatment, particularly in rural areas. In 2023, less than 24% of individuals aged 12 and older who needed SUD treatment were able to access it, and only around 6% received medication-assisted treatment for alcohol or opioid use disorders.[7] These challenges reflect not only an equity issue but also a spending inefficiency that could be addressed through better network adequacy and targeted investments in culturally and linguistically responsive care, outpatient prevention, early intervention, and treatment.

We strongly support OHCA's goal of orienting the health and behavioral health care system towards high value care. Several of our organizations serve on HCAI's Office of Health Care Affordability (OHCA) Advisory Committee and Investment and Payment workgroup where we have provided regular input as OHCA developed the proposed spending definition and measurement methodology. We agree with OHCA's starting premise, that *"increased behavioral health investments should help individuals in need of behavioral health care to receive more timely, high quality, and culturally-responsive care, in more appropriate settings, and with less out-of-pocket spending via improved access to outpatient and community-based services that are in-network."*[8] OHCA's proposed behavioral health definition and measurement methodology provides a strong framework that will help to achieve those goals by:

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[2] Sparks, Grace; Lopes, Lunna, Montero, Alex; Presiado, Marley; and Hamel, Liz. "Americans' Challenges with Health Care Costs," Kaiser Family Foundation, updated July 11, 2025: https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

[3] Lee S, Martinez G, Ma GX, et al. Barriers to health care access in 13 Asian American communities. *Am J Health Behav*. 2010;34(1):21-30. doi:10.5993/ajhb.34.1.3https://pmc.ncbi.nlm.nih.gov/articles/PMC6628721/

[4] "Majority of eligible Native Hawaiians and Pacific Islanders didn't receive mental health care, food assistance during pandemic," UCLA, Mike Fricano, April 2025. https://newsroom.ucla.edu/releases/covid-mental-health-and-economic-impact-on-NHPIs

[5] "Curbing the Risk of Medical Debt Among American Indian and Alaskan Native (AI/AN) Communities," Community Catalyst, Jenny Chiang: https://communitycatalyst.org/wp-content/uploads/2023/10/FINAL_Updated-Med-Debt-Fact-Sheet-Native-American.pdf

[6] Pelech, Daria and Hayford, Tamara, "Medicare Advantage and Commercial Prices for Mental Health Services," Health Affairs, Vol. 38, No. 2, February 2019: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05226

[7] Substance Abuse and Mental Health Services Administration, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health," July 2024, pp. 43-45. https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf.

[8] OHCA Investment and Payment Workgroup, February 19, 2025, slide presentation, p. 33 https://hcai.ca.gov/wp-content/uploads/2025/02/February-2025-Investment-and-Payment-Workgroup-Presentation.pdf

- Measuring the percentage of total health care expenditures allocated to behavioral health and set spending benchmarks. Building and sustaining methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Analyzing behavioral health spending and growth, and relevant quality and equity performance measures, and incorporating these in the annual report.
- Measuring behavioral health spending provided by a range of providers in outpatient, non-clinical settings by tracking claims and non-claims spending.
- Including as part of BH measurement, BH spending in primary care settings in order to encourage more collaborative and integrated behavioral health care practices, including screenings for health related social needs and referrals for behavioral health related clinical and/or social services as well as payments to non-clinical staff such as peer support specialists.
- Allowing claims to still be considered for behavioral health if it includes a service code for mental health or SUD screening or assessment as listed in the OHCA code set.

OHCA's proposed measurement and definitions are a critical step towards reducing behavioral health care costs and advancing more equitable care. With these shared goals in mind, we highlight the following key points that we believe will further strengthen OHCA's proposed definition and methodology:

**Recommendations: Proposed Behavioral Health Spending Definition and Measurement Methodology and Associated Code Set:**

- **Timely Adopt a Behavioral Health Spending Benchmark and a Concrete Timeline for Setting Spending Goals** in order to make behavioral health care services more accessible to the communities that need them most, especially communities of color, rather than defaulting to costly crises and inpatient care**.** We support OHCA's decision to delay adoption of a behavioral health spending benchmark for one year. However, the delay must be time limited. We strongly concur with the Board's request that OHCA continue to analyze data from existing sources and revisit readiness to set a benchmark in 2026. Consumers cannot continue to shoulder the burden of high behavioral health care costs. The preliminary aggregated data OHCA shared with us in May showed significant cost increases in behavioral health across the continuum of care, while raising significant questions about underlying cost triggers. Understanding these triggers will help OHCA to set a benchmark that is targeted and evidence based.

  Additionally, we were dismayed to learn that the spending data OHCA currently can access is not disaggregated by race, ethnicity, and language, making it impossible to identify gaps and propose meaningful recommendations for more equitable spending in key target areas. Racial disparities in access to behavioral health services persist across all payers. In Medi-Cal, White enrollees have the highest access rate (16.1%), while Asian and Pacific Islander (API) enrollees experience the lowest access rate (6.4%).[1] These patterns extend into the commercial market, where 30% of commercially insured Californians report needing help for mental health or substance use issues, yet only 21% actually see a healthcare provider, including a primary care provider, for those concerns.[2] For communities of color, this gap is even wider. API and Native Hawaiian/Pacific Islander (NHPI) populations report high need of care, but have the lowest rates of access, at 12.9% and 1.8% respectively, followed by Black Californians at 17.4%.[3] While we appreciate

OHCA's pause on setting a behavioral health spending benchmark until more is understood about the underlying cost triggers and available datasets in order to adequately address spending gaps and disparities, communities of color cannot afford to wait indefinitely. We urge focused attention on addressing these data gaps without further delay.

- **Adopt a Concrete Plan and Timeline for an Alternate Approach for Supplemental Analysis of Out-of-Plan, Out-of-Pocket Spend:** We strongly support OHCA setting a behavioral health benchmark and spending targets. However, the current spending definition and methodology will not adequately capture the significant out-of-pocket costs consumers pay. As previously noted, fifteen percent of mental health spending nationally is paid directly out-of-pocket by individuals and families, and the burden is particularly high for communities of color in California. In the commercial insurance market, individuals seeking mental health services are six times more likely to have to go out-of-network for care compared to other services, and in one-third of these cases, they bear the full cost themselves. On the SUD side, out-of-pocket costs have been documented as a significant barrier to accessing medications for opioid use disorders, not just because of the number of people who are uninsured and need treatment, but also because individuals with coverage often face lack of provider availability in their networks, lack of coverage for specific services or medications, or high cost-sharing imposed by plans.[9] Individuals who received coverage from their employers also often pay for SUD services out-of-pocket due to privacy and confidentiality concerns related to stigma.

  These challenges reflect not only an equity issue but also a spending inefficiency that could be addressed through better network adequacy and targeted investment. We urge OHCA to set a concrete plan and timeline for an alternate approach to track what people pay out-of-pocket so we can remove cost barriers and make behavioral health care more affordable and equitable. This should necessarily include out-of-pocket spending on drug treatment and substance use disorder services.

- **Include Mobile Clinic Services as part of Data Collection Reporting Categories:** In California, Medi-Cal and commercial providers are required to offer mobile clinic services as part of behavioral health crisis care.[10] Despite this requirement, OHCA's preliminary analyses of historical behavioral health spending in California using data from the Health Payments Database (HPD) showed little to no behavioral health spending for mobile services for commercial, Medicare Advantage, and Medi-Cal.[11] Mobile crisis services are crucial for Californians because they provide timely, community-based de-escalation and stabilization for mental health and substance use crises. These services prevent unnecessary emergency room visits and

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[9] Bowser, Diana; Bohler, Robert; Davis, Margot T.; Hodgkin, Dominic; Horgan Constance, "Payment-Related Barriers to Medications for Opioid Use Disorder: A Critical Review of the Literature and Real-World Application," 165 J. Substance Use & Addiction Treatment 209441, Oct. 2024, https://www.jsatjournal.com/article/S2949-8759(24)00153-X/fulltext.

[10] Specifically, AB 988 (2022) requires private plans in California to cover medically necessary behavioral health crisis services provided by a mobile crisis team, regardless of whether the service is provided by an in-network or out-of-network provider, at the in-network cost-sharing amount. *See* CAL. HEALTH & SAFETY CODE § 1374.724; CAL. WEL. & INST. CODE § 10144.57. Similarly, Section 9813 of the federal American Rescue Plan Act of 2021 (ARPA) requires all states to cover behavioral health mobile crisis services in their Medicaid plans. *See* 42 U.S.C. § 1396w-6.

[11] "Office of Health Care Affordability: Proposed Behavioral Health Spending Definition and Measurement Methodology," August 2025: https://hcai.ca.gov/wp-content/uploads/2025/08/OHCA-Proposed-Behavioral-Health-Definition_2025.08.04-1.pdf

hospitalizations, reduce involvement with law enforcement for issues better handled by clinicians and public health professionals, and connect individuals with ongoing, appropriate care. This is particularly critical for communities of color who are disproportionately overrepresented in inpatient psychiatric care, while their access to preventive and early intervention services is inadequate.[12] Some workgroup members supported removing mobile clinic services from OHCA's service categorization for behavioral health spending as a way of reducing reporting burden given such low spending in this area. While we appreciate OHCA's commitment to using HPD to continue to analyze mobile clinic services and crisis care as care delivery changes, we strongly request that OHCA continue to require separate reporting on mobile crisis spending as a way of encouraging greater transparency and ultimately adoption of these critical services by all California payers.

- **Recognize more real-world needs through expanded Z-codes so that culturally and linguistically relevant care is counted and supported through funding:** We appreciate OHCA's inclusion of Z-codes that touch on behavioral health diagnoses in the definition and methodology for behavioral health care spending. Z-codes are a critical assessment tool that can offer a fuller picture of a patient's health, help with treatment planning, communication and preventive care. We urge OHCA to assess spending and utilization of broader Z-codes and consider adding additional Z-codes such as a subset of codes in Z55 to Z65 — that focus on the social determinants of health (SDOH) or the non-medical factors that influence outcomes across populations including housing, education, employment, discrimination, financial stress, and family disruption. For example, Z-59 covers homelessness, inadequate housing, extreme poverty and food insecurity, all of which can be co-morbid with mental health conditions. Z-60 as another example, highlights problems related to one's social environment including isolation, rejection and acculturation stress. By coding for these conditions, mental health professionals can help outline a more holistic picture of the client, one that supports better clinical decisions and informs systemic change.

- **Look at all levels of care, from prevention to crisis services, so spending isn't concentrated only in inpatient settings:** OHCA's mandate is to measure and report the level of spending on behavioral health services, promote sustained investment in behavioral health, and improve behavioral health outcomes. We support OHCA's goal of orienting the health and behavioral health care system away from costly, inefficient care towards high value, upstream care. OHCA's benchmark straw model clearly encapsulates our shared vision that "increased investment should help individuals in need of behavioral health care to receive more timely, high quality, and culturally-responsive care, in more appropriate settings, and with less out-of-pocket spending via improved access to outpatient and community-based services that are in-network."[12]

  Unfortunately, as the data presented to the OHCA workgroup shows, funding for behavioral health services has shifted in the past few years and is now increasingly concentrated in inpatient and residential settings, despite strong evidence indicating that individuals with mental health conditions or SUD experience better outcomes when receiving upstream preventive care and

[12] OHCA Investment and Payment Workgroup, February 19, 2025, slide presentation, p. 33 https://hcai.ca.gov/wp-content/uploads/2025/02/February-2025-Investment-and-Payment-Workgroup-Presentation.pdf

treatment in their communities. Further, only measuring the level of care or setting fails to account for the specific type of services an individual is receiving while at that level of care. For example, many SUD residential facilities, particularly those who only accept private insurance, still refuse to offer medication-assisted treatment, despite its importance as part of the standard of care for this condition.[13] While we agree with OHCA's approach that seeks to measure all levels of care, we urge OHCA to consider ways to document the specific types of services, either preventive or treatment services, that are being provided in each setting in order to better evaluate whether and to what extent individuals are accessing high-quality and appropriate care.

Thank you for your time! We look forward to our continued work together to address behavioral health care costs and ensure more equitable health outcomes. Please contact Cary Sanders/CPEHN for further questions.

Sincerely,

Bay Area Regional Pacific Islander Task Force

California Pan-Ethnic Health Network

Health Access California

National Health Law Program

Pacific Asian Counseling Services

[13] Nichols, Cynthia; Baslock, Daniel; Lloyd Sieger, Margaret, "Buprenorphine Use Among Non-Hospital Residential Programs," 264 J. Drug and Alcohol Dependence, 112465, Nov. 2024, https://www.sciencedirect.com/science/article/abs/pii/S0376871624013814.

California Academy of Family Physicians
816 21st Street, Sacramento, CA 95811
(415) 345-8667
www.familydocs.org

**September 3, 2025**

Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Ave Conference Room 900
Sacramento, CA 95833

*Sent via email to OHCA@hcai.ca.gov*

RE: Office of Health Care Affordability (OHCA) Recommendations to the Board:
Proposed Behavioral Health Spending Definition and Measurement Methodology

Dear Ms. Johnson,

The California Academy of Family Physicians (CAFP) and our more than 10,000 family physicians, residents, and medical students thank you for considering our comments regarding the Office of Health Care Affordability's (OHCA) proposed behavioral health spending definition and measurement methodology.

CAFP appreciates the opportunity to be a part of OHCA's groundbreaking health system reform efforts. In particular, our participation in the OHCA Investment and Payment Workgroup has been a valuable forum for CAFP to engage in discussions about how to measure the percentage of total health care expenditures allocated to behavioral health and how to integrate primary care and behavioral health services.

CAFP recognizes that California behavioral health is in crisis. More than 1.2 million adults in California have a serious mental illness and 1 in 13 children has a serious emotional disturbance.[1] Family physicians receive a mandatory 400 hours of training in mental and behavioral health during residency and are often the first point of contact for patients

[1] California Department of Health Care Services, "California To Expand Behavioral Health in Lost Angeles County" May 16, 2025, https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2025/25-17-BHCIP-Sycamores-5-16-25.aspx.

needing mental health and substance use disorder care. Up to 75% of primary care visits include mental or behavioral health components.[2] Nearly 40% of all visits by patients seeking treatment for depression, anxiety, or mental illness are with primary care physicians, making family medicine a crucial front line for safeguarding the behavioral health and wellbeing of Californians.[3] In addition, primary care providers are sometimes the only source of behavioral health care for those of lower socioeconomic status.

CAFP supports integration of behavioral health services into primary care. Behavioral health integration has shown significant cost-savings for payers and physicians, as well as more equitable access to mental health services for traditionally underserved populations.[4] Integrated care models that connect primary care, behavioral health and community services are key to effective management of behavioral health conditions including substance use disorders. Behavioral health integration with primary care has also been shown to improve health outcomes and enhance patient experience with care. [5]

Bolstering primary care resources for behavioral health is essential to improving care access for the 11 million Californians living in mental health professional shortage areas as well as for Black and Hispanic individuals less likely than white individuals to receive care for mental illness.[6] Family physicians have seen first-hand the significant need for a greater investment in behavioral health in California. CAFP applauds efforts to provide primary care providers with more resources to better integrate behavioral health into their practices.

**Measuring Behavioral Health in Primary Care**

OHCA's proposal includes an expansion of the list of primary care provider taxonomies to include select behavioral health professionals, such as psychologists, social workers, and marriage and family therapists in its 2026 Data Submission Guide. CAFP appreciates OHCA's

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[2] Schrager, S. Integrating Behavioral Health into Primary Care. Family Practice Management. 2021; 28(3): 3-4.
[3] AAFP Advocacy Focus: Behavioral Health. https://www.aafp.org/advocacy/advocacy-topics/prevention-public-health/Behavioral-Health.html.
[4] Tyler Barton, et. al., "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration." Bipartisan Policy Center, 2021.
Su Yeon Lee-Tauler, et. al. A systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. Psychiatric Services. 2018 June 1, 69(6):628-647.
[5] Bijal A Balasubramanian, et. al. Outcomes of Integrated Behavioral Health with Primary Care. Journal of the American Board of Family Medicine. 2017, 30(2): 130-139.
[6] Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). December 31, 2024.

intention to ensure behavioral health clinicians who are working in primary care settings integrated with behavioral health are included in the behavioral health spend measure. However, there is currently no way for available claims data to distinguish between an office-based behavioral health clinician working in private practice independently from a primary care practice or clinic and a behavioral health clinician that is working as part of an integrated primary care team. As a result, the proposed policy to broaden the taxonomy of providers included in the primary care definition and spend measurement would result in a significant amount of spending on non-primary care services being counted in the primary care spending measurement. This would have the very problematic outcome of erroneously inflating primary care spend measurement by including behavioral health services that have nothing to do with integrated primary care. Due to these concerns, CAFP is opposed to the proposed expansion of primary care taxonomies.

It is important to note that services provided by behavioral health providers will already be captured in the measurement for the behavioral health spending target including behavioral health claims-based payments. The risk of diluting the primary care spending measurement with non-primary care services is not worth any potential benefit of capturing a relatively small amount of integrated behavioral health services that will not be measured by the current primary care measurement definition, especially as the behavioral health spending target already incentivizes increased spending for behavioral health integration in other ways.

An important goal of developing a behavioral health spending benchmark is to recognize the significant role primary care plays in delivering behavioral health services. CAFP is supportive of including behavioral health services that occur in primary care settings or by primary care providers in the behavioral health spending benchmark. However, simply expanding the list of primary care taxonomies to include behavioral health professionals in OHCA's measure of primary care would not meet this goal. We recommend maintaining the primary care definition already adopted by OHCA and having the Investment and Payment Work Group continue to work with OHCA to explore valid approaches to accurately measuring behavioral services that are truly provided as part of integrated, comprehensive primary care services.

Thank you for the opportunity to provide input on the pathway forward for measuring and advancing equitable, accessible primary care and behavioral health in California. Creating incentives for more comprehensive, coordinated, and equitable care is a significant step towards better health for Californians.

Sincerely,

Lisa Folberg, MPP
CEO, California Academy of Family Physicians

Cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
Sandra Hernández, MD
Richard Kronick, PhD
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Richard Pan, MD,

CALIFORNIA MEDICAL ASSOCIATION

September 3, 2025

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

Sent via email to OHCA@hcai.ca.gov

**RE: Proposed Behavioral Health Spending Definition and Measurement Methodology**

Dear Ms. Brubaker:

On behalf of the California Medical Association (CMA) and its more than 50,000 physician and medical student members, we are pleased to have the opportunity to comment on OHCA's proposed Behavioral Health Spending Definition and Measurement Methodology.

CMA appreciates the thorough process the Office of Health Care Affordability (OHCA) underwent in providing the OHCA Board, Health Care Affordability Advisory Committee, and Investment and Payment Workgroup with numerous opportunities to review and provide feedback to help strengthen the proposal. CMA also appreciates having a representative serving on the Investment and Payment Workgroup and the discussions that have taken place there on these topics. Overall, CMA believes that OHCA's proposed measurement of claims, non-claims and integration of behavioral health in primary care is a reasonable approach in working to analyze a very complex delivery system. CMA also believes the proposal could benefit from a few modifications.

Capturing Behavioral Health Treatment Spending Beyond Screening and Assessment

Under the proposed model, claims with a behavioral health primary diagnosis are then categorized into a specific subcategory using place of service, revenue and service codes on claims. Based on the primary diagnosis of the claim, all behavioral health spending will be categorized as either mental health or substance use disorder spending. For claims with a primary diagnosis field that does not have a behavioral health diagnosis code, these claims can still be considered behavioral health if it includes a service code for mental health or substance use disorder screening or assessment. CMA recommends including other services in addition to screening and assessment for behavioral health conditions as part of the model. For instance, if a woman goes to the hospital to deliver a baby, she should be screened not only for post-partum depression or anxiety but may also receive treatment that

1201 K Street, Suite 800, Sacramento, CA 95814 T (916) 444-5532 F (916) 444-5689 cmadocs.org

should also be counted under this model. The primary diagnosis is post-partum care, but services may also include mental health services.

Behavioral Health Benchmark

In terms of the timeline for setting the Behavioral Health Benchmark, CMA appreciates that OHCA is allowing for more time to collect and analyze behavioral health spending data from commercial, Medi-Cal, and Medicare Advantage Payers to study trends and impacts before setting a benchmark. CMA looks forward to continuing the benchmark conversation in 2026 after more data has been collected and analyzed.

Long-Term Care Services

While CMA understands the reasoning behind removing the long-term care and mobile clinic reporting categories due to low rates of services being provided, it is important that behavioral health services in nursing homes and assisted living facilities, and other long term care facilities continue to be measured and included, as you have indicated will occur. As California's aging population continues to grow, these services are likely to increase in which case you might separate out this category. In addition, due to the limited mobility of these patients, it is likely they are getting primary care and Behavioral Health services at these facilities, and it is important that this information be captured.

Behavioral Health in Primary Care Module

An area that CMA believes needs further refinement is how to capture behavioral health spending in primary care. The integration of primary care and behavioral health stands to greatly benefit patients, and it is important that OHCA track these claims and spending as they increase over time. Integration of behavioral health in primary care is a relatively new phenomenon and currently, there are sometimes challenges with entities getting paid for these services. CMA has concerns with re-opening the previously agreed upon definition of primary care to revise the measurement definition to include in the primary care provider definition "all mental health professionals providing ambulatory services", even if they are not practicing in an integrated Behavioral Health primary care model. **While CMA appreciates the attempt to limit over counting by only including 30 minute psychotherapy appointments and not 45 or 60 minutes, this will still lead to overcounting of services. Only those practicing in an integrated Behavioral Health primary care model should be included or this could lead to double counting these services.** It is more appropriate for these providers to be included in claims for the Behavioral Health spending category.

Out of Pocket Behavioral Health Spending and County Behavioral Health Services

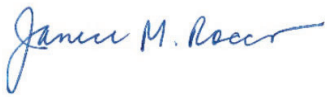
Finally, CMA wants to acknowledge that, as you are aware, key pieces of California's behavioral health spending are missing from the proposal – payments made out-of-pocket for behavioral health services that are not available or accessible through commercial

insurance, and also county behavioral health spending. CMA appreciates that several Board Members also raised these issues at the July Board meeting. While out-of-pocket spending in particular will be difficult to track, it is essential to try and determine how much patients are spending, what percentage of behavioral health services are out-of-pocket, and what steps can be taken to bolster the availability of behavioral health services in commercial and Medi-Cal plans.

Further, CMA encourages OHCA also to take steps to measure this spending in future years in order to gain a more accurate picture of overall behavioral health spending in the state. In terms of specialty behavioral health spending by counties and managed care plans, if federal reimbursement payments are being processed for services by DHCS, then this data should be available for OHCA to analyze to get information about Medi-Cal behavioral health services provided and costs. CMA looks forward to seeing OHCA incorporate this data in the future.

Thank you for the opportunity to comment. CMA looks forward to continuing to work collaboratively with OHCA and other stakeholders on the behavioral health definition and measurement methodology and other critical topics before the board in the months to come.

Sincerely,



Janice Rocco
Chief of Staff

CC: Secretary Kim Johnson, Chair, Office of Health Care Affordability Board
Dr. Sandra Hernandez, Vice Chair
Richard Kronick, Ph.D., Board Member
Dr. Richard Pan, Board Member
Elizabeth Mitchell, Board Member
Ian Lewis, Board Member
Don Moulds, Ph.D., Board

NUHW NATIONAL UNION OF HEALTHCARE WORKERS

866-968-NUHW • nuhw.org • info@nuhw.org

September 3, 2025

Attachment #4

Office of Healthcare Affordability
2020 West El Camino Avenue, Suite 1200,
Sacramento, CA 95833
OHCA@hcai.ca.gov

Re: Proposed Behavioral Health Spending Definition and Measurement Methodology

Dear OHCA Staff and Healthcare Affordability Board Members:

The National Union of Healthcare Workers (NUHW) represents thousands of behavioral health providers across California in both community-based and institutional settings, working both directly for health plans and for their contractors. Over the past fifteen years, NUHW has demonstrated its steadfast commitment to improving California's behavioral health system, and has played a leading role in passing legislation that promotes mental health parity.

We thank OHCA staff and Board members for your continued work to capture health plans' behavioral health spending accurately, and make the following recommendations for your consideration as you finalize your methodology to accomplish that important objective.

1. Measure spending against unmet needs and desired outcomes

According to survey data from the Kaiser Family Foundation, as of 2022, 9.4% of California adults reported an unmet need for counseling or therapy.[1] As OHCA works to examine current expenditures and set behavioral health spending benchmarks, it is critical that any final framework measure spending against unmet needs and desired outcomes. OHCA must develop a more detailed understanding of California's unmet behavioral health needs and a more specific set of desired outcomes, including measures of plans' compliance with relevant state and federal laws and regulations, in order to ensure the delivery of higher value services that succeed in improving behavioral health and reducing disparities population-wide across California's diverse communities, a key component of OHCA's mandate.

2. Observe the distinction between screening/referral and treatment, and report expenditures on each of them separately

Behavioral health screening and referral, integrated as core elements of primary care, are essential to ensuring access to timely and appropriate treatment, and must be accurately measured and appropriately incentivized. At the same time, their primary function is to identify potential needs and direct patients for definitive diagnosis and indicated care by behavioral health professionals. Screening and referral do not improve behavioral health outcomes unless paired with timely and appropriate treatment that can meaningfully improve patients' health. Distinguishing between assessment/referral and treatment in measurement and incentives is necessary for OHCA to set targets that ensure expenditures on screening and referral are matched by expenditures on treatment that is sufficient to meet patients' needs and achieve systemwide objectives of efficiency and effectiveness. Moreover, we suggest for your consideration that to avoid any dilemmas that might arise due to double counting of various expenditures toward both primary care and behavioral health targets, behavioral health screening and referral expenditures be credited toward the primary care target, while complex diagnosis and treatment by behavioral health professionals ultimately be credited toward the behavioral health target.

3. Measure the cost savings associated with different modalities of care

We support OHCA's approach to categorizing behavioral health services by subcategory, defined through place of service, revenue, and service codes. This level of detail is a critical step toward creating a more accurate and transparent picture of how behavioral health dollars are being spent. Such categorization will allow us better to measure both the direct and the indirect cost savings and health outcomes associated with early intervention and outpatient treatment compared to more costly inpatient or otherwise highly restrictive forms of care.

4. Examine whether reimbursement rates for outpatient care by non-physician behavioral health professionals are adequate to recruit and retain a sufficient, stable, and experienced workforce

Reimbursement rates for outpatient care by non-physician behavioral health clinicians must be examined to ensure they are adequate to recruit and retain a sufficient, stable, and experienced workforce, both statewide and specifically to meet the needs of our state's chronically underserved geographies and demographic groups. Several recently published studies indicate that insufficient reimbursement rates, which systemically undervalue behavioral health care versus medical/surgical care, contribute to many non-physician behavioral health providers leaving insurance networks for cash-paying clients who can afford higher rates out of pocket, thereby reducing access for patients who must rely on insurance for care and exacerbating existing disparities. Assessing these reimbursement rate issues and incorporating needed remedies in behavioral health spending targets is essential if OHCA is to achieve its objectives.

We appreciate the opportunity to provide comments and encourage OHCA to move forward with a definition of behavioral health spending and a measurement methodology that provide staff and Board members with the tools necessary to set targets that prioritize improved patient outcomes, increased preventive spending that backs up screening and referral with diagnosis and treatment, and expanded access to affordable care through insurance, while also promoting sustained investment, better reimbursement methods, and higher value care.

Sincerely,

Sophia Mendoza
President

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[1] Unmet Need for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic | KFF State Health Facts

California Quality Collaborative

2041 East St. Suite 1128
Concord, California, 94520

calquality.org

September 3, 2025
Department of Health Care Access and Information
Office of Health Care Affordability
Megan Brubaker
2020 West El Camino Avenue, Suite 1200, Sacramento CA 95833

Submitted via Email: OHCA@hcai.ca.gov

Dear Ms. Brubaker,

The Purchaser Business Group on Health's California Quality Collaborative (CQC) applauds the Office of Health Care Affordability (OHCA)'s efforts to measure and promote sustained systemwide investment in primary care and behavioral health - essential to creating a more responsive, equitable, and cost-effective health system. Our comments below leverages our broad stakeholder engagement experience and reflects CQC's specific expertise from our Behavioral Health Integration Initiative, leading health care system transformation and providing technical assistance directly to provider organizations and health plans in California.

**Key Points of Support and Recommendations**

**1. Integration of Behavioral Health and Primary Care Yields Better Outcomes**

As acknowledged in OHCA proposal, integrated primary care–behavioral health models demonstrably improve health outcomes, reduce costs, and yield a return on investment. National literature supports that individuals with mental health or substance use disorders incur two to three times higher medical costs than those without—and yet integrated models have been shown to improve reduce downstream spending.[i] Counting behavioral health within primary care delivery catalyzes payer incentivization, helping providers to implement and scale these successful models.

**2. Modular Accounting Ensures Accuracy and Prevents Double-Counting**

OHCA's design of a discrete "Behavioral Health in Primary Care" module allows analysis either as part of behavioral health spending or primary care spending—including both claims- and non-claims-based integration payments—while avoiding double-counting. This modularity enhances transparency and analytic clarity for providers, plans and purchasers.

**3. Expanded Taxonomy Includes Behavioral Health Providers in Primary Care**

The proposal to expand primary care provider taxonomies to include psychologists, social workers, behavioral health care managers, and community health workers and marriage and family therapists is vital. These professionals frequently deliver behavioral health services within primary care and should be reflected accordingly. This inclusion underscores OHCA's commitment to capturing the full scope of integrated care, and statewide interviews CQC conducted in 2025 (and which will be published in Q4 2025).

**Recommended Enhancements**

To further bolster the proposed methodology, CQC respectfully urges OHCA to consider:

- **Explicit Inclusion of Brief Behavioral Interventions in Primary Care**
  Acknowledging current data limitations, OHCA should commit to include brief

counseling, therapy, or behavioral interventions delivered in primary care settings—specifically, the inclusion of the 90832 and 90833 CPT codes.

- With the two formal clinical models of integrated care, Collaborative Care has a distinct code set billed "incident to" the primary care provider. The Primary Care Behavioral Health model uses traditional therapy codes for brief visits. (CQC, 2024).
- Without the inclusion of these codes, we foresee a lack of incentive health plans from investing in one of leading models of BHI as a lever of primary care investment, which they are already at risk of doing in California due to the carve-out and highly delegated systems of care (CQC, 2024).
- As noted in OHCA workgroup stakeholder calls, the Behavioral Health in Primary Care module can be separated for analysis, which we believe address concerns about over-counting.
- By including those codes, we believe OHCA could reinforce the message that advanced primary care does include behavioral health provided in primary care, aligning with recent federal direction as evidenced by the CMS Proposed Physician Fee Schedule.

**Conclusion**

In summary, the inclusion of behavioral health in primary care through the proposed modular methodology is a landmark step toward system-wide adoption of integrated, accessible, equitable, and cost-effective care. By capturing behavioral health delivered in primary care settings, OHCA can accelerate progress toward high-value, advanced primary care health care across California. We urge OHCA to adopt these recommendations as part of the final Behavioral Health Spending Definition and Measurement Methodology.

Thank you for your thoughtful work and the opportunity to comment. The California Quality Collaborative welcomes the opportunity to engage in further discussion on these recommendations.

Respectfully submitted,

Crystal Eubanks

Crystal Eubanks
Vice President, Care Transformation and California Quality Collaborative

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1. [i] Balasubramanian BA, Cohen DJ, Jetelina KK, et al.; Outcomes of integrated behavioral health with primary care. *J Am Board Fam Med.* 2017;30(2):130-139.

California Hospital Association

September 3, 2025

Health Care Affordability Board
2020 W. El Camino Ave.
Sacramento, CA 95833

**Subject:** **CHA Comments on August 2025 Proposed Behavioral Health Spending Definition and Measurement Methodology**
*(Submitted via Email to OHCA@HCAI.CA.GOV)*

The California Hospital Association (CHA), on behalf of nearly 400 hospitals and health systems, appreciates the opportunity to comment on the Office of Health Care Affordability (OHCA) August 2025 Proposed Behavioral Health Spending Definition and Measurement Methodology. As part of its efforts to promote high-value health care, OHCA has a historic opportunity to promote growth in behavioral health care access in California. To achieve this, OHCA is tasked with measuring behavioral health spending and, eventually, setting a behavioral health investment benchmark. Hospitals urge the office to incorporate the following changes as it works to finalize its spending methodology and the benchmark that follows:

- Analyze and ultimately include spending for patients whose behavioral health diagnoses are secondary to a physical diagnosis, as these patients often receive extensive treatment that would be missed under OHCA's proposed approach
- Collect Medi-Cal behavioral health spending data, a critical piece given that Medi-Cal covers millions of Californians
- Encourage improved access across the full continuum of treatment settings

## Include Spending on Patients with Secondary Behavioral Health Diagnoses

OHCA's proposed methodology for identifying behavioral health spending is a two-step process. First, it would include claims and any associated spending for individuals with a **primary** diagnosis of a behavioral health condition. Then, for individuals without a primary behavioral health diagnosis, it would add spending on behavioral health screenings and assessments.

This process is promising because it would reflect not only the full range of behavioral health services provided to patients with a behavioral health primary diagnosis, but also screenings and assessments (a critical component to encourage earlier identification of behavioral health needs). However, this proposal would unnecessarily exclude a wide range of clinically appropriate behavioral health services simply because they are provided secondary to an individual's physical health condition.

Hospitals, including their outpatient clinics and emergency departments, deliver concurrent medical care and behavioral health treatment every day to patients with primary diagnoses related to physical health conditions (e.g., heart conditions, liver failure or transplants, pregnancy or post-partum care). Those

patients may simultaneously be **treated** for a secondary or tertiary behavioral health diagnosis during a visit — not simply receive a behavioral health screening or assessment. For example, a patient being seen for heart failure after many years of methamphetamine addiction may receive motivational interviewing and substance use disorder (SUD) counseling services during a visit to a hospital's heart failure clinic. Patients with alcohol use disorder could receive similar SUD treatment services, as well as begin medication-assisted treatment such as Naltrexone during a visit to a hospital's outpatient transplant clinic or during inpatient treatment for an infection related to their substance use disorder.

For patients with SUD, hospitalization is often required for serious conditions, such as infections. A common case is endocarditis following intravenous (IV) drug use, which requires weeks of inpatient IV antibiotics. Though the primary diagnosis on this claim would likely be endocarditis, hospitals routinely use this type of hospitalization as a vital opportunity to initiate comprehensive SUD care, including starting medication for opioid use disorder, offering detox and recovery services, and connecting patients to outpatient medications like buprenorphine. While these types of services may not list a behavioral health diagnosis as the **primary** diagnosis, they are crucial behavioral health interventions and can represent a meaningful turning point in patient care. OHCA should investigate whether services such as these are indeed coded with a primary diagnosis of a behavioral health condition or a physical condition.

To help OHCA more accurately understand this spending, it should analyze and incorporate into its methodology specific procedural and service codes — such as the initiation of medication for the treatment of opioid disorder in the emergency department setting (G2213), inpatient telehealth pharmacological management (G0459), and alcohol and drug detox (e.g., H0008, and H0009 and H0014) — in addition to screening and assessment codes. These codes are clinically meaningful and represent the type of behavioral health spending that OHCA should track and encourage.

Recent research acknowledges the importance of leveraging inpatient admissions to address SUDs and only underscores the need to accurately and appropriately capture this spending in OHCA's methodology. For example, one study highlights how hospitals are working to expand methadone and buprenorphine initiation to overcome their historical underuse in inpatient settings.[1] Another study found that the B-Team model — an interprofessional, hospitalist-led program through which buprenorphine administration is initiated during acute hospitalization — led to substantial increases in both inpatient SUD treatment initiation and connections to outpatient care continuity.[2] A recent California-based randomized controlled trial also found that initiating medication for SUD during hospitalization significantly improved treatment engagement, a ringing endorsement for this approach's effectiveness.[3]

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[1] Shearer, R., Hagedorn, H., Englander, H., Siegler, T., Kibben, R., Fawole, A., Patten, A., Fitzpatrick, A., Laes, J., Fernando, J., Appleton, N., Oot, E., Titus, H., Krawczyk, N., Weinstein, Z., McNeely, J., Baukol, P., Ghitza, U., Gustafson, D., Bart, G., ... Bazzi, A. (2024). Barriers and facilitators to implementing treatment for opioid use disorder in community hospitals. *Journal of substance use and addiction treatment*, *167*, 209520. https://doi.org/10.1016/j.josat.2024.209520

[2] Christian, N., Bottner, R., Baysinger, A., Boulton, A., Walker, B., Valencia, V., & Moriates, C. (2021). Hospital Buprenorphine Program for Opioid Use Disorder Is Associated With Increased Inpatient and Outpatient Addiction Treatment. *Journal of hospital medicine*, *16*(6), 345–348. https://doi.org/10.12788/jhm.3591

[3] Ober, A. J., Murray-Krezan, C., Page, K., Friedmann, P. D., Anderson, J., Osilla, K. C., Ryzewicz, S., Huerta, S., Mazer, M. W., Hoskinson, R. A., Garvey, R., Peltz, A., Watkins, K. E., Nuckols, T., IsHak, W. W., Mariano, L. T., & Danovitch, I.

To guide its behavioral health spending definition and measurement methodology, OHCA has relied upon the Milbank Memorial Fund's *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending*. According to the organization's advisory group, "behavioral health diagnoses in secondary position on a claim also result in spending to treat individuals with behavioral health conditions." The report's recommendations include exploring this area with stakeholders and considering the data submission burden, if any, associated with counting these claims. Under its current proposal, OHCA would count screening and assessment claim line items even when a claim does not include a primary behavioral health diagnosis; counting additional behavioral health services line items on those claims would not be materially more burdensome.

Given that OHCA's goal is to establish a sound baseline for how much behavioral health spending occurs today, and in what settings, the measurement approach should be as inclusive as possible. **OHCA should evaluate and consider capturing behavioral health services provided to patients with primary medical diagnoses as appropriate to measure behavioral health spending.**

## Collect Medi-Cal Behavioral Health Spending Data

OHCA's enabling statute requires it to measure and promote a sustained **systemwide** investment in primary care and behavioral health, as well as to consider differences among payers and their patient populations. The Medi-Cal program is critical to ensuring millions of Californians have access to behavioral health services, and therefore, it should be included in OHCA's measurement of spending as soon as possible. In California in 2021, Medi-Cal provided coverage for 36% of all children, 23% of all non-elderly adults, and 17% of all adults over age 65. Further, Medi-Cal is the source of coverage for 37% of Latino/x Californians and 24% of Black Californians.

While Medi-Cal's policy framework and behavioral health delivery systems are complex for consumers to navigate, OHCA will be able to obtain Medi-Cal behavioral health spending data from the Department of Health Care Services (DHCS). As the single statewide Medicaid agency, DHCS collects substantial utilization data from Medi-Cal managed care plans and county behavioral health plans and processes their claims for federal reimbursement.

**OHCA must incorporate Medi-Cal spending data, or its foundational work on behavioral health spending measurement will be incomplete.**

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(2025). Hospital Addiction Consultation Service and Opioid Use Disorder Treatment: The START Randomized Clinical Trial. *JAMA internal medicine*, *185*(6), 624–633. https://doi.org/10.1001/jamainternmed.2024.8586

## Encourage Behavioral Health Investment Across the Continuum of Care

This summer, the OHCA board indicated support for delaying the establishment of a behavioral health spending benchmark until 2026 to allow additional time for data collection and analysis, and to evaluate the impact of recent behavioral health reforms. As OHCA further refines its timeline and approach to setting the benchmark, it must consider the need to increase behavioral health care access across the entire continuum of care settings — including residential and inpatient care — instead of solely focusing on outpatient behavioral health care, as the office previously proposed.

This thoughtful approach is particularly important given California's behavioral health care crisis. All aspects of care — navigation and peer services, therapy, medication-assisted treatment, intensive outpatient services, inpatient psychiatric care, and long-term nursing and supportive care — are impacted, and patients routinely struggle to find the care they need. A 2021 RAND study found that California was nearly 5,000 psychiatric beds short of meeting patients' needs. Investment to improve care is urgently needed, a fact recognized in California's major recent efforts to reform its behavioral health care system. For example:

- The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Medicaid Demonstration Waiver aims to "strengthen the continuum of mental health services for Medi-Cal beneficiaries living with serious mental illness," including by ensuring greater access to residential and inpatient treatment and unlocking new federal Medicaid funding for these levels of care.
- The Behavioral Health Continuum Infrastructure Program (BHCIP) is providing billions of dollars to support the construction, acquisition, or expansion of additional treatment capacity, including for residential facilities; this will add 2,601 beds and 128 outpatient facilities that will increase the state's outpatient capacity by 281,146 slots.
- The Behavioral Health Services Act (Proposition 1, 2024) builds on BHCIP, providing billions more dollars to expand behavioral health inpatient and outpatient treatment, residential care, and supportive housing for Californians with the highest needs.
- Senate Bill 855 (2020) requires health plans and insurers to cover behavioral health services at parity with other covered health benefits in California, addressing long-standing inequities in the coverage of behavioral health care and extending to commercial plans the same types of services covered by the Medi-Cal program.
- The California Health and Human Services Agency's Behavioral Health Crisis Continuum Plan from May 2023 states that the behavioral health continuum "is only complete when connected to more intensive services that can be accessed when medically necessary, and from which people will exit and return to the community where recovery and resiliency support will be critical. This idea of a 'continuum of care' applies broadly to all levels of care but can be specifically examined from the lens of a complete crisis system."

**In establishing its methodology for measuring behavioral health spending and setting an investment goal, OHCA must include all medically appropriate care settings for which increased access is needed.** It is vital that the office's work support these broader efforts — not compete with them.

OHCA has tremendous authority to transform health care delivery in California, including through encouraging critically needed improvements in behavioral health care access. Hospitals thank OHCA for the opportunity to provide feedback and look forward to continued engagement on achieving more accessible, equitable, and affordable health care in the state.

Sincerely,

Jenny Nguyen
Vice President, Financial Policy

Kirsten Barlow
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency (CalHHS)
Stephanie Welch, Deputy Secretary of Behavioral Health, CalHHS
Tyler Sadwith, State Medicaid Director, Department of Health Care Services

Attachment #7

**From:** Anete Millers
**To:** HCAI OHCA
**Subject:** CAHP Comments re: OHCA Proposed Behavioral Health Spending Definition and Methodology
**Date:** Wednesday, September 3, 2025 4:28:20 PM



Dear Ms. Brubaker,

Below please find comments from the California Association of Health Plans (CAHP) in response to OHCA's proposed **Behavioral Health Spending Definition and Methodology.** We appreciate OHCA's consideration of our comments.

**General comments:**

- We appreciate the opportunity to review OHCA's proposed methodology and provide feedback; however, due to the September 1, 2025 THCE submission deadline, many payers found it challenging to dedicate the necessary resources required to conduct the data analysis for a comprehensive review of the BH Proposal and Code Set to provide meaningful feedback. We request that OHCA permit payers to continue to submit feedback beyond the deadline, as they are able, given the overlap in deadlines and other competing priorities.

**Comments on sections of the methodology:**

- **Page 7, Figure 2, "Behavioral Health in Primary Care Model"** – Plans strongly support the inclusion of and thank OHCA for creating the behavioral health in primary care module. Measuring this spending will be critical to understanding payer and provider implementation of integration models and should inform the development of the behavioral health spending benchmark.
- **Page 7, "Claims-Based Behavioral Health Spending"** – The last paragraph on page 7 mentions a primary diagnosis field. Plans recommend that OHCA also include claims and encounter spending data that include a secondary behavioral health diagnosis. Mental health and substance abuse disorders are more often secondary than primary diagnoses in medical care settings because the primary driver for seeking care is a medical condition or complaint. Providers often code visits with a non-behavioral health primary diagnosis code where the provider addresses both an underlying, non-behavioral health concern, and a behavioral health concern, either due to a comorbidity of conditions or an integrated behavioral health model.
- **Page 8, Figure 3, "Identifying Behavioral Health Care Paid via Claims"** – We recommend OHCA include all para-professional provider types included in the state's Children and Youth Behavioral Health Initiative All Payer Fee Schedule to ensure alignment with other state behavioral health initiatives working to expand behavioral health coverage.

**Comments on the code set:**

- Overall, we are pleased to see OHCA is relying on diagnosis codes, rather than provider taxonomy, to identify behavioral health care paid via claims. However, there are still services commonly provided in conjunction with a behavioral health diagnosis that are not included in the Service Codes spreadsheet. For example, speech and occupational therapy are common components of autism treatment but are not included in the Service Codes. The goal should be to capture all the spending on treatment related to a behavioral health diagnosis before any benchmark is set. Excluding physical health treatments provided for behavioral health diagnosis could lead to undercounting of the current behavioral health spend.
- A significant amount of the BH services performed by non-billable providers will not be captured through the proposed methodology. We request that OHCA consider incorporating encounter data into the methodology to account for more of these critical BH services.
- Payers request that OHCA include additional places of service, including partial hospitalization, long term care services, and intensive community treatment programs. BH services provided in these setting are clinical best practice and payers and providers should be incentivized to provide necessary services in those locations.
- Payers have requested that OHCA reconsider including only F codes associated with dementia and Alzheimer's and consider also including G codes. For OHCA's awareness, F codes are typically more common in a FFS system, whereas G codes are more likely to be utilized in a capitated system and are equally critical for measuring spend.

Please contact me if you have any questions.

Thank you,

**Anete Millers**
**Vice President of Legal and Regulatory Affairs**
California Association of Health Plans
1415 L Street, Suite 850
Sacramento, CA 95814

amillers@calhealthplans.org
Cell: 279-666-8506
www.calhealthplans.org

*Advocating for California's health plans since 1984*