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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

February 19, 2025

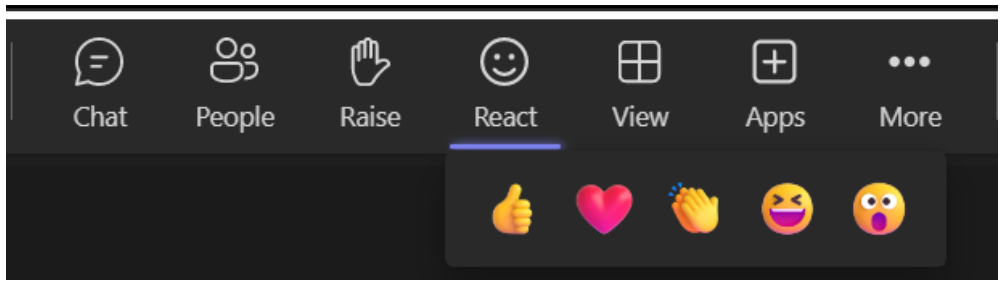
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:05 a.m.	**2.**	**Measuring Non-Claims Behavioral Health Spending**
9:40 a.m.	**3.**	**Behavioral Health in Primary Care**
10:15 a.m.	**4.**	**Benchmark Definition**
10:25 a.m.	**5.**	**Next Steps**
10:30 a.m.	**6.**	**Adjournment**

Meeting Format

Reminder: Workgroup members may provide verbal feedback during the meeting. Non-Workgroup members are welcome to participate during the meeting via the chat or provide written feedback to the OHCA team after the meeting.

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- Remote participation via Teams Webinar only
- Meeting recurs the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: February 19, 2025

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:
Join the meeting now

Meeting ID: 289 509 010 938
Passcode: r5gbsW

Or call in (audio only):
+1 916-535-0978

Conference ID:
456 443 670 #

Investment and Payment Workgroup Members

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Value-Based Care Payment Branch Chief, California Department of Health Care Services (DHCS)

Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care

Stakeholder Feedback

Advisory Committee (January meeting)
Benchmark Framework • Several members expressed support for proposed benchmark structure • A member supported including inpatient spending in the benchmark to align with Proposition 1 • Interest in linking benchmark performance to outcomes, and measuring continuity of care, to ensure goals are being met • Mixed feedback on telehealth: Recognition that telehealth is an important access point vs. challenges in ensuring high quality and equitable access • Suggestion to exclude artificial intelligence (chatbot care) from the benchmark

Stakeholder Feedback

Investment and Payment Workgroup Members

- Members raised questions about coding for behavioral health screenings and use of episode-based payments for OHCA to follow up at future meetings
- Overall strong Workgroup support for benchmark straw model though a few members have raised questions or expressed concern that the straw model excludes inpatient, long-term care, and residential settings
- Appreciation for including spend for screening and assessments for behavioral health conditions regardless of outcome or diagnosis
- Interest in exploring alignment with the federal mental health parity law and final rule

Measuring and Benchmarking Behavioral Health Spend: Intersection with Parity Laws

Using a broader parity lens to measure behavioral health spend could substantially increase the level of spending measured and reflect care typically considered to be medical services

- *Does this serve OHCA's mandate and goals?*

Parity Requirements

- California SB 855 (effective 2021): Requires coverage of "medically necessary" treatment of mental health and substance use disorders, in accordance with the generally accepted standards for this care
- MHPAEA Final Rule (effective 2025): Covered benefits include any* services related to an individual's mental health or SUD condition

Use Cases

- Parity: ensure that behavioral health benefits align with medical and surgical benefits
- OHCA: measure and report level of spending on behavioral health services, promote sustained investment in behavioral health, and improved behavioral health outcomes

*includes medical services

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Measuring Non-Claims Behavioral Health Spending

Debbie Lindes, Health Care Delivery System Group Manager
Mary Jo Condon, Principal Consultant, Freedman HealthCare

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.

Behavioral Health Non-Claims Data

Milbank Principles

- Data collection via Expanded Non-Claims Payments Framework
- Include all behavioral health-specific non-claims subcategories
- Apportion professional and global capitation payments and payments to integrated, comprehensive payment and delivery systems to behavioral health
- Consider including portions of other payer investments in behavioral health made to providers (e.g., practice transformation, EHR/HIT)

Figure 6. Expanded Framework Behavioral Health Categories

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

Expanded Framework, Categories A-C

Green = Include all of payment (if for BH)
Orange = Include portion of payment
Blue = Under discussion

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Pay-for-reporting payment	2B
B2	Pay-for-performance payment	2C
C	**Shared Savings Payments and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A
C2	Procedure-related, episode-based payments with risk of recoupments	3B
C3	Condition-related, episode-based payments with shared savings	3A
C4	Condition-related, episode-based payments with risk of recoupments	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
https://hcai.ca.gov/wp-content/uploads/2023/11/HCAI-Expanded-Non-claims-Payments-Framework-Handout_11-28-23-1.pdf

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Expanded Framework, Categories D-F

Green = Include all of payment
Orange = Include portion of payment

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care Capitation	4A
D2	Professional Capitation	4A
D3	Facility Capitation	4A
D4	Behavioral Health Capitation	4A
D5	Global Capitation	4B
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

Freedman HealthCare supported the California Department of Health Care Access and Information in developing the Expanded Non-Claims Payment Framework. The framework builds on the work of Bailit Health and the Milbank Memorial Fund and the Health Care Payment Learning and Action Network.
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Overview of Challenges of Non-Claims Payments

- High percentage of professional and global capitation in California increases need to accurately capture non-claims payments.
- Currently, there is no standard among states for allocating non-claims payments to behavioral health care.
- There is no ideal method for precisely capturing non-claims payments for behavioral health care.
- Most non-claims payments cannot be tied to a specific provider.
- Most non-claims payments cannot be tied to specific services, let alone behavioral health care services.

RAND Corp.: Advancing the Development of a Framework to Capture Non-Fee-For – Service Health Care Spending for Primary Care. https://www.rand.org/pubs/research_reports/RRA204-1.html

Non-Claims Behavioral Health Care Payments: Draft Recommendations

Expanded Framework Category (Types of Payments)	Draft Recommendation
Subcategory A2 (Primary Care and Behavioral Health Integration)	All non-claims payments in this subcategory are considered to be behavioral health care payments.
Subcategories A4 (Practice transformation payments) and **A5** (EHR/HIT infrastructure and other data analytics payments)	Consider including a portion of non-claims payments in this category when paid to behavioral health care providers and organizations. Consider a limit on the percent of total medical expense that counts toward measurement.

Non-Claims Behavioral Health Care Payments: Draft Recommendations

Expanded Framework Category (Types of Payments)	Draft Recommendation
Category B (Performance Payments) *Examples:* • Pay for reporting bonus payment • Pay for performance bonus payment	Non-claims payments in this category are allocated to behavioral health when paid to behavioral health care providers and organizations. For multi-specialty practices and health systems, payers identify any behavioral health programs they support and allocate only the payments associated with those programs.

Non-Claims Behavioral Health Care Payments: Draft Recommendations

Expanded Framework Category (Types of Payments)	Draft Recommendation
Subcategories C3 and C4 (Condition-related, episode-based payments with shared savings or risk of recoupments)	Allocate non-claims payments in these subcategories to behavioral health when the shared savings or risk associated with episode-based payments is for a behavioral health condition.

Non-Claims Behavioral Health Care Payments: Draft Recommendations

Expanded Framework Category (Types of Payments)	Draft Recommendation
Category D (Capitation and Full Risk Payments)	For behavioral health capitation, 100% is allocated to behavioral health. For other capitation payments, data submitters calculate a fee-for-service equivalent based on a fee schedule for behavioral health care services and the number of encounters.

Apportioning Professional and Global Capitation to Behavioral Health

Example for a Professional Capitation arrangement:

$$\frac{\Sigma\,(\#\text{ of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\,(\#\text{ of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

x Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Example of Non-Claims Capitation Formula

Payer A has four types of capitation arrangements with provider groups. Three of the arrangements cover some behavioral health services. The table below describes the portion of the payer's capitation payments that would be allocated to behavioral health.

	Total Dollars Paid Via Capitation Category	Dollars Attributed to Behavioral Health	Dollars Attributed to Behavioral Health Equal To
Behavioral Health Capitation	$100,000,000	$100,000,000	Total amount paid in behavioral health capitation
Professional Capitation	$250,000,000	$5,000,000	Use formula on the previous slide to calculate FFS equivalents for behavioral health services.
Global Capitation	$1,000,000,000	$10,000,000	Use formula on the previous slide to calculate FFS equivalents for behavioral health services.
Facility Capitation	$500,000,000	$0	N/A

Discussion

- Do members have feedback on:
  - The proposed Expanded Framework subcategories that count towards behavioral health spending?
  - The recommendations for the specific approach to identifying non-claims behavioral health spending for each subcategory?
  - The methodology to apportion capitation payments to behavioral health?
  - The primary care definition limits the portion of practice transformation payments and EHR/HIT infrastructure that can be allocated to primary care. Should OHCA employ a similar approach for behavioral health?
- Are there other categories of payer clinical behavioral health spending that OHCA should consider including in non-claims spending measurement?

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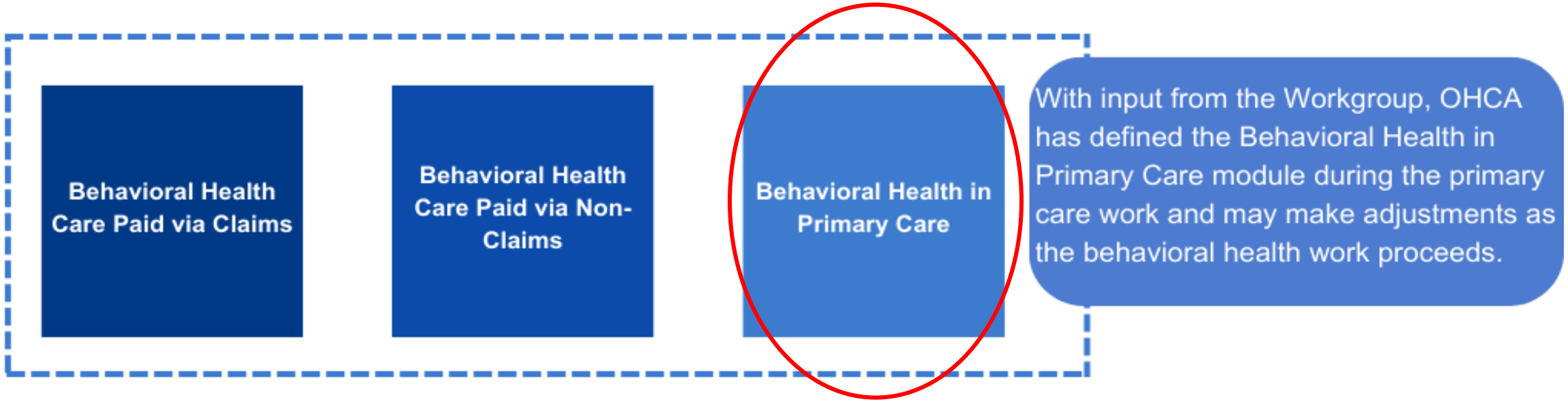
Behavioral Health in Primary Care

Debbie Lindes, Health Care Delivery System Group Manager
Mary Jo Condon, Principal Consultant, Freedman HealthCare

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.



Why include a behavioral health in primary care "module"?

It allows OHCA to:

- Calculate combined behavioral health and primary care spending without double counting
- Calculate behavioral health spending occurring in the primary care setting, to the extent the data allows
  - Counting this spending only as primary care would significantly undercount spending on behavioral health services and distort understanding of where behavioral health services are provided
  - Measuring and tracking supports further integration of primary and behavioral health care

Behavioral Health in Primary Care Module: Proposed Approach

"Always" BH Services
w/ primary BH Dx and PC POS, Provider

- MH & SUD screening
- Integrated BH

"Sometimes" BH Services
w/ primary BH Dx and PC POS, Provider

Examples:
- Office visits
- Case management

Non-Claims BH

- BH integration (Cat. A2)
- Capitation* (Cat. D)

Expand Primary Care Taxonomies
w/primary BH Dx and PC POS, Service

Examples include:
- Social workers
- Psychologists
- BH clinicians

Current Primary Care Definition

- BH in PC module would include certain PC services when a BH diagnosis is present.

Add BH Providers to Primary Care Definition

- To capture their spend for specific BH in primary care codes

*Methodology described in Slide 18 would be applied

Trade-offs for Expanding Primary Care Provider List

Reasons to expand	Reasons not to expand
• Would capture some integrated behavioral health spend for services such as coordination payments made to behavioral health professionals practicing in an integrated setting • Consistent definitions of provider for primary care and Behavioral Health in Primary Care Module required to support mutually exclusive, collectively exhaustive approach • Less data submitter burden than capturing integrated behavioral health spend using a separate, additional data collection	• May capture some behavioral health spend, such as assessments and brief interventions ***not*** occurring in an integrated primary care setting • Due to data limitations, current code set would exclude therapy and other behavioral health services from the Behavioral Health in Primary Care Module, ***regardless*** of whether they occurred in an integrated primary care setting • Alters primary care definition

Calculating Behavioral Health and Primary Care Spend Without Double Counting

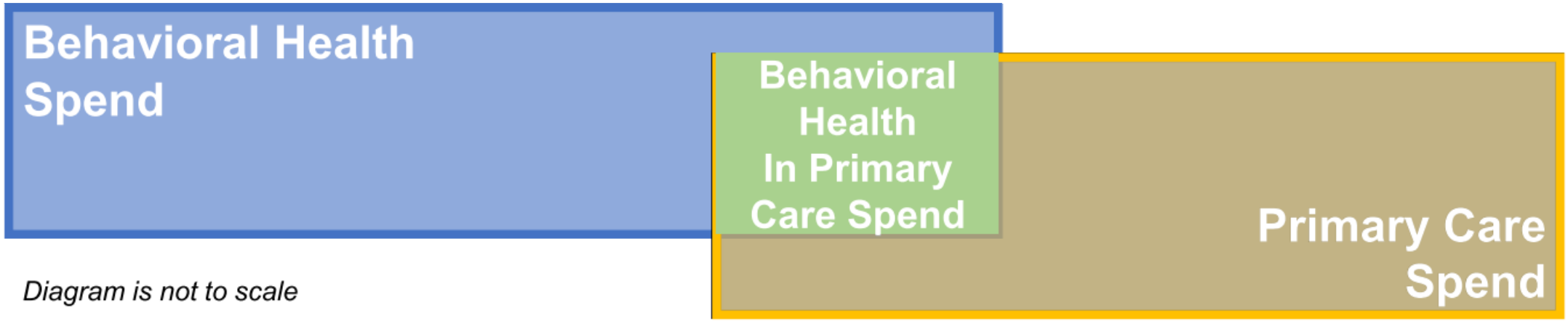


Diagram is not to scale

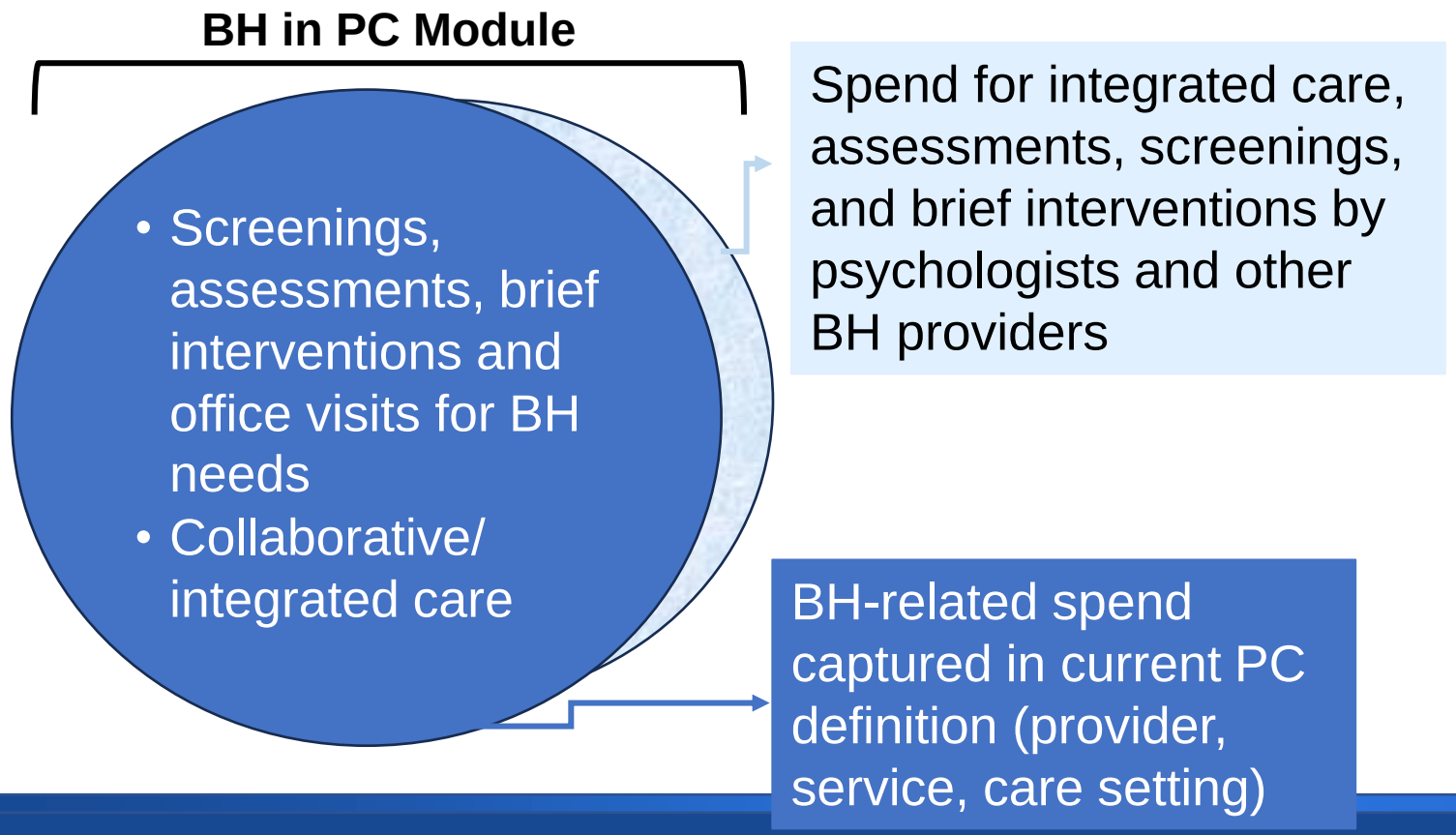
$$\text{Combined Primary Care and Behavioral Health Spend} = \left(\text{Primary Care Spend} + \text{Behavioral Health Spend}\right) - \text{Behavioral Health in Primary Care Spend}$$

Rationale for Proposed Approach

- Maintains focused primary care definition
  - Best option to achieve use cases without capturing non-primary care spend
  - Likely minimal increase in spend not initially envisioned as primary care
  - Communicates importance of integrated behavioral health while recognizing data limitations
- Allows for mutually exclusive, collectively exhaustive results
- Would undercount level of integration but less than if provider list were not expanded
- Consistent with general approach to behavioral health measurement

Why would OHCA expand the primary care provider list?

All modules must capture the same behavioral health-related spend.



- Prevents double-counting
- Provides consistency across use cases
- Helps ensures the primary care, behavioral health, and behavioral health in primary care module definitions are mutually exclusive and collectively exhaustive

Discussion

- Should OHCA expand the primary care taxonomy list to include behavioral health providers?
- Are these the right use cases for the Behavioral Health in Primary Care Module?
  - Calculate behavioral health and primary care spending without double counting
  - Calculate behavioral health spending occurring in the primary care setting
- Are there other use cases to consider?
- Are there other modifications to the approach to consider?

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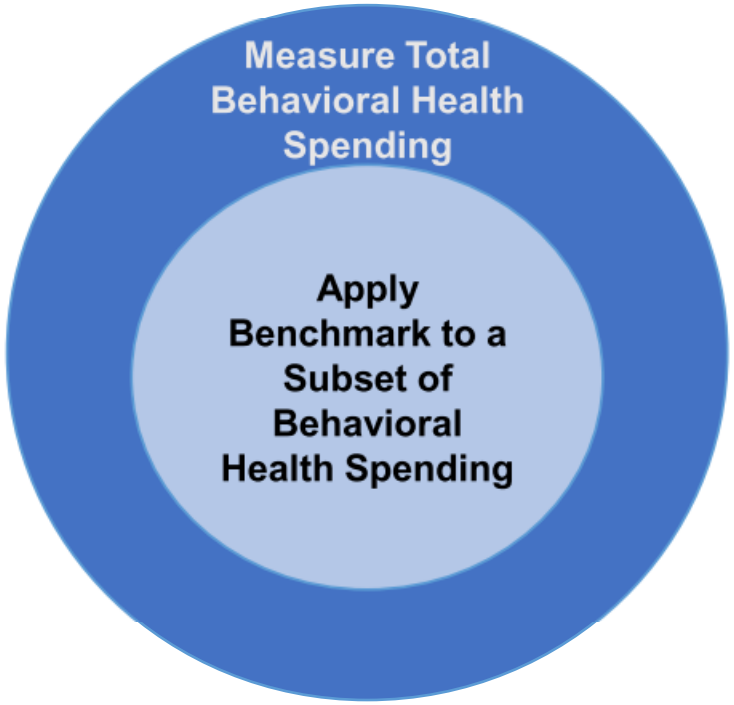
Benchmark Definition

Debbie Lindes, Health Care Delivery System Group Manager
Mary Jo Condon, Principal Consultant, Freedman HealthCare

Broad Measurement, Focused Benchmark

- **Measurement:** OHCA will be measuring **total** behavioral health spending as a percentage of total health care expenditures.
- **Benchmark**: OHCA proposes that the behavioral health investment benchmark applies to a **subset** of behavioral health care spend.

Spending Included



Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner's (OHIC) **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

Spending obligation (benchmark):

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending)
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC
- Includes claims and non-claims spending for community-based behavioral health care
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island
- If carriers do not reach the benchmark, they will be subject to penalties as determined by the Commissioner

What should the increased behavioral health investment achieve?

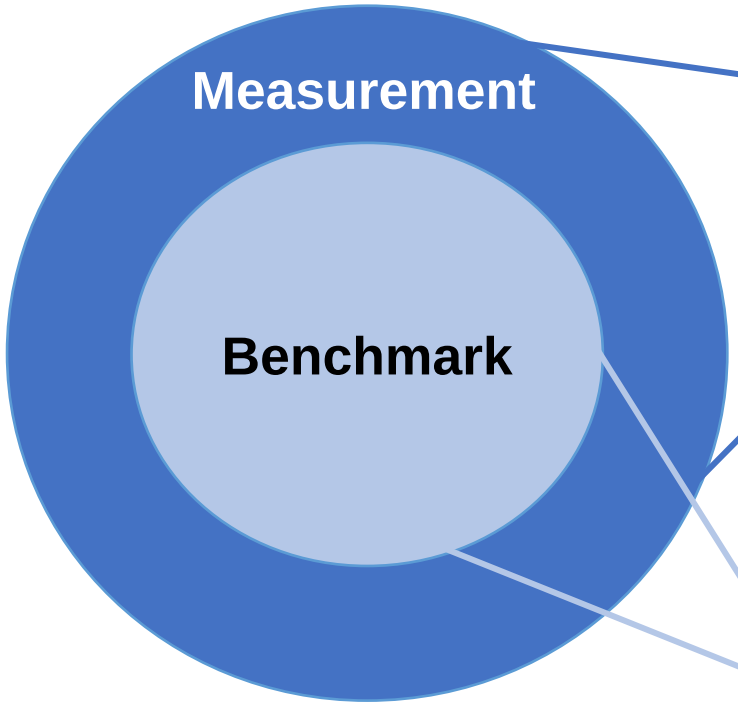
OHCA Proposal:
Increased investment should help individuals in need of behavioral health care to receive more timely, high quality, and culturally-responsive care, in more appropriate settings, and with less out-of-pocket spending via improved access to outpatient and community-based services that are in-network.

How Should OHCA Structure the Benchmark to Achieve This Aim?

OHCA Proposal:
Include in-network, outpatient and community-based behavioral health services covered via commercial and Medicare Advantage* plans, excluding pharmaceutical spending.**

*OHCA would initially focus on commercial and Medicare Advantage and expand to Medi-Cal when data collection and methodology allow.
** Still under consideration

Example Measurement vs. Benchmark



Proposed Service Categories for Total Spend Measurement:

- Long-term Care
- Residential
- Inpatient (including partial hospitalization)
- Emergency Department/Observation
- Outpatient Facility and Professional, including
  - Primary Care
  - Telehealth
  - Community-based services
- Community-based Mobile Clinic Services

Proposed Service Categories for Benchmark:

- Outpatient Facility and Professional (including Primary Care, Telehealth, Community-based Services)
- Community-based Mobile Clinic Services

How should the benchmark be focused?

OHCA Proposal:

For in-network, outpatient and community-based behavioral health services:

- Include mental health and substance use disorders and define broadly.
- Include specific high-value behavioral health services with limited access and the highest potential to improve outcomes.
- Include spending for all California commercial and Medicare Advantage* members, regardless of age or geography.

*OHCA would initially focus on commercial and Medicare Advantage and expand to Medi-Cal when data collection and methodology allow.

What supplemental analyses could support monitoring whether the aim is achieved?

Potential Analyses*:

- Proportion of behavioral health services that occur in outpatient and community-based setting
- Emergency department and crisis service use for behavioral health needs
- Monitoring access to inpatient behavioral health services
- Average therapy sessions per member**
- Rates of behavioral health screening
- Spending specifically for integrated behavioral health care
- Quality measures related to behavioral health care and follow-up
- Number and distribution of providers and facilities billing for behavioral health services
- Licensed providers in payer networks as a percentage of total licensed providers in California

*OHCA will evaluate the feasibility of these potential analyses.
** Still under consideration

Key Decisions for Benchmark Setting

- Should the benchmark be a percentage of total medical expenses or a per member, per month amount?
- Should the benchmark focus on incremental or long-term improvement, or some combination?
- What should the timeline be for achieving the benchmark?

Set a benchmark based on the percent of total medical expense or a per member, per month amount?

Statute suggests a preference for using percent of total medical expense (TME) as a basis for benchmarking, which would be consistent with other approaches.

Reasons for Percent of TME

- Statute suggests preference for this approach
- Communicates that increased spending on behavioral health care should reallocate rather than increase total spending

Reasons for Per Member, Per Month (PMPM)

- Easier to reflect the cost of achieving behavioral health delivery goals
- May guard against the benchmark becoming unnecessarily inflationary if total medical expense increases are higher than expected
- More consistent with how payers typically measure health care costs and the only state benchmark

Set an annual improvement or long-term investment benchmark? Or some combination?

An annual improvement benchmark meets each payer where they are today, and the long-term investment benchmark offers a vision for the future across all payers.

Reasons for Annual Improvement

- Consistent with statutory guidance to recognize differences across payers and patient populations
- Acknowledges care delivery transformation takes time
- Current spending level is unclear, so annual improvement gives more latitude to make adjustments

Reasons for Long-Term Investment Goal

- Sets a vision for the future
- Can reflect the potential budget needed to develop necessary behavioral health infrastructure
- Can reflect current thinking on the “right” level of behavioral health care investment

Reason for Combination

- Allows all to succeed at a reasonable pace.

How long should the time horizon be for the behavioral health investment benchmark?

Considerations

- Benchmark should be aggressive in pursuit of the policy goals underlying it
- Benchmark should also reflect reasonable expectations of how long it will take to achieve
- Align benchmark with other adopted OHCA benchmarks:
  - Spending growth (2029)
  - Primary care investment and alternative payment model adoption (2034)

Other OHCA Benchmarks

Health Care Spending Growth Target	• 3.5% in 2025 and 2026 • 3.2% in 2027 and 2028 • 3.0% in 2029 and beyond
APM Adoption	• Biannual improvement goals by payer type • By 2034: 95% for Commercial HMO and Medicare Advantage; 75% for Medi-Cal; 60% for Commercial PPO
Primary Care Investment	• For each payer, 0.5 to 1.0 percentage points per year as percent of TME • By 2034, 15% of TME for all payers

- Combines incremental and long-term goals
- Acknowledges payers' different starting points and capacity for short-term improvement
- Allows for adjustment as picture becomes clearer with more data
- Sets a long-term vision aligned with state policy goals

Discussion

- Should OHCA structure the benchmark for behavioral health investment as an annual improvement goal, a long-term investment goal, or a combination of the two?
- What is a reasonable yet assertive timeline for a long-term investment benchmark?
- Should the benchmark be based on a percentage of total medical expenses or on a per member, per month spending?

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Next Steps

Margareta Brandt, Assistant Deputy Director

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

	Jul-Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Workgroup	X	X	X	X	X	X	X	X	X	X	X
Advisory Committee		X			X		X			X	
Board				X		X		X		X	✓

X Provide Feedback ✓ Board Approval

March Workgroup Meeting Preview

- Continue benchmark discussion and develop more granular definition

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Adjournment