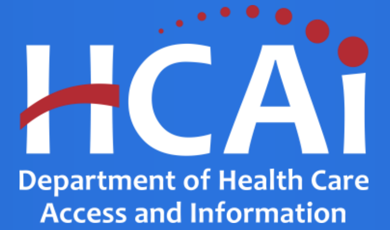


OHCA Investment and Payment Workgroup

January 15, 2025

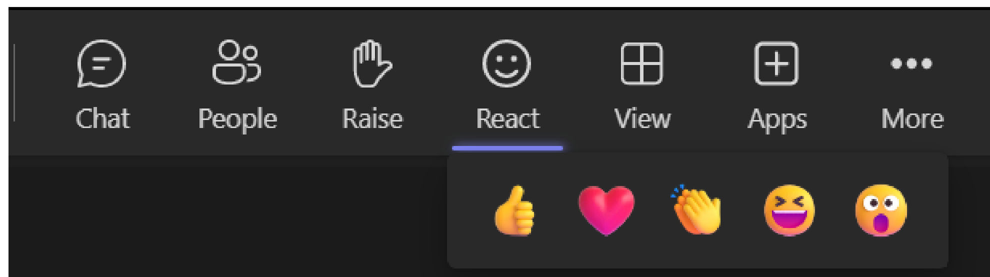
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:05 a.m.	**2.**	**Defining Behavioral Health Spending: Review Work and Feedback To Date**
9:20 a.m.	**3.**	**Proposed Approach for Using Claims to Measure Behavioral Health Spending**
10:15 a.m.	**4.**	**Measuring Non-Claims Behavioral Health Spending**
10:25 a.m.	**5.**	**Next Steps**
10:30 a.m.	**6.**	**Adjournment**

HCAI
Department of Health Care Access and Information

Meeting Format

- 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: January 15, 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

Providers & Provider Organizations

Bill Barcellona, Esq., MHA
Executive Vice President of Government Affairs, America's Physician Groups

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Chief Executive Officer, California Academy of Family Physicians (CAFP)

Paula Jamison, MAA
Senior Vice President for Population Health, AltaMed

Amy Nguyen Howell MD, MBA, FAAFP
Chief of the Office for Provider Advancement (OPA), Optum

Parnika Prashasti Saxena, MD
Chair, Government Affairs Committee, California State Association of Psychiatrists

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Chief Financial Officer, Inland Empire Health Plan (IEHP)

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Yagnesh Vadgama, BCBA
Vice President of Clinical Care Services, Autism, Magellan

Consumer Reps & Advocates

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Contract Lobbyist, Health Access California

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Transplant Recipient and Cancer Survivor, Patients for Primary Care

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Vicky Mays, PhD
Professor, UCLA, Dept. of Psychology and Center for Health Policy Research

Catherine Teare, MPP
Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)

State & Private Purchasers

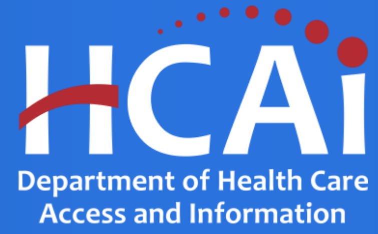
Cristina Almeida, MD, MPH
Medical Consultant II, CalPERS

Teresa Castillo
Chief, Program Policy Section, Medical Behavioral Health Division, Department of Health Care Services

Jeffrey Norris, MD
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



Defining Behavioral Health Spending: Review Work and Feedback to Date

Margareta Brandt, Assistant Deputy Director

Measuring Behavioral Health Spending

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health investment

X 100% = Behavioral health investment as a % of total medical expense

Total claims-based payments + Total non-claims-based payments = Total medical expense*

Denominator

Note: The numerator will include patient out-of-pocket responsibility for behavioral health services obtained through the plan i.e., services for which a claim or encounter was generated. The denominator will include pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.*

Still to Come

- **Measurement** of spending using non-claims payments
- **Defining the Benchmark**: claims and non-claims
- **Behavioral Health in Primary Care Module**

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.

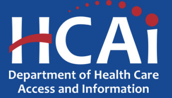
Spending Included

Today's discussion will focus on defining behavioral health using claims for use in the ***measurement of total*** behavioral health spending.

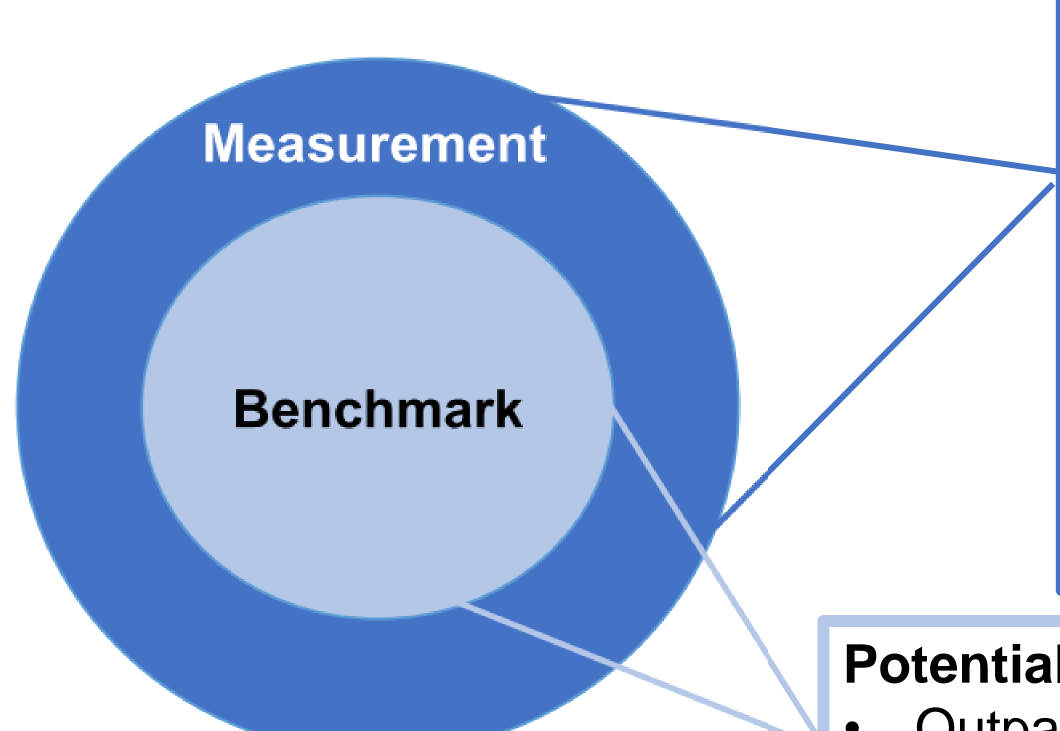
Recap: Benchmark Straw Model

Question	Working Straw Model
What should the increased behavioral health investment achieve?	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?	Include in-network outpatient and community-based behavioral health services covered via commercial and Medicare Advantage* plans, excluding pharmaceutical spend.**

*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



Potential 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

Potential Service Categories for Benchmark:

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

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Alignment Opportunities: Prop 1 (2023)

Legislation	Element	OHCA Alignment
Proposition 1	Behavioral Health Services Act focus on community-based care.	Focused benchmark incentivizes payers to increase investment in community-based services.
	Behavioral Health Infrastructure Bond Act authorizes $6.4 billion in bonds to finance behavioral health treatment beds, supportive housing, community sites, and funding for housing veterans with behavioral health needs.	Focused benchmark on community-based services would complement Proposition 1 investments and direct investment to additional areas of need.

Alignment Opportunities: SB 855 (2020)

Legislation	Element	OHCA Alignment
SB 855	Requires insurers cover "medically necessary treatment" for all mental health and substance use disorders.	Includes a broad set of services to treat mental health and substance use disorders.
	Mandates in-network coverage for out-of-network providers when access is not available within geographic and timely access standards.	Incentivizes payers to increase investment in-network BH coverage.
	Prohibits plans from denying medically necessary services on the basis they should be or could be covered by a public entitlement program.	Benchmark focus on in-network care.

Alignment Opportunities: SB 221 (2021)

<table>
<tr><th>Legislation</th><th>Element</th><th>OHCA Alignment</th></tr>
<tr><td rowspan="3">SB 221</td><td>Ensures that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements.</td><td rowspan="3">Focused benchmark on community-based services provided in-network seeks to increase access.

Potential HPD Analyses that can leverage OHCA’s behavioral health measurement definition:
• 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</td></tr>
<tr><td>Ensures that an enrollee undergoing a course of treatment for an ongoing mental health or substance use disorder condition can get a follow-up appointment within 10 business days.</td></tr>
<tr><td>If a plan operates in an area with a shortage of providers and is not able to meet the geographic and timely access standards with an in-network provider, the bill requires the plan to arrange coverage outside its contracted network.</td></tr>
</table>

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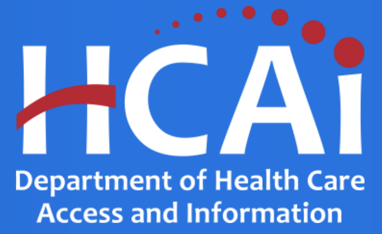
December Board Feedback

Feedback
• Support for a focused benchmark approach. • Interest in shaping the benchmark to support clearly-articulated statewide goals. • Highlighted importance of future incorporation of Medi-Cal. • Need for continued collaboration and information sharing with parallel efforts including those measuring out-of-plan spending. • Interest in alignment with other transformation efforts including legislation to strengthen behavioral health system and enhance access to school-based care.

December Workgroup Feedback

Feedback
• Strong Workgroup support for including autism and other developmental disorders in claims-based behavioral health measurement. • Mixed support for including the medical procedures related to dementia and adverse effects of self-harm, though stronger support for including the behavioral health treatments related to those diagnosis categories. • Workgroup members favor a broad definition of diagnoses and a wide, yet more focused, list of services for behavioral health treatments. • Interest in aligning with Proposition 1, SB 855, and SB 221.

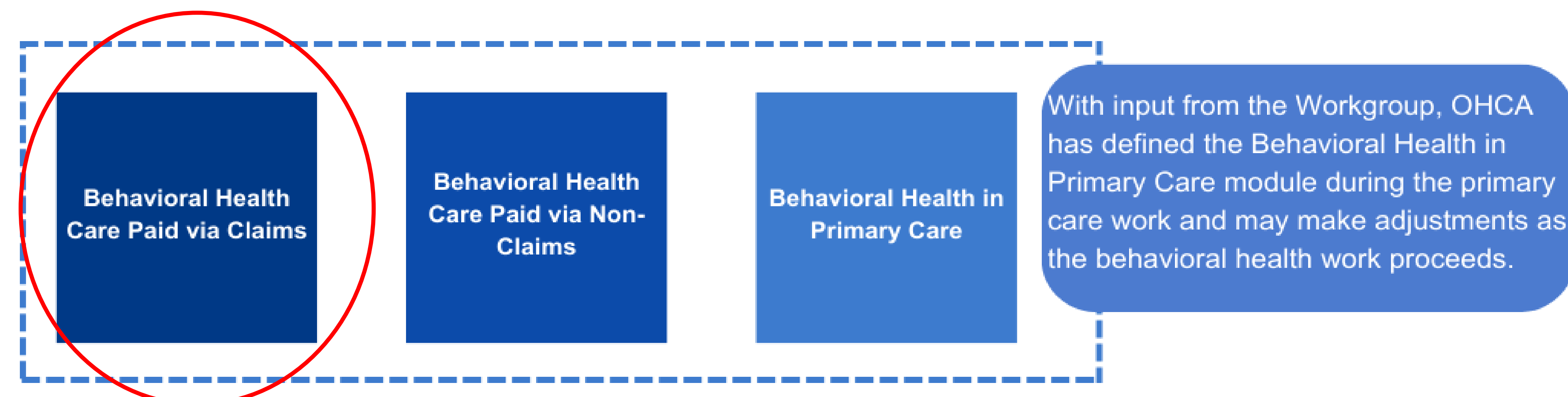


Proposed Approach for Using Claims to Measure Behavioral Health Spending

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.



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Proposed Phased Approach to Behavioral Health Spending Measurement Definition and Data Collection

Define Commercial/ Medicare Advantage Spending

- Initial measurement definition and data collection focused on commercial and Medicare Advantage market

Define Medi-Cal Spending

- Adapt commercial and Medicare Advantage market definition to Medi-Cal market, if needed
- Consider data sources specific to Medi-Cal

Revise Definitions

- Revise definitions based on learnings

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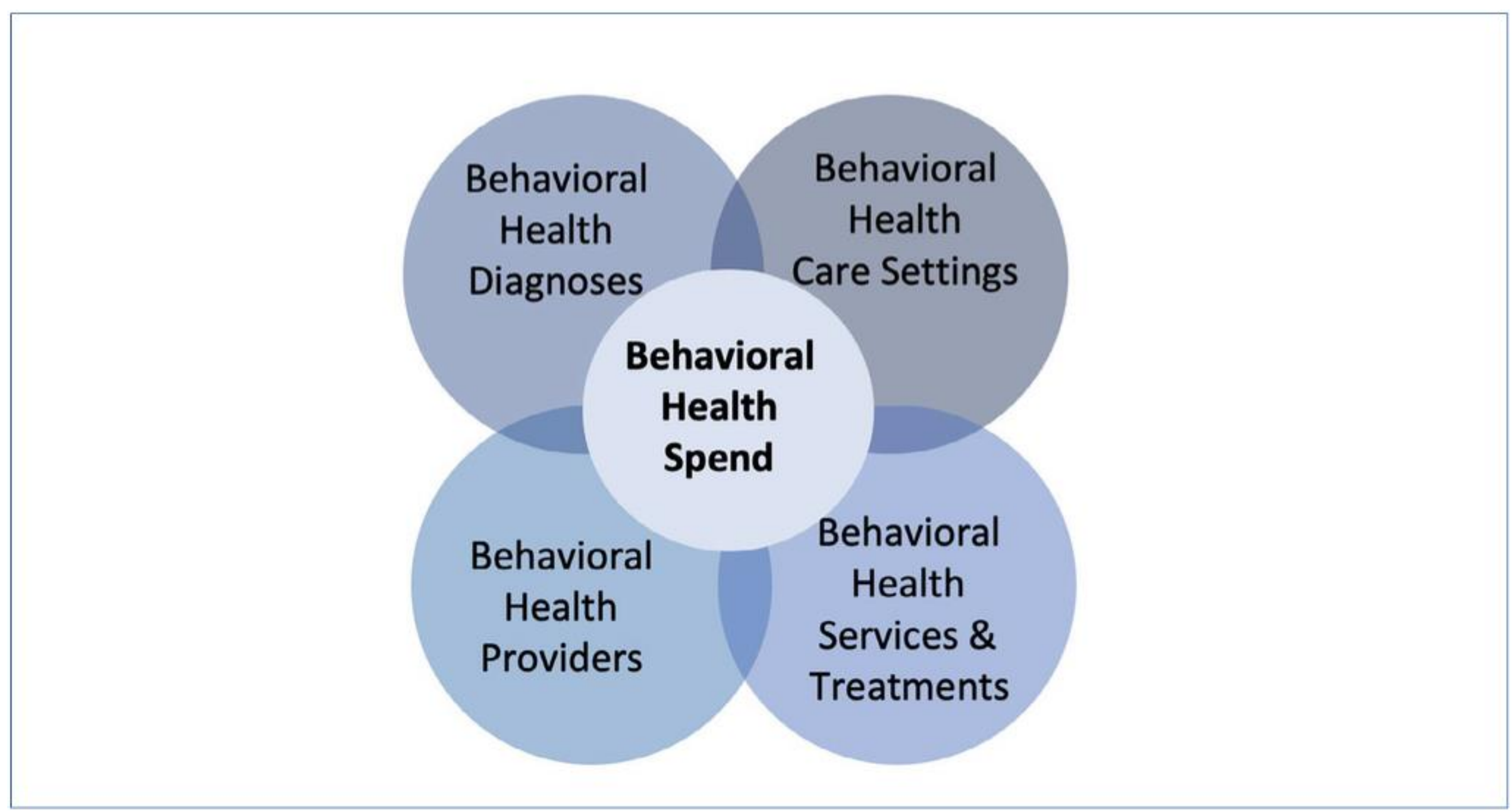
Defining Behavioral Health Spending



Proposed Approach to Defining Code Sets

1. Review Milbank definition
2. Review Department of Managed Health Care coverage requirements and Medi-Cal code sets; incorporate additions
3. Circulate draft code sets to Workgroup members for review and feedback

Proposed Approach to Claims-based Behavioral Health Spending Measurement

Medical claims:

- ✓ The primary diagnosis is a behavioral health diagnosis
- ✓ Include a broad list of services defined as behavioral health
- ✓ Services provided by any provider taxonomy; not restricted

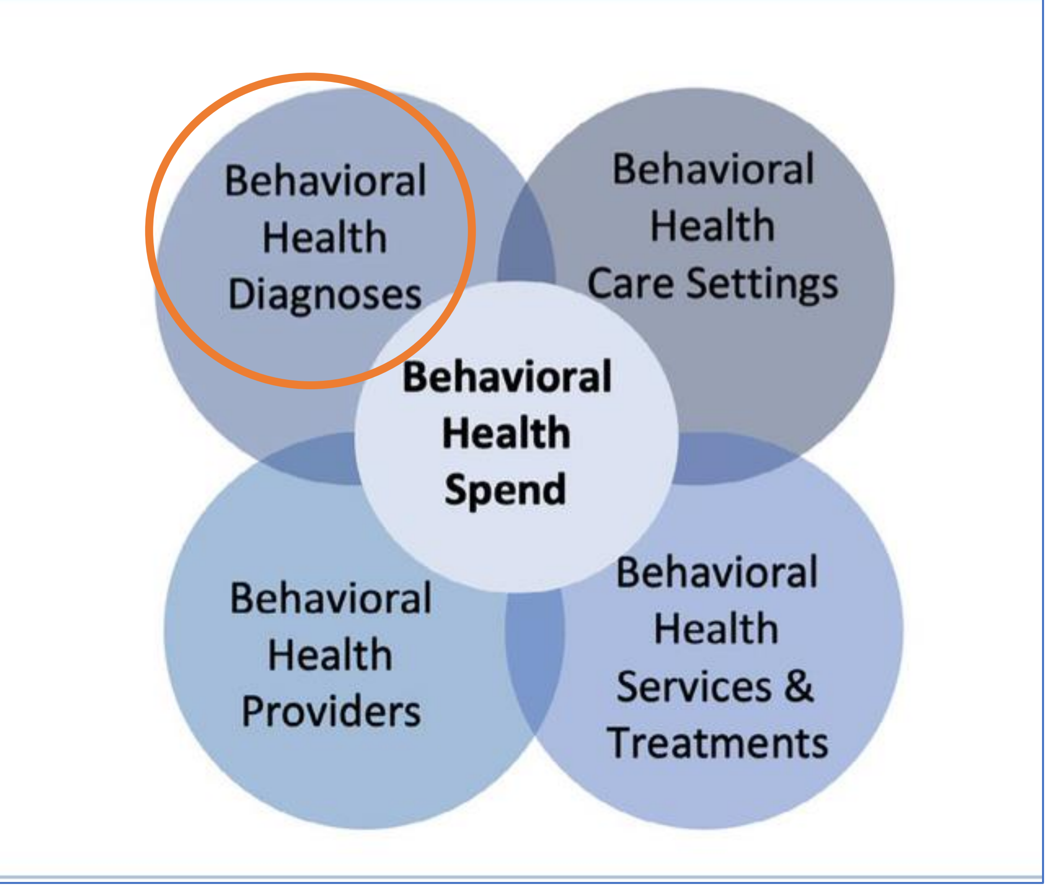
Pharmacy claims:

- ✓ Include National Drug Codes for behavioral health pharmaceutical treatments

Measurement Component: Diagnosis

Milbank Principles

- Include a specific set of diagnosis codes to identify patients with a primary diagnosis of a behavioral health condition
- Include all diagnosis codes for mental health and substance use disorders consistently used in state definitions (Maine, Massachusetts, Rhode Island)
- Assign diagnoses and associated spending to mental health and substance use disorder categories



The Milbank Memorial Fund, April 2024. Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

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Identifying Behavioral Health Spending via Diagnosis

<table>
<tr><th>Approach</th><th>Considerations</th><th>Recommendation</th></tr>
<tr><td>Primary behavioral health diagnosis only</td><td>• Reduces likelihood of overcounting, such as for medical (non-BH) services in facility and professional claims
• Only primary diagnosis is used for payment; other diagnosis fields are generally not well populated</td><td rowspan="2">OHCA recommends using the primary diagnosis only to identify behavioral health spending. Using other diagnoses creates a risk of greatly overcounting behavioral health spend, particularly in facility settings where medical services are also provided. Selective use of additional Dx adds to data submitter burden.</td></tr>
<tr><td>Behavioral health in any diagnosis place on the claim</td><td>• Patients seeking primary care may have several conditions, so some behavioral health services can be missed if looking only at primary diagnosis
• Primary care providers may not code with the same precision as in other settings
• Captures more behavioral health spending in integrated settings, where providers are more likely to include a secondary diagnosis</td></tr>
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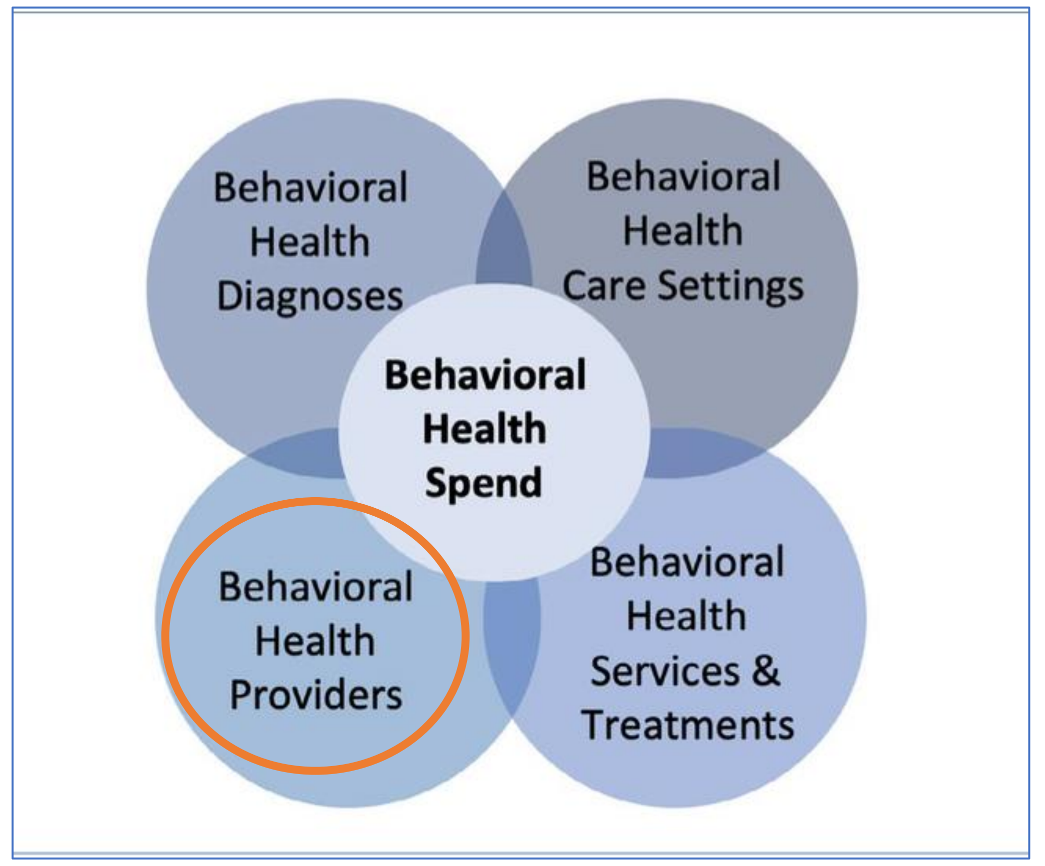
Measurement Component: Provider

Milbank Principles

- Do not restrict by provider type, consistent with all state approaches
- Track behavioral health services delivered by primary care providers in the primary care setting



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Restricting Behavioral Health Spending Measurement by Provider Type

Approach	Considerations	Recommendation
Do not restrict by provider type	• Captures behavioral health services delivered by non-specialty providers	OHCA recommends not restricting the behavioral health definition to only certain provider types. Recommend tracking behavioral health services and treatments delivered in a primary care setting using PCP taxonomy codes.
Include only certain provider types (e.g., psychologist, social worker, peer specialist) in behavioral health definition	• Would include only services delivered by certain providers • Does not reflect how care is delivered; likely to miss a lot of behavioral health spending (e.g., primary care) and innovative care delivery • Burden for data submitters	

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Process Map for Identifying Behavioral Health Claims

DEFINING

Claim includes BH diagnosis as primary diagnosis?

Yes → BH Service Subcategory (see CATEGORIZING)

No ↓

Claim includes code for MH or SUD screening or assessment?

- No → Not a BH Claim
- Yes → BH Claim

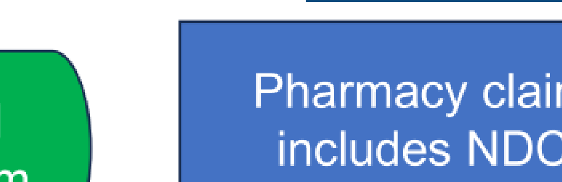
CATEGORIZING

BH Service Subcategory, defined by place of service, revenue, and service codes?

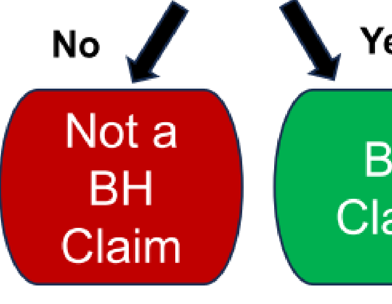
- Inpatient Facility
- Long-Term Care
- ED/Observation Facility
- Outpatient Facility
- Residential Care
- Mobile Services
- Inpatient Professional
- ED/Observation Professional
- Outpatient Professional Primary Care
- Outpatient Professional Non-Primary Care
- Other BH Services

Yes → BH Claim

DEFINING



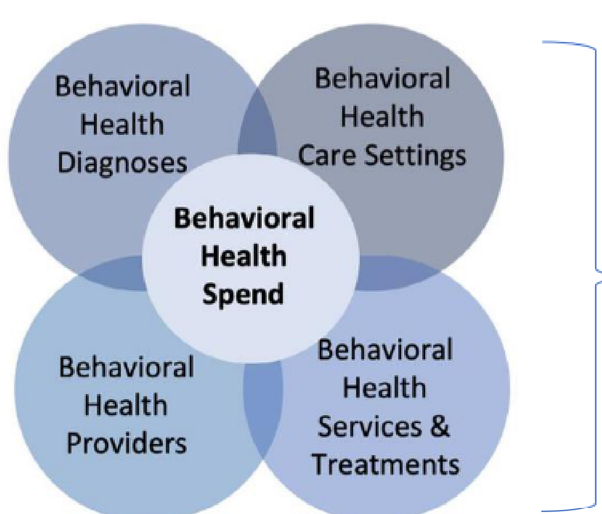
Pharmacy claim includes NDC specified as BH treatment?



- No → Not a BH Claim
- Yes → BH Claim

Organizing Behavioral Health Spending Data for Analysis and Reporting

Step 1: Code sets define what is included as behavioral health spend.



Subcategories

Subcategories

Subcategories

Subcategories

Step 2: Care Settings, Services, and Treatments are grouped together into subcategories to support analyses.

Step 3: Subcategories can be grouped into Categories for more streamlined reporting.

Service Category

Defining Behavioral Health Claims Using Service Subcategories

Subcategory	All Claim Lines?	Codes Used
Inpatient Facility	Yes	Revenue
Long-Term Care	Yes	Revenue
ED/Obs Facility	Yes	Revenue
Outp Fac	Yes	Revenue
Residential	Yes	Revenue
Mobile Services	Yes	Place of Service (POS) ***or*** specified HCPCS
Inpatient Prof	No	POS ***and*** CPT
ED/Obs Prof	No	POS ***and*** specified CPT codes
Outp Prof PC	No	POS ***and*** CPT/HCPCS, with primary care taxonomy
Outp Prof Non-PC	No	POS ***and*** CPT/HCPCS
Other BH Services	No	Claims with BH diagnosis that do not fit into a subcategory

The Milbank Memorial Fund, April 2024. Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.
https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Example #1: Patient with dementia admitted to hospital with hip fracture

- Dementia is a behavioral health diagnosis
- However, the primary diagnosis on the hospital claim is hip fracture
- While the patient's dementia may have contributed to the circumstances that resulted in the hip fracture, the claim is not considered a behavioral health claim because the primary diagnosis is not in the code set

Example #2: Poisoning related to intentional self-harm

- Poisoning related to intentional self-harm diagnoses are in the code set as behavioral health diagnoses
- Claims for emergency department facility and professional services have primary diagnosis of T400X2, "Poisoning by opium, intentional self-harm"
- The revenue code in the facility claims and place of service and procedure codes in the professional claim are included in the behavioral health claim code set
- Though the services connected to the claim may be predominantly medical, poisoning related to intentional self-harm is a serious behavioral health event, and the immediate treatments are directly related to that event
- All claim lines on the facility claim and claim lines on the professional claim with POS code 23 (Emergency Room) and CPT codes in the code set are considered behavioral health claims

Example #3: Adolescent with Autism Receiving Applied Behavior Analysis Services

- Outpatient professional claim includes primary diagnosis code F840, "Autistic disorder"
- Claim includes Place of Service code 11 (Office) and service codes include CPT 97153 (Adaptive Behavior Treatment by Protocol)
- This combination of codes is included in the code set specifications for the outpatient professional claim subcategory

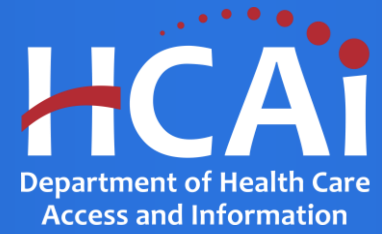
Discussion

- Do members have feedback on:
  - Using primary diagnosis on the claims?
  - Including a broad set of services, not all services?
  - Including those services regardless of the provider rendering the service so long as it has a primary behavioral health diagnosis?

- Is there feedback on which care settings or service categories would be most interesting to report separately and distinctly?

BH Service Subcategory

- Inpatient Facility
- Long-Term Care
- ED/Observation Facility
- Outpatient Facility
- Residential Care
- Mobile Services
- Inpatient Professional
- ED/Observation Professional
- Outpatient Professional Primary Care
- Outpatient Professional Non-Primary Care
- Other BH Services



Measuring Non-Claims Behavioral Health Spending

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

Behavioral Health Non-Claims Data

Milbank Principles

- Data collection via Expanded Non-Claims Payment Framework
- Include all behavioral health non-claims subcategories
- Apportion professional and global capitation payments and payments to integrated, comprehensive payment and delivery systems to behavioral health
- Include other non-claims payments to third-party providers and consider whether to include a limited amount of payer investments in behavioral health

Figure 6. Expanded Framework Behavioral Health Categories

Payments to Integrated Payment and Delivery Systems

*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.

The Milbank Memorial Fund, April 2024. Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Expanded Framework, Categories A-C

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

	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

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	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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Apportioning Professional and Global Capitation to Behavioral Health

$$\left[\frac{\Sigma\,(\#\text{ of BH Encounters} \times \text{FFS-equivalent Fee})_{segment}}{\Sigma\,(\#\text{ of All Prof Encounters} \times \text{FFS-equivalent Fee})_{segment}}\right] \times \text{Capitation Payment}$$

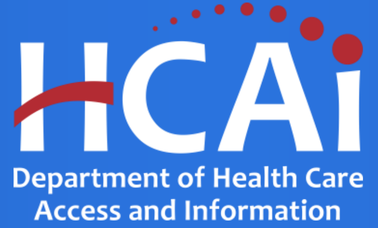
$$= \text{Behavioral Health spend paid via capitation}$$

"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.

Discussion

- Do members have feedback on:
  - The proposed Expanded Framework subcategories that count towards behavioral health spending?
  - The methodology to apportion capitated payments to behavioral health?
- Do payers make behavioral health non-claims payments to provider organizations or other third-party providers that would not be included in the Expanded Framework behavioral health non-claims payment subcategories?
- Are there other categories of payer clinical behavioral health spending that OHCA should consider?



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

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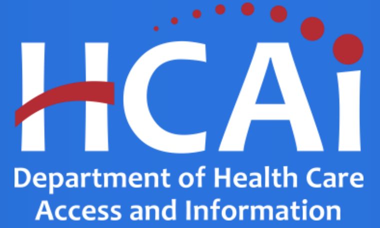
February Workgroup Meeting Preview

- Defining the Benchmark: claims and non-claims
- Behavioral Health in Primary Care Module



Adjournment