HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

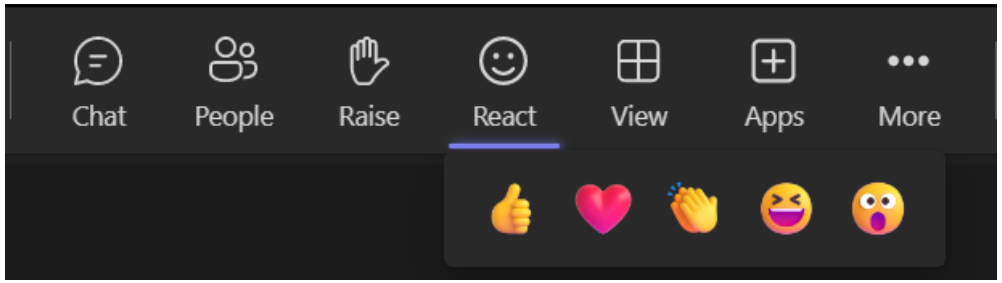
July 17th, 2024

Agenda

9:00 a.m.	1.	**Welcome, Updates, and Introductions**
9:10 a.m.	2.	**Review Behavioral Health Workstream Timeline and Purpose**
9:20 a.m.	3.	**Overview of the Behavioral Health Landscape in California**
9:50 a.m.	4.	**Data on Behavioral Health Condition Prevalence and Service Use in California**
10:10 a.m.	5.	**Begin Discussion on Priorities for Behavioral Health Investment**
10:30 a.m.	6.	**Adjournment**

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: July 17, 2024

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 #

APM Standards and Goals Adopted

At the June 2024 meeting, the Board adopted the proposed APM Standards and Adoption Goals.

Thank you to the Workgroup, Advisory Committee, and other stakeholders for their meaningful contributions to this work!

APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

See OHCA website for APM Standards and Goals: https://hcai.ca.gov/affordability/ohca/#laws-and-regulations

Primary Care Measurement Definition and Benchmark Updates and Next Steps

Measurement Definition

- OHCA is considering Board feedback and public comments. Planned additional codes to be included in the definition:
  - Provider taxonomy codes: Community Health Worker, Community Health Center/Clinic, Allopathic & Osteopathic Physicians, Adult Medicine*
  - Place of service codes: Telehealth provided somewhere other than patient's home, independent clinic
  - CPT/HCPCS service codes: Digital Evaluation and Management*

Benchmark

- OHCA is seeking a Board vote in August on the 15% statewide investment benchmark for 2034.

*Note: Code officially replaced by other codes but still sometimes billed.

Investment and Payment Workgroup Introduction Instructions

Welcome new and returning Investment and Payment Workgroup members! We look forward to getting to know our new members and connecting you with each other as we get started on our behavioral health work.

Please keep introductions brief today and include the following:

1. Name
2. Organization
3. Title/Role
4. Location

Example: Hi, I'm Julia Sledzik, a Health Policy Analyst with Freedman HealthCare. I live in Boston.

Then, in the chat please provide one goal for advancing high-value behavioral health care. We encourage members to respond or react to other members' goals.

Investment and Payment Workgroup Members

Providers & Provider Organizations

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

Lisa Folberg, MPP
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

Catrina Reyes, Esq.
Deputy General Counsel, California Primary Care Association (CPCA)

Janice Rocco
Chief of Staff, California Medical Association

Hospitals & Health Systems

Ash Amarnath, MD, MS-SHCD
Chief Health Officer, California Health Care Safety Net Institute

Kirsten Barlow, MSW
Vice President Policy, California Hospital Association (CHA)

Jodi Nerell, LCSW
Director of Local Mental Heath Engagement, Sutter Health

Health Plans

Rhonda Chabran, LCSW
Director of Behavioral Health Quality & Regulatory Services, Kaiser Foundation Health Plan/Hospital, Southern CA & HI

Keenan Freeman, MBA
Chief Financial Officer, Inland Empire Health Plan (IEHP)

Mohit Ghose
State Affairs, Anthem

Nicole Stelter, PhD, LMFT
Director of Behavioral Health, Commercial Lines of Business, Blue Shield of California

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

Consumer Reps & Advocates

Beth Capell, PhD
Contract Lobbyist, Health Access California

Jessica Cruz, MPA
Executive Director, National Alliance on Mental Illness (NAMI) CA

Nina Graham
Transplant Recipient and Cancer Survivor, Patients for Primary Care

Héctor Hernández-Delgado, Esq.
Senior Attorney, National Health Law Program

Cary Sanders, MPP
Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)

Academics/ SMEs

Sarah Arnquist, MPH
Principal Consultant, SJA Health Solutions

Crystal Eubanks, MS-MHSc
Vice President Care Transformation, California Quality Collaborative (CQC)

Kevin Grumbach, MD
Professor of Family and Community Medicine, UC San Francisco

Reshma Gupta, MD, MSHPM
Chief of Population Health and Accountable Care, UC Davis

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

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, CalPERS

Palav Babaria, MD
Chief Quality and Medical Officer & Deputy Director of Quality and Population Health Management, Department of Health Care Services (DHCS)

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

Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care

An additional hospital and health system representative has been invited.

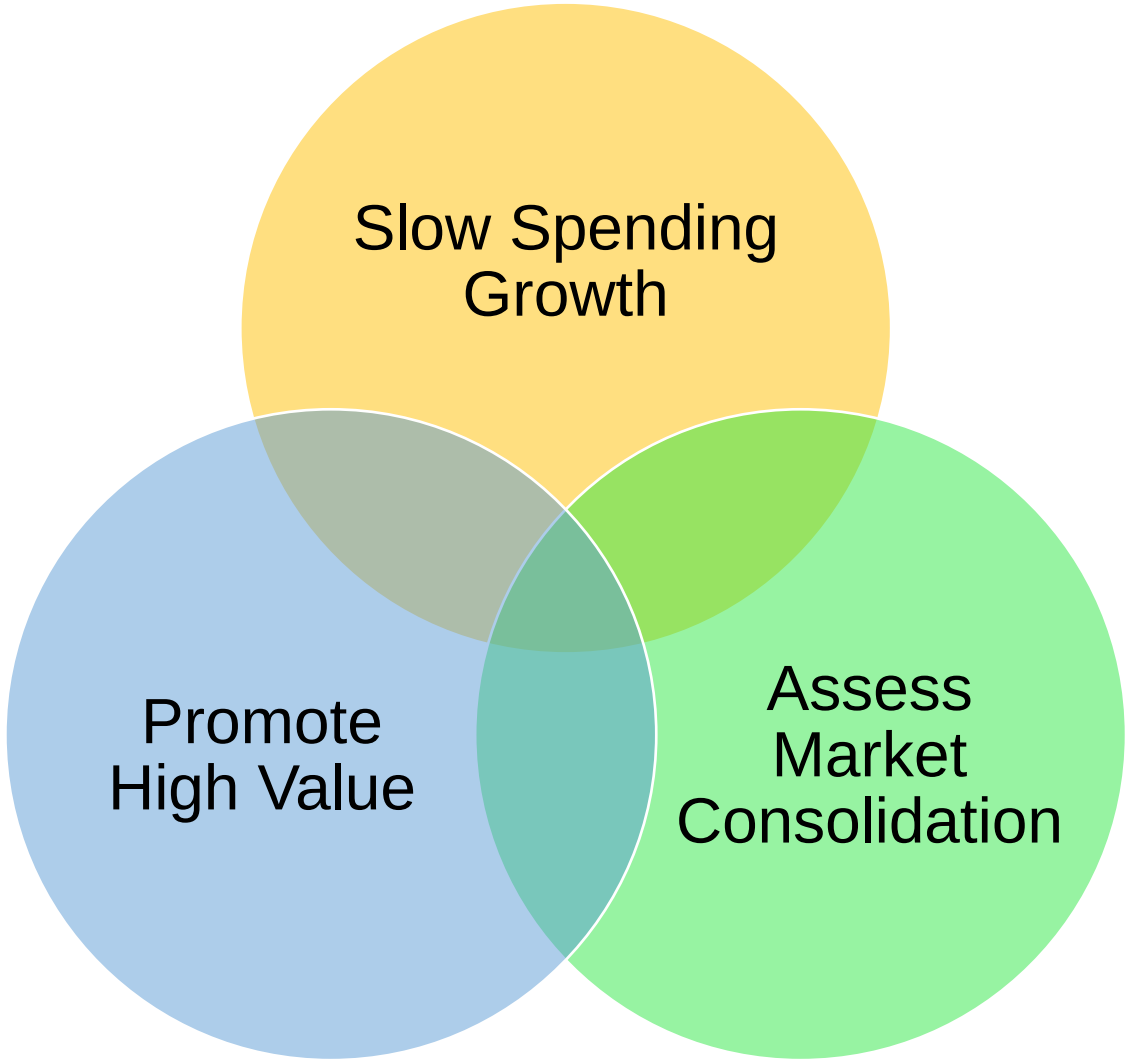
Etiquette for Easy Collaboration

- Mute your microphone when you are not speaking to avoid background noises
- Use of your camera is encouraged
- Raise your hand to make a comment, provide feedback, or offer an idea
- Use the chat box, reactions, and emojis to contribute to the conversation
- Be present and practice active listening, we want to hear your insights
- Be respectful of differences in understanding and perspective
- Hold the tension of both/and thinking, rather than either/or thinking

Review Behavioral Health Workstream Timeline and Purpose

Debbie Lindes, Health Care Delivery System Group Manager

OHCA Key Components



Focus Areas for Promoting High Value

APM Adoption	• Define, measure, and report on alternative payment model adoption • Set standards for APMs to be used during contracting • Establish a benchmark for APM adoption
Primary Care Investment	• Define, measure, and report on primary care spending • Establish a benchmark for primary care spending
Behavioral Health Investment	• Define, measure, and report on behavioral health spending • Establish a benchmark for behavioral health spending
Quality and Equity Measurement	• Develop, adopt, and report performance on a single set of quality and health equity measures
Workforce Stability	• Develop and adopt standards to advance the stability of the health care workforce • Monitor and report on workforce stability measures

Primary Care & Behavioral Health Investments

Statutory Requirements

- **Measure and promote a sustained systemwide investment in** primary care and **behavioral health.**
- **Measure the percentage of total health care expenditures allocated to** primary care and **behavioral health and set spending benchmarks**.
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Primary Care & Behavioral Health Investments

Statutory Requirements

Promote improved outcomes for behavioral health, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

a. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
b. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.
c. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
d. Deliver higher value behavioral health services with an aim toward reducing disparities.
e. Leverage telehealth and other solutions to expand access to behavioral health, care coordination, and care management.

Timeline for Behavioral Health Work

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

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

X Provide Feedback ✓ Board Approval

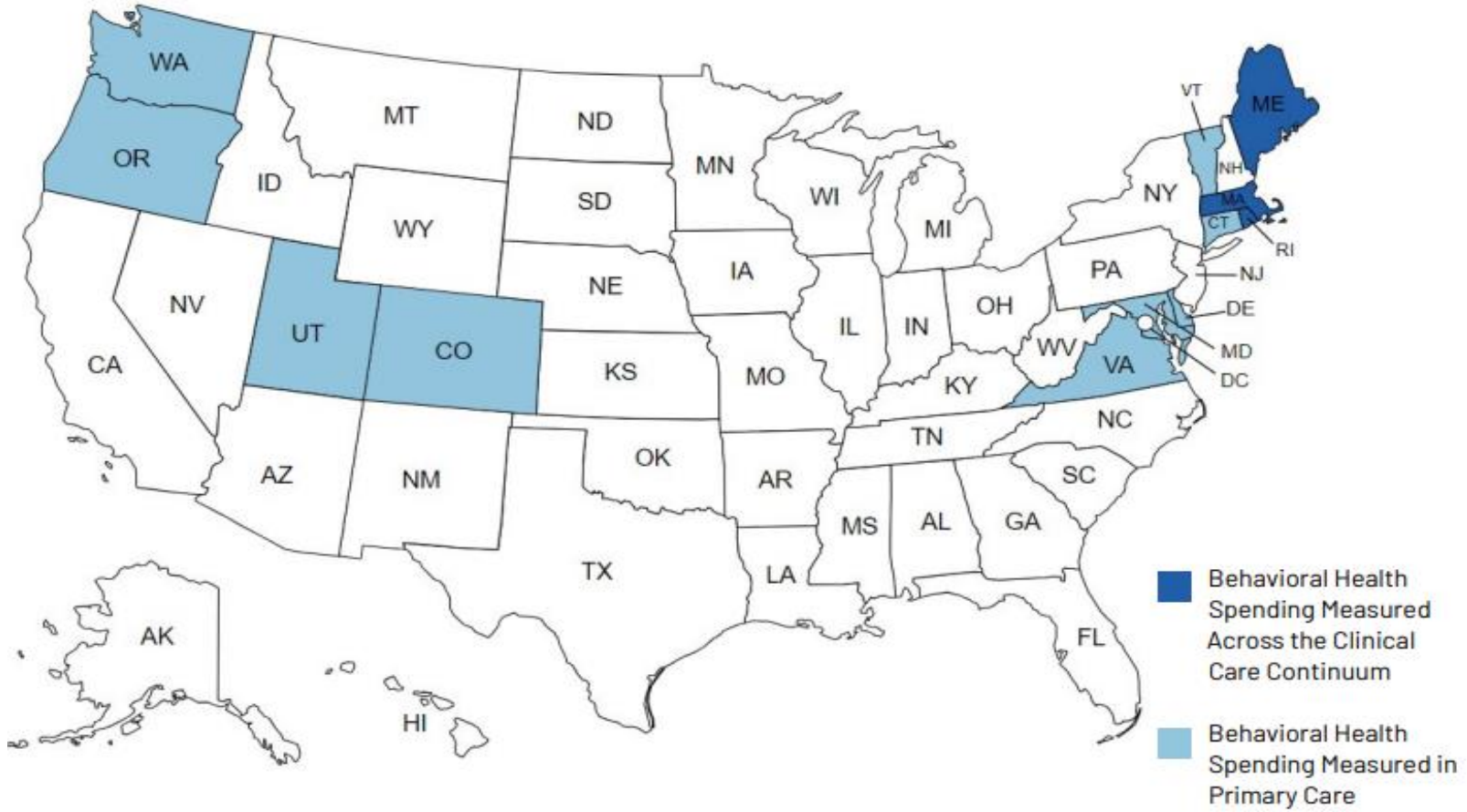
Measuring Investment: Behavioral Health vs. Primary Care

Primary Care	Behavioral Health
• Most spending can be captured from health care providers and payers • Policy goals include monitoring investment and shifting more investment to primary care to improve equity, access, quality, and lower total costs • Measures primary care ***services*** as a discrete portion of the delivery system	• More care delivered outside traditional health care delivery system; more spending not paid by health care payers • Measures treatment of behavioral health ***conditions*** across delivery system • Payment structures vary across delivery systems and payers; difficult to compare • Data can be elusive • Policy goals similar to primary care, but spread across the care continuum • Data privacy concerns

States Measuring Behavioral Health Clinical Spending

Nine states measure behavioral health spending as part of their efforts to measure primary care spending.

Three states measure behavioral health spending across the full care continuum (Maine, Massachusetts, and Rhode Island). This is California's mandate as well.



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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Data Collection and Measurement Scope

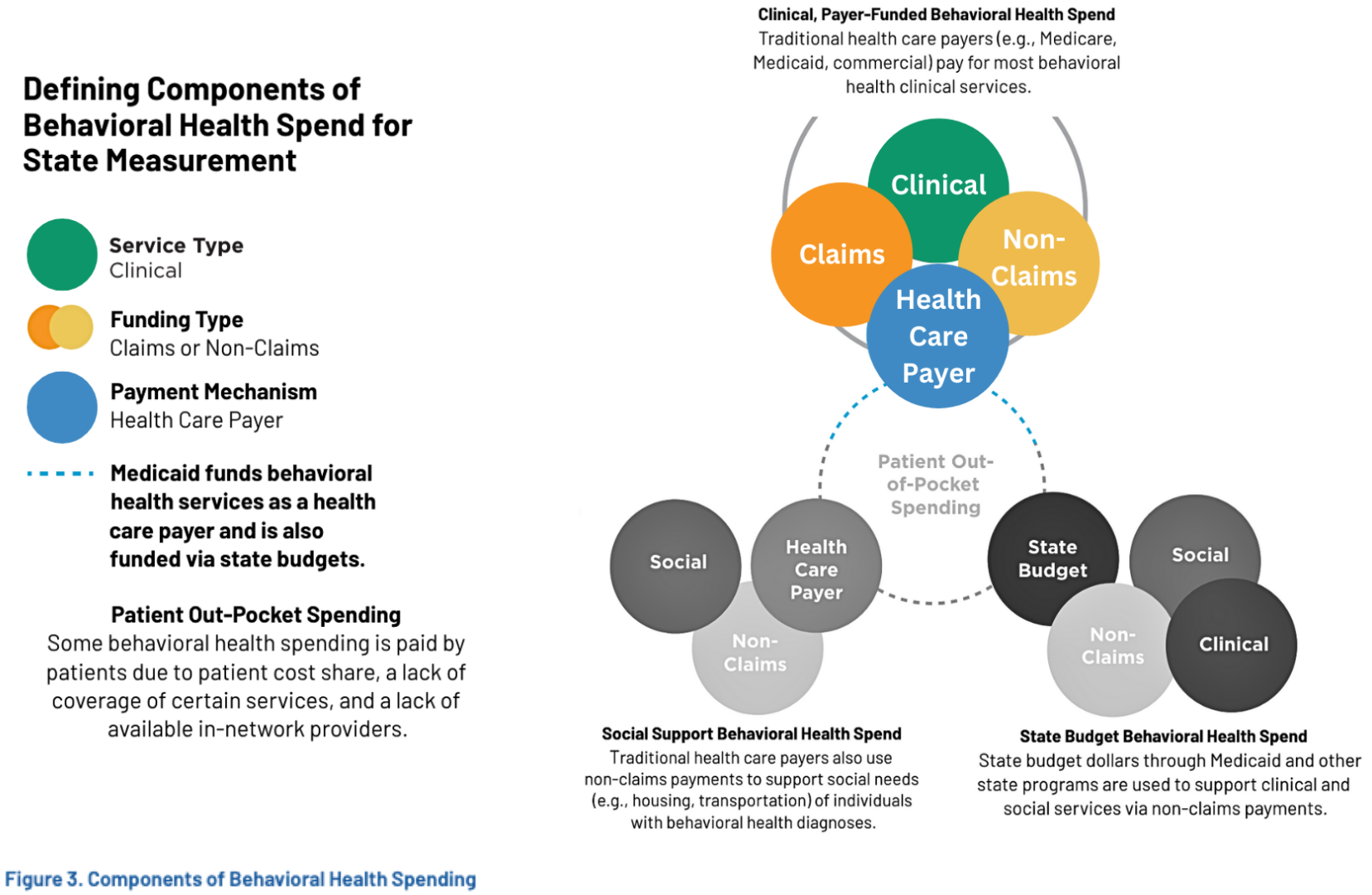
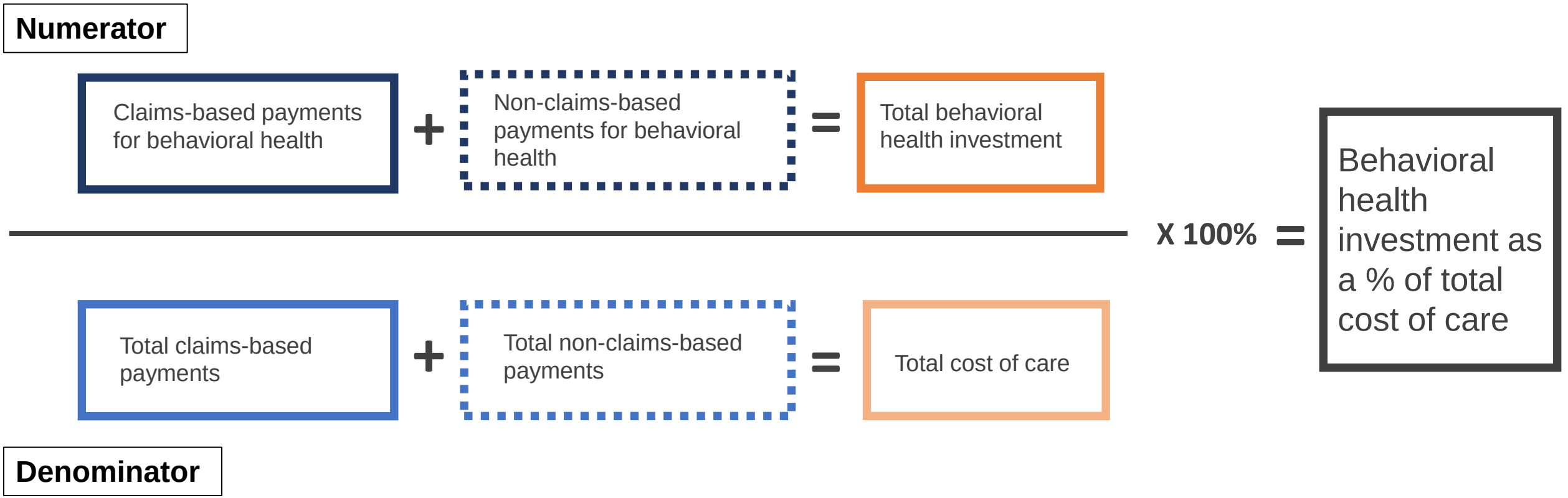


Figure 3. Components of Behavioral Health Spending

- Initial focus on clinical services and health care payers
- Possibility of using supplemental data sources to capture other spending in the future

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/

Measuring Behavioral Health Investment



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. The Workgroup will inform the Behavioral Health Care Paid via Claims and Behavioral Health Care Paid via Non-Claims modules.

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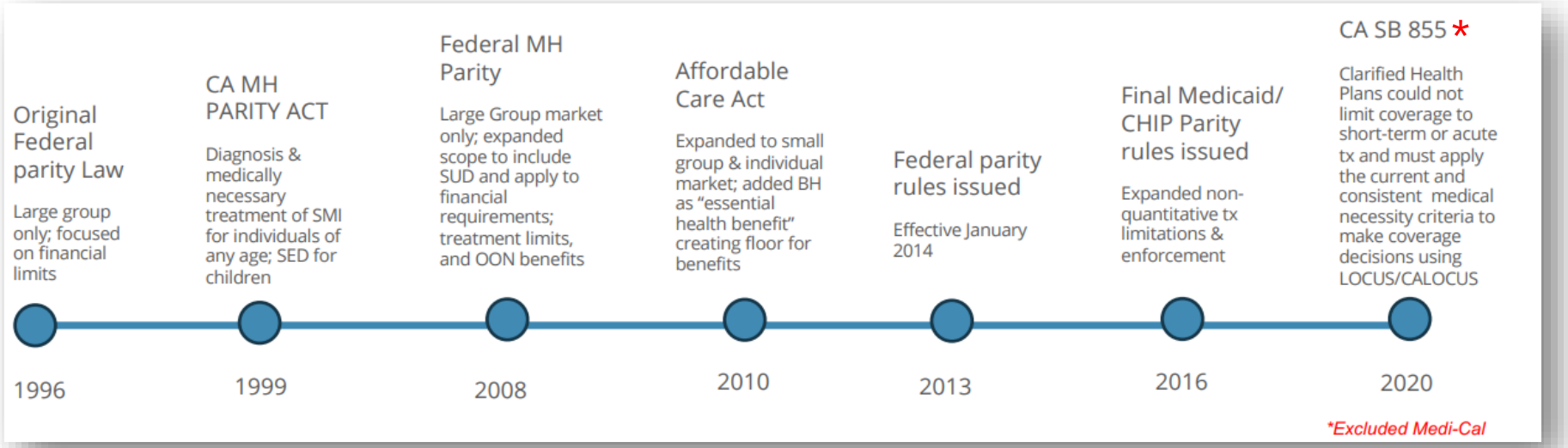
Overview of the Behavioral Health Landscape in California

Robert Seifert, Consultant, Freedman HealthCare

The Behavioral Health Policy Landscape in California

- Mental health treatment access has been the top health care priority Californians want their elected officials to focus on four years in a row, according to a California Health Care Foundation survey findings published in 2023.[1]
- Mental health parity laws have continued to evolve since originally passed in 1996.
  - Since 2020, California has continued expanding parity requirements in Health and Safety Code § 1374.72 by mandating commercial coverage of certain school-linked services, CARE Court related services, and Mobile crisis and services linked to 988.[2]



1. California Health Care Foundation (CHCF). The 2023 CHCF California Health Policy Survey. 2023. https://www.chcf.org/publication/2023-chcf-california-health-policy-survey/
2. Kaiser Family Foundation (KFF). Mental Health Parity at a Crossroads. Aug 2022. https://www.kff.org/mental-health/issue-brief/mental-health-parity-at-a-crossroads/

Overview of Behavioral Health Payers and Covered Services in California

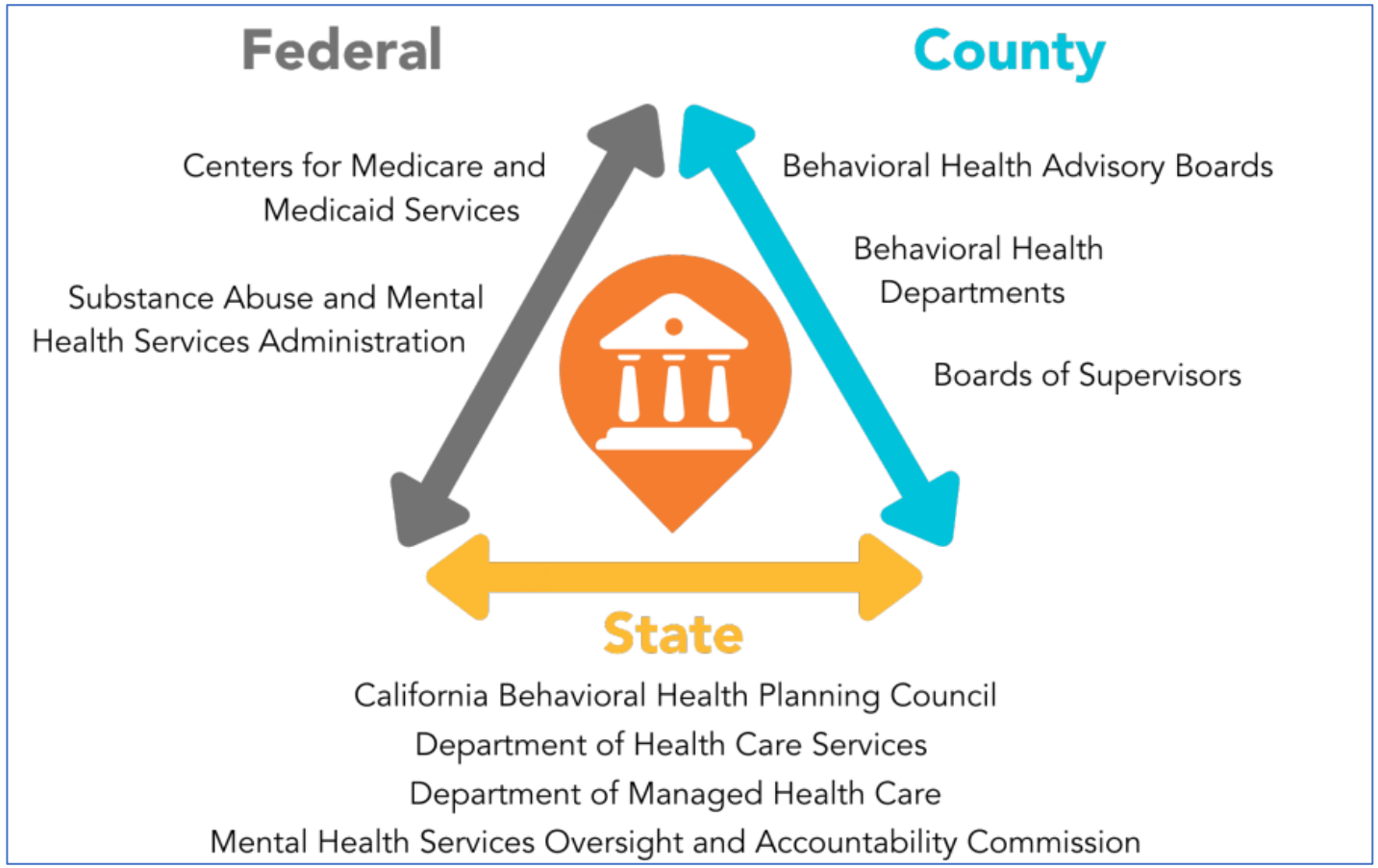
State (DHCS)	Commercial	Medicare
• Medi-Cal Managed Care Plans/Fee-For Service ○ Primary care ○ Non-Specialty Mental Health Services • County Health Plans ○ Medi-Cal Specialty Mental Health Services ○ Drug Medi-Cal • Behavioral Health Services Act ○ Payments to local programs from Mental Health Services Fund	• Covered benefit in HMO and PPO (fully-insured and self-insured) ○ Health plan pays providers directly for all covered services ***or*** ○ Health plan contracts with behavioral health service plan (carve-out) for most covered services	• Medicare Advantage: ○ Similar to commercial; health plan pays providers directly or contracts with a behavioral health service plan ○ Traditional Medicare: ○ Medicare providers directly for all covered services

State funding of school-based services

Covered services and benefit design vary.

Governance of California's Public Mental Health Services

Federal, state, and county government play a role in the governance and oversight of public mental health services.



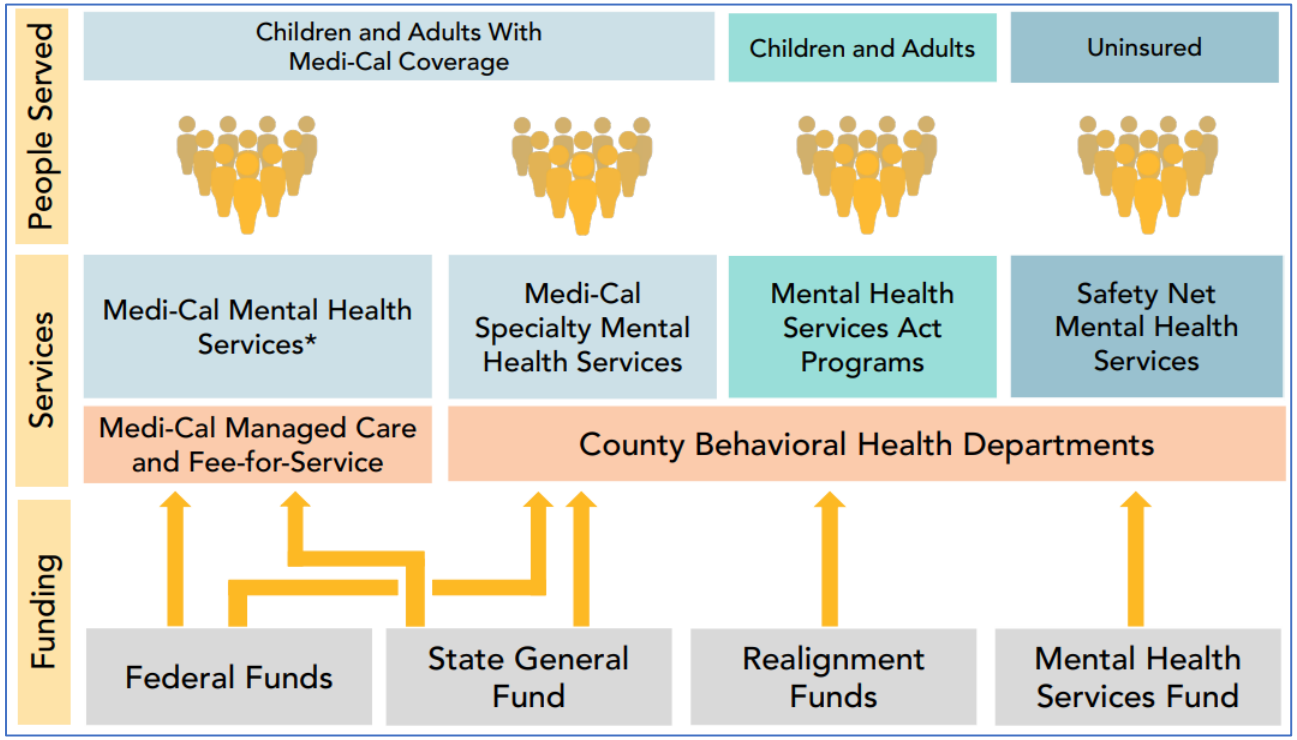
The Public Mental Health Services Landscape in California

Medi-Cal provides mental health services through:

1. Managed care plans (MCPs)
2. Fee-for-service (FFS) system
3. County mental health plans (MHPs)

The state requires MCPs and MHPs to coordinate services. However, there are often "serious disconnects" between the two sets of providers.

The implementation of Proposition 1, passed in March 2024, is intended to break down these silos, reduce inequities, and fill remaining gaps in the continuum of care.



* Medi-Cal managed care plans provide services to adults age 21 and older with mild-to-moderate conditions. For children and youth under age 21, Medi-Cal managed care plans must provide medically necessary non-specialty mental health services regardless of the severity of the impairment.
Note: Graphics are not scaled proportionately to the number of people served or to the amount of funding in each category.

California Budget & Policy Center. Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding. March 2020. https://calbudgetcenter.org/app/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf

The Public Substance Use Disorder Services Landscape in California

This table provides an overview of substance use disorder services provided under public programs in California and the populations served under each program.

Each funding stream provides specific services with block grant dollars available to fill in gaps.

	Primary Public Programs for SUD Treatment			
	COUNTY SUD PROGRAMS			
	STANDARD DRUG MEDI-CAL STATE PLAN	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)	PROGRAMS FUNDED THROUGH SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT	MEDI-CAL MANAGED CARE AND FEE-FOR-SERVICE
Payer	Medi-Cal (federal and state/local)	Medi-Cal (federal and state/local)	Substance Abuse and Mental Health Services Administration	Medi-Cal (federal and state/local)
People Served	Medi-Cal enrollees with SUD	Medi-Cal enrollees with SUD	People with SUD who are either uninsured or are Medi-Cal enrollees (for services not covered by Medi-Cal)	Medi-Cal enrollees needing preventive services, addiction medication management, or inpatient withdrawal management
Services Provided	Outpatient and intensive outpatient SUD services, perinatal residential SUD treatment, narcotic treatment programs	Standard Drug Medi-Cal benefit plus target case management, residential SUD treatment (not limited to perinatal), withdrawal management continuum, recovery services, physician consultation, and at county option, additional medication-assisted treatment and partial hospitalization	Nonresidential treatment, residential treatment, ancillary services, and recovery support services	Prevention and early intervention; Screening, Brief Intervention, and Referral to Treatment (SBIRT); medication-assisted treatment provided in medical settings; inpatient withdrawal management in general and freestanding facilities

California Health Care Foundation. Substance Use Treatment in California: Prevalence and Treatment. January 2022. https://www.chcf.org/wp-content/uploads/2022/01/SubstanceUseDisorderAlmanac2022.pdf

Commercial Behavioral Health Coverage in California

California law requires all commercial plans to provide coverage for medically necessary treatment of mental health and substance use disorders at the same cost to the enrollee as physical health conditions, including co-pays, deductibles, and maximum annual and lifetime benefits.

Examples of covered conditions: generalized anxiety disorders, eating disorders-bulimia and anorexia nervosa, post traumatic stress disorder, depression, all substance use conditions, bipolar disorder, schizophrenia

Covered treatments, when medically necessary: Sessions with a therapist, medication management, outpatient intensive treatment, and inpatient residential treatment

California Department of Managed Health Care (DMHC). Know Your Health Care Rights. February 2024. https://www.dmhc.ca.gov/Portals/0/Docs/DO/MentalHealthFactSheet.pdf
California Health Care Foundation (CHCF). The Private Insurance Market in California, 2015. April 2017. https://www.chcf.org/publication/the-private-insurance-market-in-california-2015/
California Health Care Foundation (CHCF). California Health Insurers, Enrollment- 2023 Edition. October 2023. https://www.chcf.org/publication/ca-health-insurers-enrollment-2023-edition/

Commercial Behavioral Health Coverage Arrangements and Data Availability

	Fully Insured Plan	Self-Insured Plan
Behavioral health covered by fully insured or self-insured plan (not carved out)	Detailed behavioral health spending data part of full-service plan's submission to OHCA	Medical third-party administrator also makes behavioral health claims and non-claims payments on behalf of plan sponsor
Behavioral health covered by behavioral health service plan (carved out)	Payer's behavioral health spend available at a high-level, but details (e.g., specific encounters) may not be	Payer's behavioral health spend available at a high-level, but details (e.g., specific encounters) may not be

Medi-Cal vs. Commercial Coverage: Continuum of Care Comparisons

Medi-Cal & Commercial Benefits	Medi-Cal Benefits ONLY
• Primary Care Physician-Based Services • Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder (ASD) • Individual, Group and Family Therapy • Medication Support • Mobile Crisis Intervention • Crisis Stabilization • Acute Inpatient • Residential	• Community Health Worker • Community Supports (CS) • Enhanced Care Management • Intensive Care Coordination • Intensive Home-Based Services • Therapeutic Behavioral Services (TBS) • Community Wraparound • First episode psychosis team • Crisis Residential • Day Rehabilitation • Day Treatment Intensive

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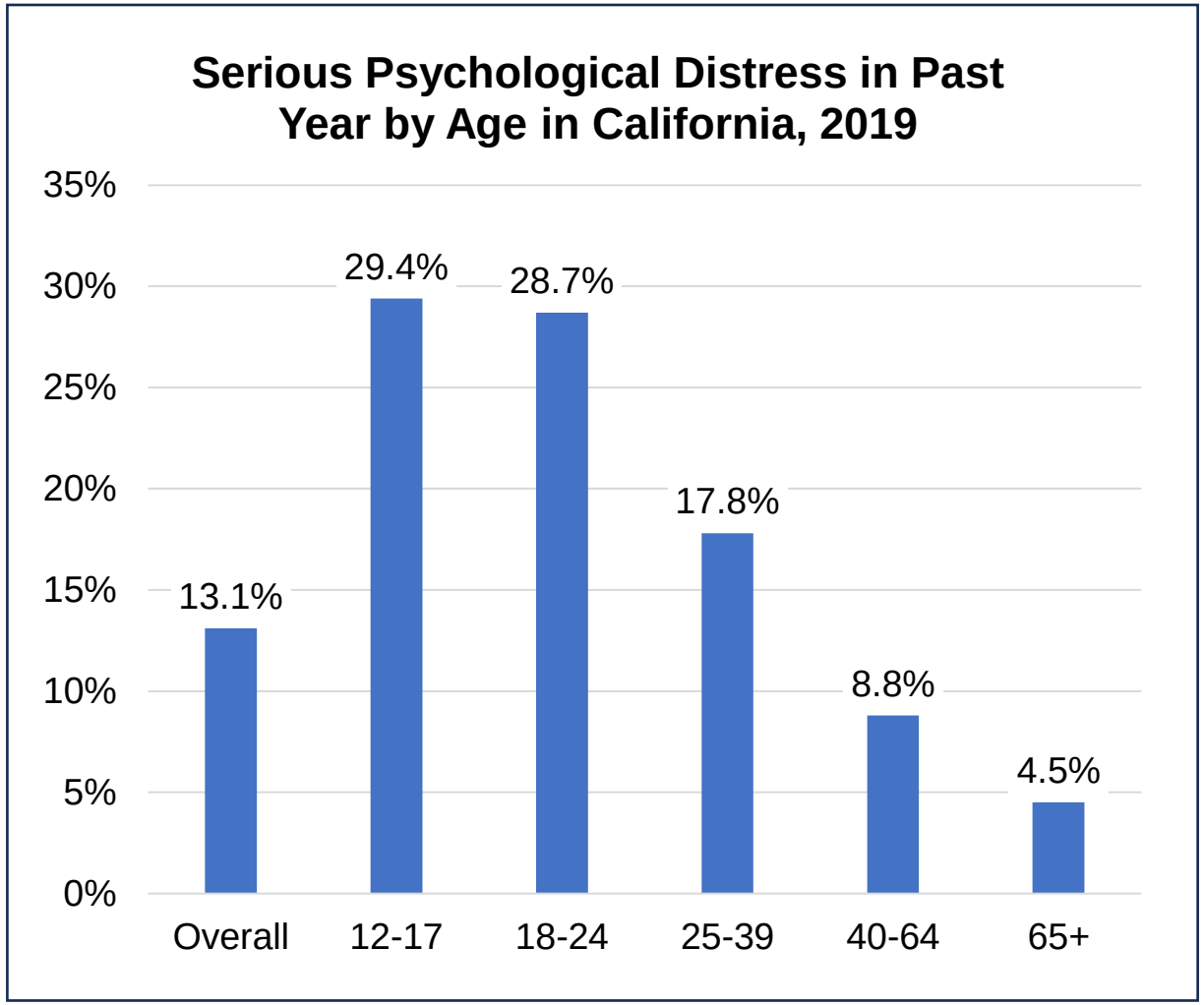
Data on Behavioral Health Condition Prevalence and Service Use in California

Robert Seifert, Consultant, Freedman HealthCare

Serious Psychological Distress by Age Group, California, 2019

In 2019, approximately 30% of Californians aged 12 to 24 experienced serious psychological distress (SPD).

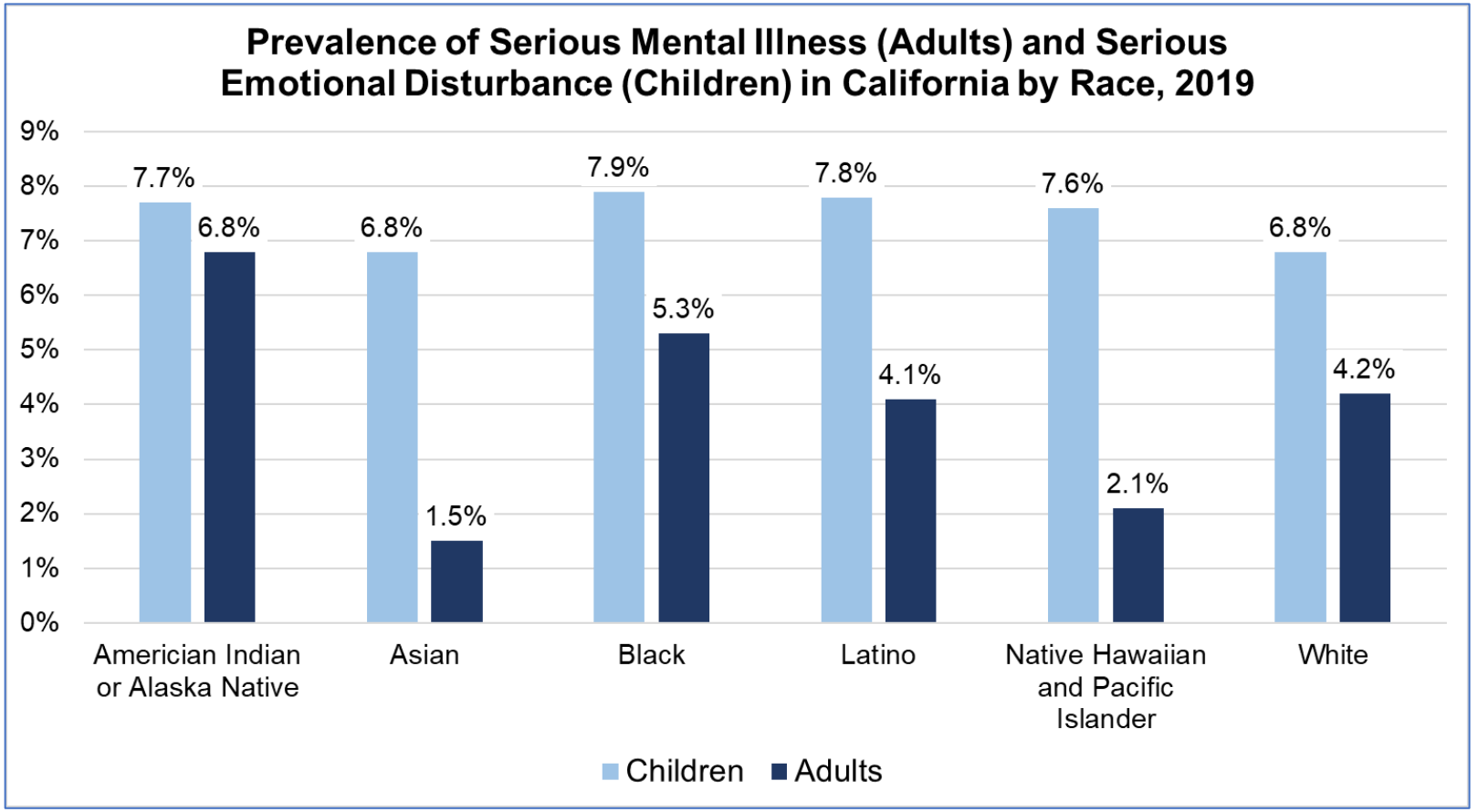


SPD is diagnosed based on The Kessler (K6) Scale, which asks respondents six questions such as "How often do you feel nervous?"

California Health Care Foundation, “Mental Health in California: Waiting for Care.” July 2022. Data for 2019. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

Serious Mental Illness and Serious Emotional Disturbance by Race

In 2019, the prevalence of serious mental illness (SMI) among adults in California varied by race and ethnicity (1.5%-6.8%) while the prevalence of Serious Emotional Disturbance (SED) among children in California varied far less by race and ethnicity (6.8%-7.9%).

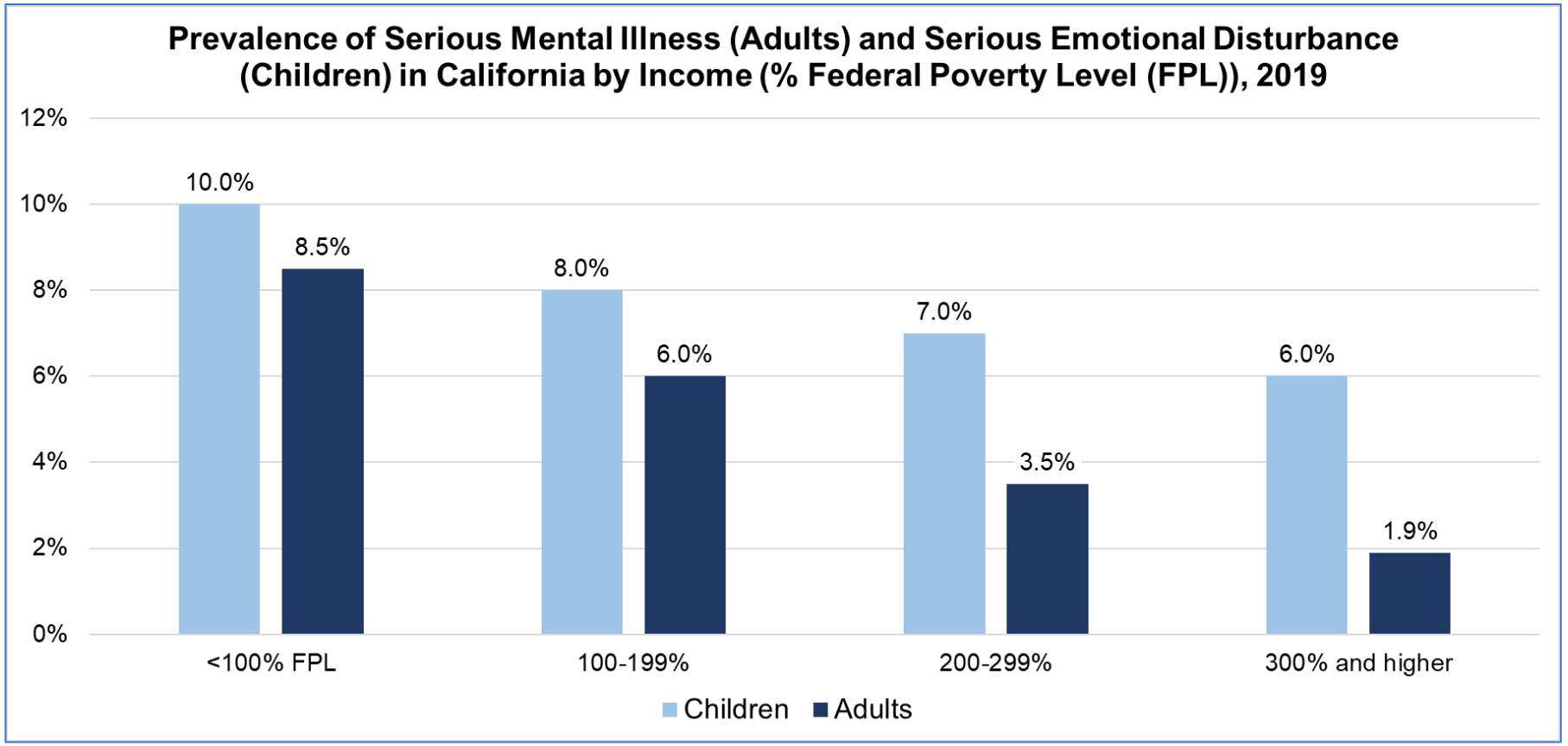


California Health Care Foundation, "Mental Health in California: Waiting for Care." July 2022. Data for 2019. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

SMI is a categorization for adults who currently have, or during the past year have had, a diagnosable mental, behavioral, or emotional disorder that interferes with or limits major life activities.
SED is a categorization for children who currently have, or during the past year had, a mental, behavioral, or emotional disorder resulting that substantially limits functioning in family, school, or community activities.

Serious Mental Illness and Serious Emotional Disturbance by Income

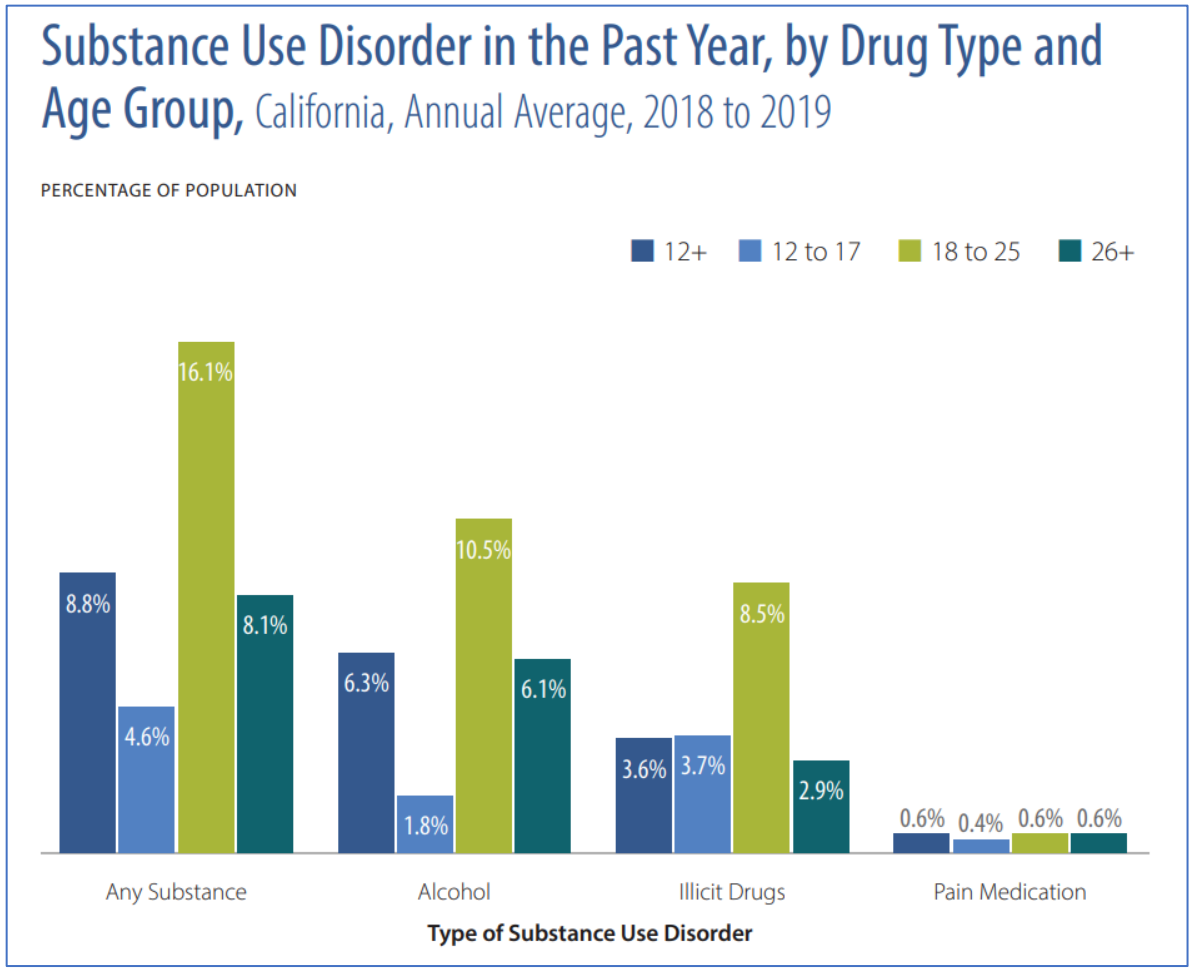
However, the prevalence of Serious Mental Illness among adults and Serious Emotional Disturbance among children increased as income decreased in California in 2019.



California Health Care Foundation, “Mental Health in California: Waiting for Care.” July 2022. Data for 2019. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

Substance Use Disorder (SUD) in the Past Year by Drug Type and Age Group

Between 2018 and 2019, the highest percent of population with any substance use disorder, alcohol, and illicit drugs use disorders was among Californians ages 18 to 25.

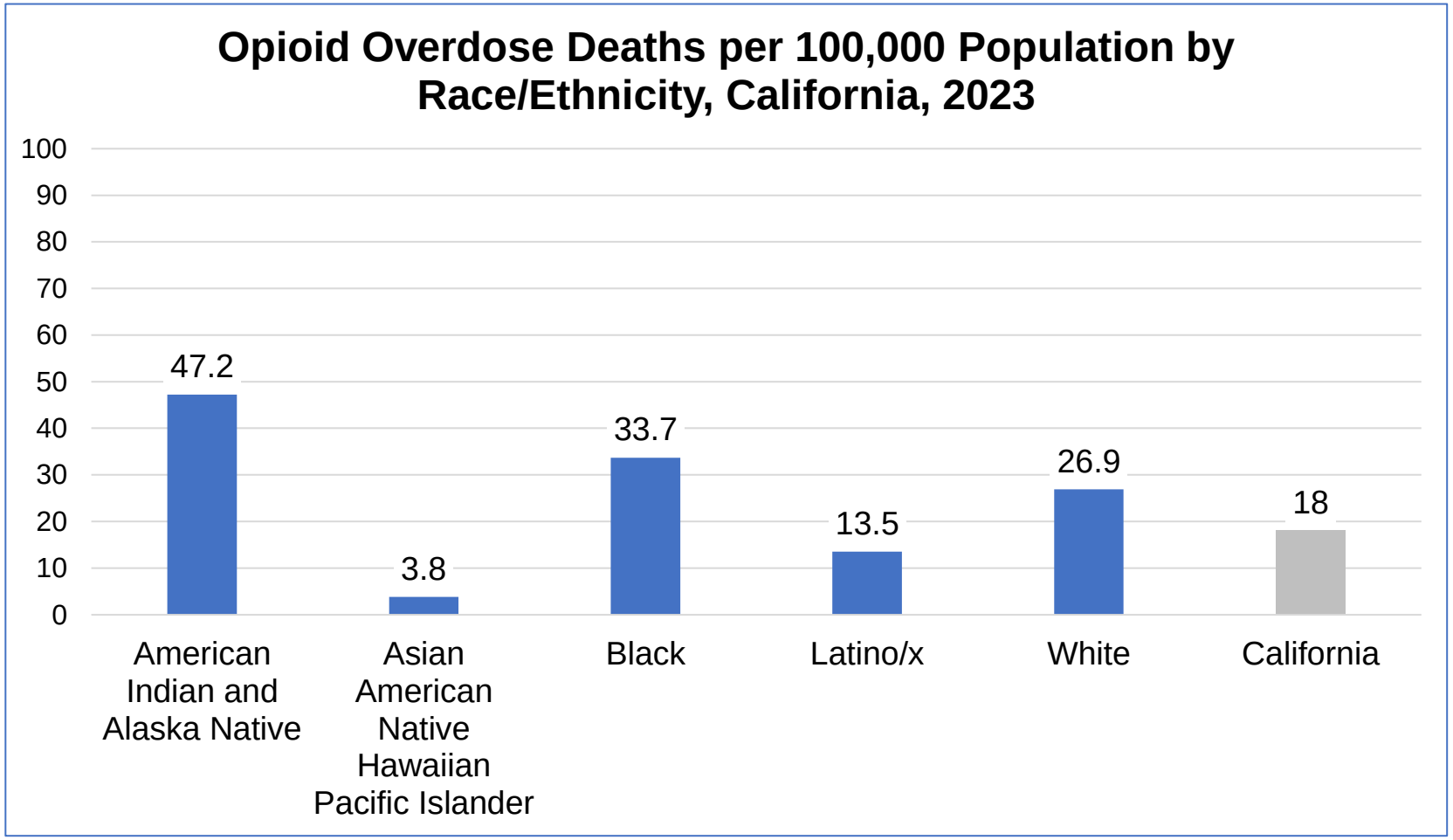


SUD is a problematic pattern of substance use leading to clinically significant impairment or distress over 12 months.

California Health Care Foundation. Substance Use Treatment in California: Prevalence and Treatment. January 2022. https://www.chcf.org/wp-content/uploads/2022/01/SubstanceUseDisorderAlmanac2022.pdf

Opioid Overdose Deaths Varied by Race/Ethnicity

In 2023, there were more opioid overdose deaths per 100,000 population among American Indian and Alaska Native (47.2) and Black (33.7) Californians than among other races/ethnicities in the state.



Depression, Bipolar, and Other Depressive Mood Disorders by Age and Payer Type, 2021

	Commercial	Medi-Cal	Medicare	All Groups
0-17	2.7%	3.1%	2.7%	3.0%
18-34	7.8%	7.7%	10.7%	7.8%
35-49	7.3%	8.5%	16.3%	8.1%
50-64	7.3%	12.7%	20.2%	10.2%
65-74	8.8%	11.7%	11.8%	11.4%
75+	13.9%	12.9%	14.0%	13.8%
All Groups	6.7%	7.1%	13.4%	7.9%

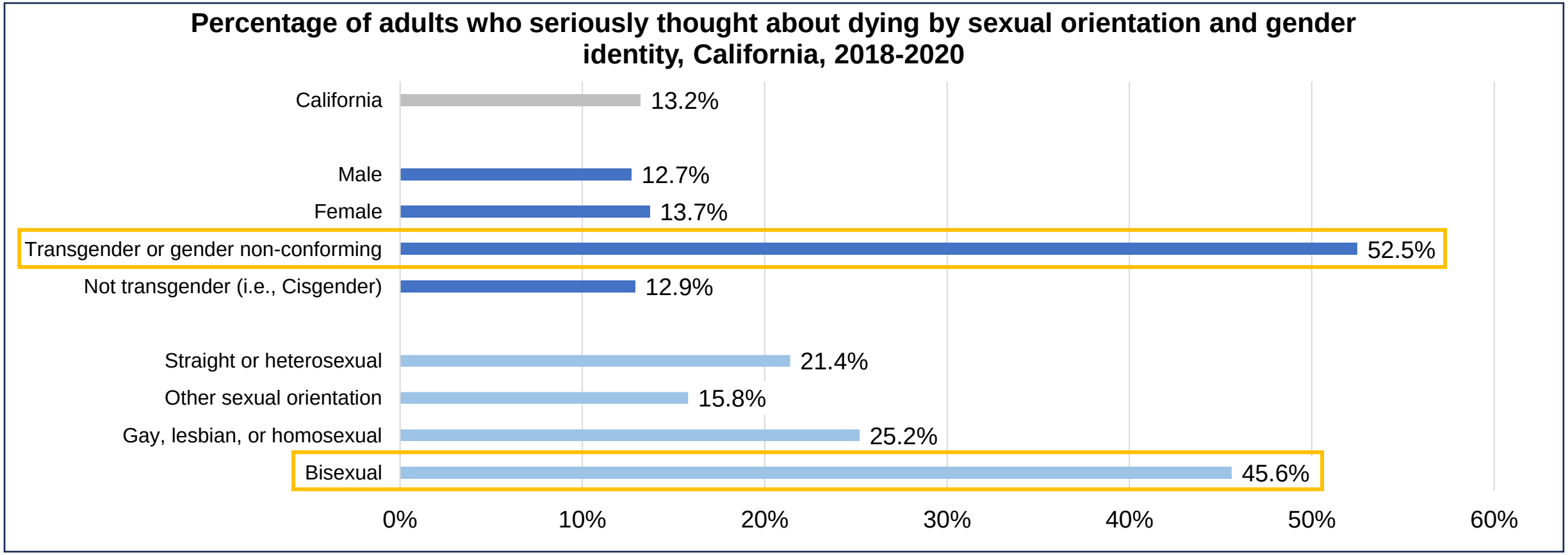
Medicare beneficiaries had the highest rates of depression, bipolar, and other depressive mood disorders.

Across all payers, individuals over age 75 had the highest rates of these conditions.

HCAI – Healthcare Payments Database – Healthcare Payments Data (HPD) Healthcare Measures, 2023.
https://hcai.ca.gov/visualizations/healthcare-payments-data-hpd-measures-health-conditions-utilization-and-demographics/

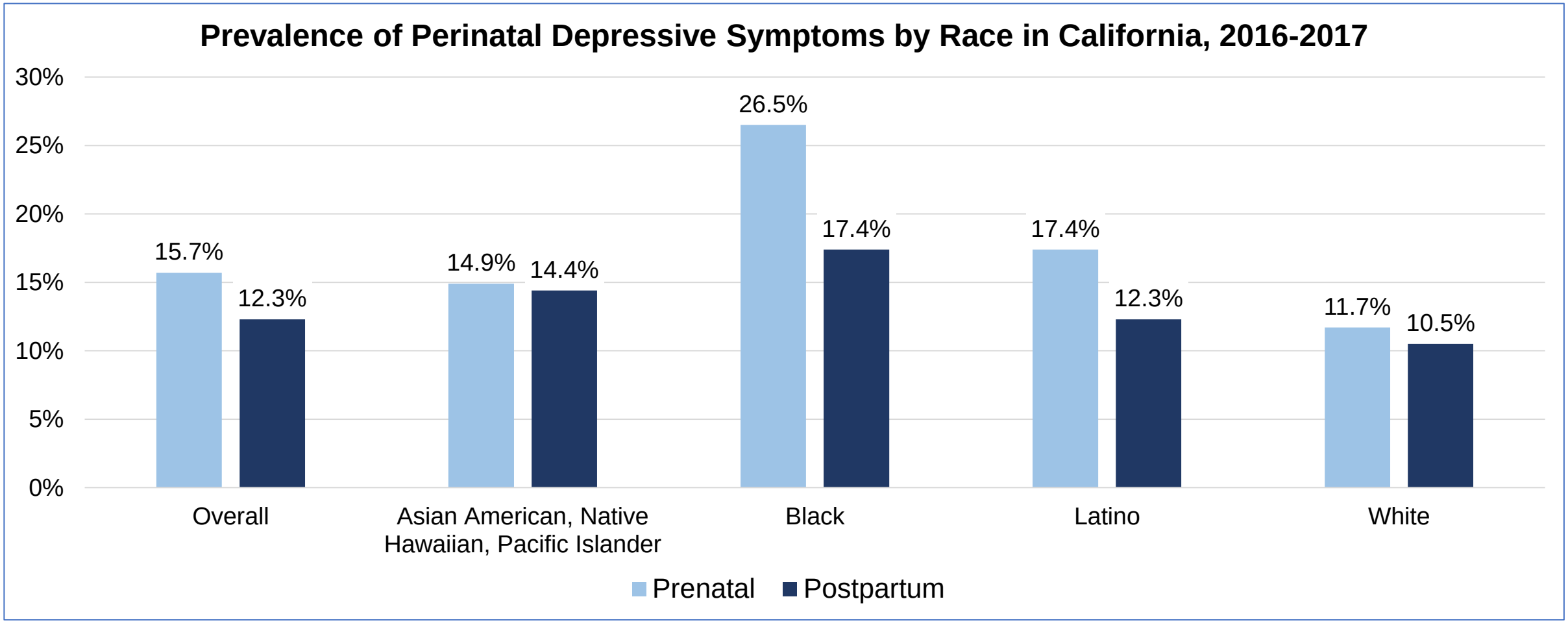
Suicidal Ideation by Sexual Orientation and Gender Identity

About **half** of bisexual and transgender or gender non-conforming adults had suicidal thoughts in California between 2018 and 2020.



Maternal Mental Health

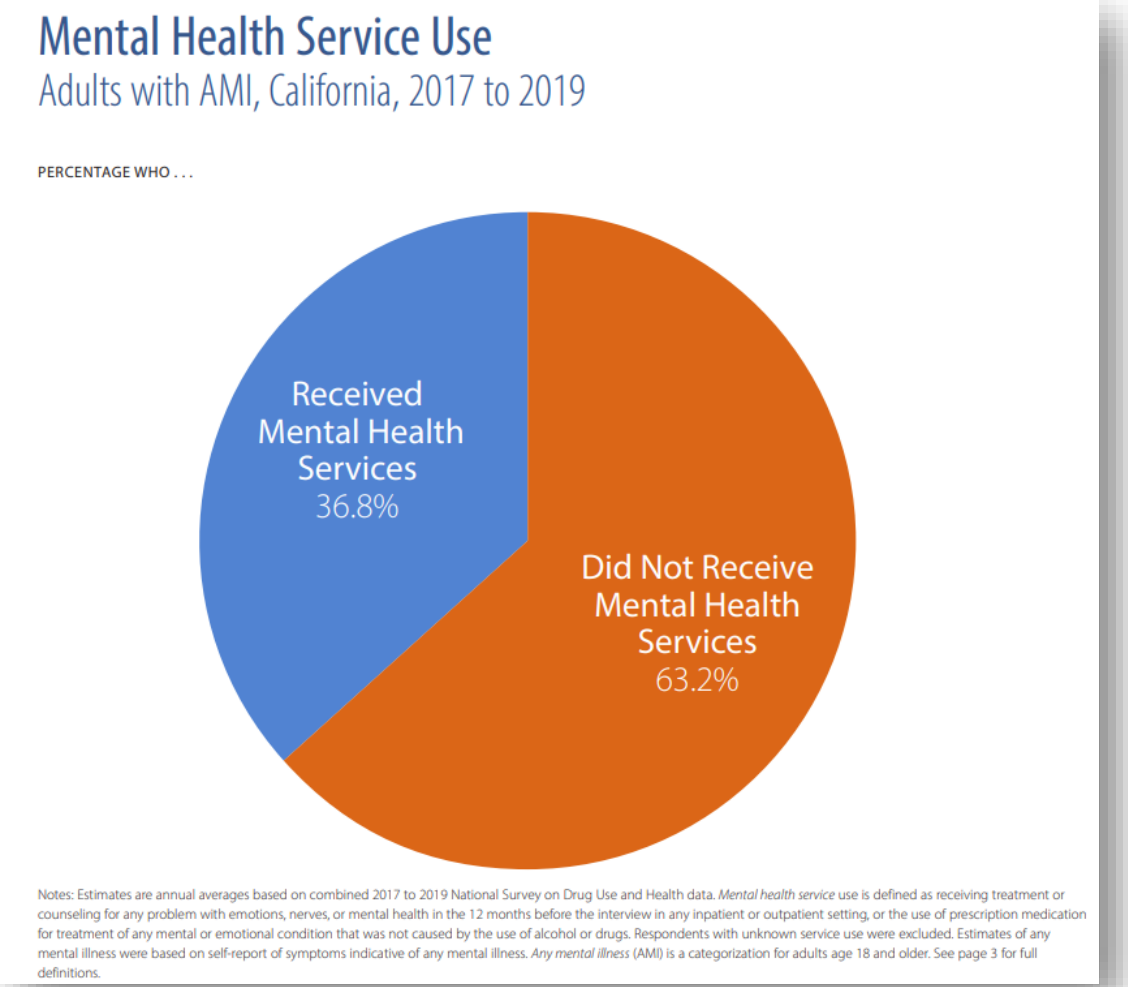
Between 2016 and 2017 in California, more than 1 in 4 Black pregnant people experienced depressive symptoms during the prenatal period.



California Health Care Foundation, “Mental Health in California: Waiting for Care.” July 2022. Data for 2016-17. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

Mental Health Service Use: Adults with Any Mental Illness, 2017- 2019

- Among California adults with any mental illness (AMI), only slightly more than one-third reported receiving mental health services, which include treatment, counseling, or prescription medication, during the past year.
- This was lower than the national rate of 43.6% (not shown).



California Health Care Foundation, 2022. Mental Health in California Almanac, 2022: Waiting for Care. Page 20. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf

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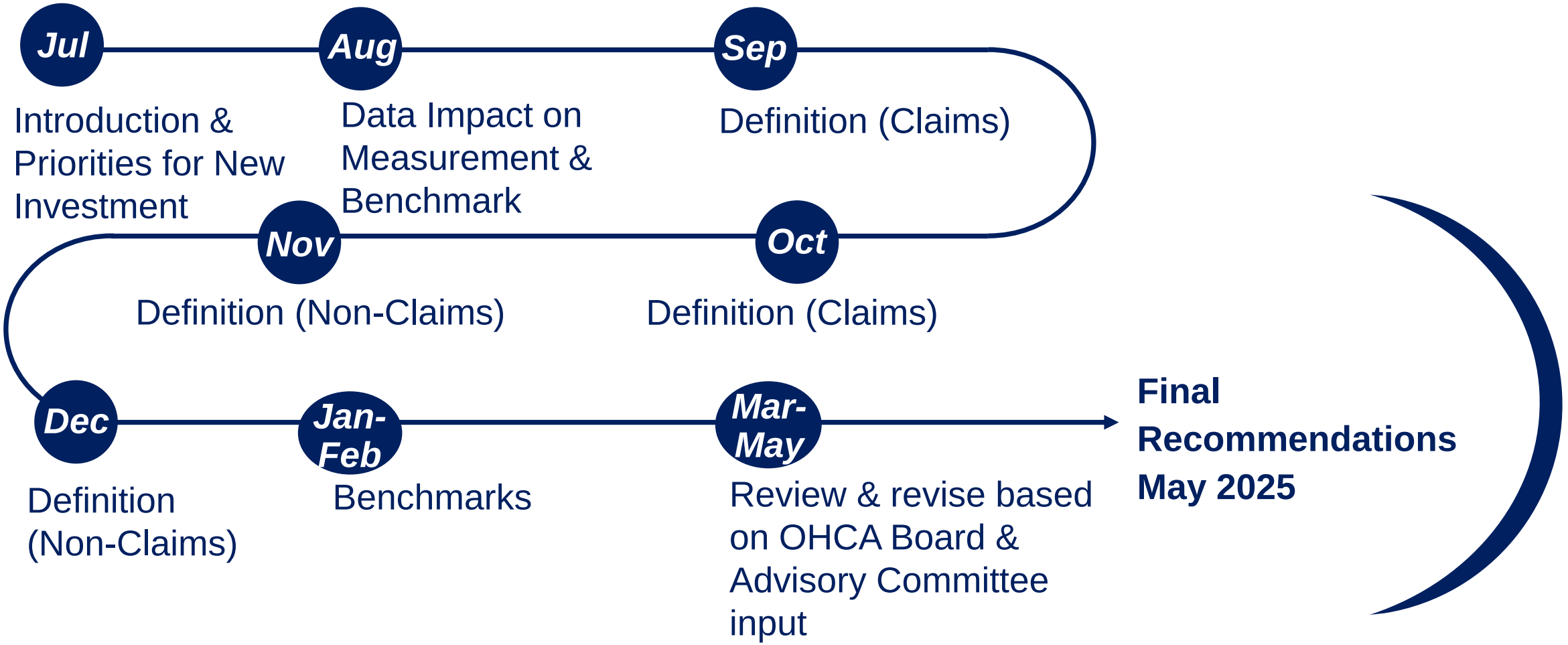
Begin Discussion on Priorities for Behavioral Health Investment

Margareta Brandt, Assistant Deputy Director

Overview of Investment and Payment Workgroup Behavioral Health Agenda Topics



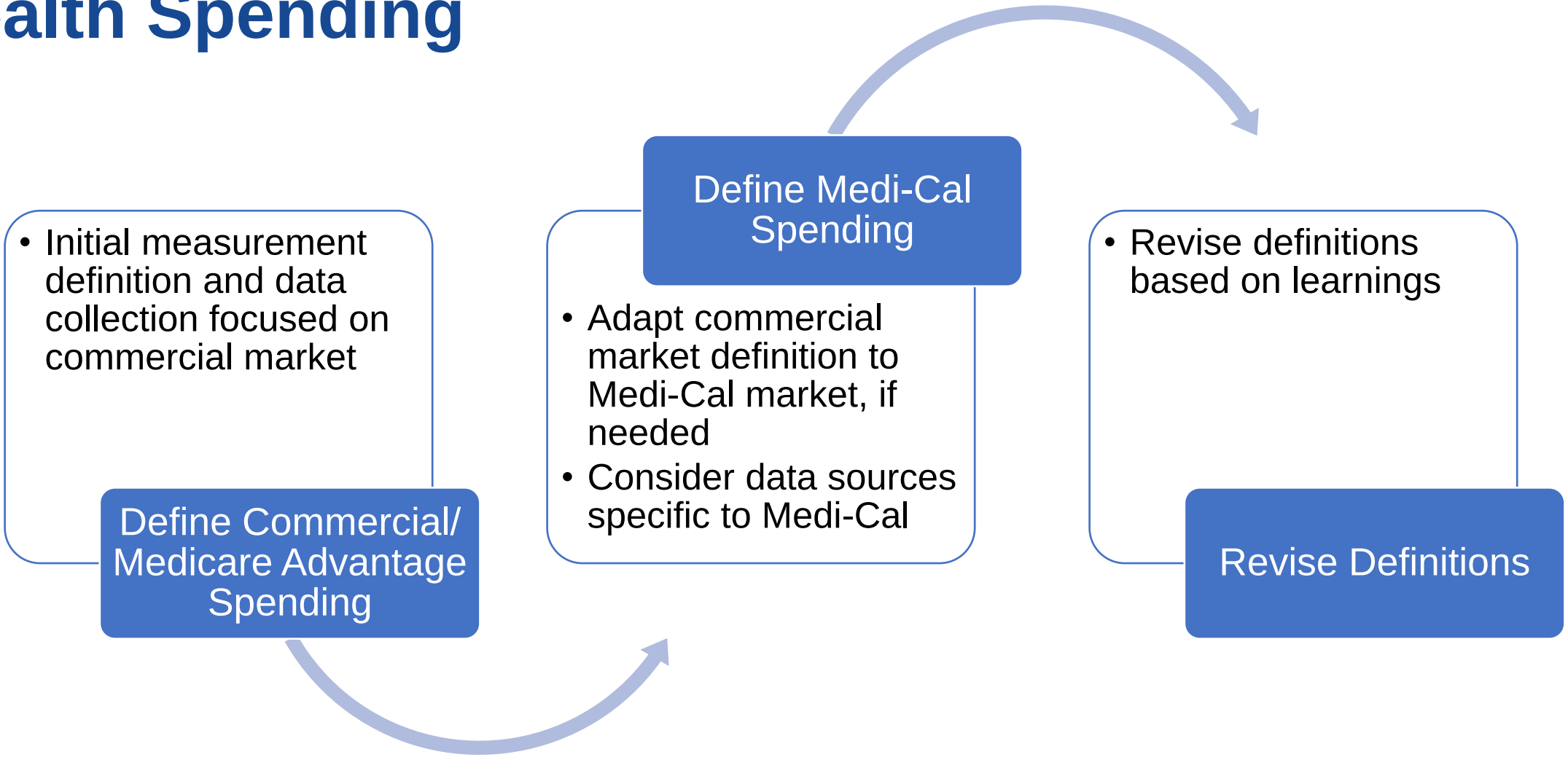
Key Decisions for Measuring Behavioral Health Spend and Benchmark Setting

- Determine priorities for measuring behavioral health spending
- Consider need for a phased approach
- Define diagnoses, services, providers, care settings
- Define approach to non-claims payments
- Define benchmark focus – conditions, care settings, population
- Define benchmark structure and timing

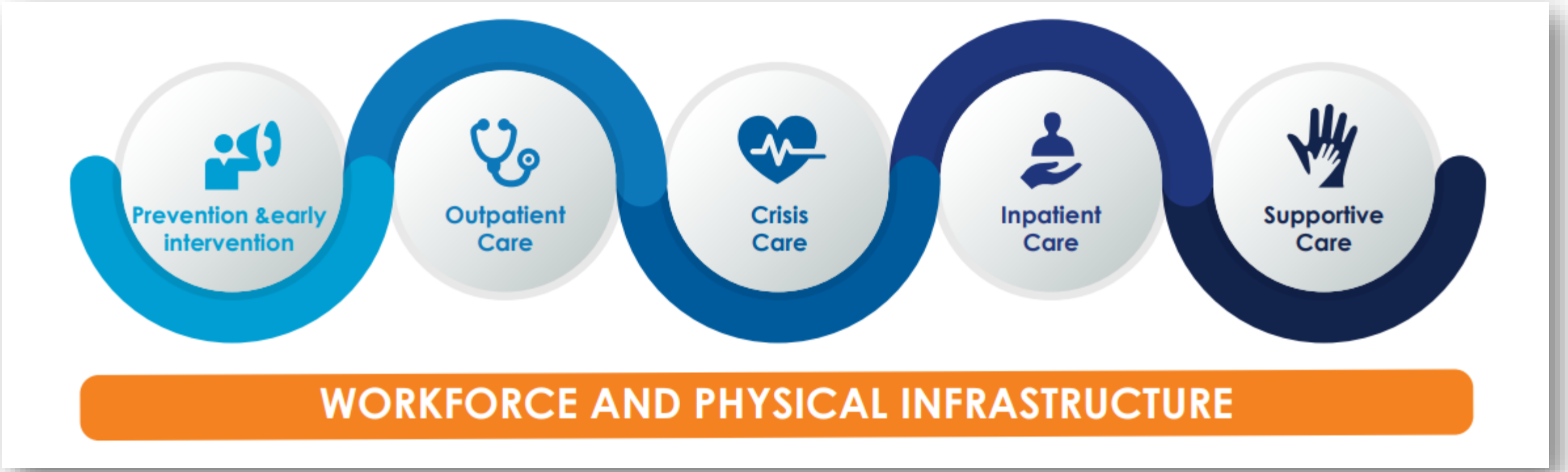
OHCA Data Source for Measuring Behavioral Health Investment

- OHCA will collect the data to measure behavioral health spending as part of its larger Total Health Care Expenditures (THCE) data collection efforts.
- Behavioral health spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework.
- OHCA will provide definitions, technical specifications, and technical assistance to submitters to support accurately allocating payments to behavioral health, particularly for non-claims payment categories.
- OHCA is planning for initial behavioral health data collection and measurement efforts to focus on the commercial population.

Proposed Phased Approach to Defining Behavioral Health Spending

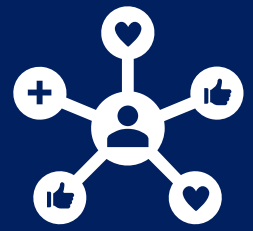


Behavioral Health Investment Continuum



CalHHS. Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts. March 2023. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

Proposed Priorities for New Investment in Behavioral Health

				
Accessible	**Comprehensive**	**Coordinated**	**Equitable**	**Quality**
• Available when needed • Culturally responsive	• Services across the continuum • More treatment in community and health care facilities, reduced need in correctional facilities	• Integrated with primary care • Attentive and responsive to health-related social needs	• Reduced misinformation, stigma, and discrimination • Reduced disparities in utilization and outcomes	• Low frustration, high satisfaction • Improved outcomes

Adapted from CalHHS, "Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts." March 2023. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

Discussion on Proposed Priorities for New Investment in Behavioral Health

- Any feedback on the proposed phased approach to defining behavioral health spending?
- Any feedback on the proposed priorities?
  - Accessible, Comprehensive Care, Coordinated, Equitable, Quality
- Any feedback on which aspects of the behavioral health continuum would benefit most from additional investment?
  - Preventive and Early Intervention, Outpatient Care, Crisis Care, Inpatient care, Supportive Care
- Other information we should use to guide our work on behavioral health investment?

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Adjournment

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Appendix
Additional Data on Behavioral Health Condition Prevalence and Service Use in California

California Data Sources

Source	Title	Data Type	Year(s)
Department of Public Health	Demographic Report on Health and Mental Health Equity in California (2023)	Statistical Profile	2015-2021
	Opioid Overdose Surveillance Dashboard*	Comprehensive Death File (Dynamic)	2023
Department of Health Care Access and Information (HCAI)	HPD Measures: Health Conditions, Utilization, and Demographics	Healthcare Payments Data (HPD)	2018-2021
	HCAI Visualizations - Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics	Healthcare Payments Data (HPD)	2020-2021
California Health Care Foundation (CHCF)	Mental Health in California: Waiting for Care (2022)	Survey	2019
	Substance Use in California: Prevalence and Treatment (2022)	Survey	2019

*Data included in the Appendix.

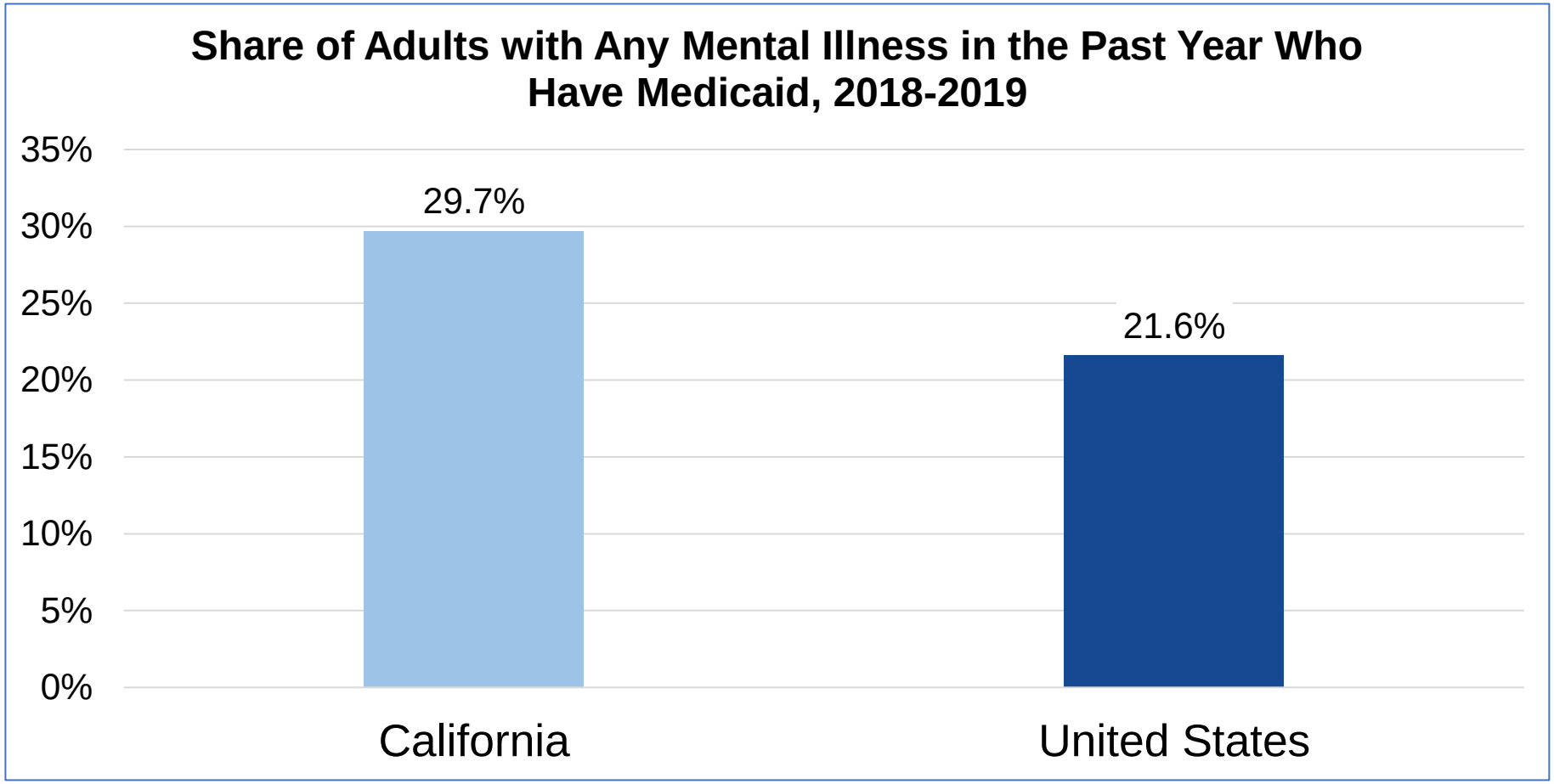
National Data Sources*

Source	Title	Data Type	Year(s)
U.S Department of Housing and Urban Development	Continuum of Care Homeless Assistance Program, Homeless Populations and Subpopulation Data	Point-in-Time (PIT) information in program application	2020
Substance Abuse and Mental Health Services Administration (SAMSHA)	Behavioral Health Barometer: California, Volume 6 (2020)*	Survey	2017-2019
Kaiser Family Foundation (KFF)	Analysis of SAMHSA's restricted online analysis. National Survey on Drug and Health.*	Survey	2018-2019

*Slides included in Appendix only

Share of Adults with Any Mental Illness that Have Medicaid

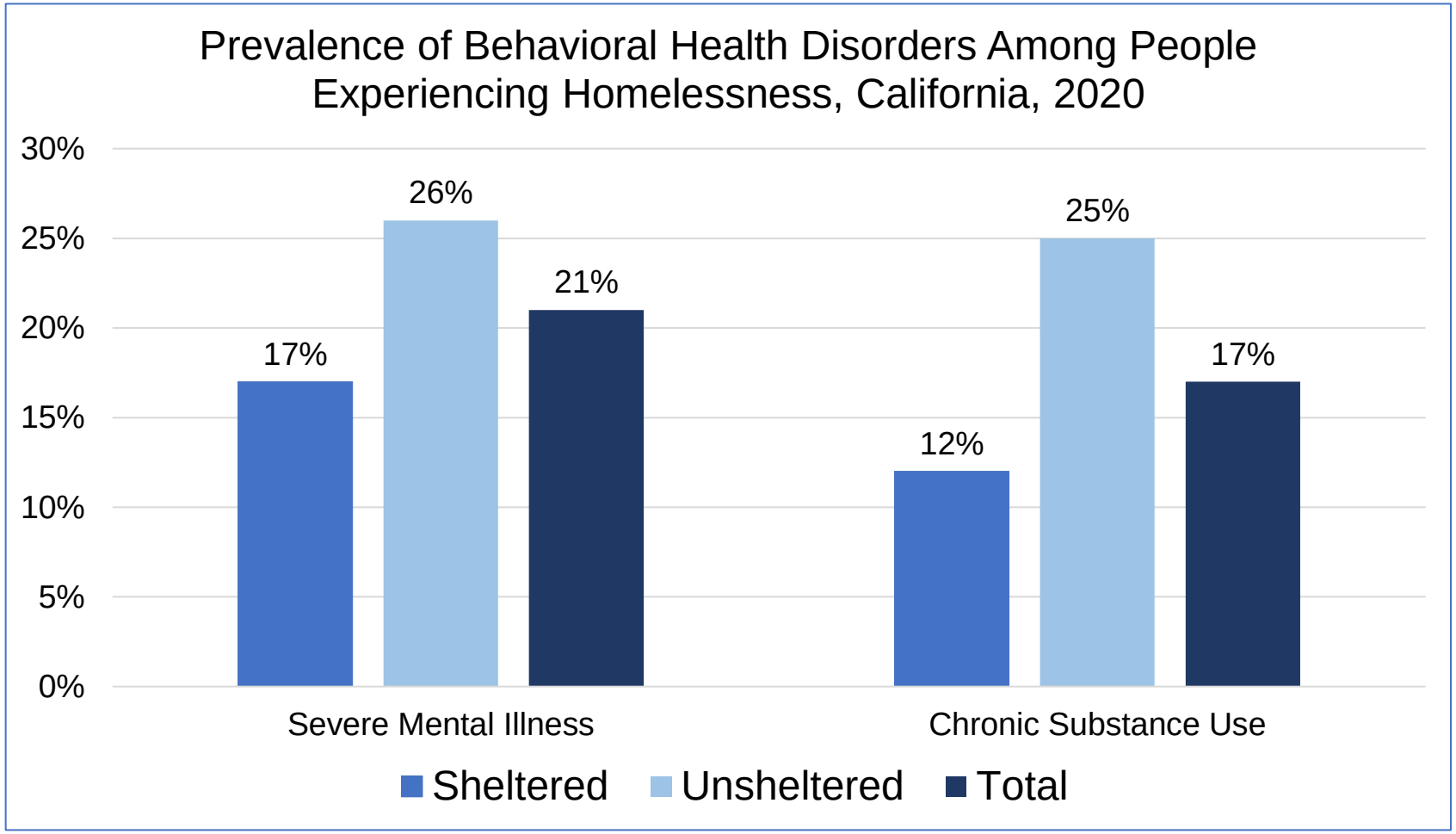
From 2018-2019, California had a greater share of adults with any mental illness in the past year who have Medicaid (29.7%) than the United States (21.6%).



KFF Analysis of SAMHSA's restricted online analysis. National Survey on Drug and Health. 2018-2019. https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases

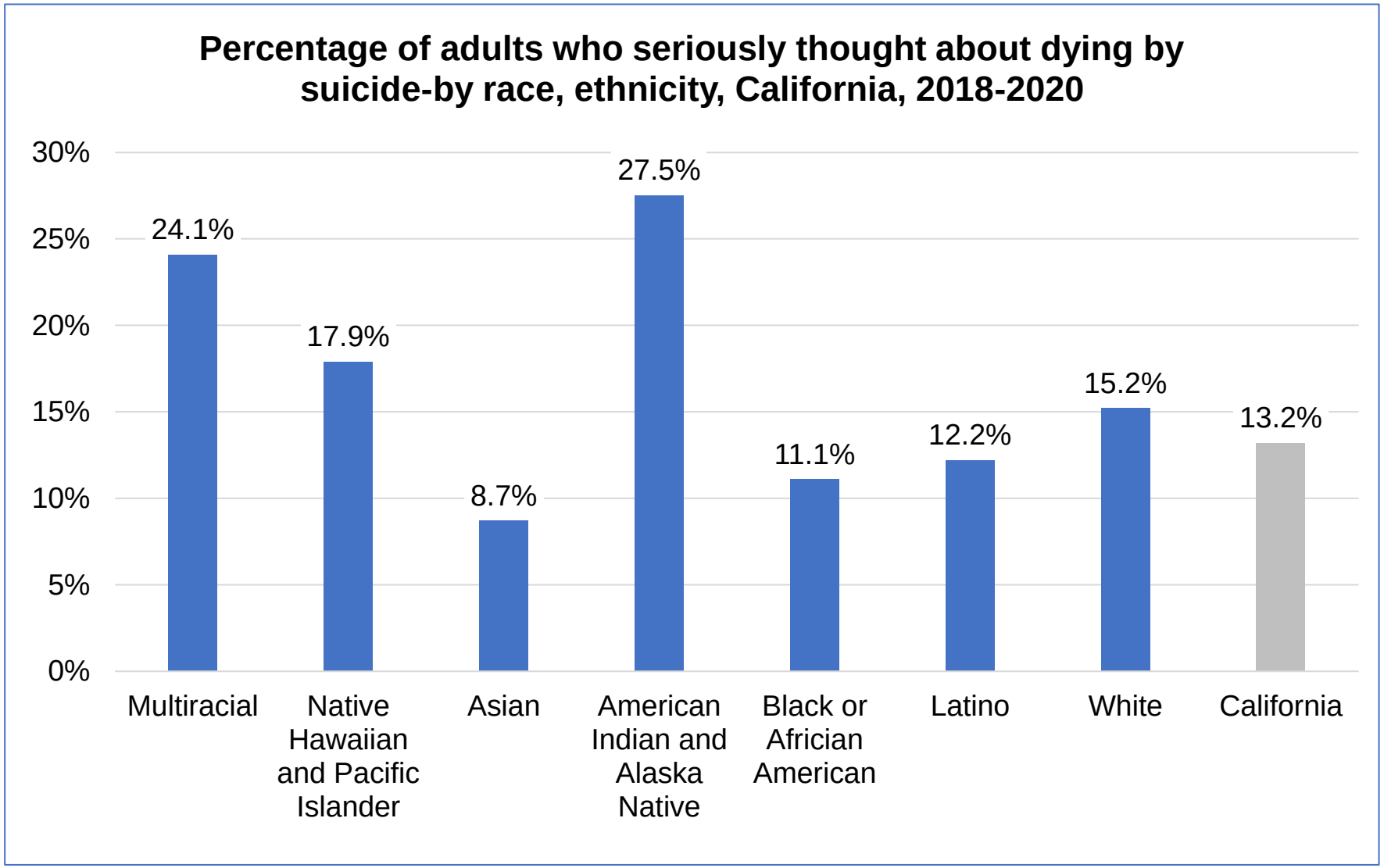
Prevalence of Behavioral Health Disorders Among People Experiencing Homelessness

Unsheltered Californians experienced a higher prevalence of Severe Mental Illness and Chronic Substance Use in 2020 than Sheltered Californians.



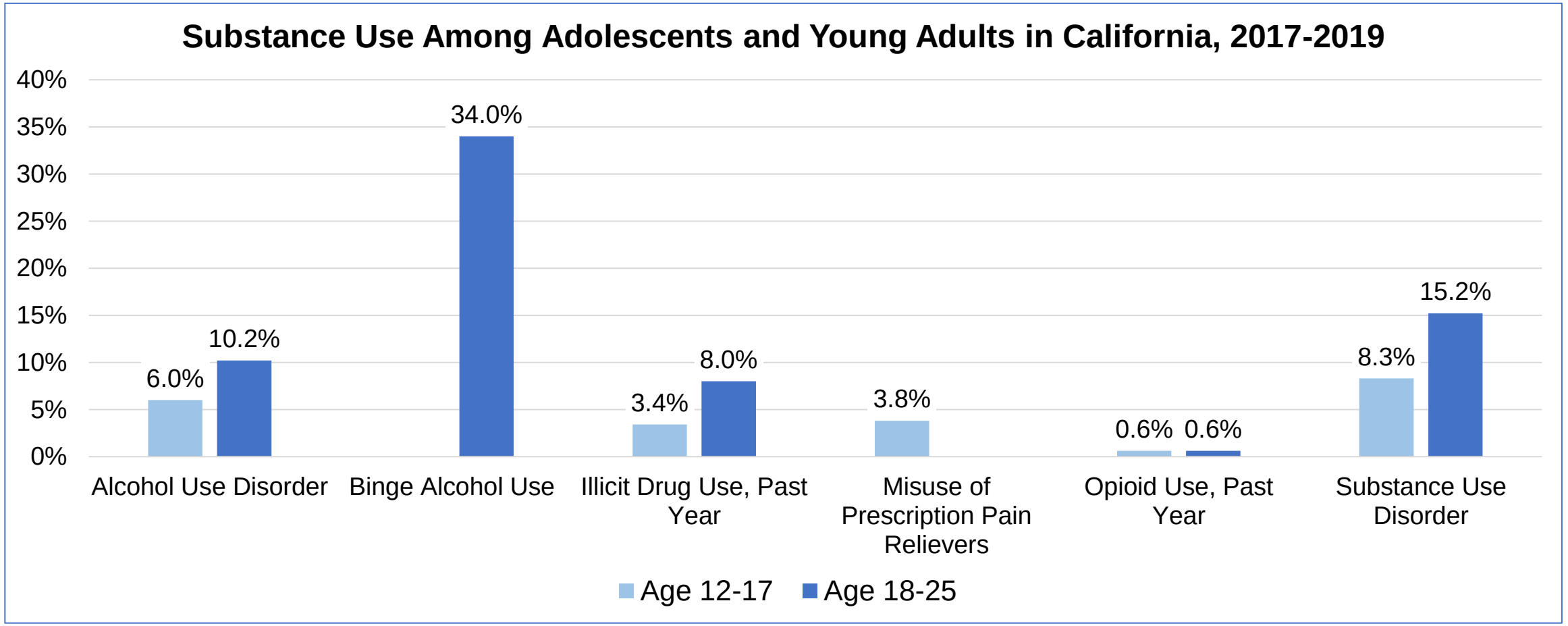
Suicidal Ideation by Race

The percentage of adults who seriously thought about dying by suicide were substantially higher among Multiracial (24.1%) and American Indian and Alaska Native (27.5%) Californians than among other races/ethnicities from 2018-2020.



Substance Use Among Adolescents and Young Adults

More than 1 in 3 Californians aged 18 to 25 reported binge alcohol use from 2017 to 2019.



SAMHSA, "Behavioral Health Barometer: California, Volume 6." 2020. Data for 2017-2019. https://www.samhsa.gov/data/report/behavioral-health-barometer-california-volume-6

Utilization Data Overview

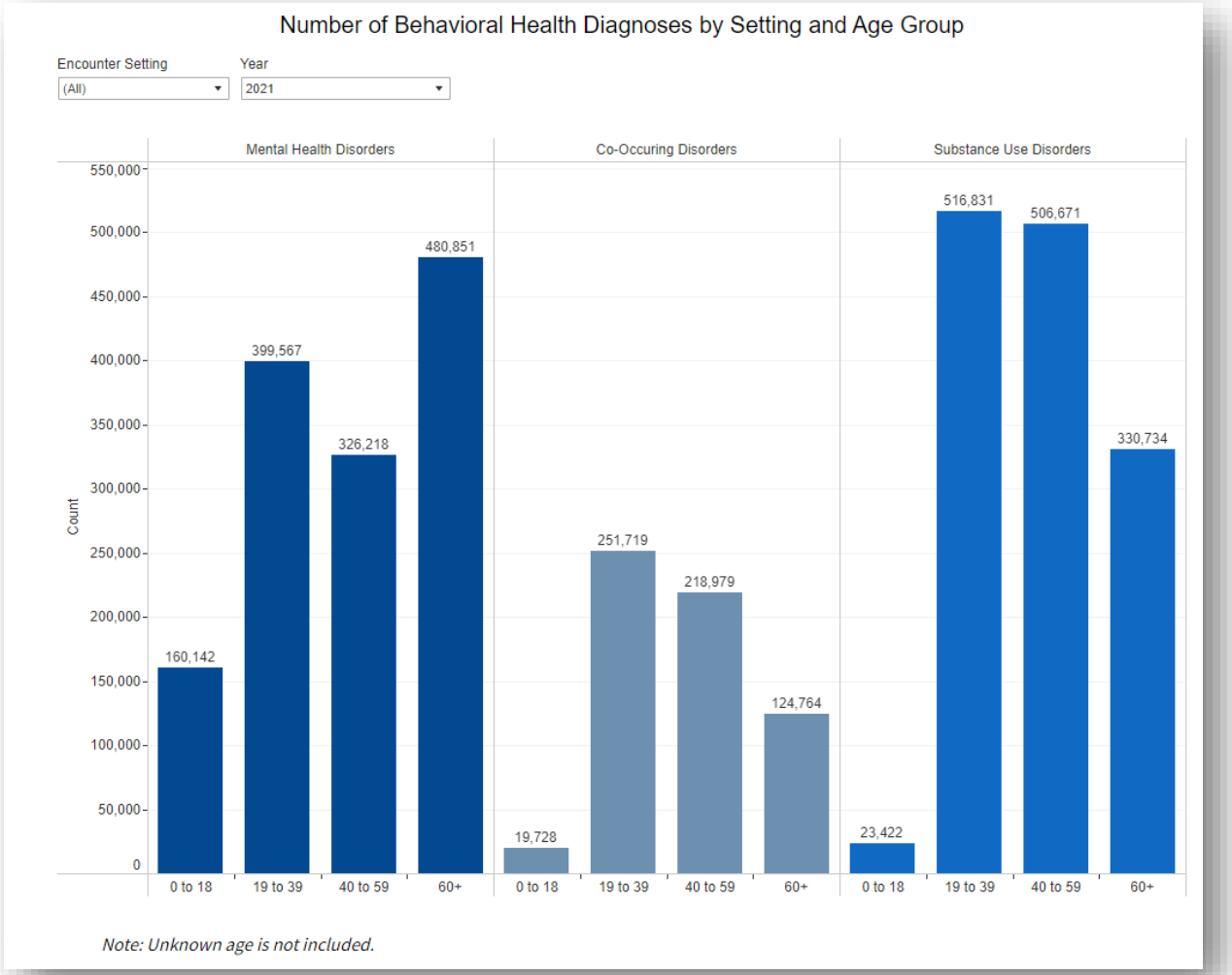
In 2020 and 2021, just over one-third of all inpatient (IP) admissions had a behavioral health diagnosis.

- For both IP and emergency department (ED), there were nearly 964,000 encounters with a mood disorder present and just over 913,000 with an anxiety disorder.
- Alcohol-related disorders were the third most prevalent behavioral health category in both the ED and inpatient settings in 2021.
- For age groups, care setting matters. Adults over 60 comprised over 41% of IP hospitalizations, while younger adults (aged 19 to 39) comprised over 40% of ED visits.
- Regardless of setting or type of disorder, Whites and Hispanics make up roughly 75% of encounters where there is a behavioral health diagnosis.*
- Males had a higher total number of diagnoses. Females are more likely to have a Mental Health Disorder and males are more likely to have a Substance Use Disorder.
- Medi-Cal and Medicare were the expected source of payment for over two-thirds of all encounters where a behavioral health diagnosis was present.

**The information is based on total numbers and not analyzed by the size each race/ethnicity group represents of the total population.*

Number of Behavioral Health Diagnoses in Hospital Inpatient and Emergency Department Settings by Age Group, California, 2021

- The “60+” age group comprises half of all inpatient hospitalizations where a patient had a Mental Health Disorder diagnosis.
- The “19 to 39” age group have the largest proportion of ED visits across all three behavioral health categories.
- The “0 to 18” age group comprises the smallest proportion of ED visits and IP hospitalizations across all three behavioral health categories

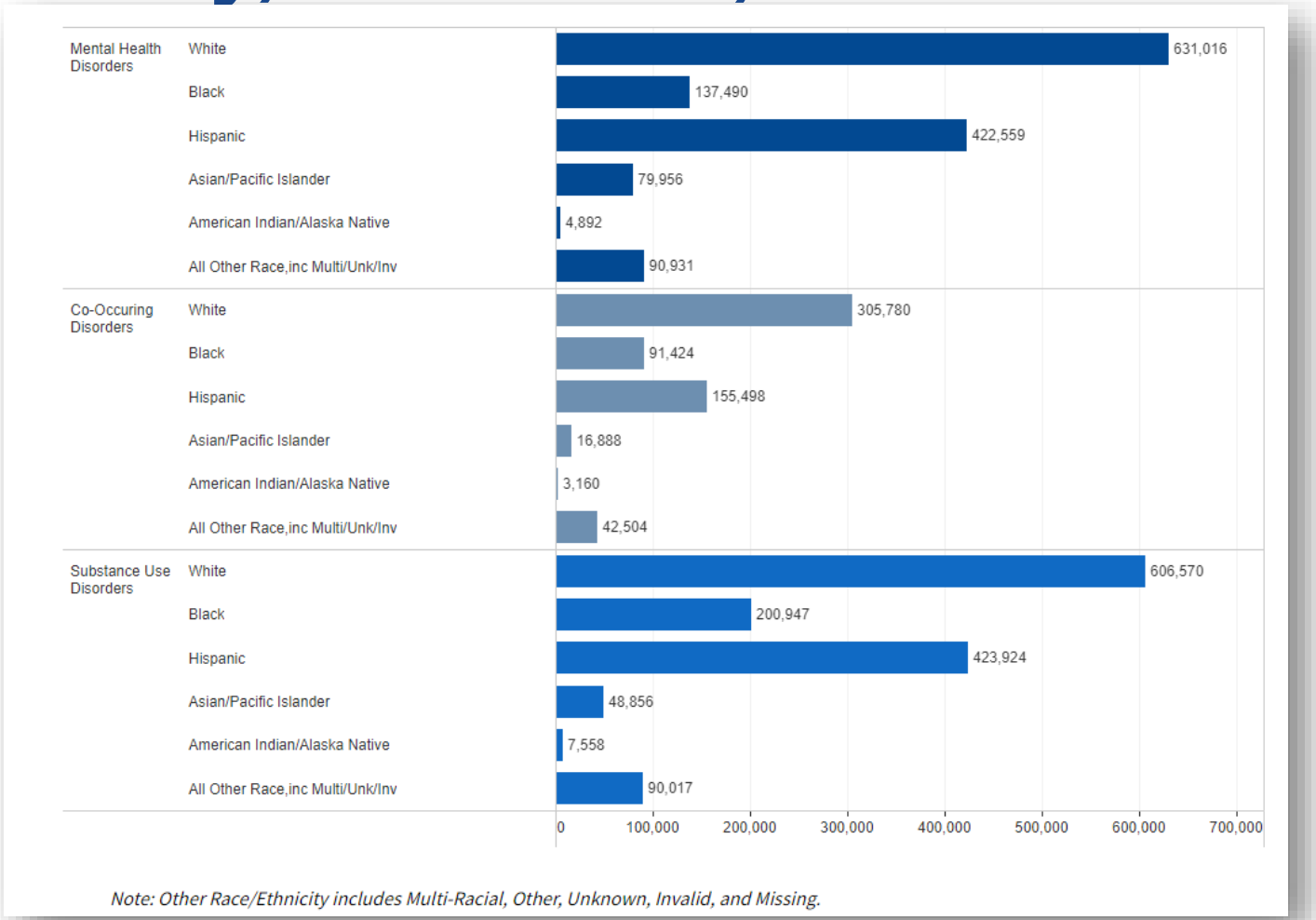


California Department of Health Care Access and Information, 2020-2021. HCAI Visualizations- Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics. *Data from the Health Care Payments Database.* https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/

HCAI Department of Health Care Access and Information

Number of Behavioral Health Diagnoses in Hospital Inpatient and Emergency Department Settings by Race/Ethnicity, California, 2021

- For each of the behavioral health categories, Whites comprised just under half of the encounters regardless of care setting.
- Asian/Pacific Islanders were more likely to be seen for a Mental Health Disorder than a Substance Use Disorder.
- Hispanics presenting to the ED were equally as likely to be seen for a Mental Health Disorder or a Substance Use Disorder.



Note: Other Race/Ethnicity includes Multi-Racial, Other, Unknown, Invalid, and Missing.

California Department of Health Care Access and Information, 2020-2021. HCAI Visualizations- Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics. *Data from the Health Care Payments Database.* https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/

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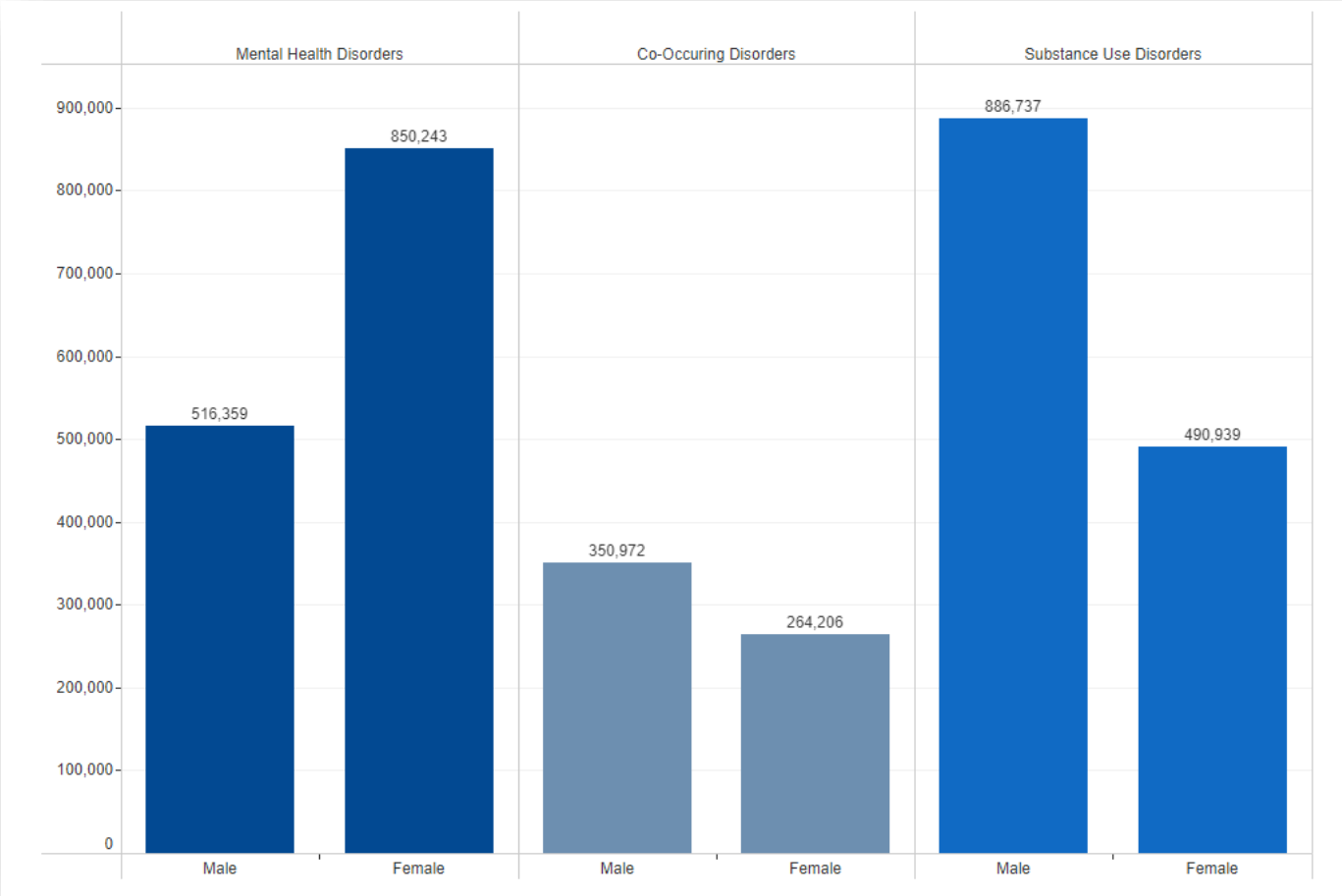
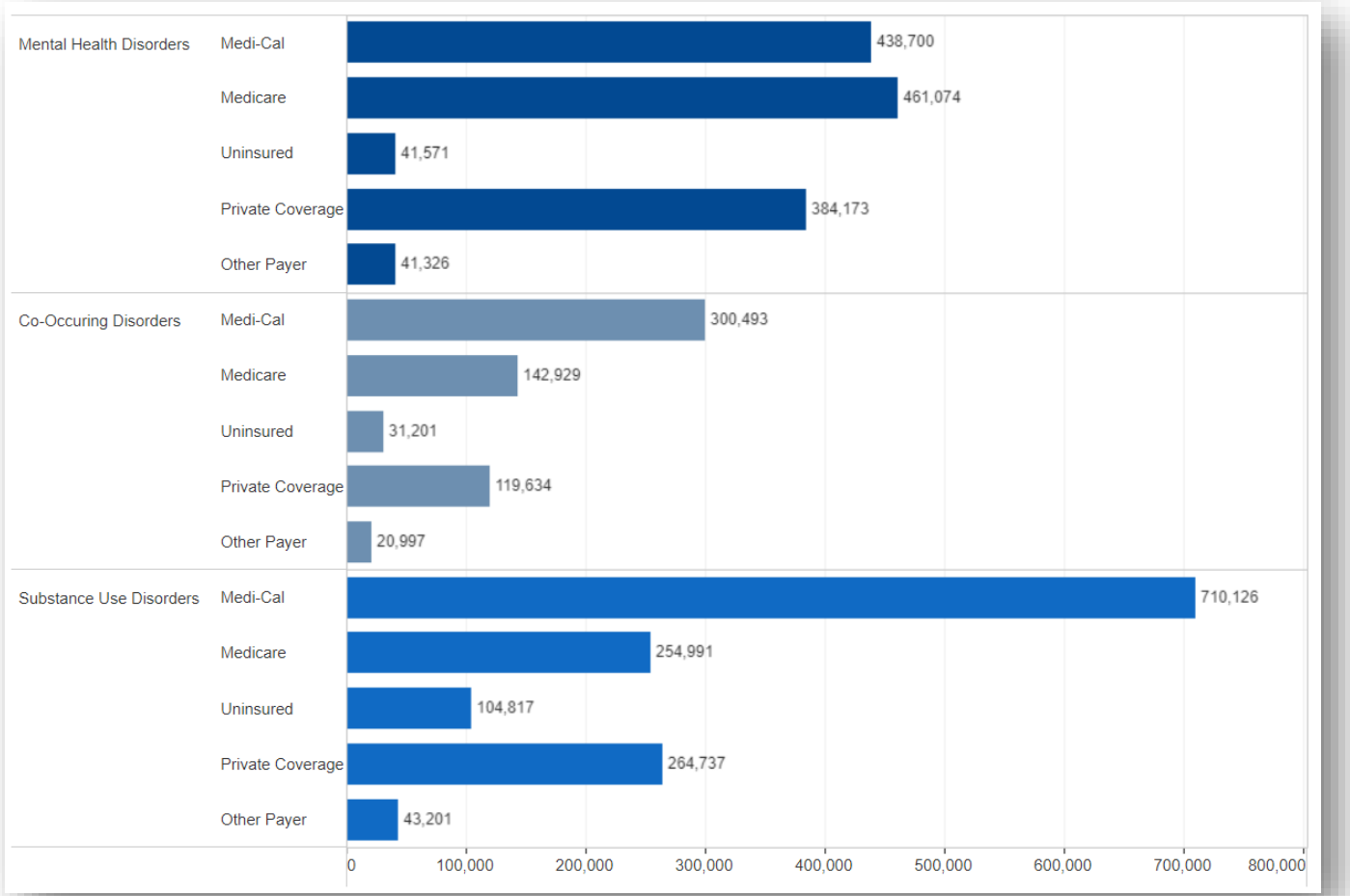
Number of Behavioral Health Diagnoses in Hospital Inpatient and Emergency Department Settings by Assigned Sex at Birth, California, 2021

- Females account for the majority of ED visits and IP hospitalizations for Mental Health Disorders.
- Males account for the majority of ED visits and IP hospitalizations for Substance Use Disorders.
- Males are more likely than females to have a Co-occurring Disorder in both care settings.



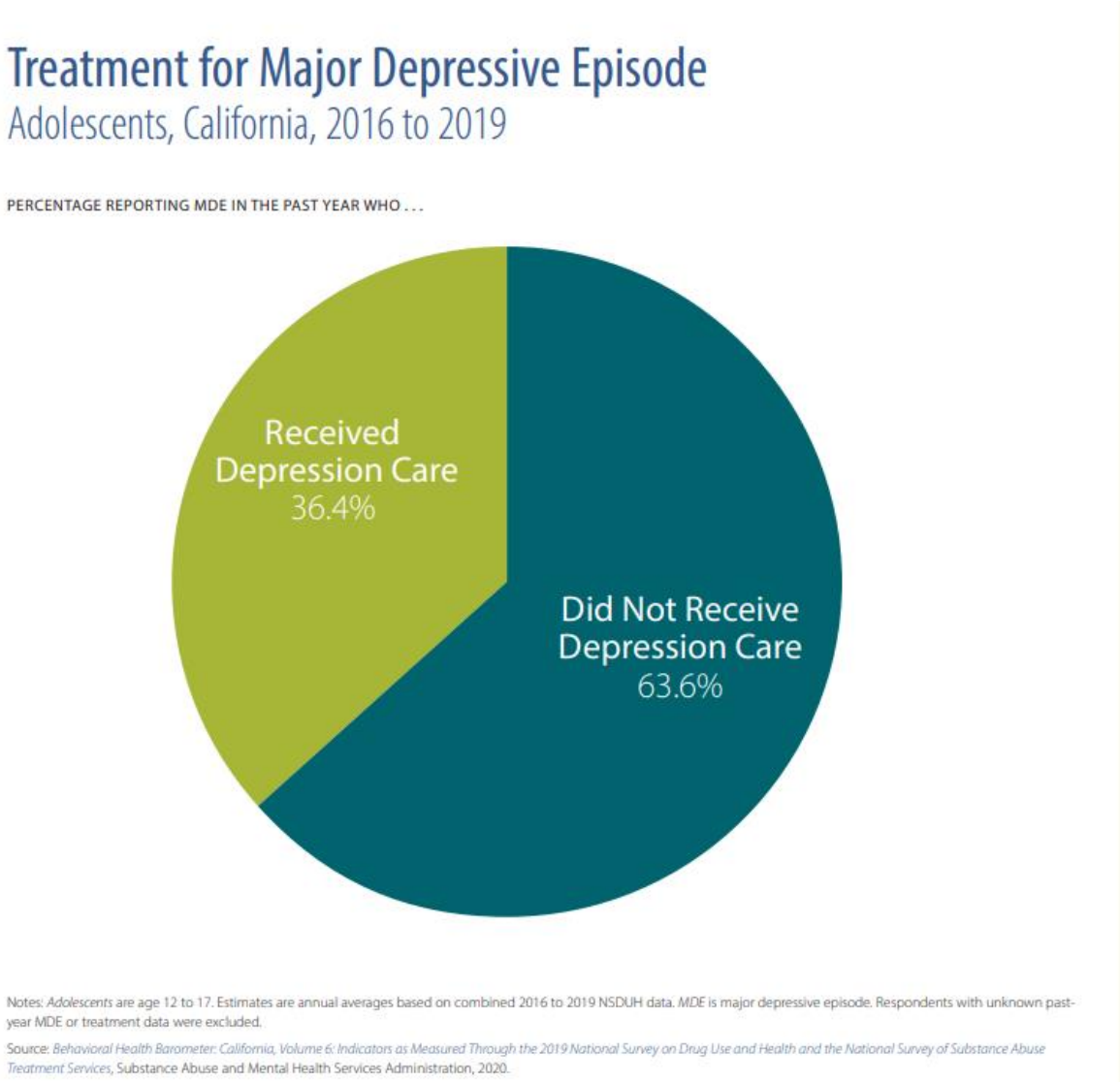
Number of Behavioral Health Diagnoses in Hospital Inpatient and Emergency Department Settings by Expected Payer, California, 2021

- Medi-Cal was the most common expected primary payer for all disorders and healthcare settings with one exception – Medicare comprised nearly half of IP Mental Health Disorders.
- In both care settings, Private Coverage covers more Mental Health Disorders than Co-occurring or Substance Use Disorders.
- Uninsured patients were more likely to be treated in the ED for Substance Use Disorders than for Mental Health or Co-occurring Disorders.



Treatment for Major Depressive Episode: Adolescents 2016-19

- Among California adults with any mental illness, slightly more than one-third reported receiving mental health services, which include treatment, counseling, or prescription medication, during the past year.
- This was lower than the national rate of 43.6% (not shown).
- While adults in California with serious mental illness were more likely to receive treatment, 40% did not receive any (not shown).



Adolescents are age 12 to 17.

California Health Care Foundation, 2022. Mental Health in California Almanac, 2022: Waiting for Care. Page 21. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf