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OHCA Investment and Payment Workgroup

July 16, 2025

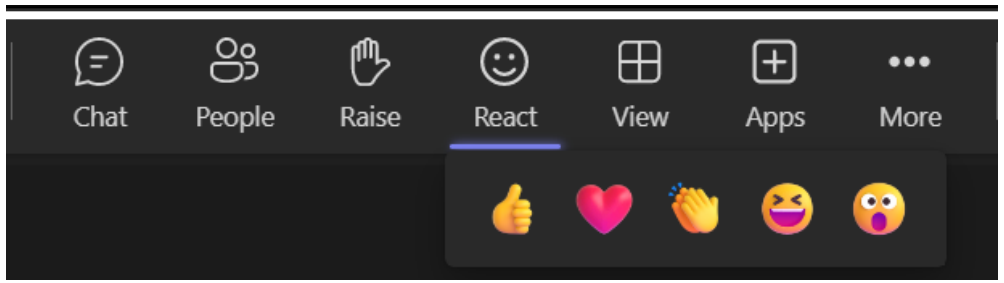
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Status of OHCA's Behavioral Health Work**
9:25 a.m.	**3.**	**Behavioral Health Definition and Measurement Methodology**
9:50 a.m.	**4.**	**Behavioral Health in Primary Care Module**
10:20 a.m.	**5.**	**Timeline and 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: July 16, 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 #

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Status of OHCA's Behavioral Health Work

Margareta Brandt, Assistant Deputy Director

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 that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Measurement

1. Schedule

- Payers will submit aggregate behavioral health spending data beginning in September 2026, covering the years 2024-2025
- OHCA will release the first report on behavioral health spending, using this data, in the summer of 2027

2. Data Submitters

- Payers and fully integrated delivery systems
  - Commercial plans
  - Medicare Advantage plans
  - Medi-Cal managed care plans

Measurement

3. What Will Be Submitted

- Claims and non-claims payments for behavioral health care (as defined by OHCA)
- Aggregated by performance year and market category; not patient or provider level
- Subcategories and categories used for analysis and reporting
- Behavioral Health in Primary Care Module
- Following the methodology in Data Submission Guide to be finalized spring 2026

Benchmark

- Board deferred setting benchmark this year
- Will revisit summer 2026, with additional data and experience to inform deliberations
- Behavioral health spending data submitted to OHCA in September 2026 will be used only for measurement and reporting, not comparison to a benchmark, for at least one year

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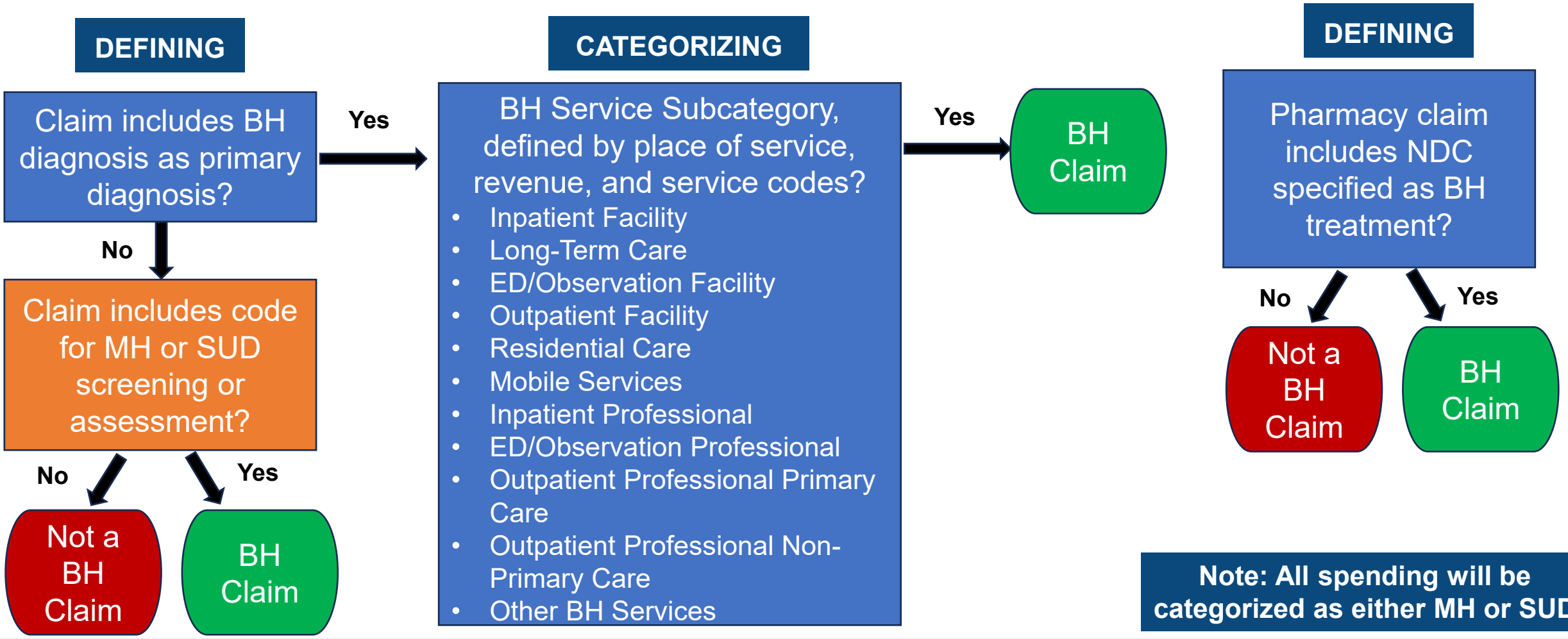
Behavioral Health Definition and Measurement Methodology

Margareta Brandt, Assistant Deputy Director
Bob Seifert, Consultant, Freedman HealthCare

Milbank-Freedman Process Map for Identifying Behavioral Health (BH) Claims



Note: All spending will be categorized as either MH or SUD

Behavioral Health Service Subcategories

Proposed Changes to Behavioral Health Reporting Subcategories

Reporting Categories	Service Subcategories
Outpatient/Community Based	~~Community Based Mobile Clinic Services~~ ~~Crisis Care~~
	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility (no inpatient admission)
	Emergency Department / Observation; Professional (no inpatient admission)
Inpatient	Inpatient; Facility
	Inpatient; Professional
Long-Term Care and Residential	~~Long-term Care~~
	Residential Care
Other	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

June stakeholder feedback showed interest in more granular analyses of behavioral health crisis care and mobile services utilization and spend than the OHCA behavioral health data collection can provide, indicating HPD would be a more appropriate data source for these analyses.

Rationale for Proposed Revisions to Behavioral Health Reporting Subcategories

- Changes to subcategories do not impact total spending.* Only impacts aggregate categorization of spending.
- Folding Community-Based Mobile Clinic Services and Crisis Care into Outpatient subcategories minimizes data submitter burden.
- OHCA can leverage the Health Care Payments Database (HPD) to measure and monitor changes in mobile clinic services and crisis care spend.
- Based on preliminary HPD results there was little to no commercial and Medicare spending on mobile clinic services spend from 2018 to 2023. There was about 4% of behavioral health spend from this category for Medi-Cal data in the HPD.
- HPD data also showed little or no spending in the long-term care subcategory in the 2018-2023 period.

*Spending not categorized is included in “Other Services.”

Behavioral Health Spending in the Commercial Market by Service Subcategory, 2018-2023

BH Subcategory	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	33.0%	36.9%	39.3%	37.9%	38.3%	42.7%
Pharmacy	22.5%	20.7%	18.1%	20.9%	20.4%	18.4%
Inpatient Facility	16.4%	15.3%	14.6%	13.0%	11.9%	10.4%
Other	8.2%	6.1%	6.1%	6.6%	7.2%	7.3%
Outpatient Facility Non-Primary Care	7.4%	7.1%	7.3%	7.5%	7.2%	6.9%
Emergency Dept/Observation	5.3%	5.2%	4.5%	4.2%	3.9%	3.4%
Residential Facility	4.4%	5.8%	7.5%	7.5%	8.4%	8.7%
Outpatient Professional Primary Care	1.7%	1.8%	1.7%	1.7%	2.0%	1.6%
Inpatient Professional	1.0%	0.9%	0.9%	0.7%	0.7%	0.6%
Mobile Services	0.1%	0.1%	0.1%	<0.1%	<0.1%	<0.1%
Long-Term Care	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	*

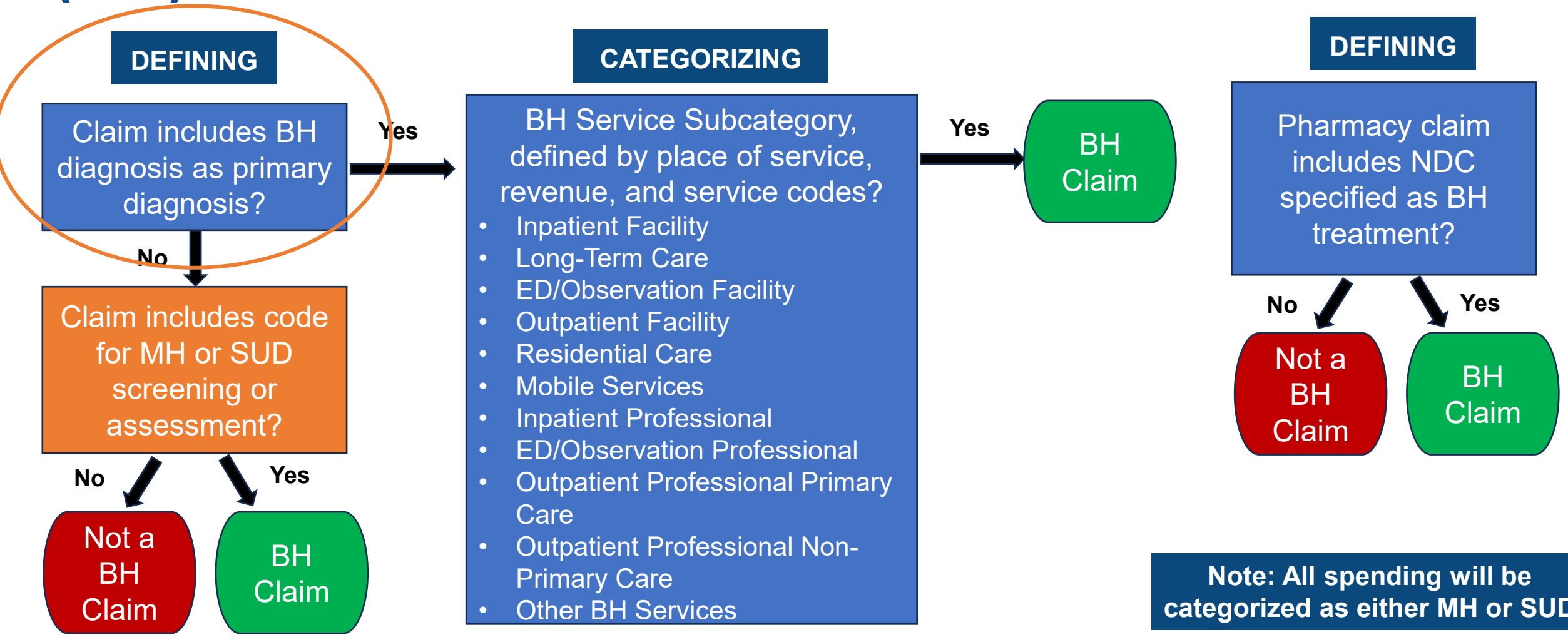
Preliminary analysis of HPD data.
*Data not included to comply with de-identification requirements

Discussion

1. Should OHCA move forward with the proposed revisions to the behavioral health subcategories?
   - Folding Community-Based Mobile Clinic Services and Crisis Care into Outpatient subcategories
   - Folding Long-Term Care subcategory into Inpatient subcategories

Behavioral Health Diagnoses

Process Map for Identifying Behavioral Health (BH) Claims



Note: All spending will be categorized as either MH or SUD

Dementia Diagnoses Codes

OHCA recommends including certain diagnosis codes related to dementia and not including others.

- Include "F" codes, typically used by behavioral health providers treating patients with dementia. For example:
  - F0281, "Dementia in other diseases classified elsewhere with behavioral disturbance"
  - F01B1, "Vascular dementia, moderate, with behavioral disturbance"
- Do not include "G" codes, for underlying conditions causing dementia (such as G30, Alzheimer's disease), which behavioral health providers do not typically use when treating patients with dementia and may include mostly medical spending.

Traumatic Brain Injury (TBI)

OHCA recommends excluding diagnosis codes for TBI from the behavioral health code set.

Rationale for exclusion:

- Including TBI may lead to capturing non-BH (i.e., medical) spend because any claim with a primary TBI diagnosis, no matter the service code billed, would count towards spend.
- BH treatment for TBIs may be captured using the current list of diagnosis codes (e.g., depression). For example, if a provider treats a patient with a TBI for depression then the primary diagnosis code may be 'Depression.'[1]
- TBI is not included in the Milbank code set or other states' code sets.

1. Health Information Management Office of Informatics and Analytics, September 2015. Fact Sheet: Coding Guidance for Traumatic Brain Injury (TBI). http://www.rstce.pitt.edu/va_tbi/documents/11192015/11192015_03.pdf

Including Z Diagnosis Codes

The ICD-10 Manual includes Z codes that were designed to identify social determinants of health. They describe issues related to education, employment, housing, finances, upbringing, family life, and legal issues.

Key question: What is the purpose of the behavioral health definition?

- If solely for measuring behavioral health spend in California, then it would be appropriate to exclude since Z codes cannot be used as a primary diagnosis code for billing and therefore will not have any claims spend associated with their use.
- If to create a definition of behavioral health for different agencies in California to leverage for spending, utilization and other related research, it may be appropriate to include since physicians are encouraged by organizations, like the American Academy of Family Physicians, to use Z codes.
    - Social determinants of health impact health outcomes, identifying and addressing them is key, especially as more payers move to value-based payment.

American Academy of Family Physicians, 2022. Screening for Social Determinants of Health in Daily Practice. https://www.aafp.org/pubs/fpm/issues/2022/0300/p6.pdf

Stakeholder Suggested Z Codes for Inclusion

Diagnosis Code(s)	Considerations
Behaviors • Z720 Tobacco use • Z726 Gambling and betting • Z72819 Child and adolescent antisocial behavior • Z72811 Adult antisocial behavior **Personal History** • Z91410 Personally history of adult physical and sexual abuse • Z91411 Personal history of adult psychological abuse • Z91414 Personal history of adult intimate partner abuse • Z91419 Personal history of unspecified adult abuse	• Physician use of Z codes is encouraged • Other similar Z codes are already included in the code set (e.g., Personal history of suicidal behavior, Personal history of other mental and behavioral disorders). • Including Z codes will not impact overall behavioral health claims measurement since Z codes cannot be used as primary diagnosis codes for billing. • Including Z codes may impact measurement of behavioral health spend in capitation. OHCA's methodology uses encounters, which are not used for payments in the same way claims are and therefore may include Z codes in the primary diagnosis position.

Discussion

1. Should OHCA exclude TBI and similar diagnoses in behavioral health measurement?

2. Should OHCA include F codes for dementia and exclude G codes?

3. Should OHCA include Z codes?
   - All behavioral health-related Z codes, or only some, such as those for personal histories, encounters for counseling, or behaviors?

Behavioral Health Non-Claims Spending

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-claims Behavioral Health Care Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not Applicable

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Discussion

1. Comments on general approach to behavioral health non-claims definition and measurement?

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Behavioral Health in Primary Care Module

Bob Seifert, Consultant, Freedman HealthCare

Three Recommended Modules for Behavioral Health Spending Measurement

As a reminder, 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.

Purpose of a Behavioral Health In Primary Care Module

To promote policy priorities, such as the advancement of integrated behavioral health and primary care and greater attention to preventive behavioral health care. The module allows OHCA to:

- 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.
- Calculate combined behavioral health and primary care spending without double counting.

Calculating Behavioral Health and Primary Care Spend Without Double Counting

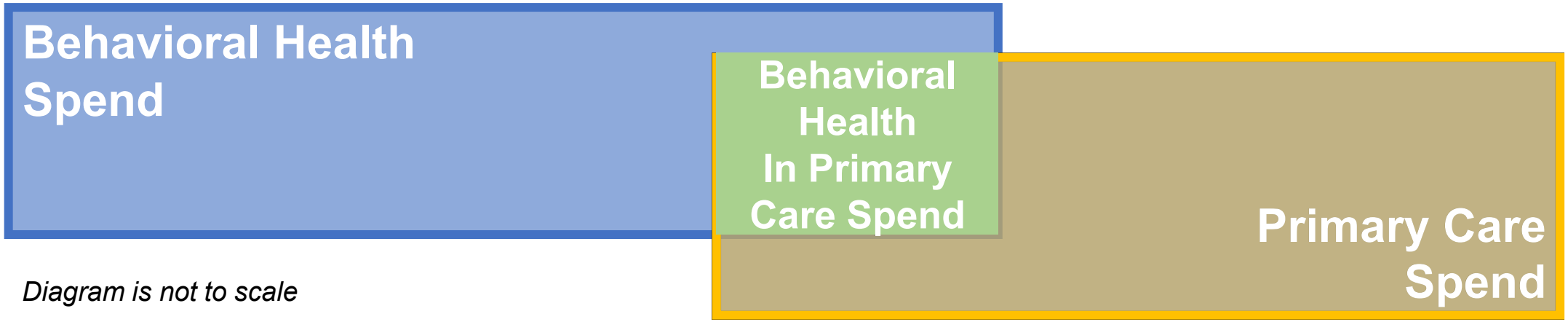


Diagram is not to scale

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

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 47 would be applied

Behavioral Health in Primary Care: Primary Care Provider Taxonomies

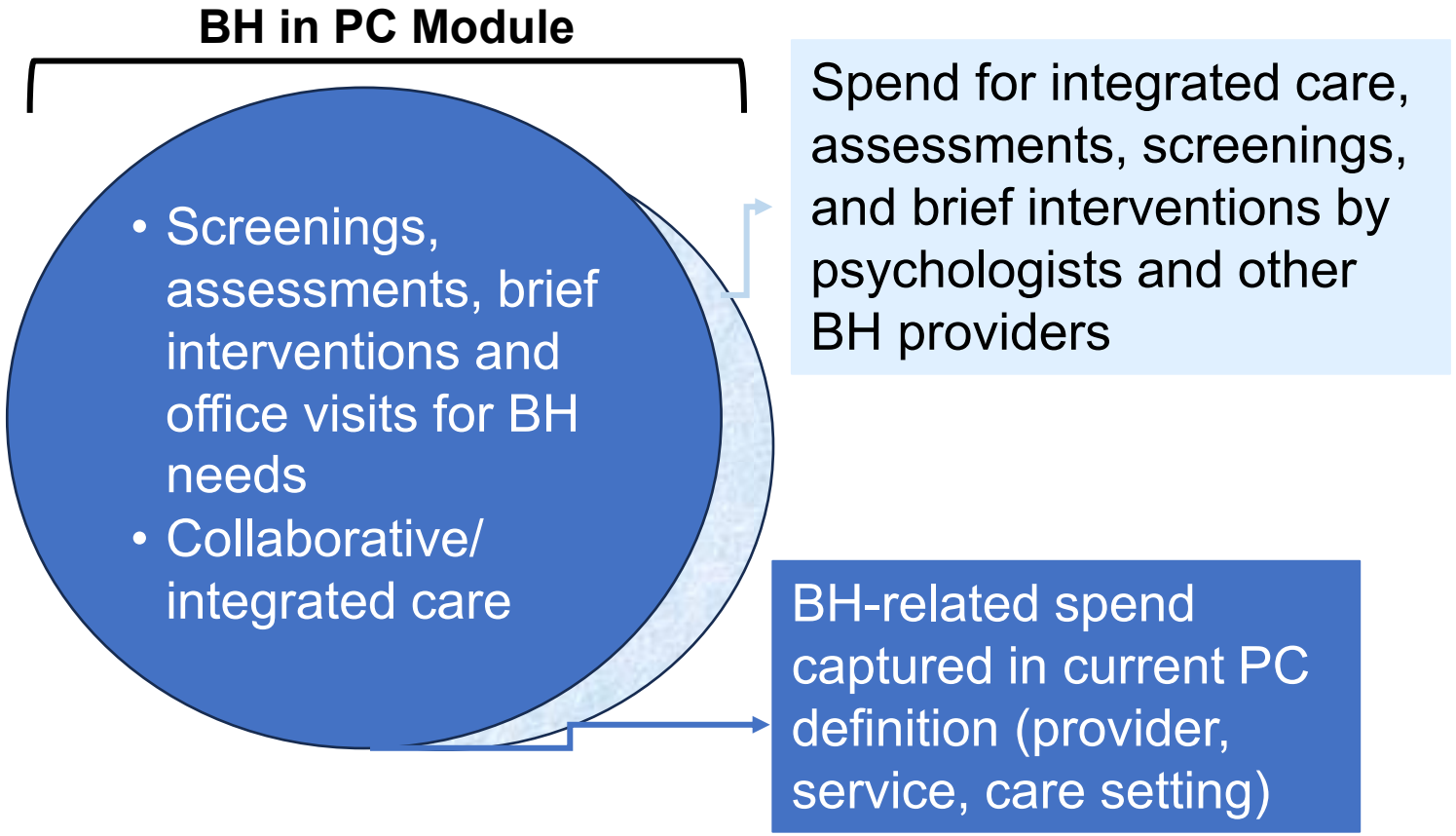
Behavioral Health in Primary Care Module: Primary Care Provider Taxonomies

OHCA recommends expanding the list of primary care providers to capture integrated behavioral health services in the module. Expansion of primary care provider taxonomies reflects the range of providers that may provide behavioral health care in an integrated primary care setting.

- Expansion of primary care provider taxonomies does not affect measurement of total behavioral health spending, which is not restricted by provider.
- Provider taxonomy is used solely to designate spending to be included in the Behavioral Health in Primary Care module and separately for primary care spend.
- Consistent definitions of "provider" for primary spend measurement and the Behavioral Health in Primary Care module are required for a mutually exclusive, collectively exhaustive approach.

Expanding the Primary Care Provider List

The Behavioral Health in Primary Care Module must capture the same behavioral health-related spend when included as part of either PC or BH spend.



- Prevents double-counting.
- Allows OHCA to add BH in PC spend to primary care spend or behavioral health spend reporting.
- Helps ensure the primary care, behavioral health, and behavioral health in primary care module definitions are mutually exclusive and collectively exhaustive.

Stakeholder Proposed Additions to Primary Care Provider List

Taxonomy	Considerations
• 106E00000X - Assistant Behavioral Analyst • 106S00000X - Behavior Technician • 103K00000X - Behavior Analyst	• An opportunity exists for behavior analytic providers to reach a wider population as part of integrated behavioral health, especially within pediatric primary care.[1] • These provider taxonomies typically work with patients with an autism spectrum disorder, intellectual or developmental disability, or traumatic brain injury diagnosis – This work is often not done in the primary care setting. • Washington and Milbank include Assistant Behavioral Health Analyst and Milbank includes Behavior Technician and Behavior Analyst in its primary care provider list.

OHCA leans toward excluding these taxonomies from the primary care provider list.

1. American Psychological Association, 2019. Applied Behavior Analysis in Pediatric Primary Care: Bringing ABA to Scale. http://dx.doi.org/10.1037/bar0000152

Stakeholder Proposed Additions to Primary Care Provider List

Taxonomy	Considerations
• 101YP2500X- Professional Counselor • 101YS0200X- School Counselor	• OHCA includes schools as a primary care place of service. • Colorado, Maryland, and Milbank include these taxonomies in their primary care provider list.
• 102L00000X- Psychoanalyst • 103TP0814X- Psychoanalyst Psychologist	• Colorado, Maryland, Washington and Milbank include Psychoanalyst and Colorado and Milbank include Psychoanalyst Psychologist. • Services are unlikely to be delivered in a primary care setting.

OHCA leans toward including only school counselors on the primary care provider list.

Discussion

1. Comments on the purpose and structure of the behavioral health in primary care module?
2. Should OHCA add Applied Behavioral Analysis (ABA) providers to the primary care taxonomy list?
3. Should OHCA add professional and/or school counselors to the primary care taxonomy list?
4. Should OHCA add psychoanalysts to the primary care taxonomy list?

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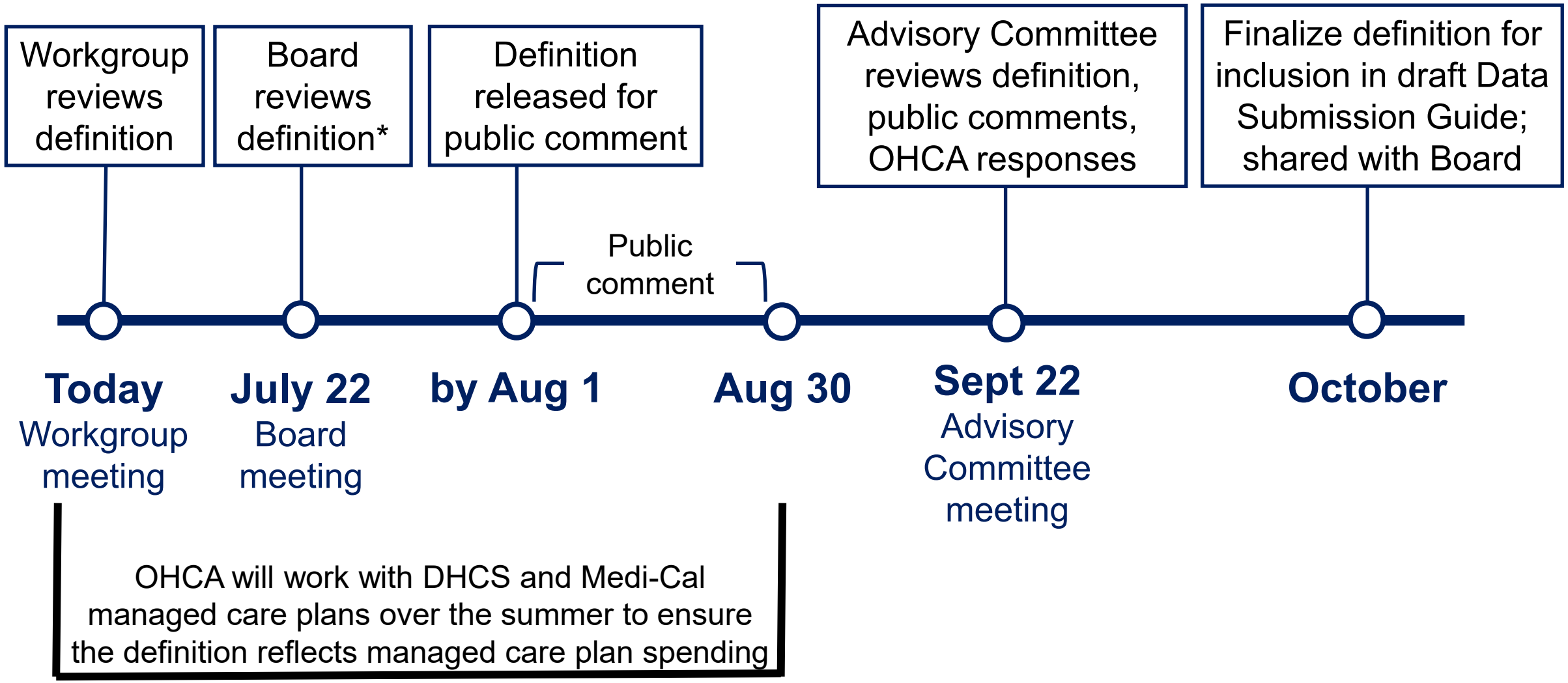
Timeline and Next Steps

Margareta Brandt, Assistant Deputy Director

Detailed Timeline for Behavioral Health Work



*The Board is not required to formally approve definitions

August Workgroup Meeting Preview

1. Data presentation

2. Follow-up analytic questions

3. Discuss goal to send potential benchmark to Board for approval in summer 2026

Future Workgroup Meetings, Post-August

1. Quarterly convening

2. Interim milestones, moving toward a benchmark recommendation in summer 2026

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Adjournment

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Appendix: Behavioral Health Non-Claims Spending Allocation Formulas

Equation for Allocating Practice Transformation, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Portion of Capitation Payments}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

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.