HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

June 18, 2025

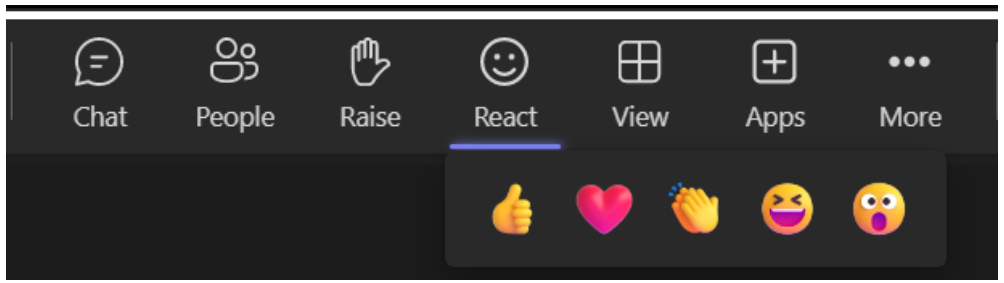
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Updated Behavioral Health Investment Benchmark Proposal**
9:55 a.m.	**3.**	**Behavioral Health Code Set Feedback and Responses**
10:25 a.m.	**4.**	**Next Steps**
10:30 a.m.	**5.**	**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: June 18, 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

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

Marie M. Eppler
Associate General Counsel, Anthem Blue Cross (Elevance)

Waynetta Kingsford
Sr. Director, Provider Delivery Systems, Kaiser Foundation Health Plan

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

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

Vickie 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

HCAi
Department of Health Care Access and Information

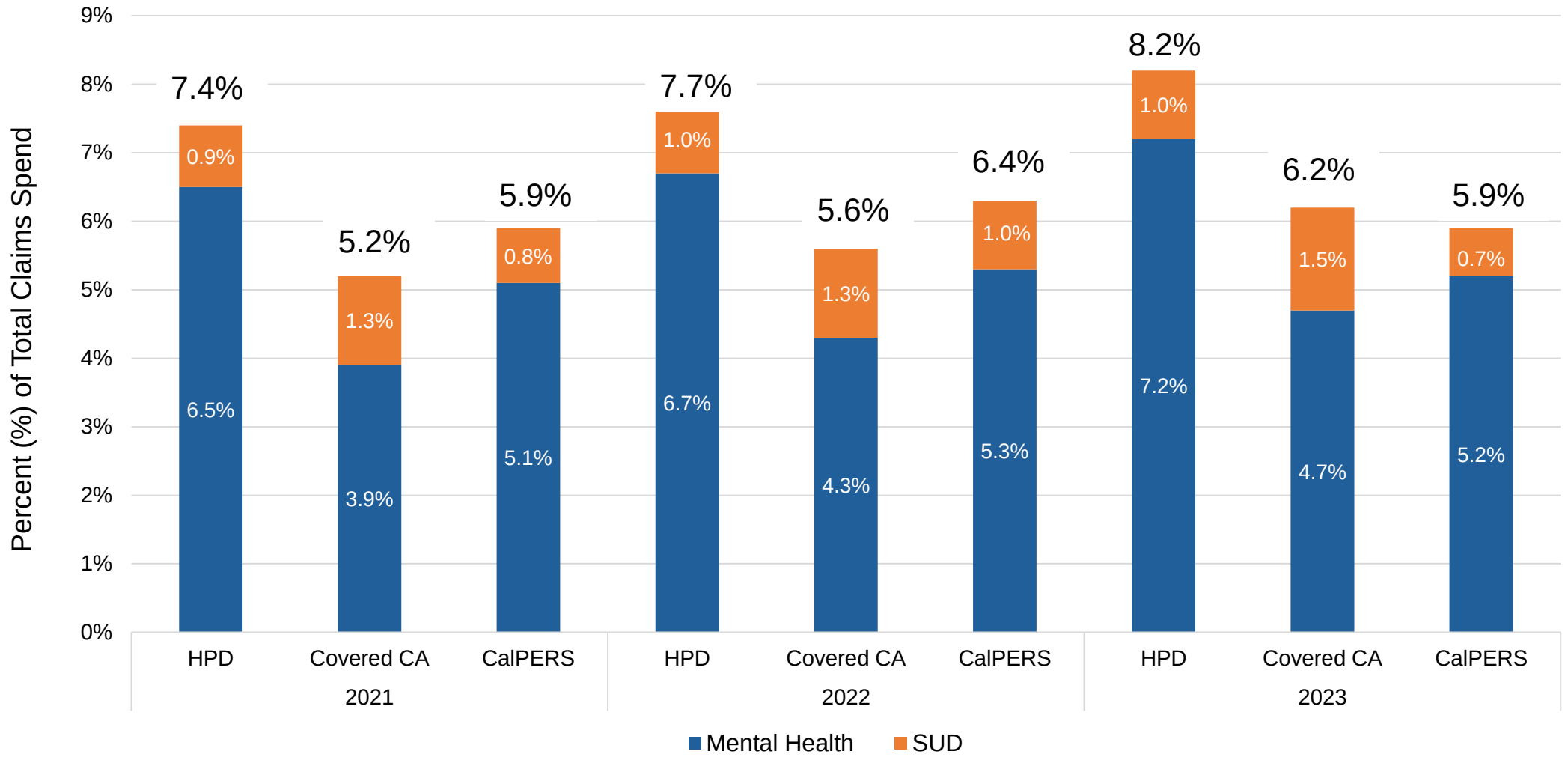
Updated Behavioral Health Investment Benchmark Proposal

Margareta Brandt, Assistant Deputy Director

Recap of May Workgroup Meeting and June Board and Advisory Committee Meetings

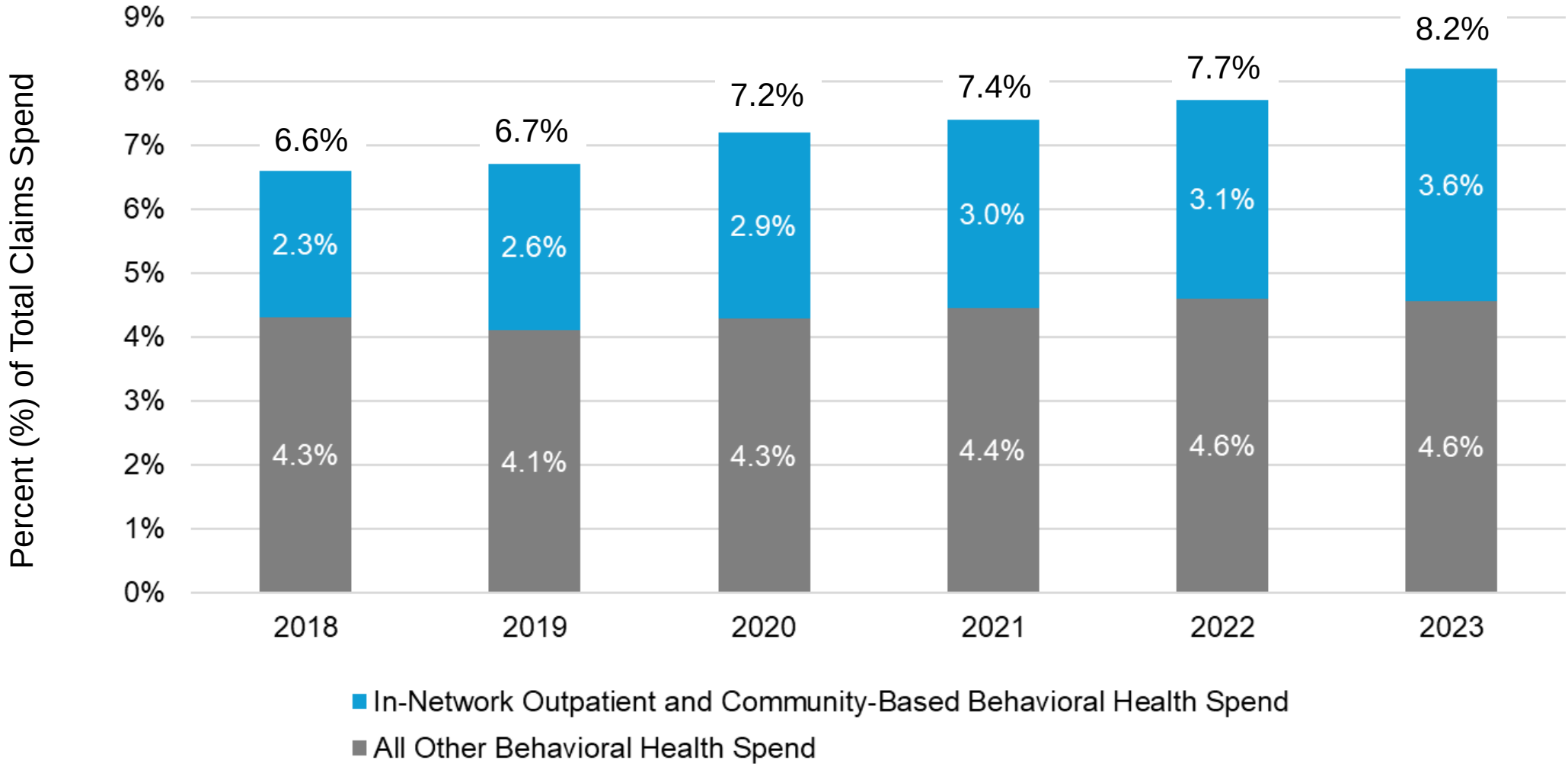
- In the May Workgroup meeting, we -
  - Reviewed behavioral health spending analysis of HCAI's Healthcare Payments Data (HPD), Covered California, and CalPERS data.
  - Discussed a behavioral health investment benchmark proposal.
  - Heard reservations about the benchmark as proposed and interest in additional data analysis.
- Based on this feedback, OHCA presented a recommendation to the Board in early June to collect behavioral health spending data first and use this data, along with further HPD analysis, to set a benchmark.
- We also presented this recommendation to the Advisory Committee.

Preliminary BH Spending Comparison: HPD Commercial, Covered CA, CalPERS 2021-2023



Note: Total claims spend includes medical and pharmacy claims spend.

Preliminary HPD Commercial In-Network Outpatient and Community-Based BH Spend 2018-2023



Note: Total claims spend includes medical and pharmacy claims spend.

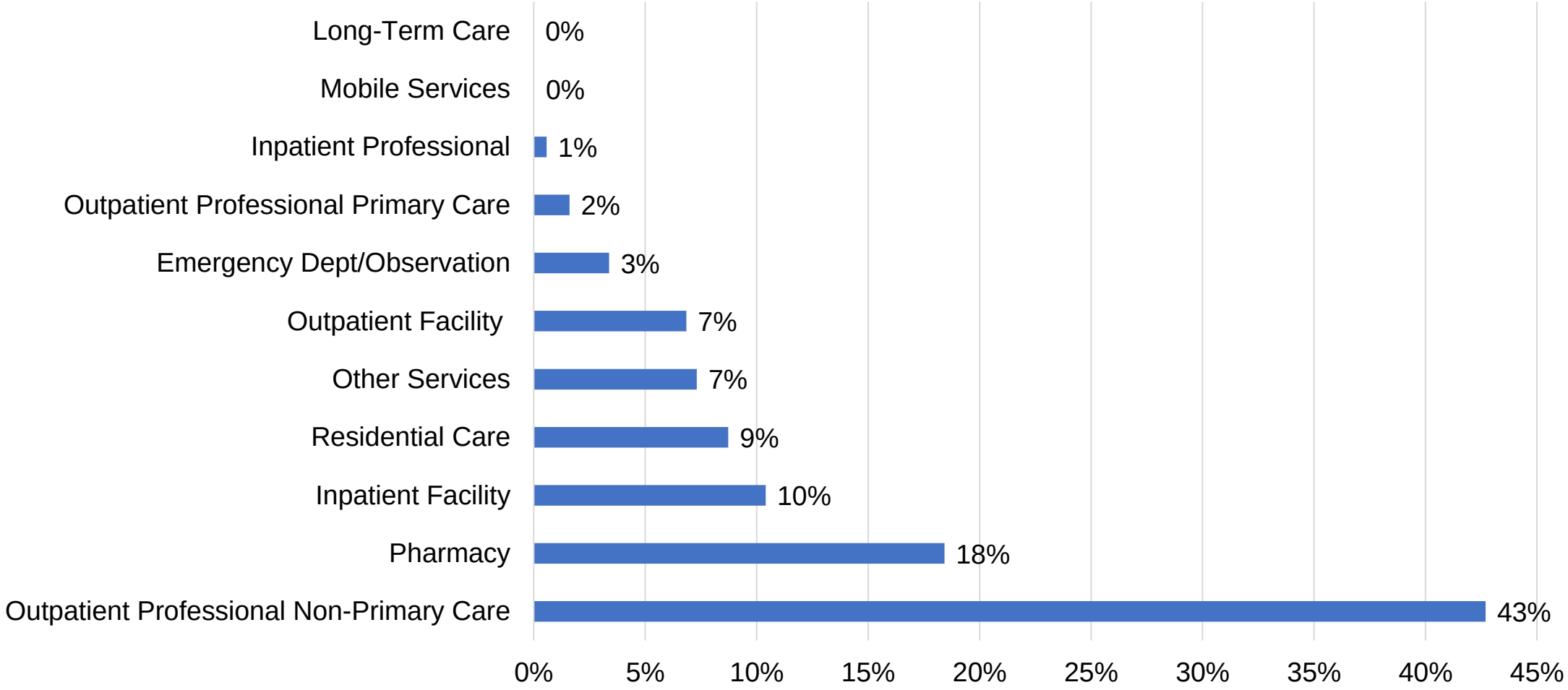
Behavioral Health Spending in the Commercial Market by Service Subcategory

	2018	2019	2020	2021	2022	2023
Emergency Dept/Observation	5%	5%	4%	4%	4%	3%
Inpatient Facility	16%	15%	15%	13%	12%	10%
Inpatient Professional	1%	1%	1%	1%	1%	1%
Long-Term Care	0%	0%	0%	0%	0%	0%
Mobile Services	0%	0%	0%	0%	0%	0%
Other	8%	6%	6%	7%	7%	7%
Outpatient Facility Non-Primary e	7%	7%	7%	7%	7%	7%
Outpatient Professional Non-Primary Care	33%	37%	39%	38%	38%	43%
Outpatient Professional Primary	2%	2%	2%	2%	2%	2%
Residential Facility	4%	6%	7%	7%	8%	9%
Pharmacy	23%	21%	18%	21%	20%	18%
Total Claims Spend	**$3,095**	**$3,281**	**$3,408**	**$4,262**	**$4,662**	**$5,114**

In millions of dollars

Preliminary analysis of HPD data.

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



Preliminary analysis of HPD data.

Workgroup, Board, and Advisory Committee Feedback on Data Presentation

- Appreciated seeing data on behavioral health spend and year-over-year changes in the benchmark category for the commercial market to ground the benchmark discussion.
- Some were surprised by the level of 2023 spend and continued growth since 2018; others were not.
- Data raised additional questions: what factors are driving the trends, how behavioral health spending varies across payers and purchasers, interest in understanding contribution of capitation to overall spending and in breakout of subcategory spending between mental health and substance use disorders.

Workgroup, Board, and Advisory Committee Feedback on Data Presentation, Continued

- Interest in expanding HPD analysis to include Medi-Cal and Medicare and in understanding County behavioral health spending.
- Members noted that using only primary diagnosis undercounts behavioral health care delivered by primary care providers.
- Interest in analyzing spending data by demographic categories and in linkage between spending and quality and clinical outcomes.
- Members noted that some of the increases in spending over the past few years may be in response to parity and timely access laws.
- Interest in capturing behavioral health spending for care in schools and the corrections system.

May Workgroup Feedback on Benchmark Proposal

- Support for iterative, phased approach, to learn from experience and additional analysis.
- Reservations about the benchmark as proposed:
  - Interest in knowing more about past trends, including drivers of growth and year-to-year volatility.
  - Want clarity that the benchmark would support equity and access; there are many focused behavioral health programs outside of claims, suggesting a more “holistic” approach.
  - Concerns about setting a specific target for year-over-year growth due to unknown payer-specific starting points and lack of knowledge on “appropriate” level of spend.
  - More consideration required for how Medi-Cal will be phased into the benchmark, particularly payments for Specialty Mental Health services.
  - Suggestion to focus benchmark more narrowly to integrated behavioral health in primary care.

OHCA Recommendation
Revised Following May Workgroup Meeting

Recommendation	Considerations
Behavioral Health Investment Benchmark: Set in spring 2028 for performance year (PY) 2029 onwards based on OHCA data collection, while also conducting further analysis on HPD data and evaluating the impact of recent behavioral health policy efforts. **Behavioral Health Spending Measurement:** Collect and analyze behavioral health data from payers for PY 2024-2026.	• More time to learn from data submitted by payers for this measurement purpose before setting benchmark. • Also allows for identification and resolution of challenges with data submission process and measurement definitions. • Benchmark's influence on policy goals delayed by at least two years.

Board Feedback on Benchmark Recommendation

- Suggestion to revise recommendation and revisit the benchmark in 2026.
  - "Measurement only" until 2028 seems too long.
  - Continue to conduct HPD analysis over the next year; evaluate whether additional information is sufficient to inform setting a benchmark in 2026.
  - If still uncertain in 2026, revisit in 2027.
- Important to incorporate county-based Specialty Mental Health Services sooner rather than later.
- Interest in summarizing the programs and funding supporting behavioral health transformation across the state.
- Interest in learning from other states' experiences with behavioral health spending measurement and benchmarking.
- Caution about overestimating capitation attributable to behavioral health.

Advisory Committee Feedback on Benchmark Recommendation

- Several members expressed support for some delay in benchmark setting and agreement with Board suggestions to revisit in 2026.
- Interest in explicit promotion of integrated behavioral health in primary care and addressing current fragmentation of care.
- Concerns that increased investment in behavioral health could lead to overall spending growth exceeding OHCA's spending growth targets.
- Interest in analyzing mental health and substance use disorder spending separately and considering separate benchmarks.

Discussion

- Reactions to OHCA's revised benchmark recommendation, and to the Board's and Advisory Committee's feedback?

HCAi
Department of Health Care Access and Information

Behavioral Health Code Set Feedback and Responses

Debbie Lindes, Health Care Delivery System Group Manager

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.

Behavioral Health Claims Code Set Feedback

Feedback	OHCA Response
Suggestions to exclude drug codes (NDC) for drugs used for non-behavioral health conditions. Example: Suggestion to remove benzodiazepines from drug code list due to multiple indications, some of which are not BH-related.	OHCA has reviewed each suggestion with a clinical expert and plans to keep drugs on the list that have multiple indications, if one of them is to treat behavioral health conditions. OHCA recognizes that inclusion of drugs with multiple indications will result in an unknown amount of "over-counting" of drug spending. OHCA does not plan to include pharmaceutical spending in its benchmark.
Inclusion of care settings not typically associated with behavioral health.	OHCA aims to capture behavioral health services delivered in a wide variety of settings. Requiring a primary behavioral health diagnosis should limit inclusion of care delivered in non-BH settings to BH care.
Suggestions to include, and others to exclude, certain diagnosis codes related to autism or dementia.	Based on Workgroup input, OHCA will update the code set to ensure that diagnoses for relevant sub-categories of autism and dementia are included.
Suggestions to expand list of behavioral health provider types who are added to the Primary Care Provider code set as part of the Behavioral Health in Primary Care module.	OHCA's methodology limits its ability to accurately distinguish behavioral health providers' care delivered in an integrated primary care setting from a non-integrated setting. For this reason, OHCA has limited its expansion of the primary care provider list to those likely to deliver services in an integrated or primary care setting.

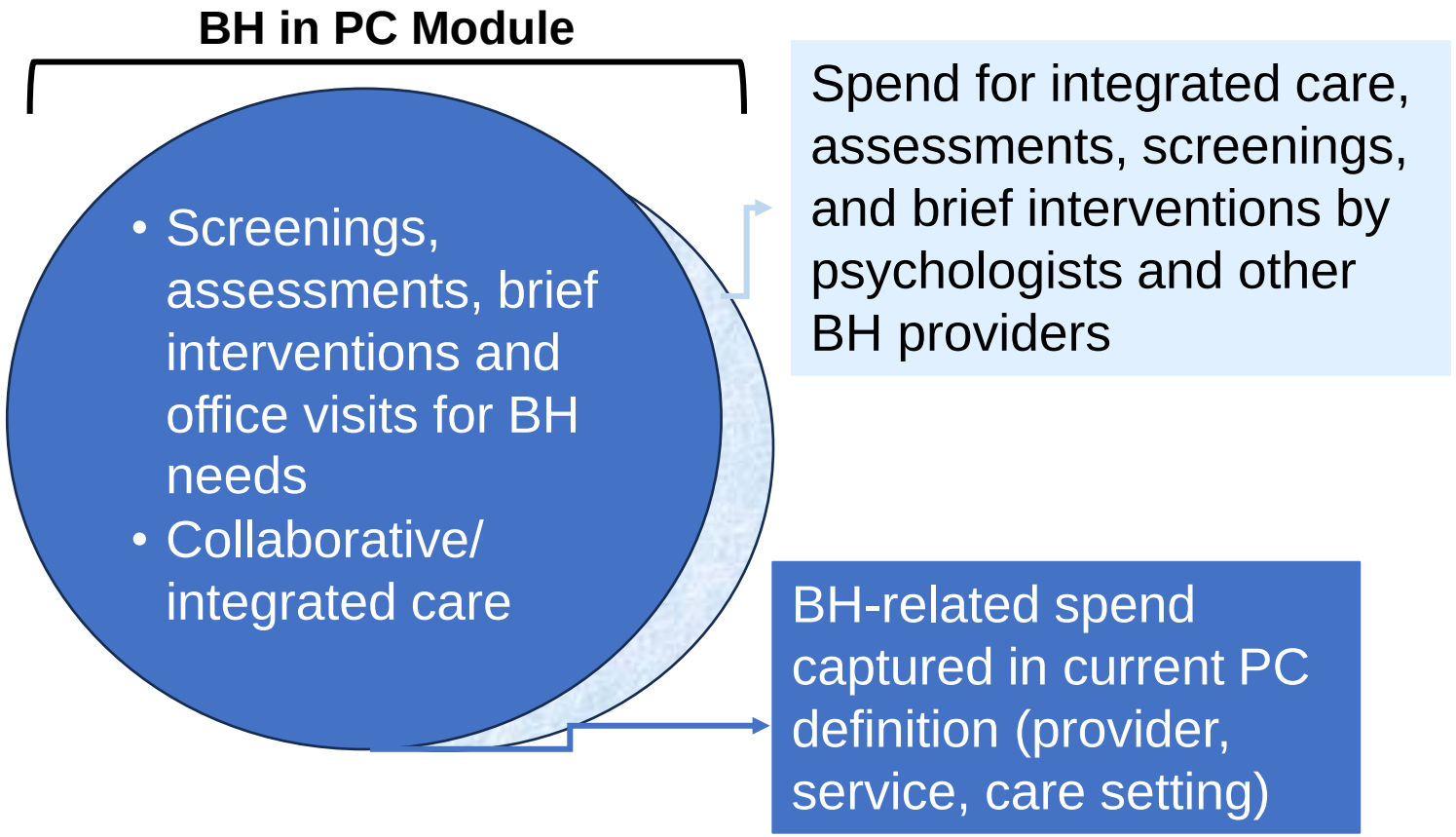
Behavioral Health in Primary Care Module: Primary Care Provider Taxonomies

OHCA recommends expanding the list of primary care providers to capture integrated behavioral health services in the Behavioral Health in Primary Care module.

- 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
- Consistent definitions of provider for primary care and the Behavioral Health in Primary Care module are required for a mutually exclusive, collectively exhaustive approach.

Expanding the Primary Care Provider List

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



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

Traumatic Brain Injury

The behavioral health code set currently includes diagnoses for dementia, but not traumatic brain injury (TBI). Considerations:

- Some workgroup members questioned this logic.
- Behavioral health conditions often stem from organic brain syndromes.
- Patients with TBI diagnoses (e.g., post-concussive syndrome) are frequently seen by psychiatrists.
- Previously discussed: The inclusion of dementia is likely to result in capturing some non-behavioral health (i.e., medical) spend, but it should be included in code set.
- TBI is not included in the Milbank code set or other states' code sets.
  - The Milbank workgroup did not think a significant portion of spend for TBI diagnoses would be behavioral health-related.

Behavioral Health Claims Code Set Feedback

Feedback	OHCA Response
Suggestions regarding specific diagnosis, service, drug, care setting, and provider codes. Example: For example, a stakeholder noted that diagnosis code Z1389 is a generic code and not used exclusively for behavioral health screenings.	OHCA is reviewing each suggestion and has sought clinical expertise when appropriate. Example: Z1389 was originally added to the code set based on input from the Wright Institute that this diagnosis code is essential for claims for SBIRT and ACES provided in integrated behavioral health settings to process correctly.
Questions regarding codes that may not be covered by a specific payer.	These codes will continue to be included in the code set because OHCA does not determine coverage or reimbursement for specific payers (e.g., CMS); inclusion encourages other payers to reimburse for the diagnosis.
Questions regarding whether we have the right organization of subcategories.	Changes to subcategories do not impact total spending. Spending not categorized is included in “Other Services”.

Reporting Categories and Service Subcategories
Proposed Revision

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

†All spending for claims with a primary behavioral health diagnosis is included (i.e. spending not in categories goes to “Other”).

Crisis Care Subcategory – Code Examples

Service Codes (HCPCS/CPT)
H0030 Behavioral Health Hotline services
H2011 Crisis Intervention service
S9484/9485 Crisis Intervention Mental Health Services
90839/90840 Psychotherapy for crisis
G0560 Safety planning interventions

Crisis codes included in DMHC APL 25-006 would be included in this subcategory.

Discussion

- General comments on the code set feedback and OHCA's responses?
- Thoughts about the inclusion or exclusion of TBI?
- Thoughts about creation of a "Crisis Care" subcategory, replacing Community-Based Mobile Clinic Services?

HCAi
Department of Health Care Access and Information

Next Steps

Margareta Brandt, Assistant Deputy Director

Tentative Timeline for Behavioral Health Work

In the coming months, OHCA will focus on revising and finalizing behavioral health definitions and the code set.

	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25
Workgroup	X	X	X	X	X	X	X	X	X	
Advisory Committee		X		X			X			X
Board	X		X		X		X	X	X	

July Workgroup Meeting Preview

- Finalize definitions and code set
- Revisit Behavioral Health in Primary Care module

HCAi
Department of Health Care Access and Information

Adjournment