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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

March 19, 2025

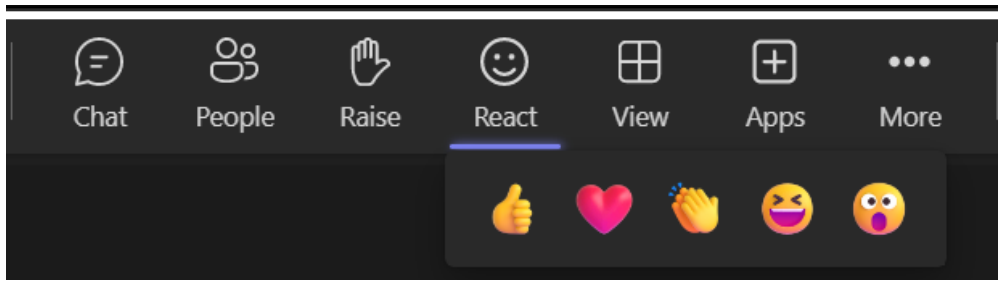
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:05 a.m.	**2.**	**Recommendations: Measuring Non-Claims Behavioral Health Spending**
9:40 a.m.	**3.**	**Proposed Methodology: Claims-Based Behavioral Health Spending**
10:05 a.m.	**4.**	**Behavioral Health Investment Benchmark Development**
10:25 a.m.	**5.**	**Next Steps**
10:30 a.m.	**6.**	**Adjournment**

Meeting Format

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

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



Date: March 19, 2025

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:
Join the meeting now

Meeting ID: 289 509 010 938
Passcode: r5gbsW

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

Conference ID:
456 443 670 #

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Monica Soni, MD
Chief Medical Officer, Covered California

Dan Southard
Chief Deputy Director, Department of Managed Health Care

February Board Meeting

Feedback

- Highlighted the importance incorporating Medi-Cal into the definition and spending data collection in the future, given OHCA's proposed phased approach to start with commercial and Medicare Advantage
- Interest in understanding the rationale behind excluding inpatient spend in the proposed behavioral health investment benchmark
- Interest in tracking inpatient behavioral health spend, pharmacy costs, and payment rates for behavioral health services
- Interest in understanding the reasons for poor access and low network participation, from payer and provider perspectives
- Interest in capturing behavioral spend occurring in schools
- Discussion of how to broadly track behavioral health transformation across the state

February Workgroup Meeting

Feedback

- Workgroup members offered thoughts about payments in Expanded Framework Category "A" that could be included in the behavioral health measurement definition
- Workgroup members expressed interest in exploring payments outside of the claims system that are not made to providers but contribute to maintenance and prevention of behavioral health conditions
- Workgroup members also cautioned against the definition becoming too broad
- More Workgroup members than not agreed that OHCA's behavioral health measurement definition does not need to align with the federal mental health parity definition
- Members expressed interest in tracking out-of-network as well as in-network utilization

March Advisory Committee Meeting

Feedback

Recommendations: Measuring Non-Claims Behavioral Health Spending

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

Three Recommended Modules for Behavioral Health Spending Measurement

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

Behavioral Health Non-Claims Measurement Definition Principles

- Data collection via Expanded Non-Claims Payments Framework
- Include all behavioral health non-claims subcategories
- Allocate payments to behavioral health by various methods:
  - **Population health, behavioral health integration, and care management payments** only when paid to behavioral health providers
  - **Practice transformation, IT infrastructure, and other analytics payments** not to exceed a set upper limit
  - **Behavioral health capitation payments** included in full
  - **Professional and global capitation payments** and **payments to integrated, comprehensive payment and delivery systems** allocated to behavioral health using a method similar to that for primary care

Expanded Framework, Categories A-C

Green = Include all of payment (if for BH)
Orange = Include portion of payment
Blue = Under discussion
White = Excluded or not applicable

	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

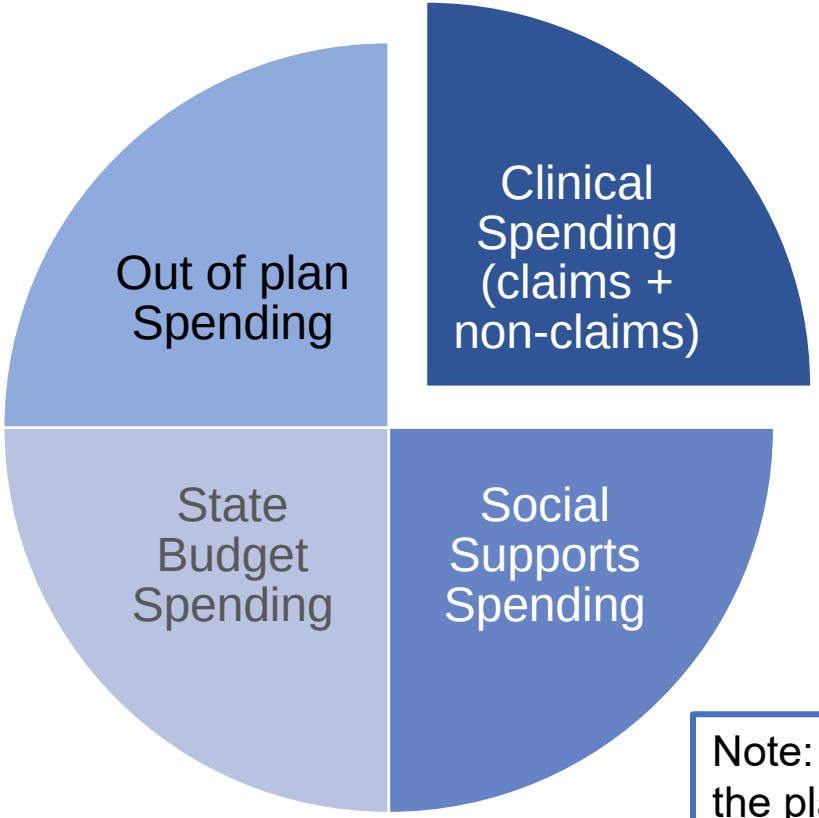
Expanded Framework, Categories D-F

Green = Include all of payment (if for BH)
Orange = Include portion of payment
Blue = Under discussion
White = Excluded or not applicable

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

Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage)
- Possibility of using supplemental data sources to capture spending from other categories in the future

Note: “Out of plan spending” includes spending by individuals on services not paid for by the plan. “Clinical spending” includes member cost share for services paid by the plan.

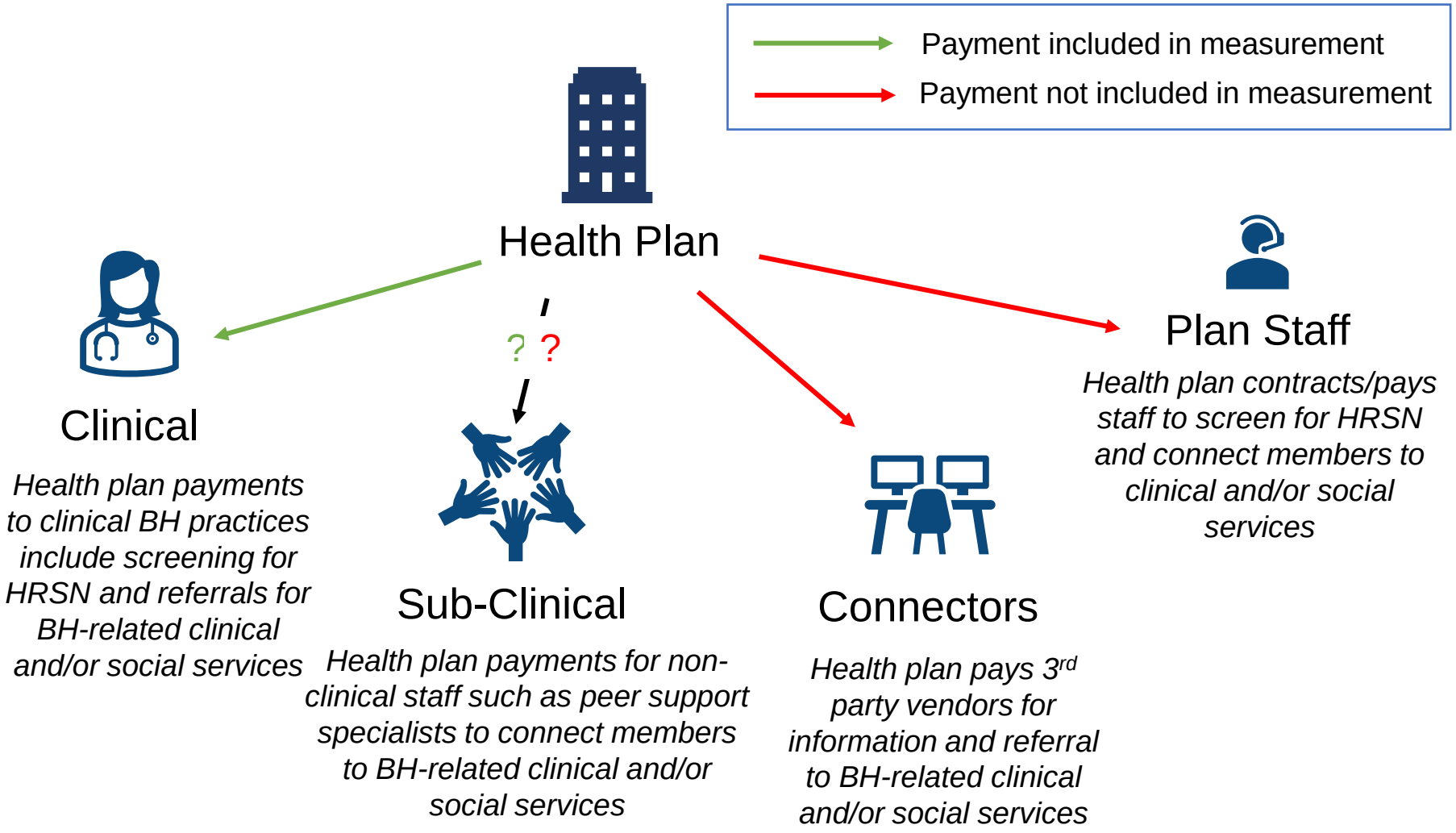
Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

Examples of Services Included or Not Included in Spending Measurement

	Behavioral Health Care	Primary Care
Included as spend	• Collaborative Care and other integration • Brief therapeutic intervention in an integrated setting • Organized peer support and coaching	• Vaccine administration • Smoking cessation counseling • Behavioral health screening
Not Included as spend	• Population health campaign focused on behavioral health screening • Mindfulness programs to support wellbeing	• Population health campaign focused on hypertension screening • Vaccine promotion

Subcategory A3: Social Care Integration Payments

Expanded Framework Definition:
Prospective non-claims payments **paid to health care providers or organizations*** to support screening for health-related social needs (HRSN), connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.



*Would be paid to behavioral health providers and organizations, analogous to primary care providers and organizations for primary care spend.

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.
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 primary care 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 primary care 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.
F	Pharmacy Rebates	Not Applicable

*May include retroactive denials, overpayments, payments made as the result of an audit, governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments).

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.

Discussion

- Reactions to the methodology to apportion capitated payments to behavioral health?
- Should all subcategories in Expanded Framework Category A (Population Health and Practice Infrastructure Payments) be included in measuring non-claims behavioral health spending, using the recommended methodologies?
  - What types of social care integration payments (subcategory A3) should be included?
  - Will it be difficult for data submitters to identify these payments, as defined?
- What "Other" non-claims payments should be included and allocated to behavioral health care?

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Proposed Methodology: Claims-Based Behavioral Health Spending

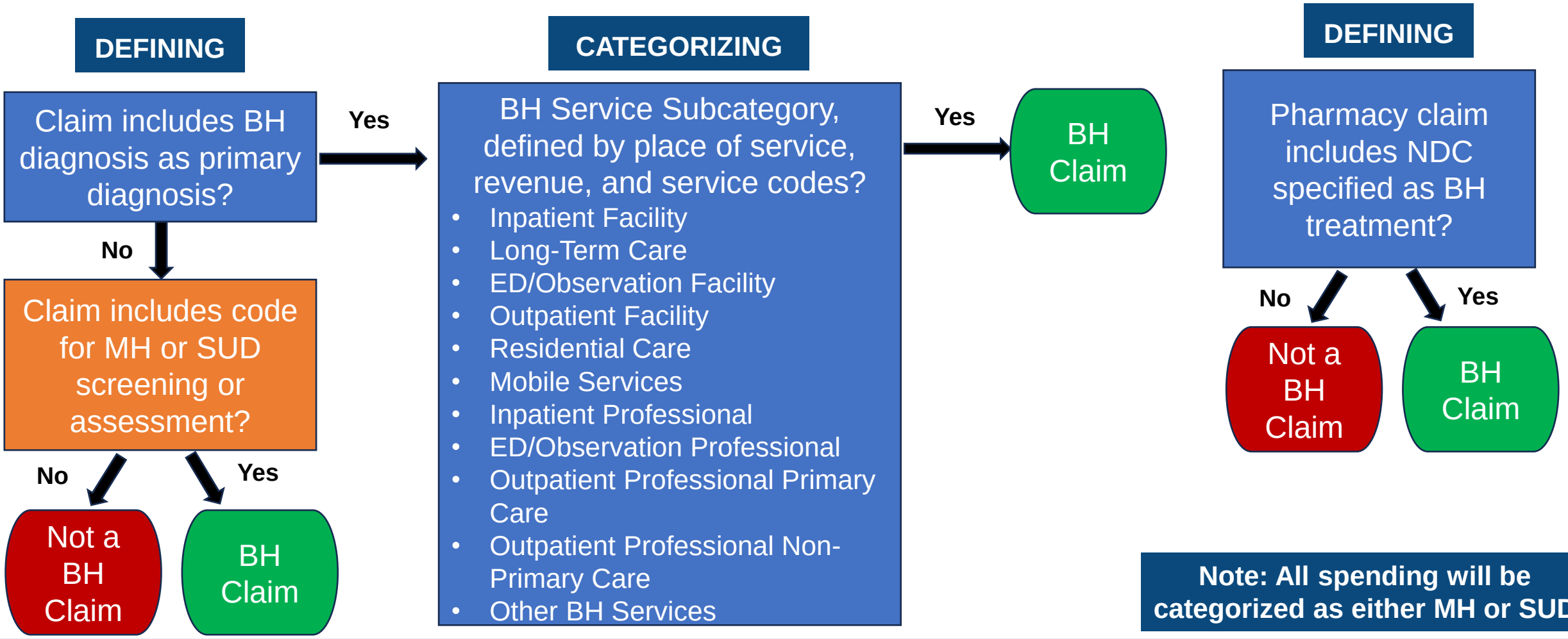
Debbie Lindes, Health Care Delivery System Group Manager
Mary Jo Condon, Principal Consultant, Freedman HealthCare

Behavioral Health Claims Measurement Definition Principles

1. **Include all claims* with a primary behavioral health diagnosis** in measurement
   - Claims with service codes for mental health or substance use disorder screening or assessment also included, regardless of primary diagnosis code
2. **Categorize claims** using place of service, revenue, and service codes
   - “Other Behavioral Health Services” category captures claims with a primary behavioral health diagnosis code that do not have a place of service, revenue, or service* code associated with another subcategory
3. **Include pharmacy claims** with a National Drug Code (NDC) specified by OHCA as a behavioral health treatment
   - Measured separately, so can be included or excluded for analysis
   - Categorized as mental health or substance use disorder claims
   - Behavioral health diagnosis not required

*OHCA is considering applying a service code filter to the "Other Behavioral Health Services" category.

Process Map for Identifying Behavioral Health (BH) Claims



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

Proposed Reporting Categories and Service Subcategories

Reporting Categories	Service Subcategories
Outpatient/Community Based*	Community Based Mobile Clinic Services
	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

These categorizations may change as OHCA develops the final behavioral health investment benchmark and begins data collection.

*Proposed behavioral health investment benchmark includes spend in this category.

Categorizing BH Screenings and Assessments

Options	Considerations and Tradeoffs
Separate subcategory and/or reporting category	• Include all spend on screenings and assessments regardless of care setting • Enables OHCA to include as part of benchmark regardless of care setting • Potential to increase data submitter burden as spend for these services would need to be separated from associated patient care
Include in each relevant subcategory (Inpatient, ED, Outpatient, Long-term Care, Residential, etc.)	• Categorizes screenings and assessments based on care setting where delivered • Benchmark would include screenings and assessments in only specific care settings • Consistent with categorization of other services/spend into subcategories using care setting codes

Note: Some screenings and assessments may not be billed separately during an office visit and therefore may not be measured discretely.

Claims Code Set

- The claims-based behavioral health definition will include the following in the code set:
  - Service Codes
  - Care Setting Codes
  - Diagnosis Codes
  - National Drug Codes

Service Codes (1 of 2) (586 total)

Reporting Category	Examples
Outpatient/ Community-Based	• Psychotherapy • Pharmacologic Management • Transcranial Magnetic Stimulation and Electroconvulsive Treatments • Psychological Testing and Evaluation • Health Behavior Assessments and Interventions • Adaptive Behavior Treatment • Care Management • Telehealth Assessment and Management • Preventive Services • Medication Assisted Treatment • Treatment for Substance Use Disorders • Detoxification Services (Non-residential) • Community Support and Peer Services • Suicide Risk Assessment
Emergency Department	• ED Visit for E/M of Patient with a Behavioral Health Disorder • Critical Care, E/M of the Critically Ill or Injured Patient • Level 1-5 ED Visits • Emergency Telehealth Services

Service Codes (2 of 2) (586 total)

Reporting Category	Examples
Inpatient	• Initial and Subsequent Hospital Care for E/M of a Patient with a Behavioral Health Disorder • Hospital Discharge/Day Management • Inpatient Consultations • Inpatient Telehealth Pharmacologic Management • Detoxification Services
Long-Term Care and Residential	• Non-Acute Behavioral Health for Patients in Long-Term Residential Facility • Detoxification Residential Addiction Programs

Care Setting Codes (238 total)

Includes CMS Place of Service and Revenue Codes

Reporting Category	Subcategories	Place of Service Code Examples	Revenue Code Examples
Inpatient	• Inpatient – Facility • Inpatient - Professional	Intermediate Care Facility, Residential Substance Use Disorder Treatment	Detoxification, Psychiatric, Intensive Care Units
Emergency Department	• ED/Observation – Facility • ED/Observation - Professional	Emergency Room, Ambulance - Land or Air or Water	Emergency Room, Medical Screening Services, Professional Fees, Specialty Services - Treatment Room and Observation Hours
Long-term Care and Residential	• Long-term Care • Residential	Psychiatric Residential Treatment Center	Nursing Home (for Hospitalization), Respite, Rehabilitation, Residential Treatment, SNFs
Outpatient/ Community-Based	• Mobile services • Outpatient professional – PC • Outpatient professional – non-PC • Outpatient Facility	School, Home, Indian Health Service and Tribal Facilities, Telehealth, Office, FQHCs, Partial Hospitalization, Non-Residential Substance Use Disorder Treatment Assisted Living Facility, Temporary Lodging, Place of Employment, Outreach Site/Street, Comprehensive Outpatient Rehabilitation	Outpatient Services, Clinics, FQHCs, Shortage Area, Telemedicine, Electroshock, Professional Fees, Rehabilitation, Alternative Therapy Services, Adult Care
Pharmaceutical	• MH Rx Treatments • SUD Rx Treatments	n/a	n/a
Other	• Other BH Services		

Diagnosis Codes (2,950 total)

Examples of Diagnoses Included
• Anxiety, Dissociative, Stress-Related, Somatoform and Other Nonpsychotic Mental Disorders • Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence • Behavioral Syndromes Associated with Physiological Disturbances and Physical Factors • Dementia • Disorders of Adult Personality and Behavior • External Causes of Morbidity • Factors Influencing Health Status and Contact with Health Services • Injury of Unspecified Body Region • Injury, Poisoning and Certain Other Consequences of External Causes • Mental and Behavioral Disorders due to Psychoactive Substance Abuse • Mental Disorders Due to Known Physiological Conditions • Mood [Affective] Disorders • Pervasive and Specific Developmental Disorders • Schizophrenia, Schizotypal, Delusional and Other Non-Mood Psychotic Disorders • Symptoms and Signs Involving Cognition, Perception, Emotional State and Behavior

National Drug Codes (164 drugs)

Examples Of Disorders Included NDCs Treat
• ADHD and similar Disorders • Anxiety and Panic Disorders • Bipolar Disorder • Dementia • Depression • Mood Disorders • Obsessive Compulsive Disorder • Postpartum Depression • Post Traumatic Stress Disorder • Substance Use Disorders • Schizophrenia • Sleep Disorders

Discussion

- Comments about how the place of service, revenue, and service codes are grouped into service categories and subcategories for measurement and reporting?
- Comments about the two options for how to categorize behavioral health screenings and assessments:
  - As a separate subcategory and/or reporting category
  - Included in each relevant subcategory
- Are there categories of services, care settings, diagnoses, or national drug codes that should be included or excluded from the code set?

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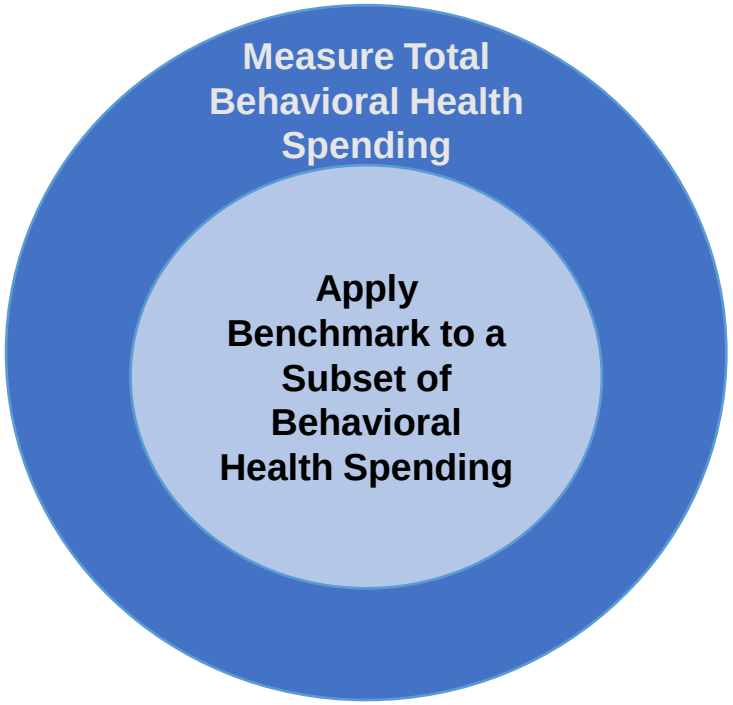
Behavioral Health Investment Benchmark Development

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

Broad Measurement, Focused Benchmark

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

Spending Included



Key Decisions for Benchmark Setting

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

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

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

Reasons for Percent of TME

- Statute suggests preference for this approach.
- Communicates that increased spending on behavioral health care should reallocate rather than increase total spending.
- Consistent with the approach to the primary care investment benchmark.

Reasons for Per Member, Per Month (PMPM)

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

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

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

Reasons for Annual Improvement

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

Reasons for Long-Term Investment Goal

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

Reason for Combination

- Allows all to succeed at a reasonable pace.
- Aligns with the approach to the primary care investment benchmark.

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

Considerations

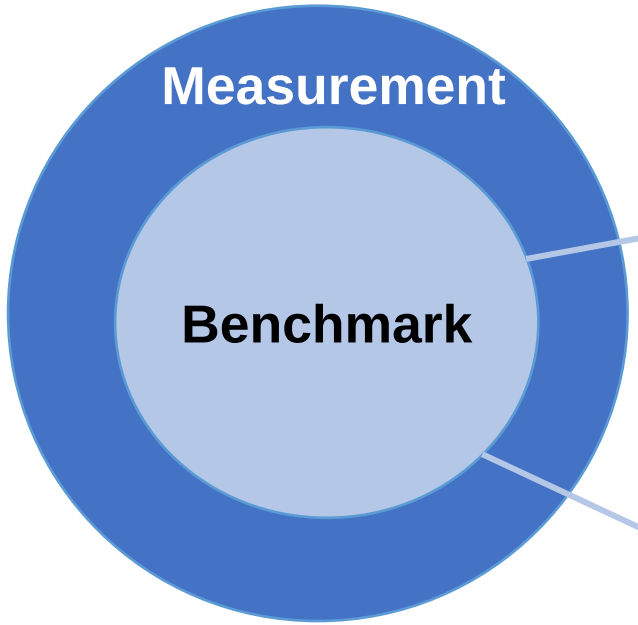
- Benchmark should be aggressive in pursuit of the policy goals underlying it
- Benchmark should also reflect reasonable expectations of how long it will take to achieve
- Align benchmark with other adopted OHCA benchmarks:
  - Spending growth (2029)
  - Primary care investment and alternative payment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

Other OHCA Benchmarks

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

- Combine incremental and long-term goals
- Acknowledge payers' different starting points and capacity for short-term improvement
- Allow for adjustment as picture becomes clearer with more data
- Set a long-term vision aligned with state policy goals

What is Included in the Benchmark? Recommendation



Outpatient/Community-Based Service Claims Subcategories:

- Community Based Mobile Clinic Services
- Outpatient Professional PC
- Outpatient Professional Non-PC
- Outpatient Facility

Non-claims payments in other Expanded Framework categories:

A: Population Health and Practice Infrastructure Payments
B: Performance Payments
D: Capitation Payments (outpatient/community-based service subcategories only)

Discussion

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

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Next Steps

Margareta Brandt, Assistant Deputy Director

Tentative Timeline for Behavioral Health Work

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

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

X Provide Feedback ✓ Board Approval

Upcoming Topics

- OHCA to share draft claims code set for Workgroup input
- Continued discussion of behavioral health in primary care module
- Review of behavioral health spending data in California
- Continued discussion of behavioral health investment benchmark

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Adjournment

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Appendix

Example of Non-Claims Capitation Formula

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

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

Example: Rhode Island Behavioral Health Investment Benchmark

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

Spending obligation (benchmark):

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