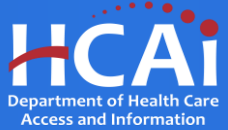
OHCA Investment and Payment Workgroup

March 18, 2026



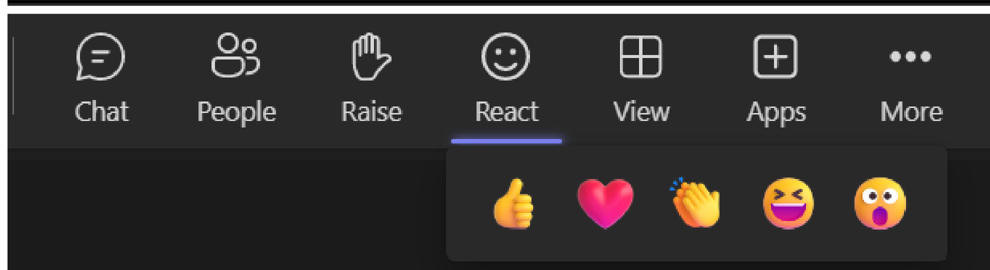
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:05 a.m.	**2.**	**Update on Data Submission Guide for 2026 Primary Care, Alternative Payment Model, and Behavioral Health Data Collection**
9:20 a.m.	**3.**	**Update on HCAI Primary Care Snapshot**
9:30 a.m.	**4.**	**Review of OHCA Behavioral Health Spending Measurement Methodology**
9:50 a.m.	**5.**	**Update on Health Care Payments Database (HPD) Behavioral Health Spending Analyses**
10:20 a.m.	**6.**	**Next Steps**
10:30 a.m.	**7.**	**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 quarterly
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: March 18, 2026

Time: 9:00 am PST

Microsoft Teams Link for Public Participation:
Join the meeting now

Meeting ID: 277 838 571 616 1
Passcode: Dm3cE6MV

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

Conference ID:
950 188 695#

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Dan Southard
Chief Deputy Director, Department of Managed Health Care

Update on Data Submission Guide for 2026 Primary Care, Alternative Payment Model, and Behavioral Health Data Collection

Margareta Brandt, Assistant Deputy Director

2026 OHCA Data Collection Regulations Timeline

Data Submission Guide (DSG) Proposed Changes for APM and Primary Care Files

Alternative Payment Model (APM) File

- Provided additional guidance on how member months are attributed based on member coverage.
- Streamlined instructions by reorganizing into step-by-step process for easier use.
- Added a process map illustrating how member expenses are reported in the APM file.

Primary Care File

- Clarified primary care spending methodology for non-claims payment subcategories.
- Clarified primary care spend is reported based on the claim line level.
- Updates to primary care code set.
    - *e.g.*, added "363A00000X Physician Assistant" to the list of taxonomy codes; added new CMS Advanced Primary Care Management codes to the list of service codes.
- Primary Care Code Set appendix replaced by standalone Primary Care Addendum.

Proposed Changes for APM and Primary Care Files – Medi-Cal Managed Care Plans Only

- Added reporting requirements clarifying which DHCS payments to include or exclude from measurement of primary care spending (numerator and denominator) and APM spending in the new Medi-Cal Payments Addendum.
  - *e.g.*, exclusion of pass-through payments; inclusion of Vaccines For Children (VFC) Program vaccine administration fees.
- In the primary care file, revised the methodology for claims payments to instruct managed care plans to use 274 file submitted to DHCS in the Annual Network Certification to determine whether a provider on a claim is designated as a primary care provider (for physicians, nurse practitioners, and physician assistants) in the payer's provider network.

New Behavioral Health File for 2026

- Data collection includes:
  - Medical claims and non-claims spending for behavioral health
    - Instructions for assigning claims spending to behavioral health
    - Allocation methodologies for non-claims payment subcategories
  - Pharmacy claims for behavioral health treatments
- Behavioral Health Addendum contains diagnosis, service, place of service, revenue, and national drug codes for behavioral health spend reporting.

Theme	Public Comment / Question Summary	OHCA Response
Alternative Payment Model File (APM)	Request for clarification on whether “link to quality” is based on the contractual payment arrangement or on the payment of a quality incentive to a provider.	OHCA plans to revise the instructions in Section 4.8 of the DSG to clarify that “link to quality” is based on member attribution to a payment arrangement where the participating provider is eligible for an adjusted non-claims payment based on specific predefined goals for quality. The participating provider does not need to successfully earn an adjusted non-claims payment for the payment arrangement to have a “link to quality”.
Alternative Payment Model File (APM)	Raises concern that Behavioral Health Capitation non-claims payment subcategory (D4) with only a quality link could result in a member's total medical expense being attributed to value-based care, potentially overstating payment transformation.	OHCA will not modify its APM methodology in DSG 3.0. OHCA recognizes this limitation of its APM methodology. OHCA's APM adoption goals are based on the percent of members in qualifying arrangements that have payments linked to quality. OHCA will continue to evaluate this issue and consider adjustments in DSG 4.0.
Alternative Payment Model File (APM)	Request to clarify whether fee-for-service (FFS) arrangements with quality-related incentives provided through increased fee schedule claims would be considered “linked to quality” and counted toward OHCA's APM Adoption Goals.	OHCA plans to revise the instructions in Section 4.8 of the DSG to clarify that FFS-only claims arrangements are never considered linked to quality, even in scenarios where FFS fee schedules are increased as a quality-related reward. In these arrangements, providers continue to be paid for each service delivered and the payment remains claims-driven. These arrangements shall be reported in the FFS-only category and do not count towards OHCA's APM Adoption Goals.

Theme	Public Comment / Question Summary	OHCA Response
Primary Care File	Recommendation that OHCA allow the use of a provider's primary taxonomy code associated with their National Provider Identifier (NPI) in National Plan and Provider Enumeration System (NPPES) when claim-level data is missing.	To ensure consistency and accuracy of provider classification, OHCA requires claim-level taxonomy codes to identify provider type and does not allow the use of NPIs to identify primary care providers. NPPES taxonomy derived from NPIs may not accurately reflect a provider's primary specialty and its use could misrepresent primary care providers and primary care spending.
Primary Care File	Request to remove Step 2 of the methodology for identifying primary care providers paid via claims, which maps providers to DHCS and DMHC provider network filings because the filings are point-in-time snapshots that may exclude providers who were active during the reporting year, potentially resulting in underestimation of primary care spending. Request to clarify which month's DHCS 274 file should be used in Step 2.	OHCA acknowledges that DHCS 274 and DMHC annual provider network review filings are point-in-time snapshots. However, OHCA will not modify Step 2, which was developed with extensive stakeholder input, as this step helps distinguish PCPs from providers with identical taxonomy codes who do not practice primary care. The request to remove Step 2 and use taxonomy codes alone would include providers who do not practice primary care, potentially resulting in overestimation of primary care spending. OHCA added language to DSG 3.0 clarifying that Medi-Cal Managed Care plans should use the January 274 file to attribute primary care spending for the prior year (e.g., January 2025 274 file applies to 2024 data submission).

Theme	Public Comment / Question Summary	OHCA Response
Primary Care File	Request to add urgent care as a place-of-service (POS) to measurement of primary care spending.	OHCA will not add urgent care as a place-of-service (POS) in the primary care reporting specifications because care delivered in this setting does not align with OHCA's vision for coordinated, comprehensive, integrated primary care. OHCA's decisions about which places of service to include as primary care were informed by extensive stakeholder engagement.
Primary Care File	Recommendation to include vaccine administration spending for Vaccines for Children (VFC) claims in primary care spending across all lines of business.	Vaccine administration fees are already included as primary care spending across all markets. The costs of vaccine doses are not included.

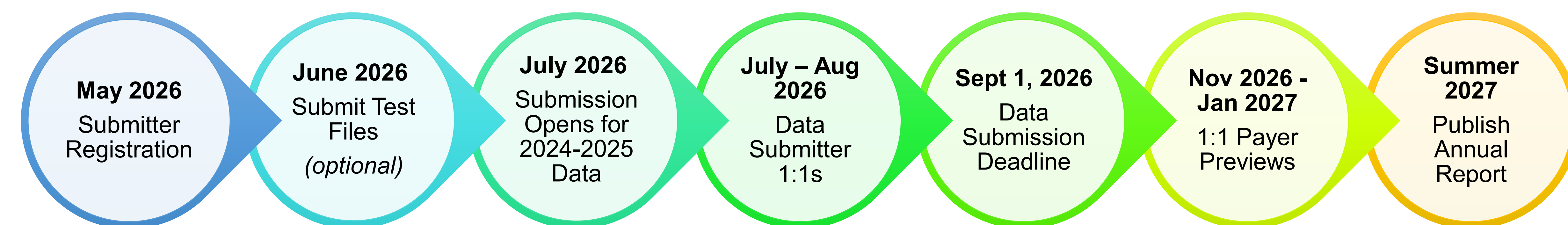
Theme	Public Comment / Question Summary	OHCA Response
Behavioral Health File	Concern that OHCA's definition of behavioral health spending may capture only a portion of behavioral health services hospitals provide, due to its requirement that claims have a behavioral health diagnosis as the primary diagnosis.	OHCA will not modify its definition of behavioral health spending, which requires a primary behavioral health diagnosis. This definition was developed with stakeholder input, including extensive discussion with the Investment and Payment Workgroup. OHCA does not count claims with secondary behavioral health diagnoses because this could significantly overcount behavioral health spending and it would increase administrative burden on submitters.
Behavioral Health Addendum	Request to add eight behavioral health treatment codes that are billable for behavioral health treatment for Medi-Cal members under 21 but were not included in OHCA's list of behavioral health services to be included in measurement for these members.	OHCA proposes to add four of the requested codes because the codes are consistent with other codes already included in the Addendum. OHCA declines to add the other four requested codes because the codes are not specific to behavioral health treatment without a behavioral health diagnosis. Including the codes would result in overcounting of non-behavioral health spending.

Theme	Public Comment / Question Summary	OHCA Response
Medi-Cal Payments Addendum	Request for the rationale for exclusion of Medi-Cal supplemental payments in the Medi-Cal Payments Addendum. Recommendation to include all Medi-Cal payments in total health care expenditure (THCE) reporting, noting exclusions such as Nonemergency Medical Transportation (NEMT), Non-Medical Transportation (NMT), Community Supports (CS), and Enhanced Care Management (ECM).	OHCA added the Medi-Cal Payments Addendum in response to questions from submitters about how to report certain Medi-Cal payment types during the 2025 data submission. The proposed Addendum ensures consistent and accurate reporting of specific Medi-Cal payments in the APM, Primary Care, and Behavioral Health files. OHCA already includes all Medi-Cal payments in the Statewide TME, Attributed TME, and Regional TME files. The NEMT and NMT payment exclusions in the Primary Care, Alternative Payment Model, and Behavioral Health files will be removed. OHCA plans to use THCE data submitted in 2026 to inform continued discussions with DHCS about future treatment of other Medi-Cal payments such as CS and ECM.

DHCS Feedback Incorporated

Theme	Feedback	OHCA Response
Behavioral Health Addendum	Request to reclassify certain poisoning codes as mental health or substance use disorder, to reflect intent of the poisoning event (e.g., intentional self-harm as mental health). Requests to include or exclude some codes that may not be considered mental health or services that may not be specific to behavioral health without a diagnosis.	OHCA updated the Behavioral Health Addendum to adopt the suggested reclassifications. OHCA reviewed and confirmed with DHCS which of the suggested codes to update in the Behavioral Health Addendum to align with OHCA's behavioral health definition and DHCS policies.
Primary Care Addendum	Request to add services that may be primary care and are commonly used in Medi-Cal at nursing and custodial care facilities. Request to add a column to the Primary Care Addendum to facilitate identification of codes that overlap with the Behavioral Health Addendum.	OHCA reviewed all suggested changes, and in consultation with DHCS made updates to the Primary Care Addendum when aligned with OHCA's primary care definition.

2026 OHCA Data Collection Timeline

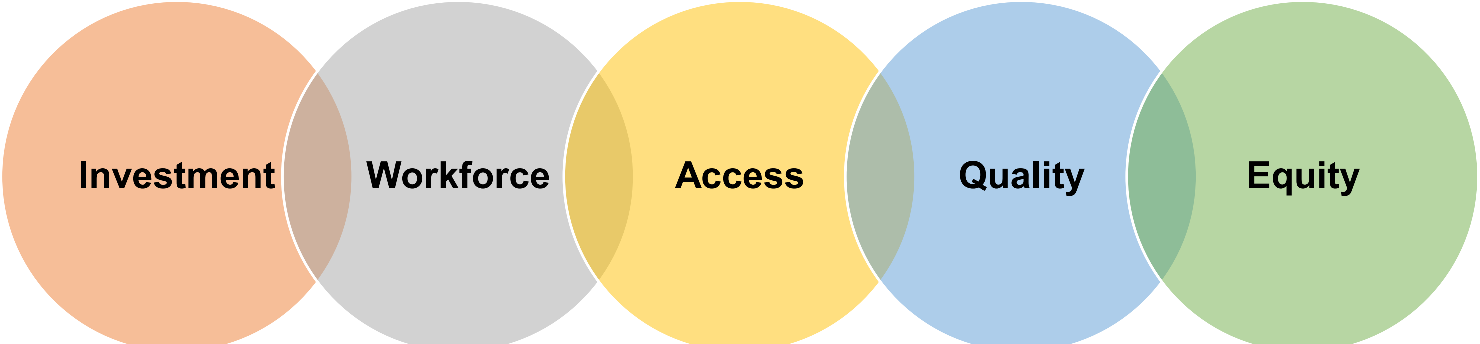


Update on HCAI Primary Care Snapshot

Miranda Werts, Senior Primary Care Specialist

Primary Care Snapshot Purpose and Approach

- Create a **shared understanding** of the health of California's primary care sector, both statewide and for geographic regions within the state, for an audience of **engaged stakeholders**
- **Track progress** toward equitable, high-quality, sustainable primary care for all Californians
- **Compile and report on data** from across HCAI and other sources to create a comprehensive picture of primary care in California using a **phased approach** that begins with a static report on the key domains and adds indicators and interactive features over time
- Monitor performance on **key elements of the health of primary care**, with a focus on **five key domains:**



Primary Care Snapshot Indicator Development

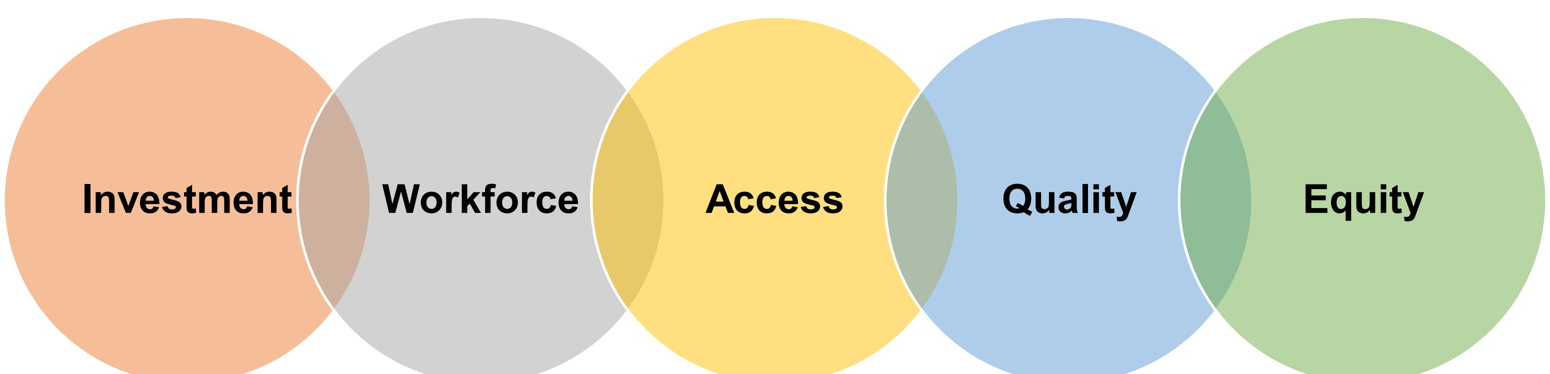
Criteria for state and national indicators for the Primary Care Snapshot

Is the indicator of interest to, and actionable for, California stakeholders?

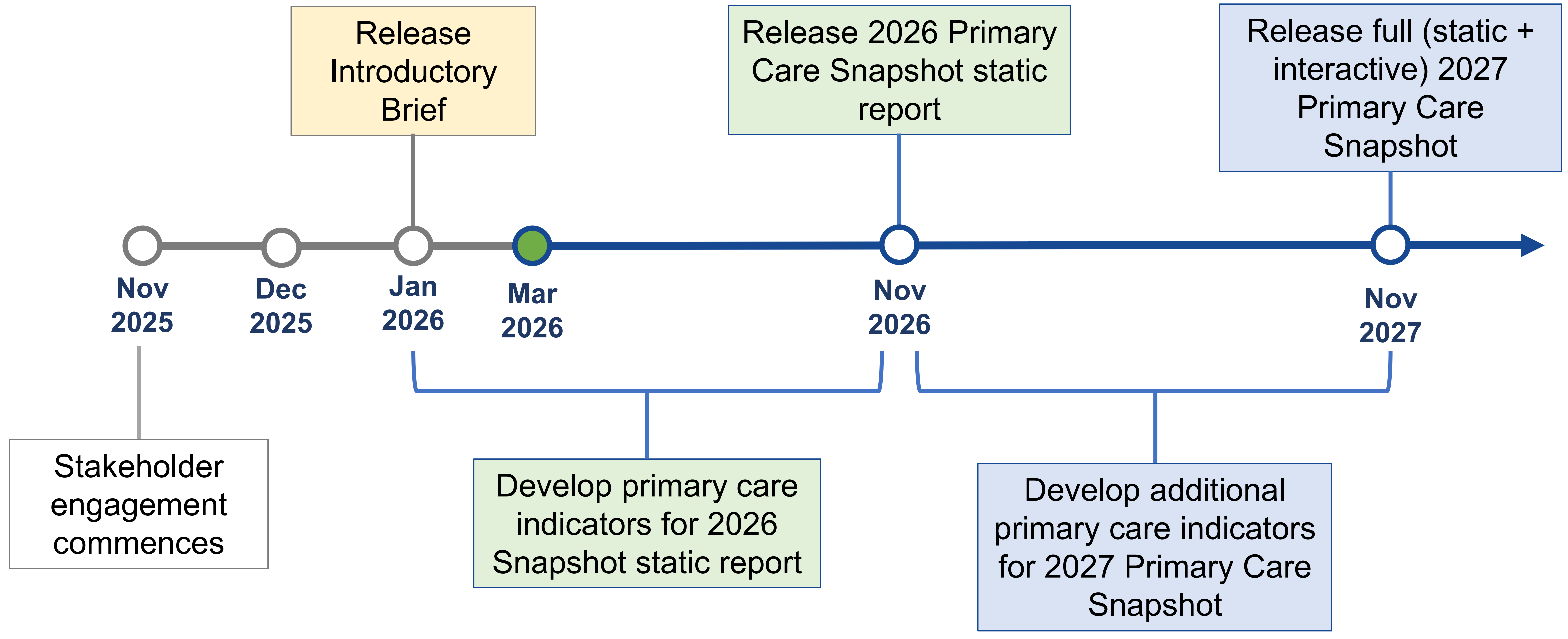
Is the indicator supported by existing, accessible, high-quality, California-specific data sources that can be tracked over time?

Does the indicator directly measure the strength of the primary care sector?

Does the indicator track change over time in the primary care sector, aligned with the five key domains?



Primary Care Snapshot Timeline



Access the brief via the HCAI Snapshot webpage: https://hcai.ca.gov/data/initiatives/health-of-primary-care-in-ca-annual-snapshot/

Review of OHCA Behavioral Health Spending Measurement Methodology

Debbie Lindes, Health Care Delivery System Group Manager

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.

Health and Safety Code § 127505

Prevalence of Behavioral Health Conditions

Prevalence of Mental Health Conditions in California Varies Across Populations

Prevalence of serious mental illness (adults) and serious emotional disturbance (children) inversely correlates to income level.[1]

Depressive mood disorders are most prevalent among Medicare beneficiaries, and among Californians over age 75 across all payers.[2]

Prevalence of serious mental illness varies by race and ethnicity, with highest rates among American Indian or Alaska Native Californians.[3]

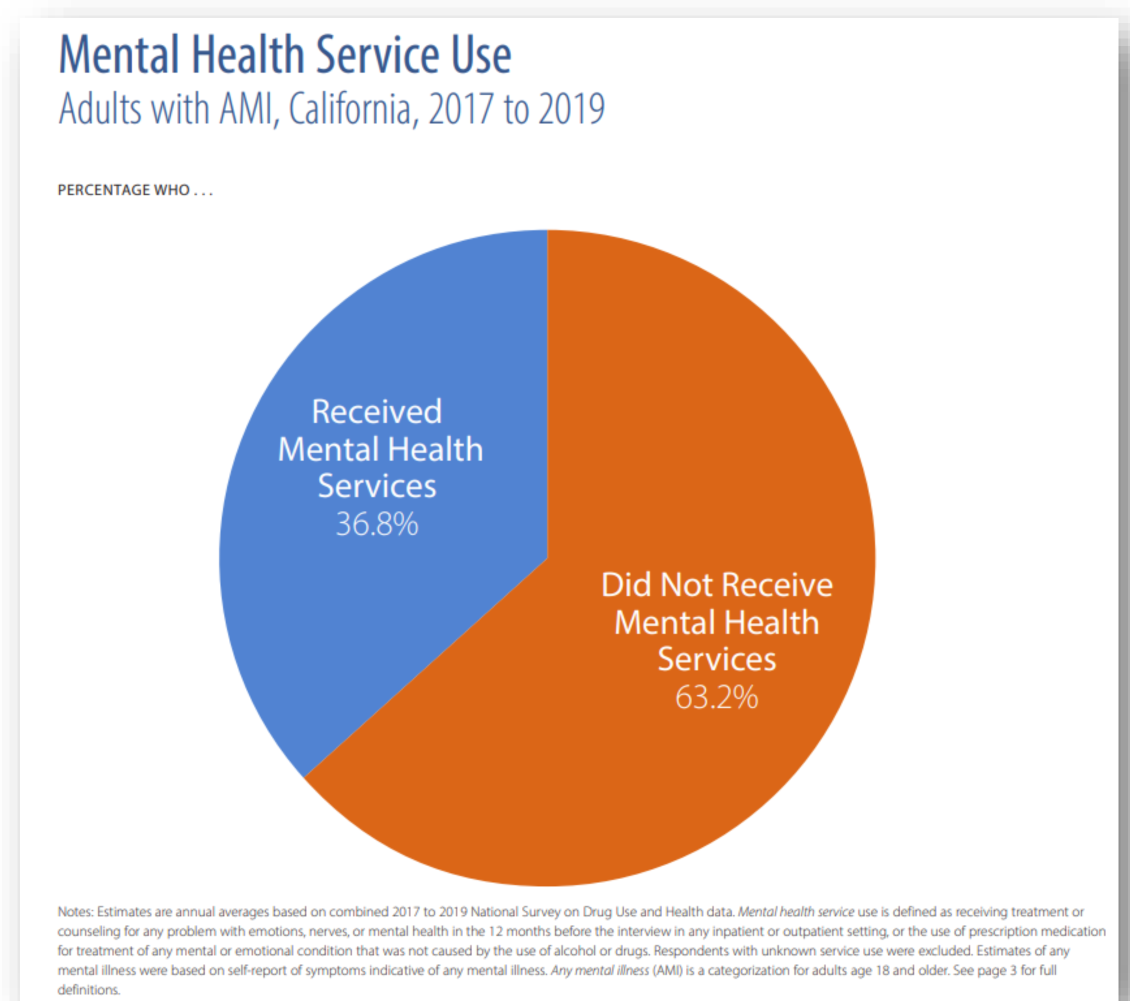
Between 2018-2020, about half of bisexual and transgender or gender non-conforming adults have suicidal thoughts.[4]

Between 2016 and 2017 in California, more than 1 in 4 Black pregnant people experienced depressive symptoms during the prenatal period.[5]

1. 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
2. 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/
3. 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
4. California Department of Public Health. "Demographic Report on Health and Mental Health Equity in California." October 2023. https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/HERSS/Demographic_Report_on_Health_and_Mental_Health_Equity_2023_ADA.pdf
5. 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

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

Prevalence of Substance Use Disorders in California Varies Across Populations

Between 2018 and 2019, Californians aged 18-25 had the highest prevalence of substance use disorders, across substances.[1]

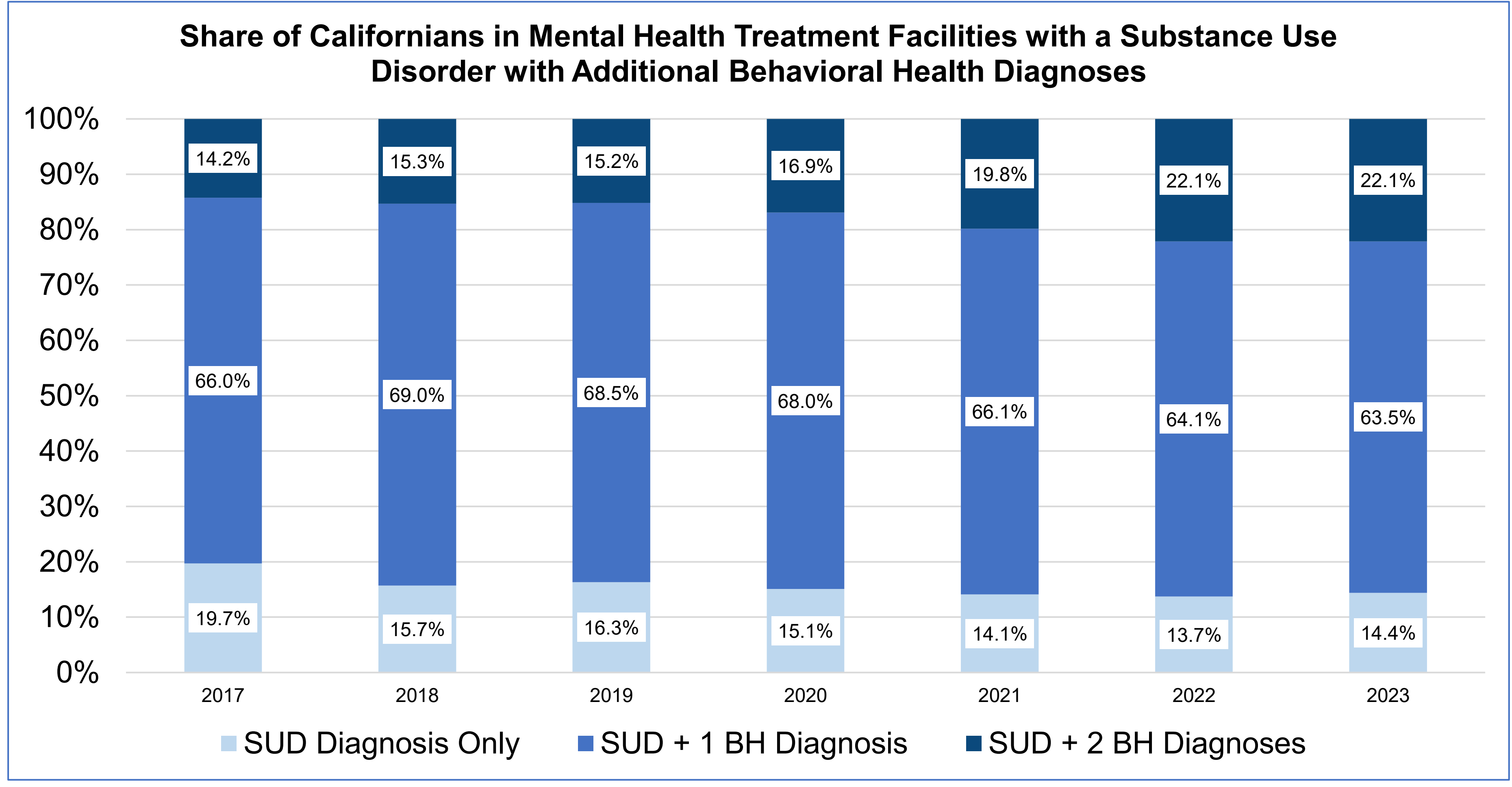
In 2023, opioid overdose deaths per 100,000 population were highest among American Indian and Alaska Native (47.2 deaths per 100,000) and Black Californians (33.7 deaths per 100,000).[2]

From 2017 to 2023, among Californians in mental health treatment facilities that report to individual state administrative data systems, the share with a mental health disorder decreased while the share with a substance use disorder increased.[3]

1. 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
2. “California Opioid Overdose Surveillance Dashboard," California Dept. of Public Health, last updated February 15, 2023. https://skylab.cdph.ca.gov/ODdash/?tab=Home
3. Substance Abuse and Mental Health Services Administration (SAMHSA), accessed March 2026. Mental Health Client-Level Data (MH-CLD), 2013-2023. https://www.samhsa.gov/data/data-we-collect/mh-cld-mental-health-client-level-data

Most Californians in Mental Health Treatment Facilities with a Substance Use Disorder Have More than One Behavioral Health Diagnosis

From 2013 to 2023, over 80% of Californians in mental health treatment facilities that report to individual state administrative data systems with a Substance Use Disorder had additional behavioral health diagnoses.



Substance Abuse and Mental Health Services Administration (SAMHSA), accessed March 2026. Mental Health Client-Level Data (MH-CLD), 2013-2023. https://www.samhsa.gov/data/data-we-collect/mh-cld-mental-health-client-level-data

Behavioral Health Spending Measurement & Potential Benchmark

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).

Out of Pocket Spending

Clinical Spending (claims + non-claims)

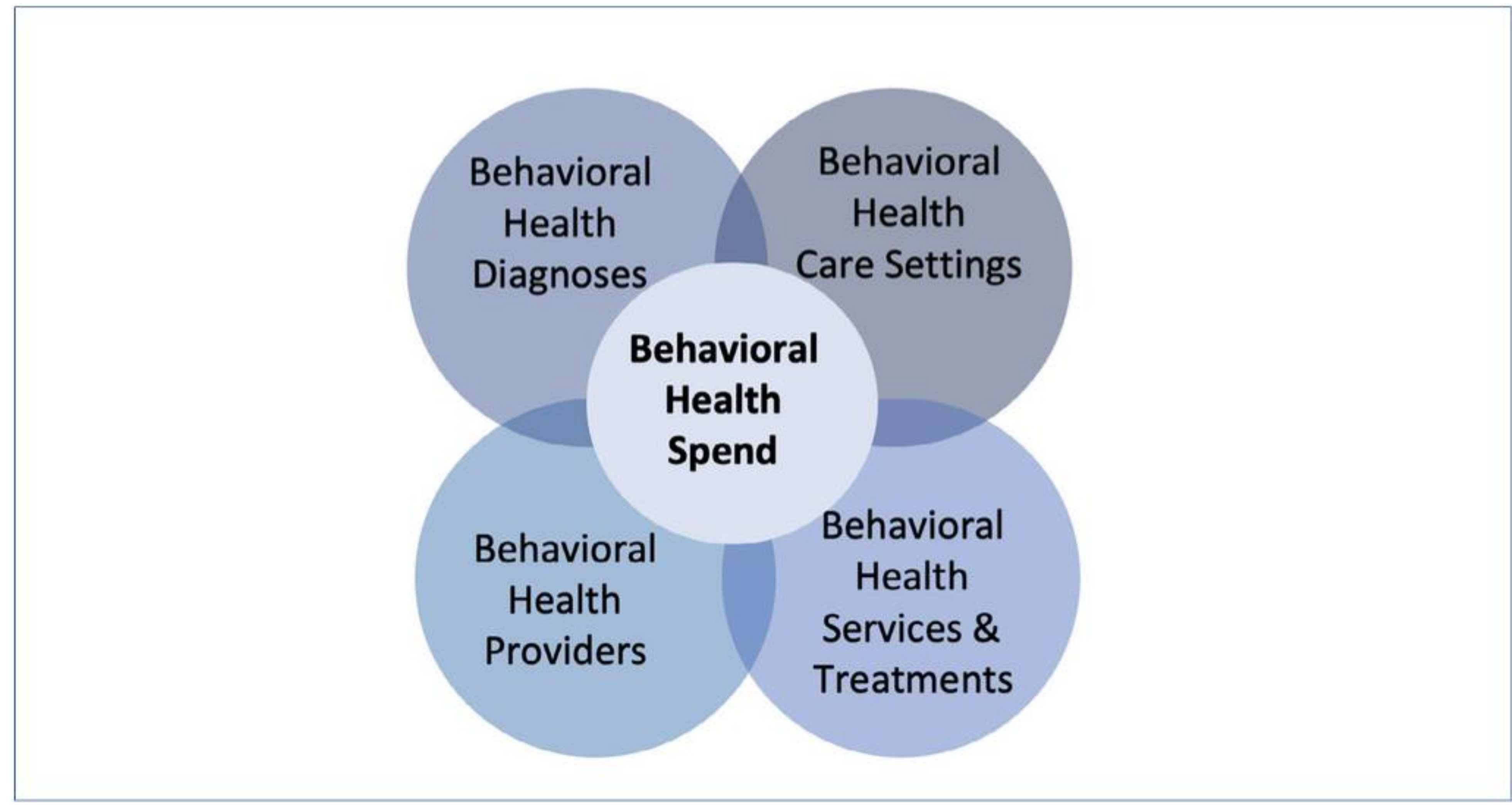
State Budget Spending

Social Supports Spending

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

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/

Defining Behavioral Health Spending



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.
   - For Medi-Cal members under 21 years old, claims for behavioral health services are included, regardless of diagnosis, to align with DHCS policies.
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.

Process Map for Identifying Behavioral Health (BH) Claims

DEFINING A BH CLAIM

Claim includes BH diagnosis as primary diagnosis?

Yes → BH Claim

No → Claim includes code for MH or SUD screening or assessment?

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

CATEGORIZING

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

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

DEFINING A PHARMACY CLAIM

Pharmacy claim includes NDC specified as BH treatment?

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

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

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

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.

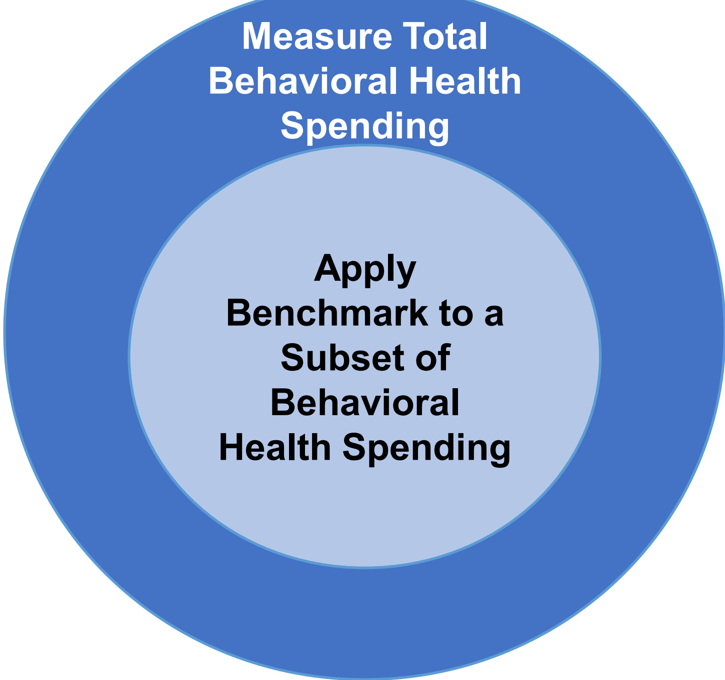
HCAI Expanded Non-Claims Payments Framework: https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

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



Example: Measurement vs. Benchmark

Measurement

Benchmark

Service Categories for Total Spend Measurement:

- Inpatient
- Emergency Department/Observation
- Residential
- Outpatient Facility and Professional, including
  - Primary Care
  - Telehealth
  - Community-based services

Potential Service Categories for Benchmark:

- Outpatient Facility and Professional (including Primary Care, Telehealth, Community-based Services)
- Behavioral health capitation payments and integrated behavioral health payments

Update on Health Care Payments Database (HPD) Behavioral Health Spending Analyses

Debbie Lindes, Health Care Delivery System Group Manager
Vinayak Sinha, Senior Consultant, Freedman HealthCare

Summary of Trends Between Milbank-FHC and OHCA Analyses

Behavioral health claims-based spending as a percent of total medical expense using OHCA's behavioral health definition is similar to estimates using the Milbank-Freedman definition previously reviewed.

Behavioral Health as a Percent of TME by Definition

Year	Definition	Mental Health	SUD	Total
2021	Milbank/Freedman BH	6.5%	0.9%	7.4%
2021	OHCA BH	6.6%	0.9%	7.5%
2022	Milbank/Freedman BH	6.7%	1.0%	7.7%
2022	OHCA BH	6.8%	0.9%	7.8%
2023	Milbank/Freedman BH	7.2%	1.0%	8.2%
2023	OHCA BH	7.3%	1.0%	8.2%

Data includes all commercial plans reporting to the HPD. HCAI is reviewing data for plans with behavioral health carved out to understand variation in behavioral health as a percent of total medical expense for full-service plans. Summed percentages may not equal the total due to rounding.

Commercial Behavioral Health Claims-Based Spend by Subcategory, 2018-2023

Behavioral Health (BH) Subcategory	Subcategory Spending as a % of Total Behavioral Health Spend					
	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	33%	36%	39%	38%	39%	44%
Pharmacy	22%	20%	18%	21%	20%	18%
Inpatient Facility	17%	16%	15%	14%	13%	11%
Residential	3%	5%	6%	6%	7%	7%
Other	7%	5%	5%	6%	6%	6%
Outpatient Facility	6%	6%	6%	7%	6%	6%
ED/Observation Facility	5%	4%	4%	4%	3%	3%
ED/Observation Professional	4%	4%	4%	3%	3%	3%
Outpatient Professional Primary Care	2%	2%	2%	2%	2%	2%
Inpatient Professional	1%	1%	1%	1%	1%	1%

Data includes all commercial plans reporting to the HPD. HCAI is reviewing data for plans with behavioral health carved out to understand variation in behavioral health as a percent of total medical expense for full-service plans. Summed percentages may not equal the total due to rounding.

Commercial Mental Health Claims-Based Spend by Subcategory, 2018-2023

Mental Health (MH) Subcategory	Subcategory Spending as a % of Total Behavioral Health Spend					
	2018	2019	2020	2021	2022	2023
Outpatient Professional Non-Primary Care	32%	36%	38%	37%	38%	43%
Pharmacy	21%	20%	17%	20%	20%	18%
Inpatient Facility	13%	12%	12%	10%	9%	8%
Other	7%	5%	5%	5%	5%	5%
Outpatient Facility	5%	5%	5%	5%	5%	5%
Residential	2%	3%	3%	3%	3%	3%
ED/Observation Facility	3%	3%	3%	2%	2%	2%
ED/Observation Professional	3%	3%	3%	3%	2%	2%
Outpatient Professional Primary Care	2%	2%	2%	2%	2%	2%
Inpatient Professional	1%	1%	1%	1%	1%	1%
Total MH Spend as a % of BH Spend	**89%**	**89%**	**88%**	**88%**	**88%**	**88%**

Data includes all commercial plans reporting to the HPD. HCAI is reviewing data for plans with behavioral health carved out to understand variation in behavioral health as a percent of total medical expense for full-service plans. Summed percentages may not equal the total due to rounding.

Commercial Substance Use Disorder Claims-Based Spend by Subcategory, 2018-2023

Substance Use Disorder (SUD) Subcategory	Subcategory Spending as a % of Total Behavioral Health Spend					
	2018	2019	2020	2021	2022	2023
Inpatient Facility	4%	4%	4%	3%	3%	3%
Residential	1%	2%	3%	3%	3%	3%
ED/Observation Facility	2%	2%	1%	1%	1%	1%
Outpatient Facility	2%	1%	1%	1%	1%	1%
ED/Observation Professional	1%	1%	1%	1%	1%	1%
Pharmacy	1%	1%	1%	1%	1%	1%
Other	0.4%	0.4%	1%	1%	1%	1%
Outpatient Professional Non-Primary Care	0.6%	0.6%	0.6%	0.6%	0.5%	0.6%
Inpatient Professional	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Outpatient Professional Primary Care	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%
Total SUD Spend as a % of BH Spend	**11%**	**11%**	**12%**	**12%**	**12%**	**12%**

Data includes all commercial plans reporting to the HPD. HCAI is reviewing data for plans with behavioral health carved out to understand variation in behavioral health as a percent of total medical expense for full-service plans. Summed percentages may not equal the total due to rounding.

Next Steps

Margareta Brandt, Assistant Deputy Director

Planned HPD Behavioral Health Analyses

- Priorities for benchmark development using HPD behavioral health spend analysis
  - What is the variation in spending and growth trends across markets and individual payers?
  - How does behavioral health spend differ by age and geography (Covered California regions)?
  - How do plan paid, member responsibility, and charge amounts differ for psychotherapy services when in network and out of network?
  - Are increases in spending driven more by increases in price or utilization?
- Effect of including secondary behavioral health diagnosis in behavioral health spending measurement
  - What would be in impact on total behavioral health spending?
  - What are the highest spend services when a claim has a secondary BH diagnosis?
  - What diagnoses are on claims that have both a primary and secondary BH diagnosis?

Next Steps

- Next meeting: May 20th, 2026
- Upcoming topics
  - Primary care and alternative payment model (APM) data analyses
  - Additional behavioral health spending analyses
  - Discuss recommendations to OHCA Board for behavioral health investment benchmark
  - APM adoption and primary care investment best practices

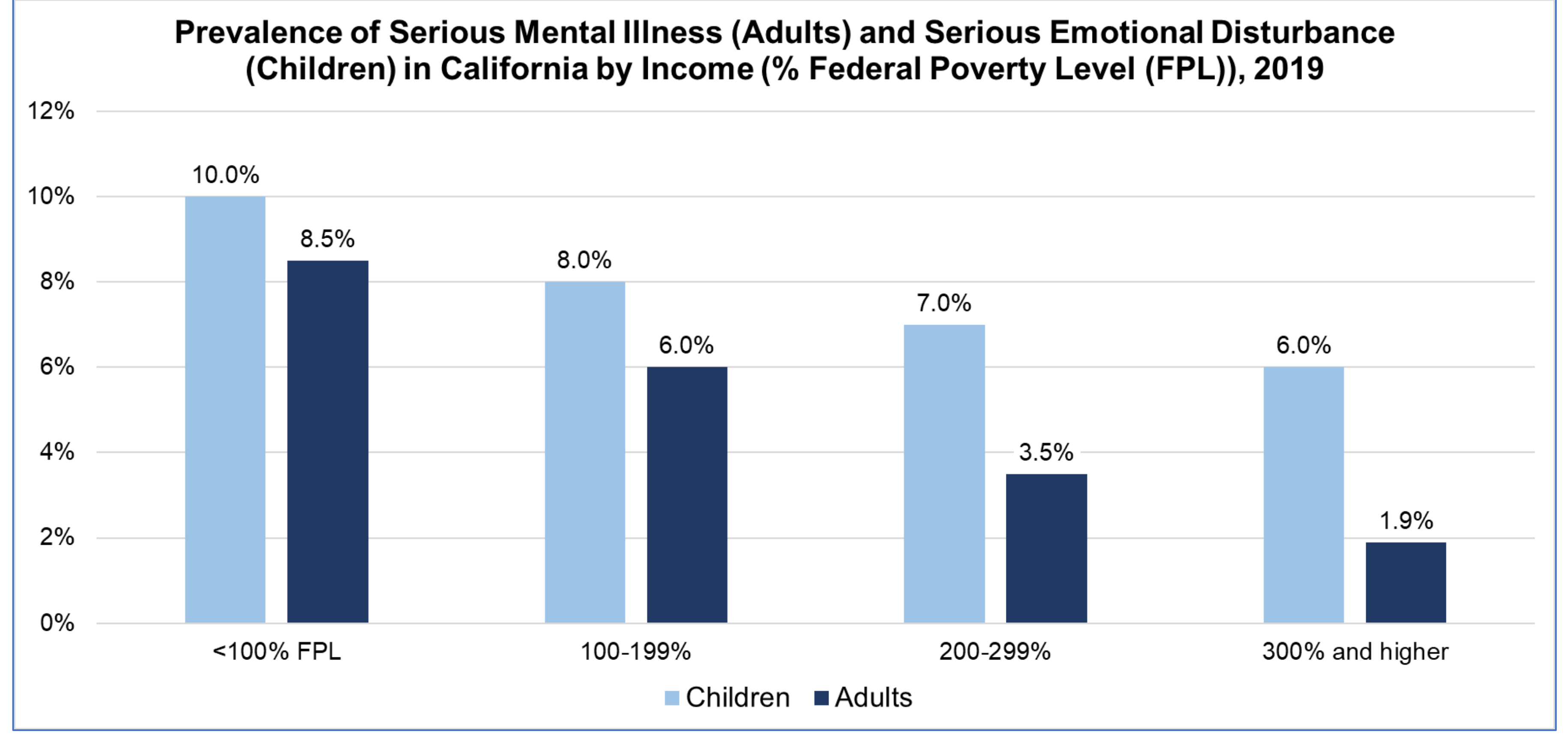
Adjournment

Margareta Brandt, Assistant Deputy Director

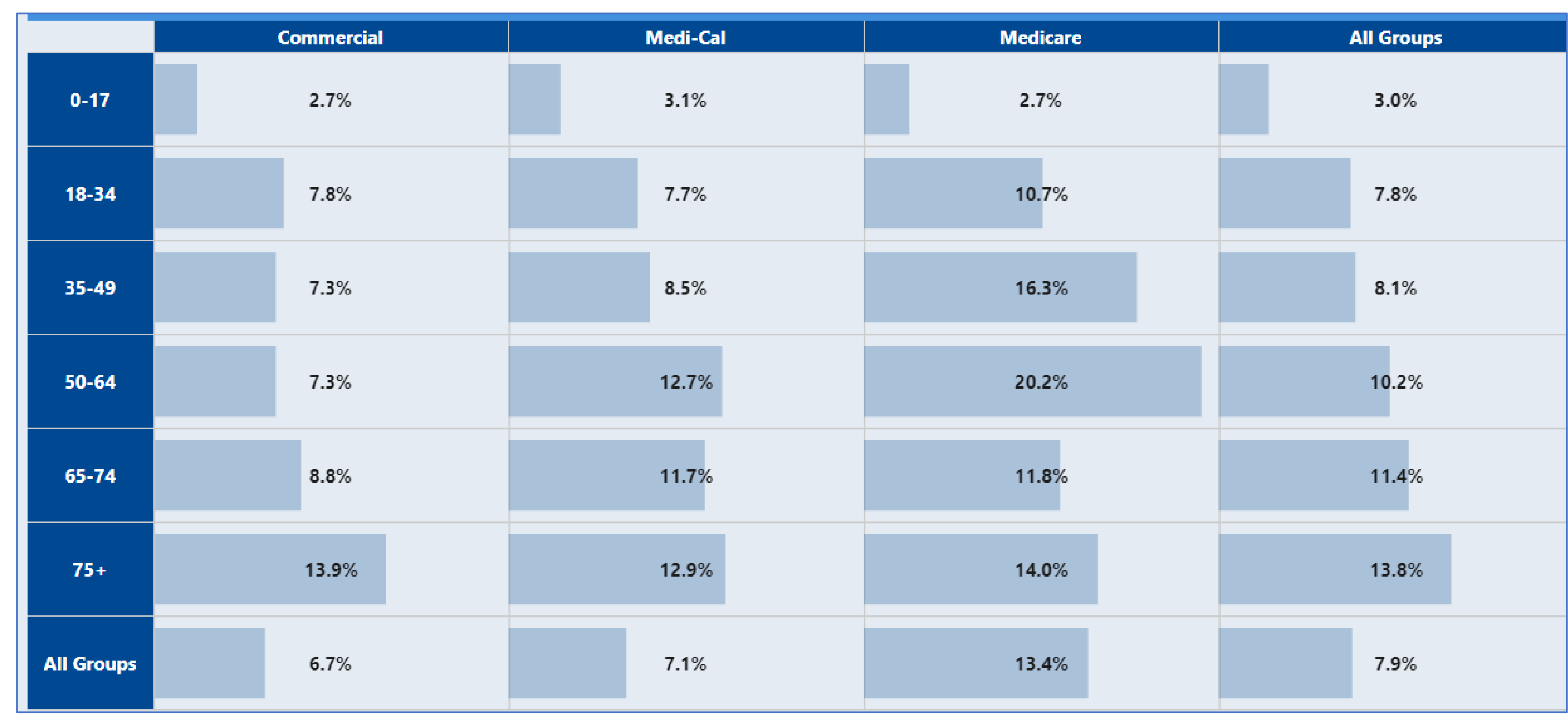
Appendix

Serious Mental Illness and Serious Emotional Disturbance by Income

The prevalence of Serious Mental Illness among adults and Serious Emotional Disturbance among children was inversely correlated with income in California in 2019.



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%

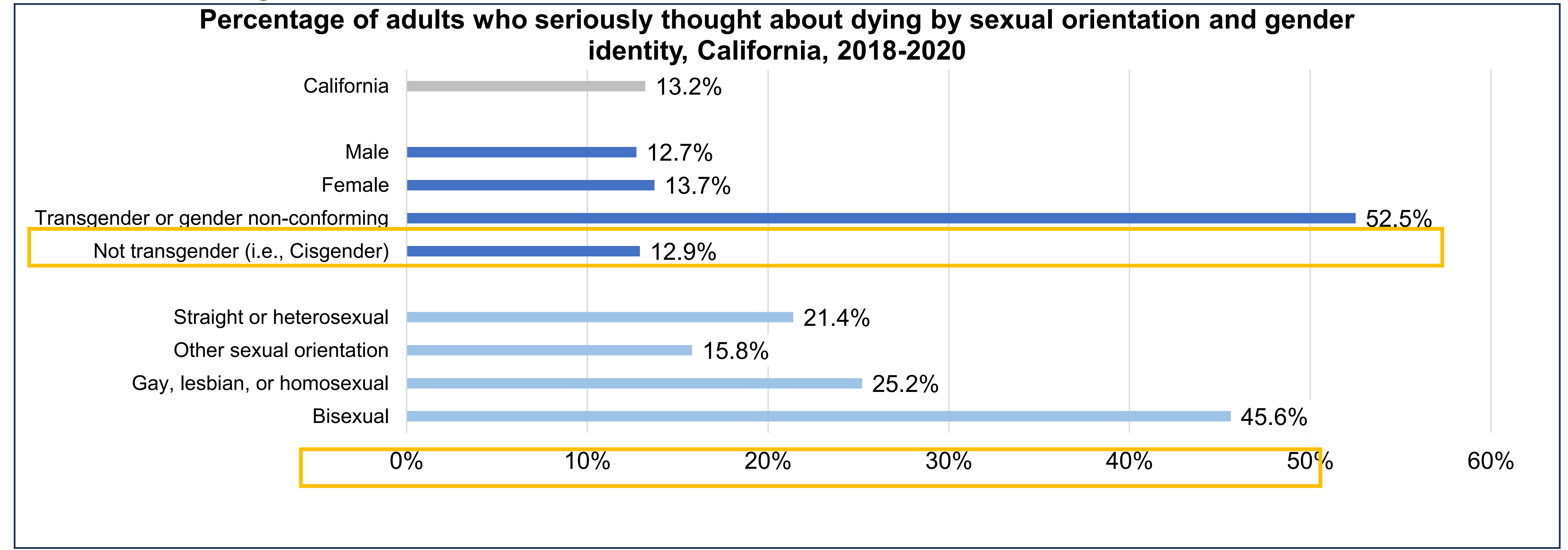
Medicare beneficiaries had the highest rates of depression, bipolar, and other depressive mood disorders.

Across all markets, 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.



California Department of Public Health. "Demographic Report on Health and Mental Health Equity in California." October 2023. https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/HERSS/Demographic_Report_on_Health_and_Mental_Health_Equity_2023_ADA.pdf

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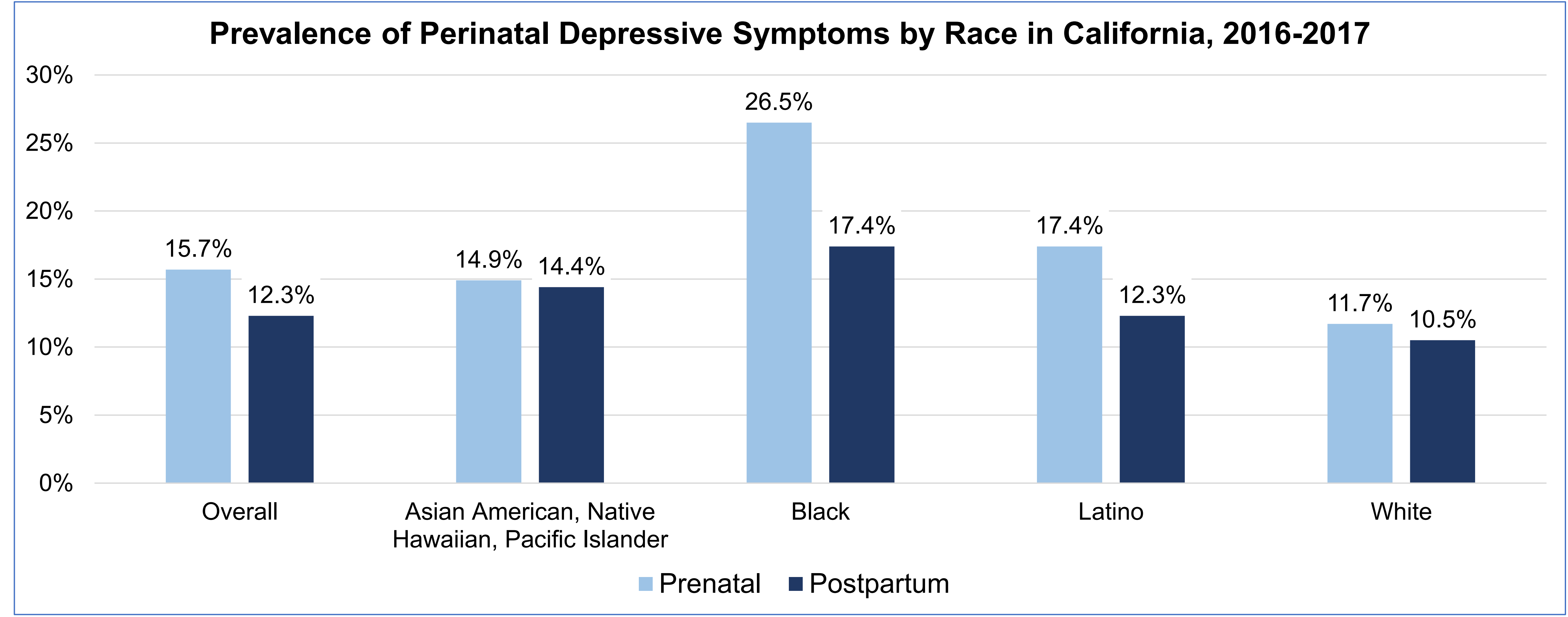
Maternal Mental Health

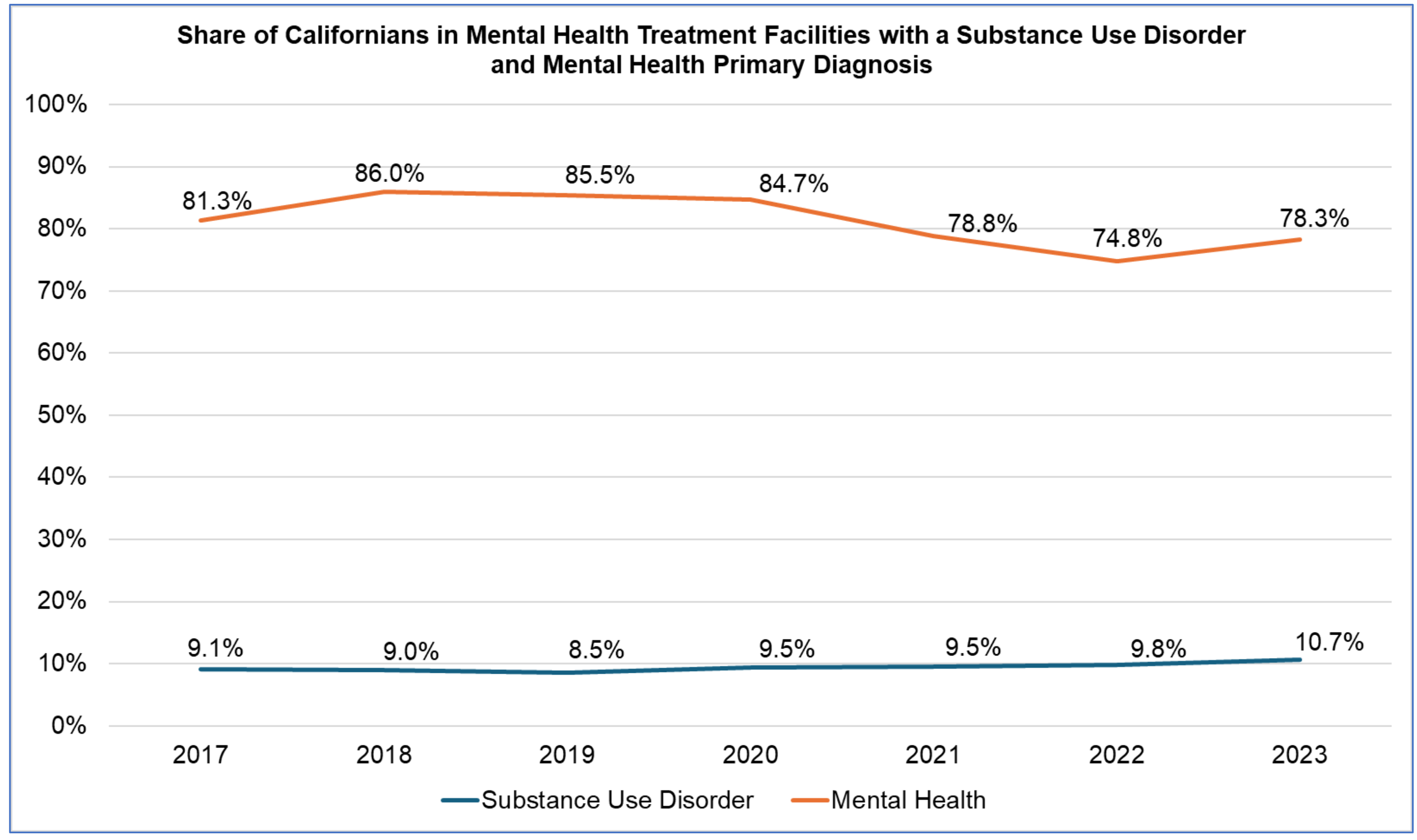
Between 2016 and 2017 in California, more than 1 in 4 Black pregnant people experienced depressive symptoms during the prenatal period.



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

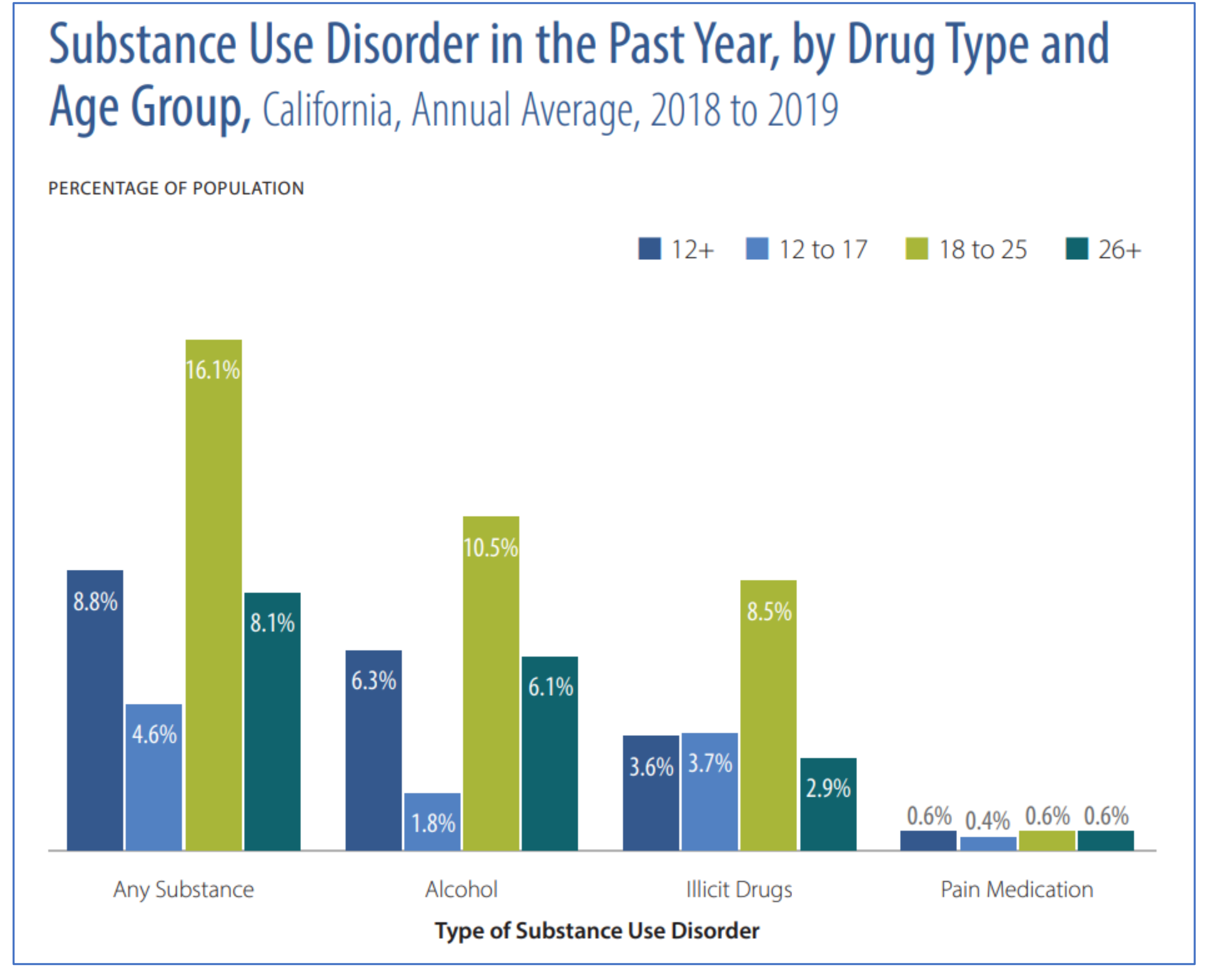
Share of Californians in Mental Health Treatment Facilities with a Substance Use Disorder or Mental Health Disorder

From 2017 to 2023, among Californians in mental health treatment facilities that report to individual state administrative data systems, the share with a mental health disorder primary diagnosis decreased while the share with a substance use disorder primary diagnosis increased.



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

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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.