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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

May 21, 2025

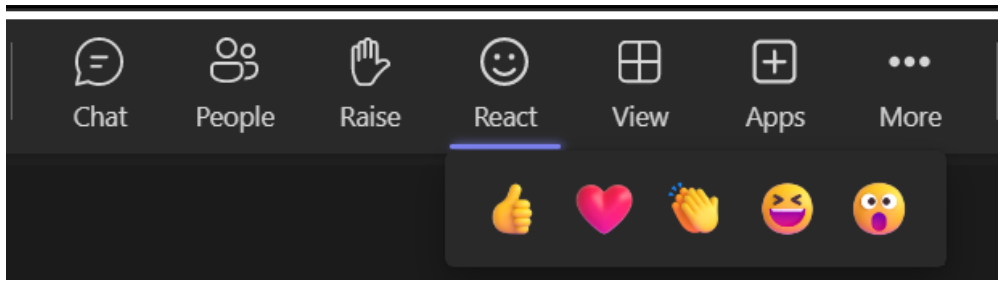
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Behavioral Health Spend Analysis**
9:45 a.m.	**3.**	**Behavioral Health Investment Benchmark Proposal**
10:10 a.m.	**4.**	**Feedback on Behavioral Health Code Set**
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: May 21, 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

Stephanie Berry, MA
Government Relations Director, Elevance Health (Anthem)

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

Primary Care & Behavioral Health Investments

Statutory Requirements

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

Primary Care & Behavioral Health Investments

Statutory Requirements

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

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

Timeline to Board Adoption of Behavioral Health Investment Benchmark

Apr

- Workgroup discussed key decisions

May

- **Workgroup reviews data and OHCA benchmark proposal**

June

- Board reviews data and Workgroup progress
- Advisory Committee and Workgroup review OHCA benchmark recommendation
- Release recommendation for public comment

July

- Board reviews recommendation and public comments

Aug

- OHCA revises recommendation
- Board votes on final recommendation

Benchmark Adopted August 2025

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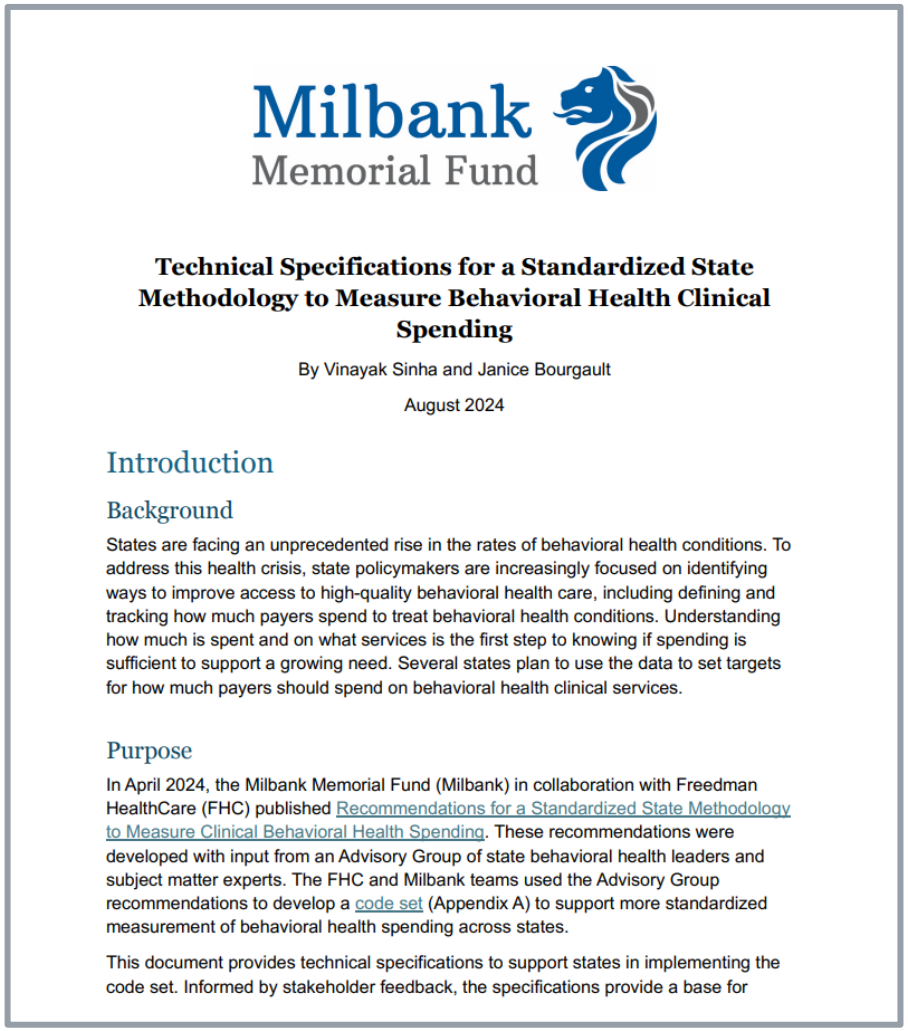
Behavioral Health Spend Analysis

Margareta Brandt, Assistant Deputy Director

Background and Purpose

- HCAI's Healthcare Payments Data (HPD) program team analyzed claims data (2018-2023) to determine behavioral health spending based on a standardized methodology developed by the Milbank Memorial Fund
- This information provides OHCA with a preliminary understanding of baseline behavioral health spending, including mental health (MH) and substance use disorder (SUD) spending



Milbank Memorial Fund

Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending

By Vinayak Sinha and Janice Bourgault

August 2024

Introduction

Background

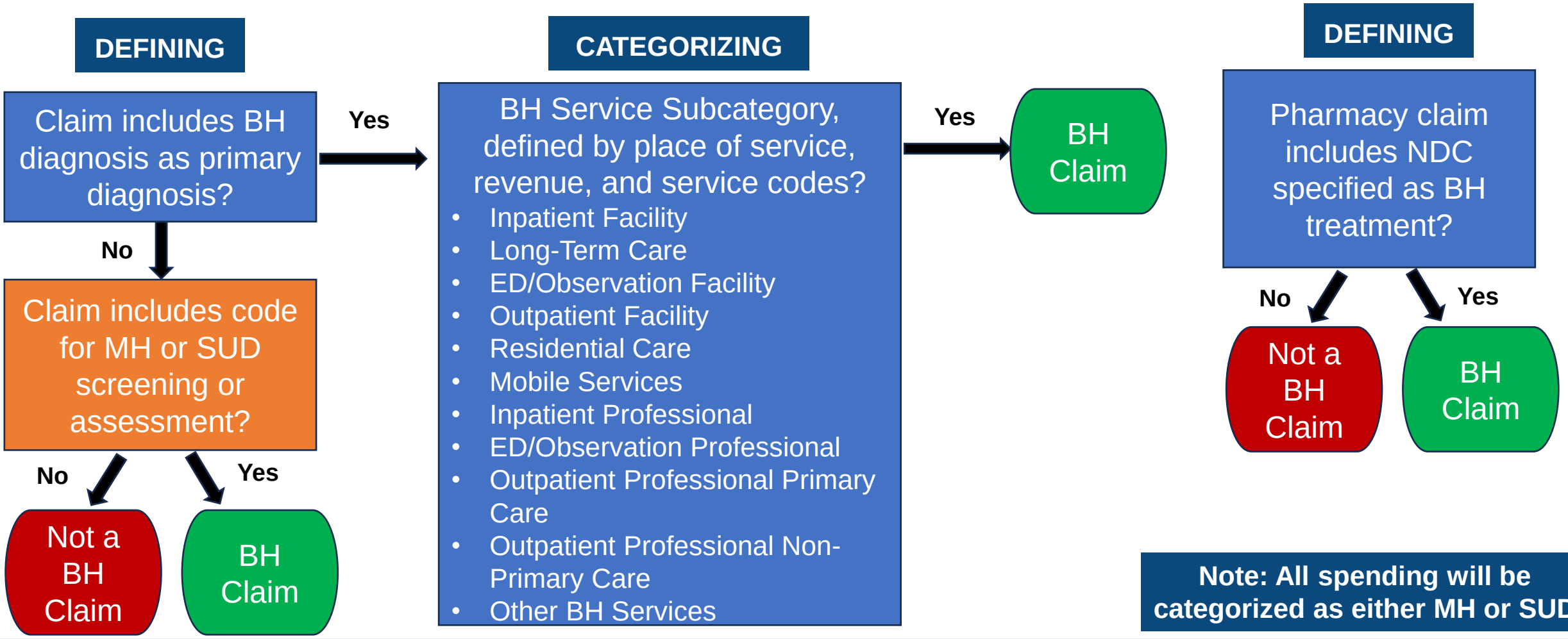
States are facing an unprecedented rise in the rates of behavioral health conditions. To address this health crisis, state policymakers are increasingly focused on identifying ways to improve access to high-quality behavioral health care, including defining and tracking how much payers spend to treat behavioral health conditions. Understanding how much is spent and on what services is the first step to knowing if spending is sufficient to support a growing need. Several states plan to use the data to set targets for how much payers should spend on behavioral health clinical services.

Purpose

In April 2024, the Milbank Memorial Fund (Milbank) in collaboration with Freedman HealthCare (FHC) published Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending. These recommendations were developed with input from an Advisory Group of state behavioral health leaders and subject matter experts. The FHC and Milbank teams used the Advisory Group recommendations to develop a code set (Appendix A) to support more standardized measurement of behavioral health spending across states.

This document provides technical specifications to support states in implementing the code set. Informed by stakeholder feedback, the specifications provide a base for

Process Map for Identifying Behavioral Health (BH) Claims

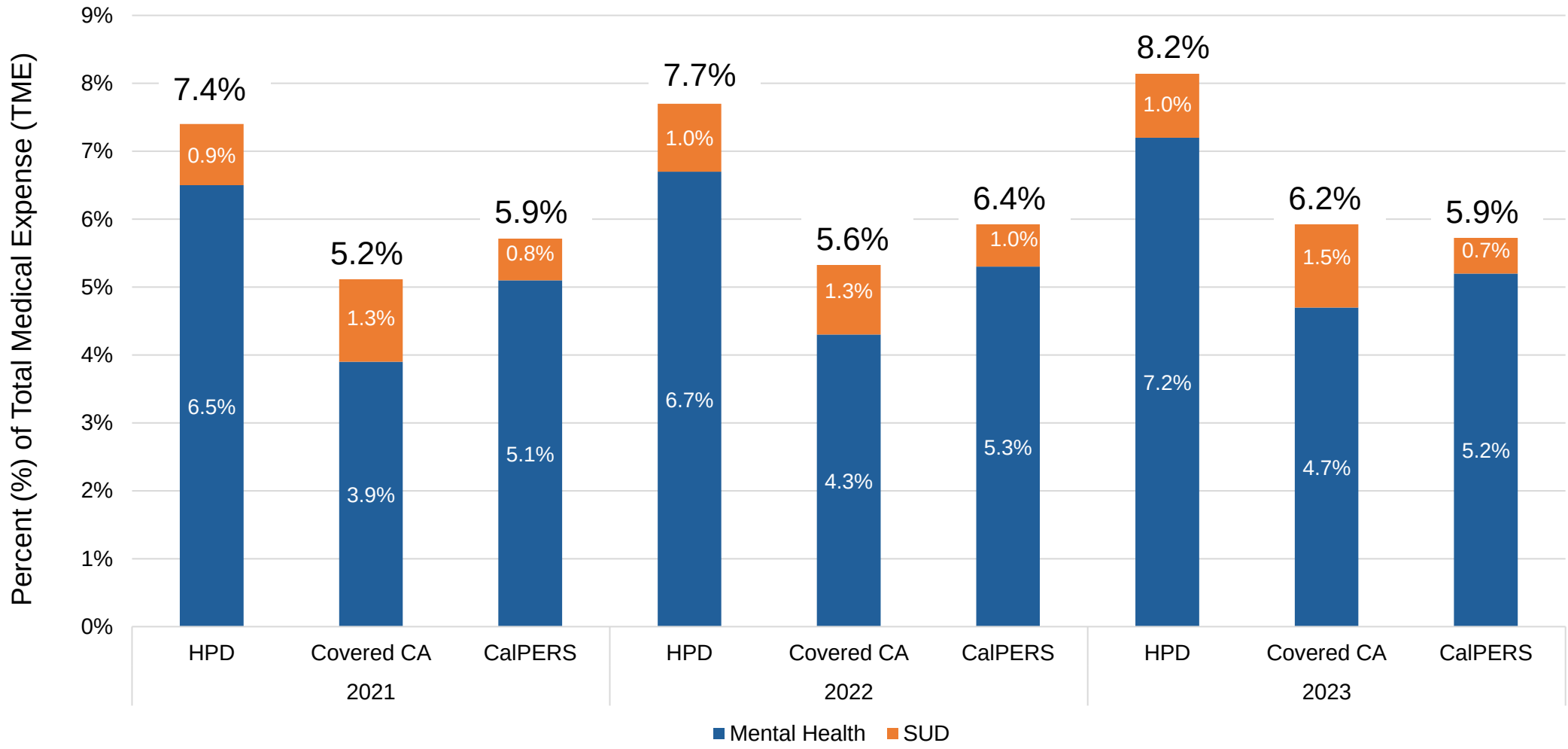


Note: All spending will be categorized as either MH or SUD

HPD Data Analysis – Methodology Details

- HPD spending analysis presented here is limited to Commercial market
- Spending analysis was performed on claims data with associated spending in the HPD
  - Type of payment arrangements include fee-for-service, percent of charges, diagnostic relative groups, pay for performance, and global and bundled payments arrangements
- Covered California and CalPERS conducted similar analyses with their data
- Results presented today are preliminary

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



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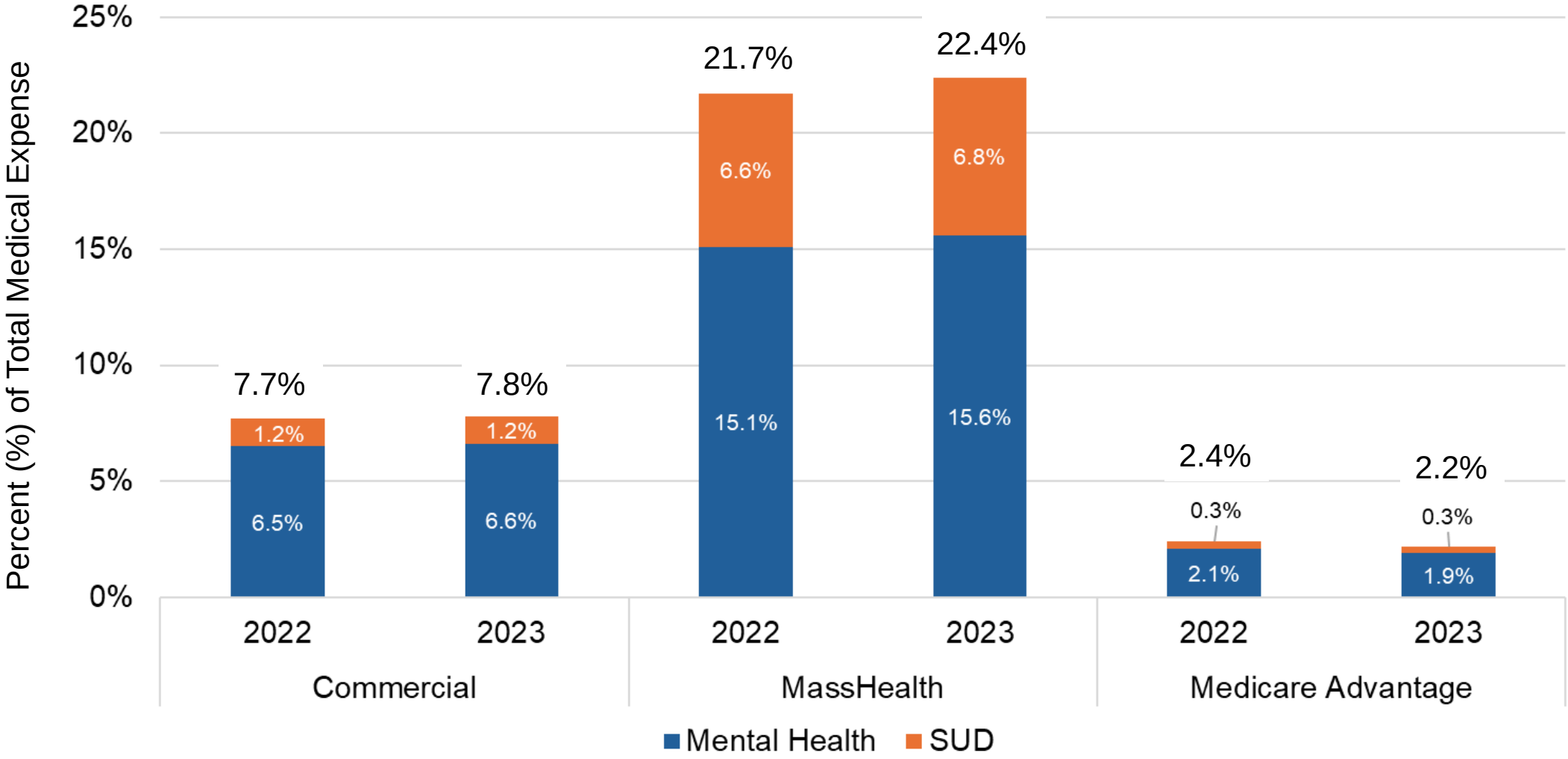
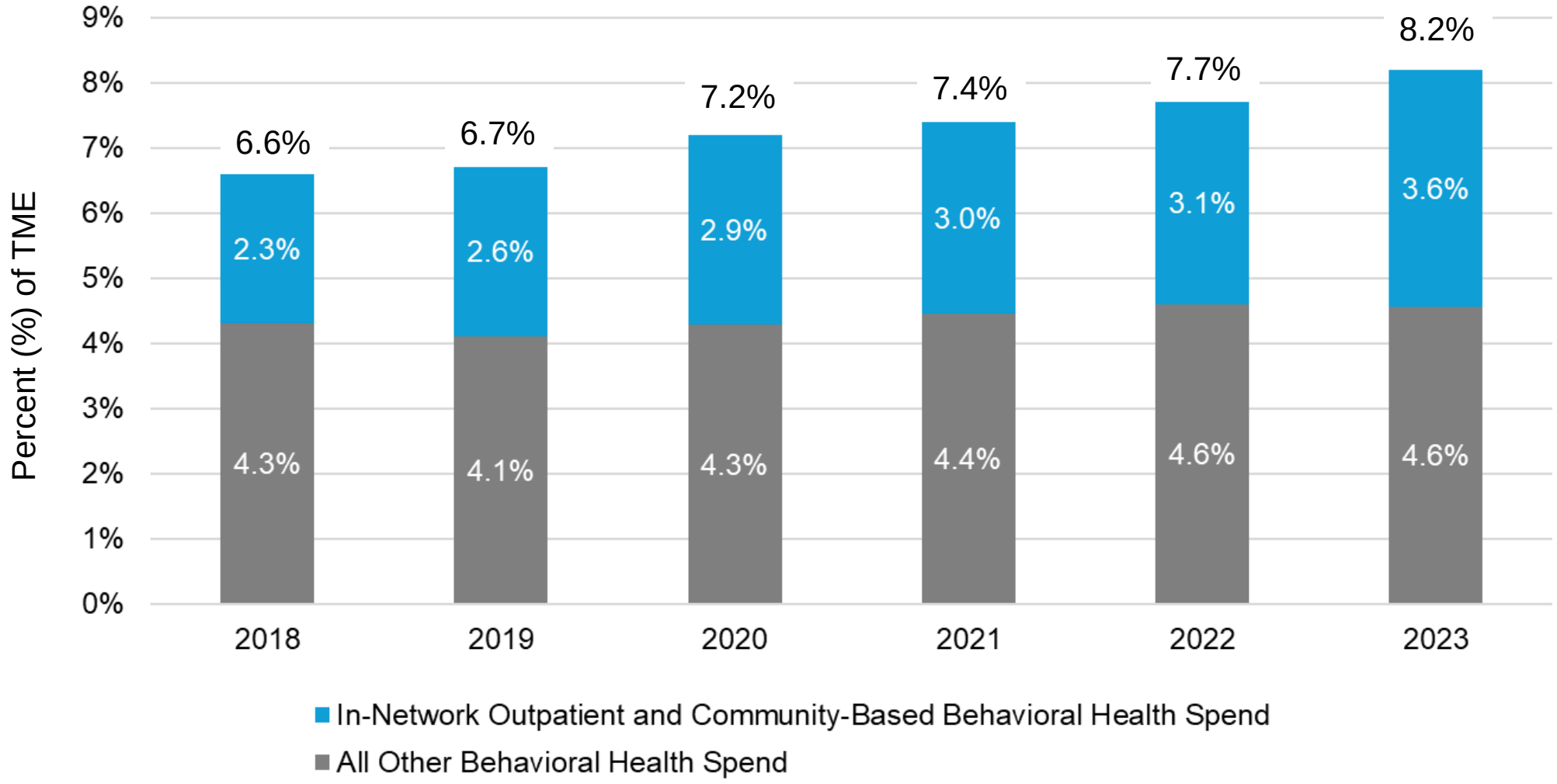
Example: Massachusetts BH Spend as a % of TME 2022-2023

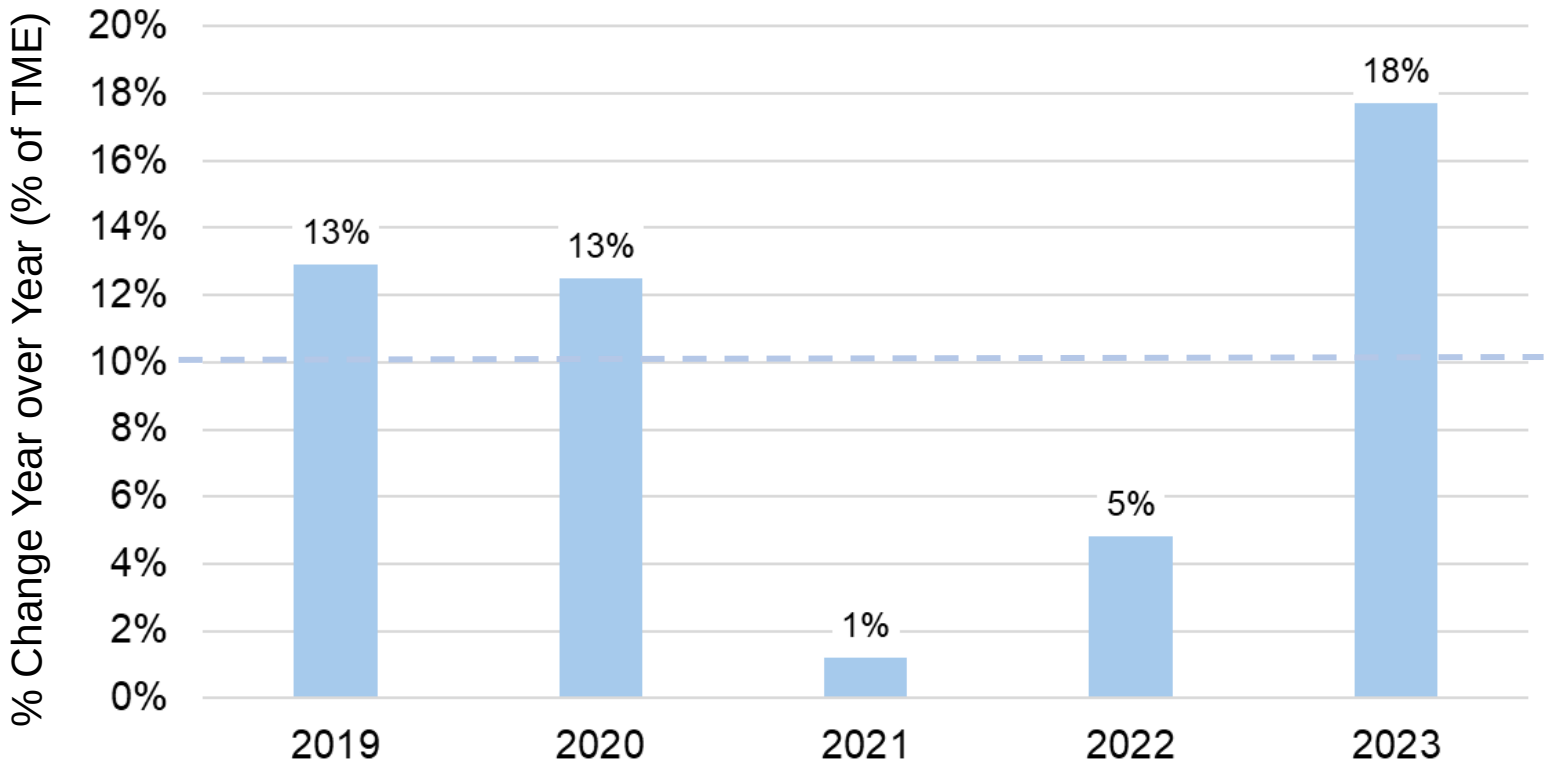


Source: Massachusetts Center for Health Information and Analysis. Primary Care and Behavioral Health Care (PCBH) Spending CY 2022 and CY 2023 Databook. https://www.chiamass.gov/primary-care-and-behavioral-health-care-pcbh-expenditures

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



Annual Change in Commercial In-Network Outpatient and Community-Based Behavioral Health Spending: % of TME



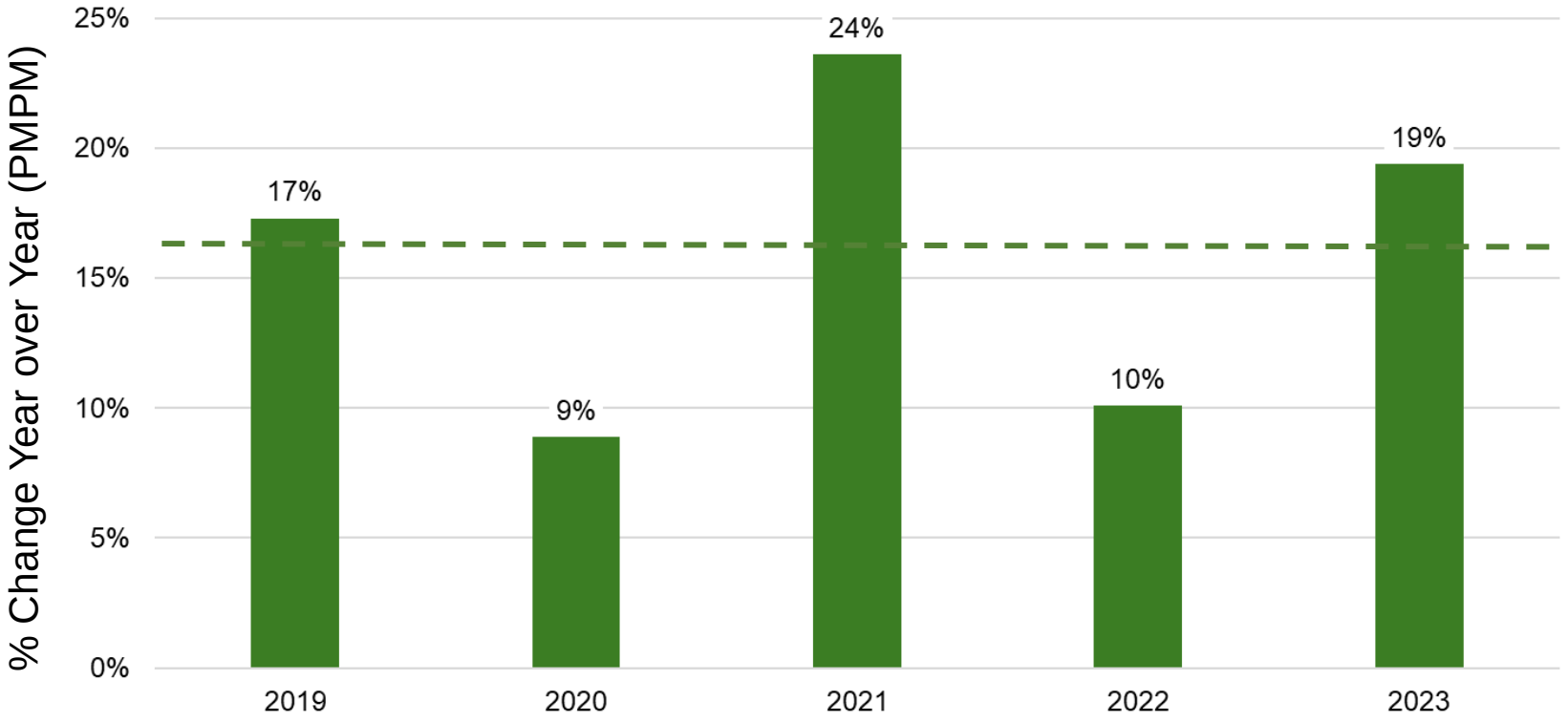
Increases reflect relative rates of change in

- Spend for outpatient/ community-based behavioral health services (numerator), and
- Total medical expenses (denominator)

Shows slower growth than when measured as PMPM increase (next slide)

Preliminary analysis of HPD data
Note: Dotted line represents average YoY change across all five years.

Annual Change in Commercial In-Network Outpatient and Community-Based Behavioral Health Spending: PMPM



- Increases reflect rate of change in spend for outpatient/community-based behavioral health services not due to membership changes
- Change in total medical expense is not a factor in this measure

Preliminary analysis of HPD data
Note: Dotted line represents average YoY change across all five years.

Potential additional analyses

This analysis provides a preliminary understanding of baseline behavioral health spending but does not answer questions about the drivers of this spending.

OHCA is considering conducting supplemental analyses to better understand drivers of in-network, outpatient and community-based behavioral health spend. Examples include:

- Are particular services or diagnoses driving the trend?
- Is it driven more by increases in price or utilization?
- What is the variation in spending and growth in spending across payers?

Discussion

- What strikes you as interesting or surprising in the data?
- Is there anything in the data that affects how you would want to structure the benchmark?
- What supplemental analyses would be helpful to inform the benchmark?

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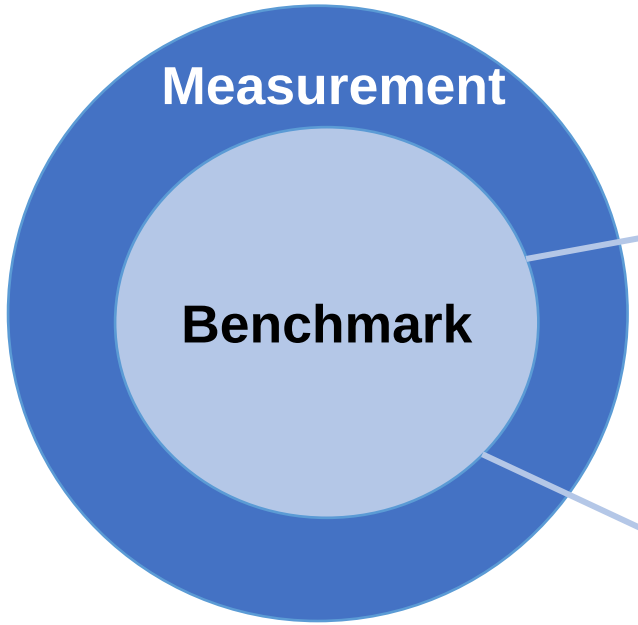
Behavioral Health Investment Benchmark Proposal

Debbie Lindes, Health Care Delivery System Group Manager

What is Included in the Proposed Benchmark?



Outpatient/Community-Based Service Claims Subcategories:

- Community Based Mobile Clinic Services
- Outpatient Professional Primary Care
- Outpatient Professional Non-Primary Care
- Outpatient Facility

Non-claims payments in Expanded Framework categories:

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

Investment and Payment Workgroup: Input on Key Decisions from April Meeting

1. Percentage of total spending or per member per month?
   - Preference for per member per month in benchmark, but also strong support for measuring and reporting both measures

2. Incremental or long-term improvement, or both?
   - Preference for both

3. Time Horizon
   - Ideally, aligned with primary care investment and alternative payment method adoption benchmarks

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

Benchmark Proposal: Phase 1 (2025-2029)

- Each payer is required to increase per-member, per-month spending on in-network outpatient and community-based behavioral health care by a set percentage for the performance years (PY) 2026-2029
  - Target for percentage increase informed by pre-benchmark trends
- Baseline is individual payer's spending in PY 2025, by line of business (commercial, Medicare Advantage)
- OHCA will assess each payer’s performance against the benchmark annually
- In 2029, OHCA will use PY 2027 data to assess each payer’s performance against the benchmark and to inform future benchmarks

Benchmark Proposal: Phase 2 (2030-2034)

- Informed by 2029 assessment of 2027 data, OHCA will update the benchmark for the next five years (2030-2034)
- Reset annual incremental improvements, informed by payers' reported performance
- May include long-term spending benchmark across all payers for 2034, aligned with timeframe for primary care investment and alternative payment method adoption benchmarks
- Plan to incorporate benchmarks for Medi-Cal

Rationale

- Increasing spend on in-network outpatient and community-based behavioral health care is desirable
    - Overall, and as a share of total behavioral health spend and of total medical expense
- Preliminary analysis indicates these subcategories of behavioral health spending have been growing 15% per member, on average, each year without a benchmark

However….

OHCA lacks insight into the drivers and variability in the recent spending increases

OHCA lacks information about individual payers' starting points

Unlike primary care, there is a dearth of research or experience about the "right" level of behavioral health spending to aim for

Therefore,

Setting an improvement benchmark using each payer's 2025 spending as a baseline is a good place to start

Data from 2026-2029 experience will fill information gaps and allow for longer term benchmark-setting

Phase 1 Benchmark Options: Commercial Per Member Per Month Spend

Examples of benchmark rate increases for in-network behavioral health spending PMPM in Performance Years 2026-2029.

	Annual Percentage Increase Benchmark		
	10%	15%	20%
Baseline (PY 2025)	$18.32	$18.32	$18.32
PY 2026	$20.15	$21.07	$21.98
PY 2027	$22.16	$24.22	$26.38
PY 2028	$24.38	$27.86	$31.65
PY 2029	$26.82	$32.04	$37.98
Cumulative Spend Increase %	46%	75%	107%

The baseline level is the actual PMPM from 2023 HPD data for commercial payers, updated to 2025 using the average annual increase in PMPM from 2018 through 2023.

Example: Report Spend as Either PMPM Amount or as Percentage of Total Medical Expense

	15% Annual Increase in PMPM	
	PMPM	% TME
Baseline (PY 2025)	$18.32	4.58%
PY 2026	$21.07	5.08%
PY 2027	$24.22	5.66%
PY 2028	$27.86	6.31%
PY 2029	$32.04	7.05%

Assumptions:

- 2026-2029 Total Medical Expense increases at rate of spending growth target
- 2026-2029 Outpatient/Community-Based spend increases 15% per year while other BH reporting categories do not exceed OHCA's statewide health care spending target

Behavioral Health Investment Benchmark Timeline

Data Year	Data Submission Year	Report Release Year
2024-2025	2026	2027
2025-2026	2027	2028
2026-2027	2028	2029
2027-2028	2029	2030
2028-2029	2030	2031

- When OHCA updates the benchmark in 2029, only data through Performance Year 2027 will be publicly available
- Payers can monitor their own performance in nearly real time

Assessing the Benchmark in 2029

Sample Questions for Assessing Payers' Performance Against the Benchmark

- What percentage of payers achieved the benchmark in each year, and over the two years cumulatively?
- What is the variation in the PMPM spend for outpatient and community-based behavioral health care among payers within a payer type?
- Are there apparent patterns among the payers that do not achieve the benchmark?
- Have the portions of total medical expenses going to behavioral health care overall, and to outpatient and community-based behavioral health, increased?

Assessing the Benchmark in 2029

Additional Information for Setting Future Benchmarks

- What are the barriers (e.g., infrastructure, provider availability) to future improvement? Have these barriers increased, decreased, or stayed the same over the performance years?
- Have there been improvements in behavioral health care delivery, for example increases in the use of behavioral health integrated with primary care, improvement in access measures, improvements in HEDIS measures related to screening for depression and anxiety?
- Has research emerged that suggests what the “right” level of behavioral health investment is?
- What is the experience in other states that measure behavioral health spending or use a behavioral health investment benchmark?

Discussion

What are your thoughts about the approach to the benchmark:

- Incremental growth from payer-specific baselines?
- Two-phase benchmark, each phase 5 years?
- Benchmark based on PMPM amounts?
- What is the appropriate rate of targeted growth, considering current trends and uncertainties?

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Feedback on Behavioral Health Code Set

Debbie Lindes, Health Care Delivery System Group Manager

Behavioral Health 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 is reviewing each suggestion and seeking clinical expertise when appropriate. 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 plans to include diagnoses for various sub-categories of autism and dementia.
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 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 seeking 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”.

Discussion: 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

Any additional feedback on how to categorize spending?

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

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

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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.

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

X Provide Feedback ✓ Board Approval

June Workgroup Meeting Preview

- OHCA's behavioral health benchmark recommendation and feedback from the Advisory Committee
- Updates to OHCA's behavioral health code set to measure behavioral health spending through claims
- Review overall definition of behavioral health

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Adjournment