OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

May 20, 2026

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Department of Health Care Access and Information

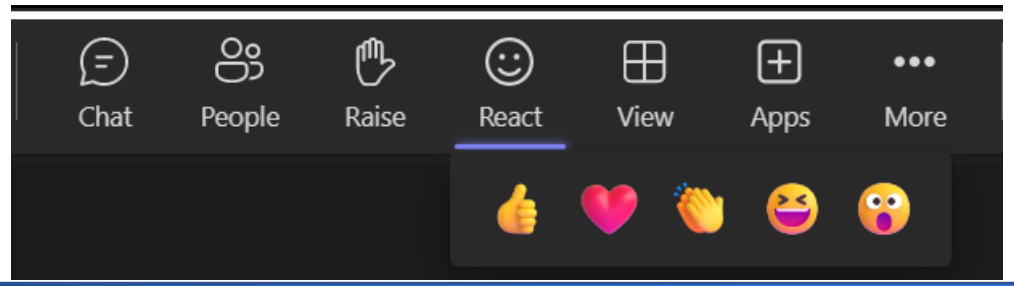
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:05 a.m.	**2.**	**2023-2024 Primary Care Spending and Alternative Payment Model (APM) Adoption De-Identified Data Preview**
9:35 a.m.	**3.**	**Update on Behavioral Health Spending Analyses and Benchmark Setting**
10:20 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 quarterly
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: May 20, 2026

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:
Join the meeting now

Meeting ID: 246 233 538 492 7
Passcode: 5DQ2Rt3X

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

Conference ID:
595 479 868#

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2023-2024 Primary Care Spending and Alternative Payment Model (APM) Adoption De-Identified Data Preview

Margareta Brandt, Assistant Deputy Director

Debbie Lindes, Health Care Delivery System Group Manager

Hamdi Abdullahi, Value-Based Payment Group Manager

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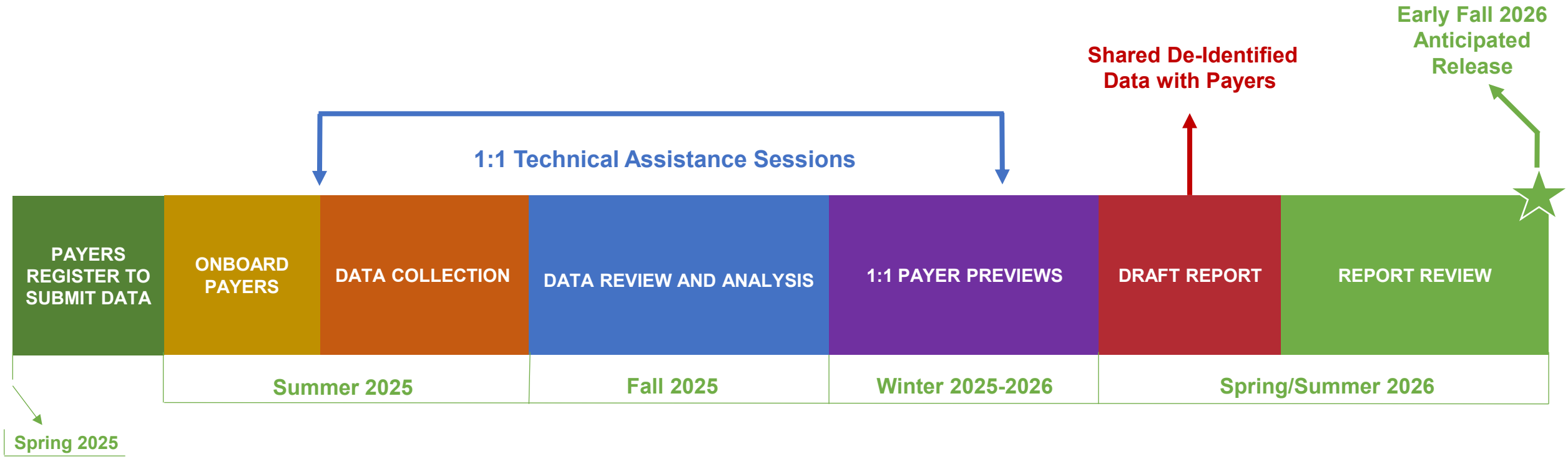
Primary Care Spending and APM Adoption Data Collection and Reporting Timeline



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Primary Care Spending and APM Adoption Data Sources

- Data collected from payers with at least 40,000 members across Commercial, Medicare Advantage, and Medi-Cal Managed Care markets.
- Payers submitted data using the technical specifications outlined in OHCA's Total Health Care Expenditures Data Submission Guide (DSG) 2.0.
- Primary Care Spending data ***includes*** claims and non-claims payments for primary care services, member months of coverage where a payment was made, and total medical expense.
- APM Adoption data ***includes*** claims and non-claims-based payments, member attribution to payment arrangements with or without a link to quality, total member months of coverage, and total medical expense.
- Primary Care Spending data and APM Adoption data ***excludes*** some payers' data due to data validation concerns, some payers' data due to low member months in the Commercial PPO/EPO market, some DHCS Medi-Cal specific payments for Medi-Cal managed care plan reporting, and spending in the "Commercial – Other" market category (enrollment and spending in this category represented less than 1% of the commercial market).

Primary Care Spending Data, 2023-2024

OHCA Primary Care Investment Benchmarks

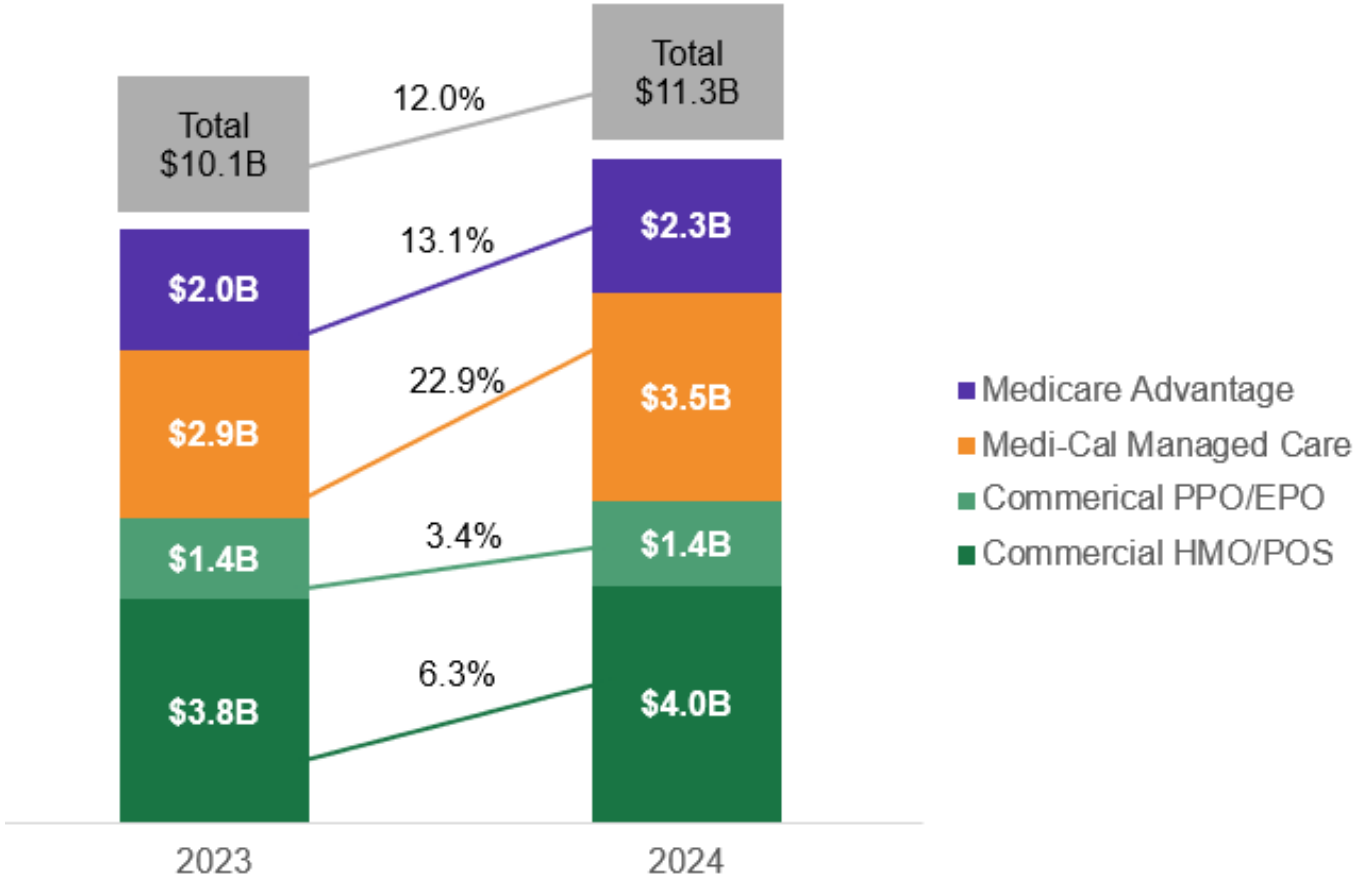
Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% increase per year for each payer by line of business and product type
Performance Year	**Investment Benchmark**
2034	15% statewide across all payers, lines of business, and product types

Baseline established on 2024 data collected in 2026, reported in 2027.
First Annual Improvement Benchmark assessed on 2025 data collected in 2027, reported in 2028.

Primary Care Investment Benchmark: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/primary-care-investment-benchmark/

Statewide Total Primary Care Spending and Primary Care Spending Growth*

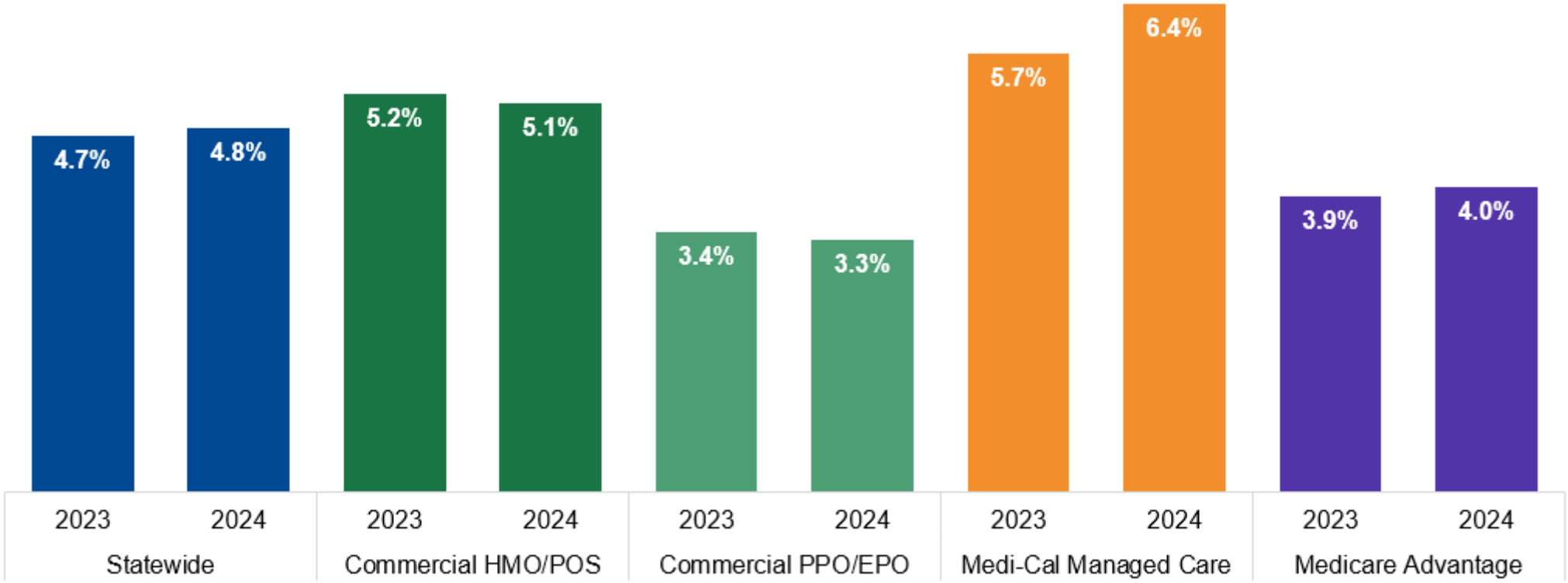
Year-over-year changes represent change in dollars spent



Note: Data excludes plans that map to other commercial product types. These plans account for 0.02% of primary care spending in 2023 and 2024.

*Some payers' primary care data has been excluded due to data validation concerns which OHCA is working with them to resolve.

Primary Care Spending as Percent of Total Medical Expense*



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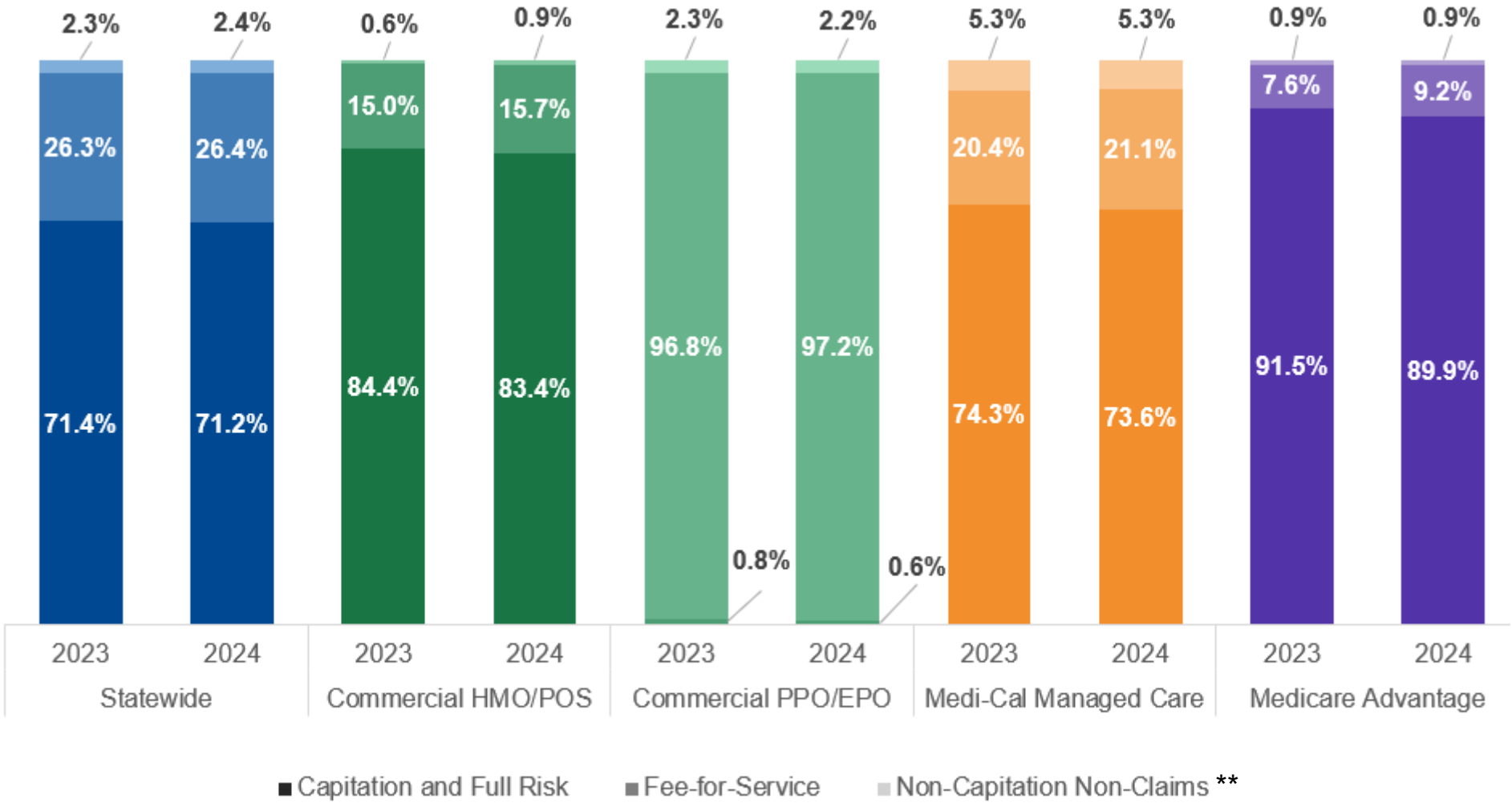
Primary Care Spending by Payment Category*



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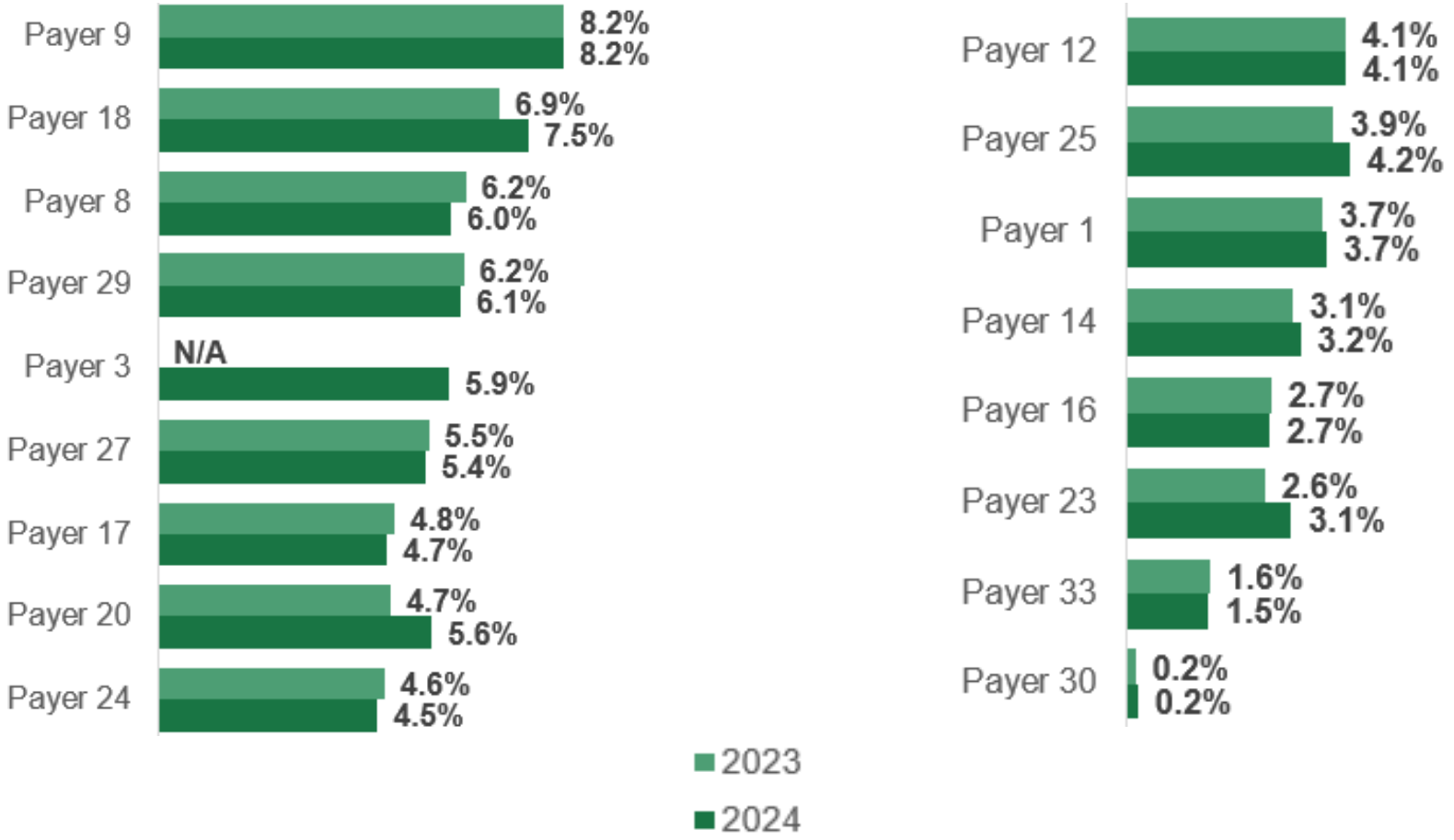
**Non-Capitation Non-Claims includes Performance Payments, Population and Practice Infrastructure Payments, Shared Savings and Shared Risk Payments, and Other Non-Claims Payments

Commercial HMO/POS - Primary Care Spending as a Percent of TME



N/A indicates no data was reported.

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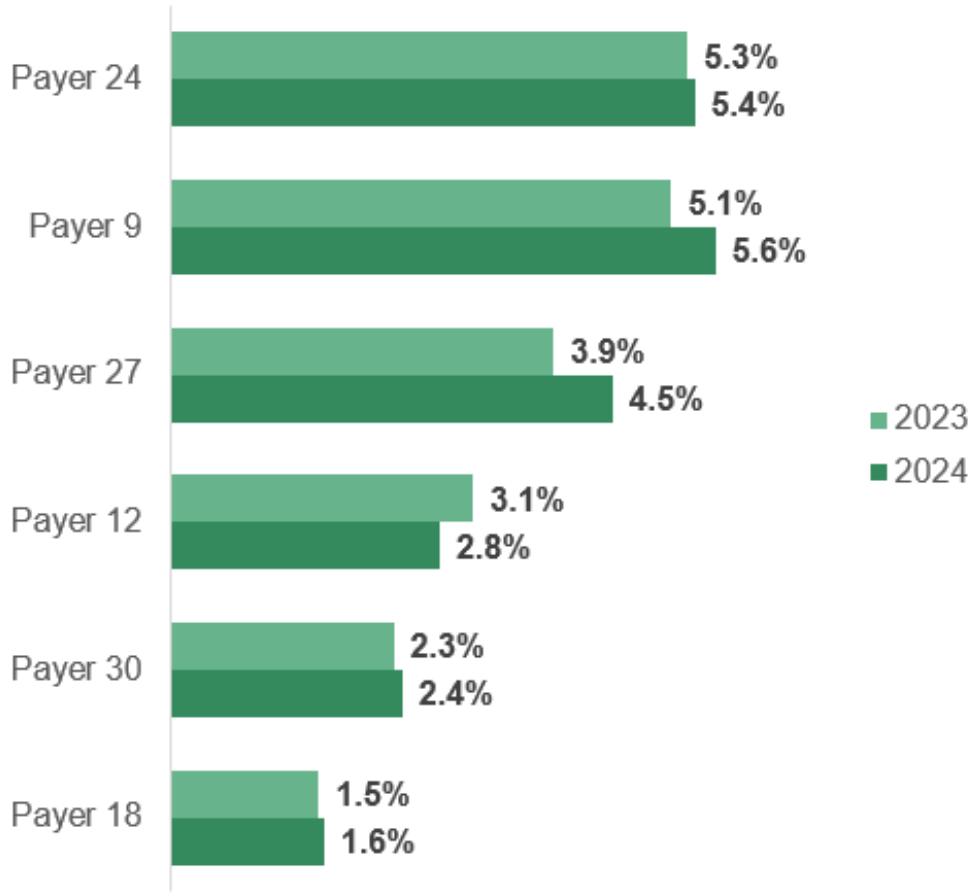
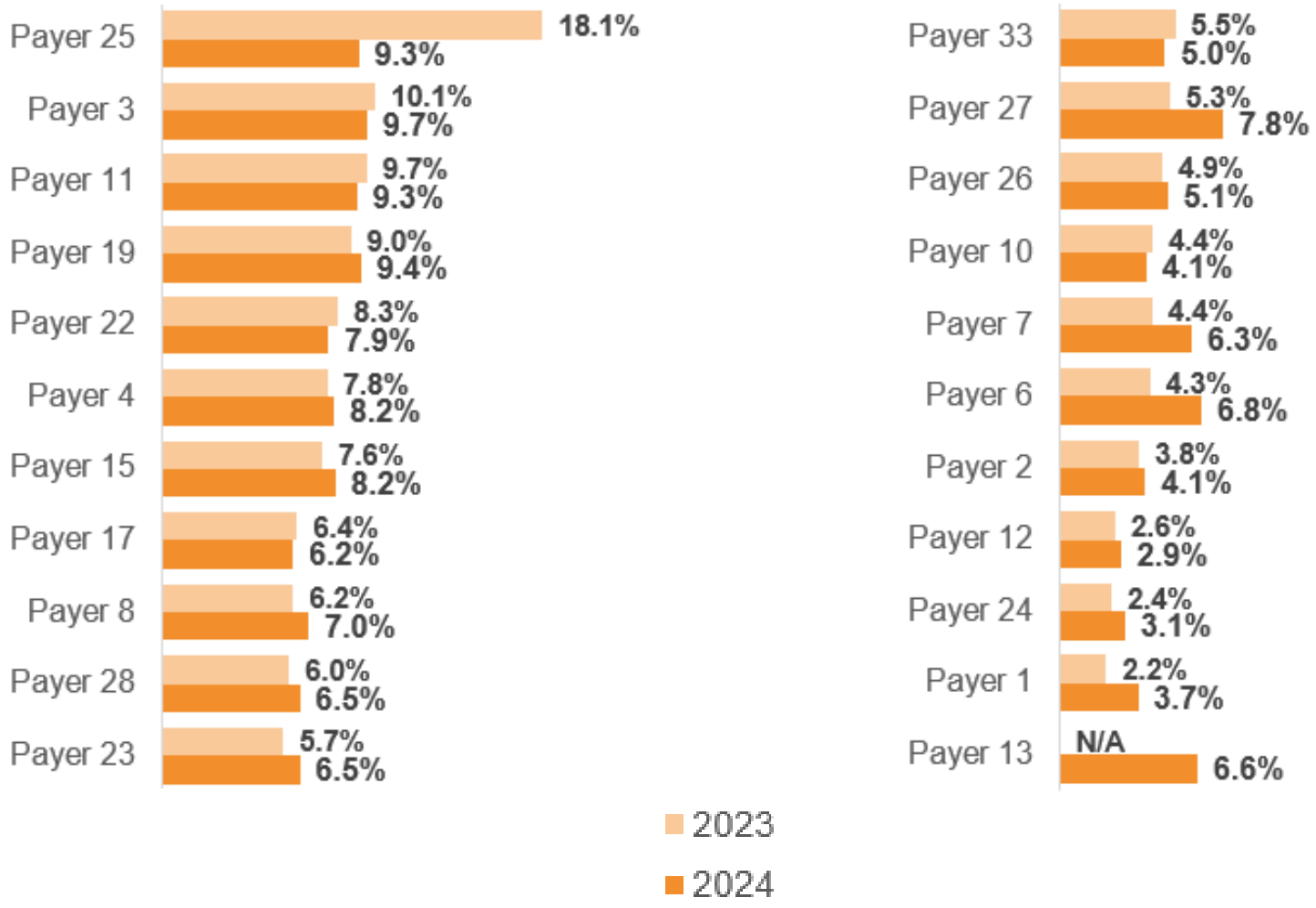
Commercial PPO/EPO - Primary Care Spending as a Percent of TME*



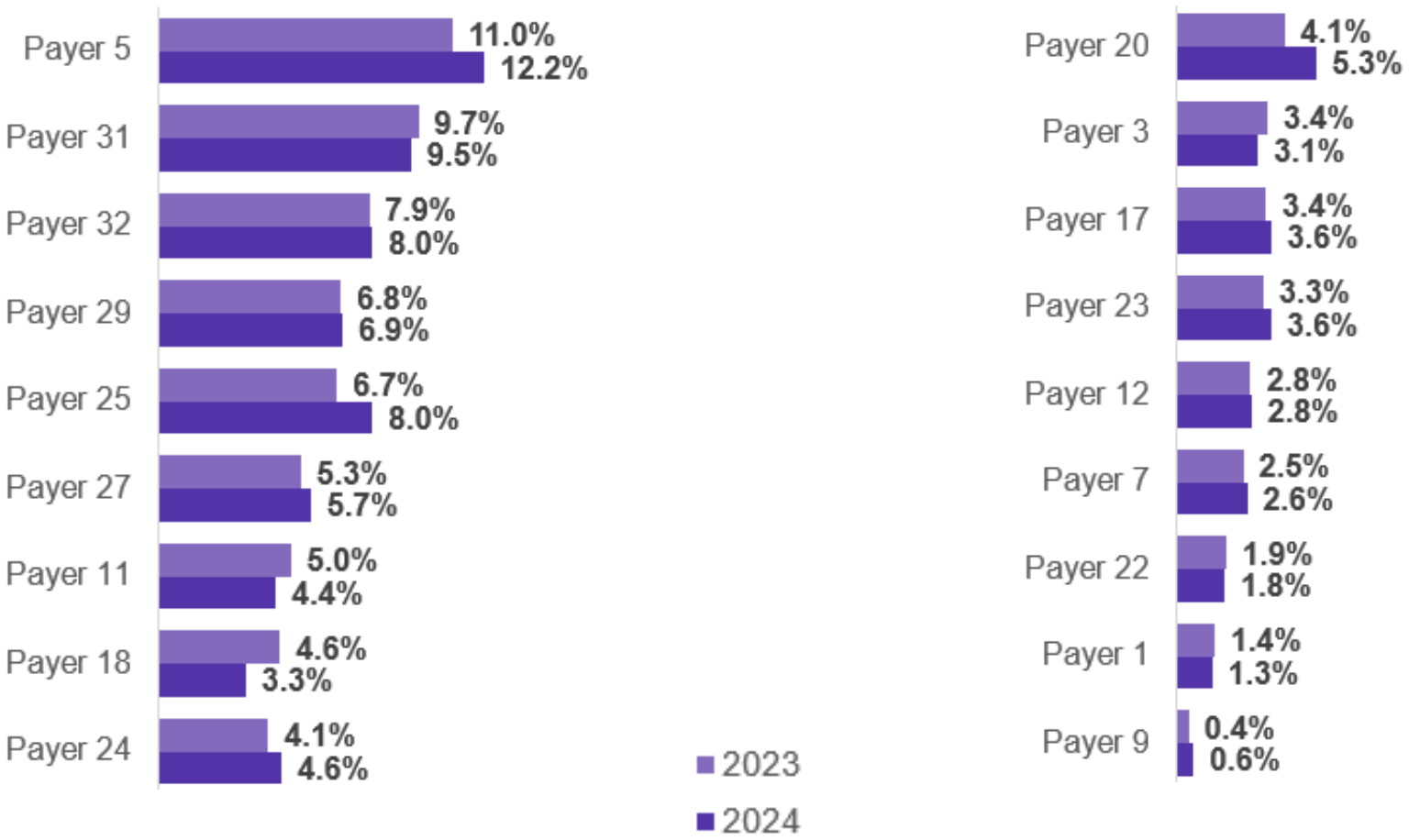
*Some payers' data has been excluded due to low member months in this market.

Medi-Cal Managed Care - Primary Care Spending as a Percent of TME



N/A indicates no data was reported.

Medicare Advantage - Primary Care Spending as a Percent of TME



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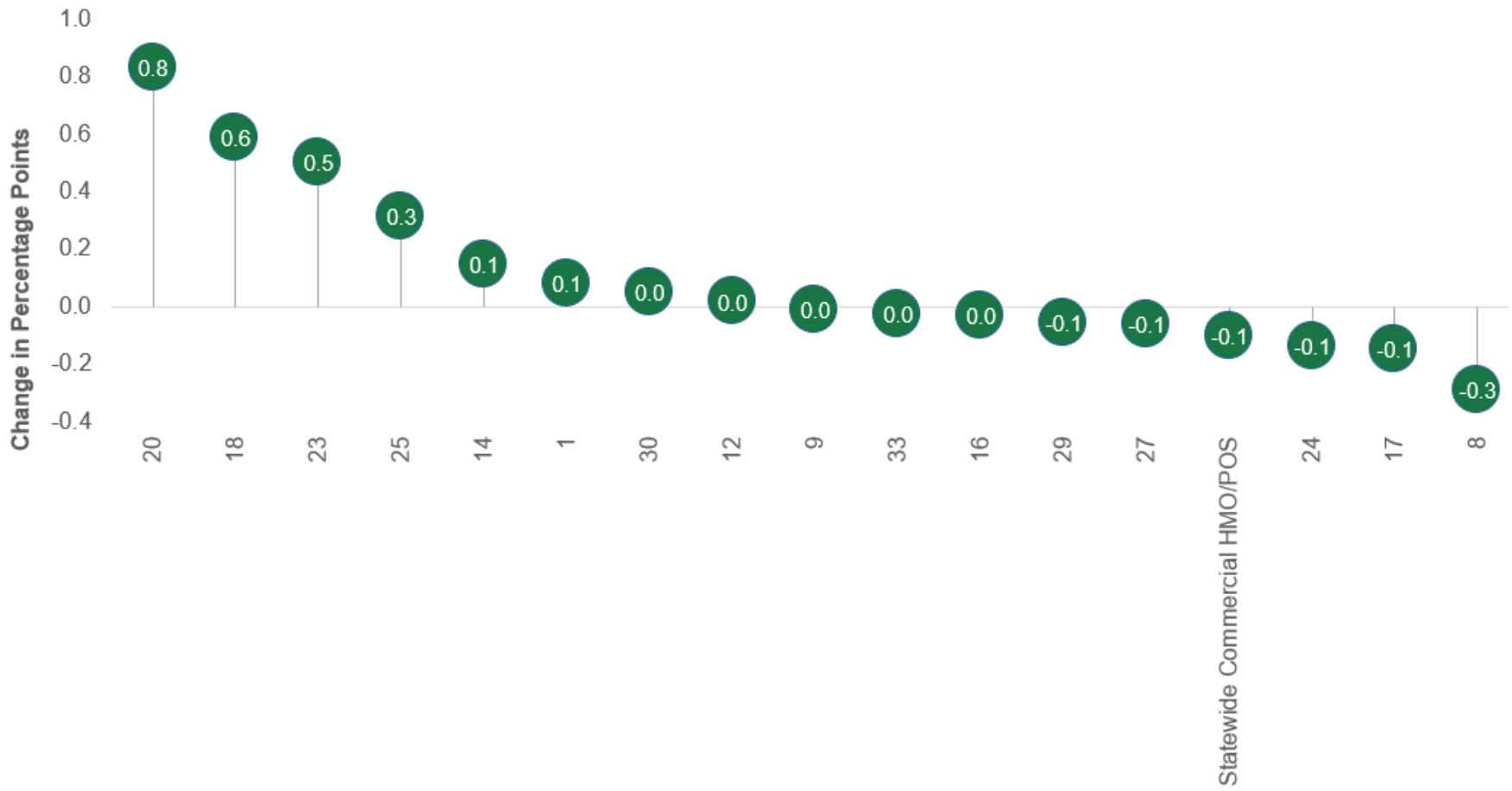
Commercial HMO/POS - Primary Care Spending as % TME Change in Percentage Points, 2023 to 2024



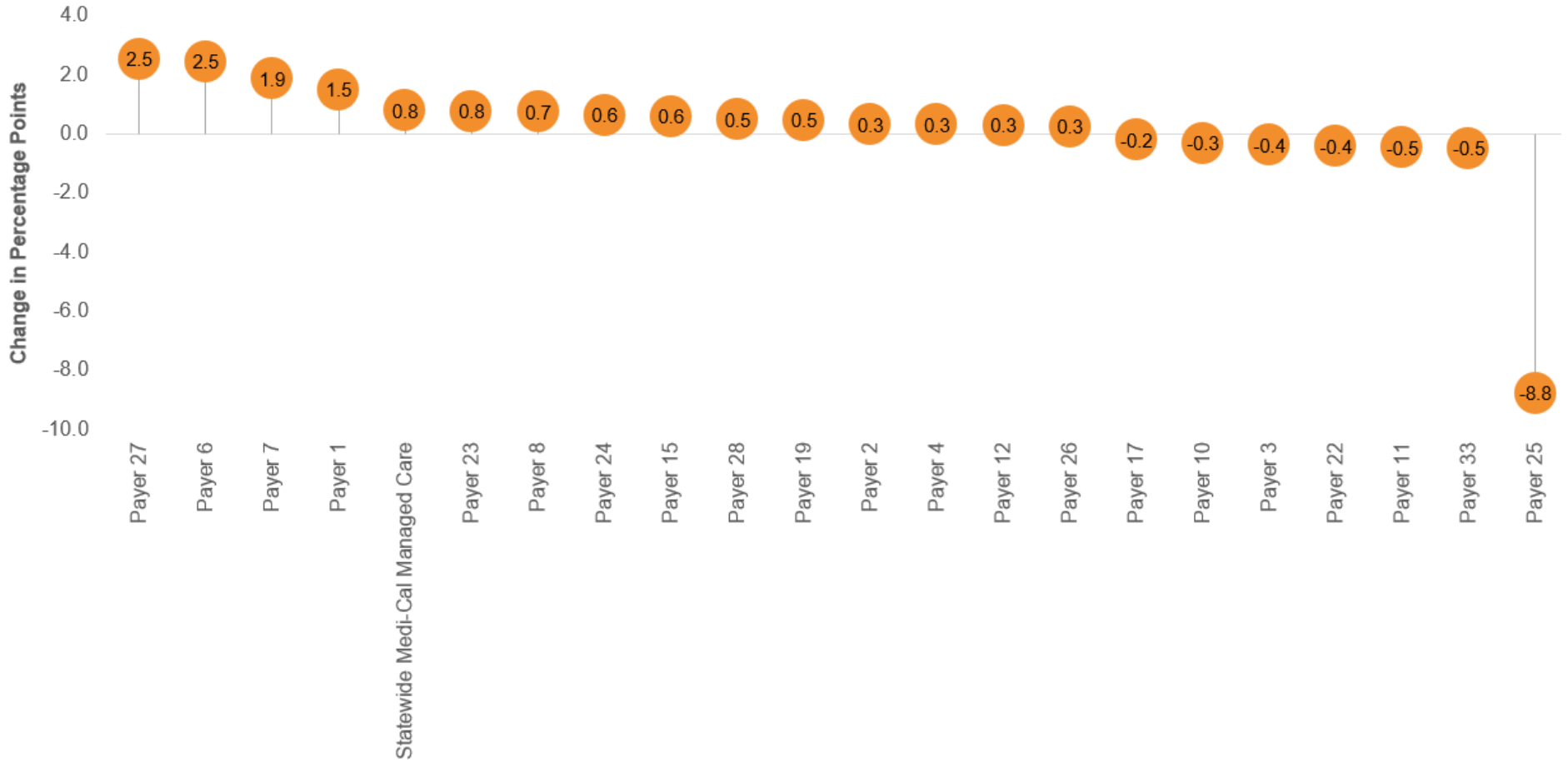
Annual Improvement Benchmark: 0.5-1 percentage point

Commercial PPO/EPO - Primary Care Spending as % TME Change in Percentage Points, 2023 to 2024*

Annual Improvement Benchmark: 0.5-1 percentage point

*Some payers' data has been excluded due to low member months in this market.

Medi-Cal Managed Care - Primary Care Spending as % TME Change in Percentage Points, 2023 to 2024



Annual Improvement Benchmark: 0.5-1 percentage point

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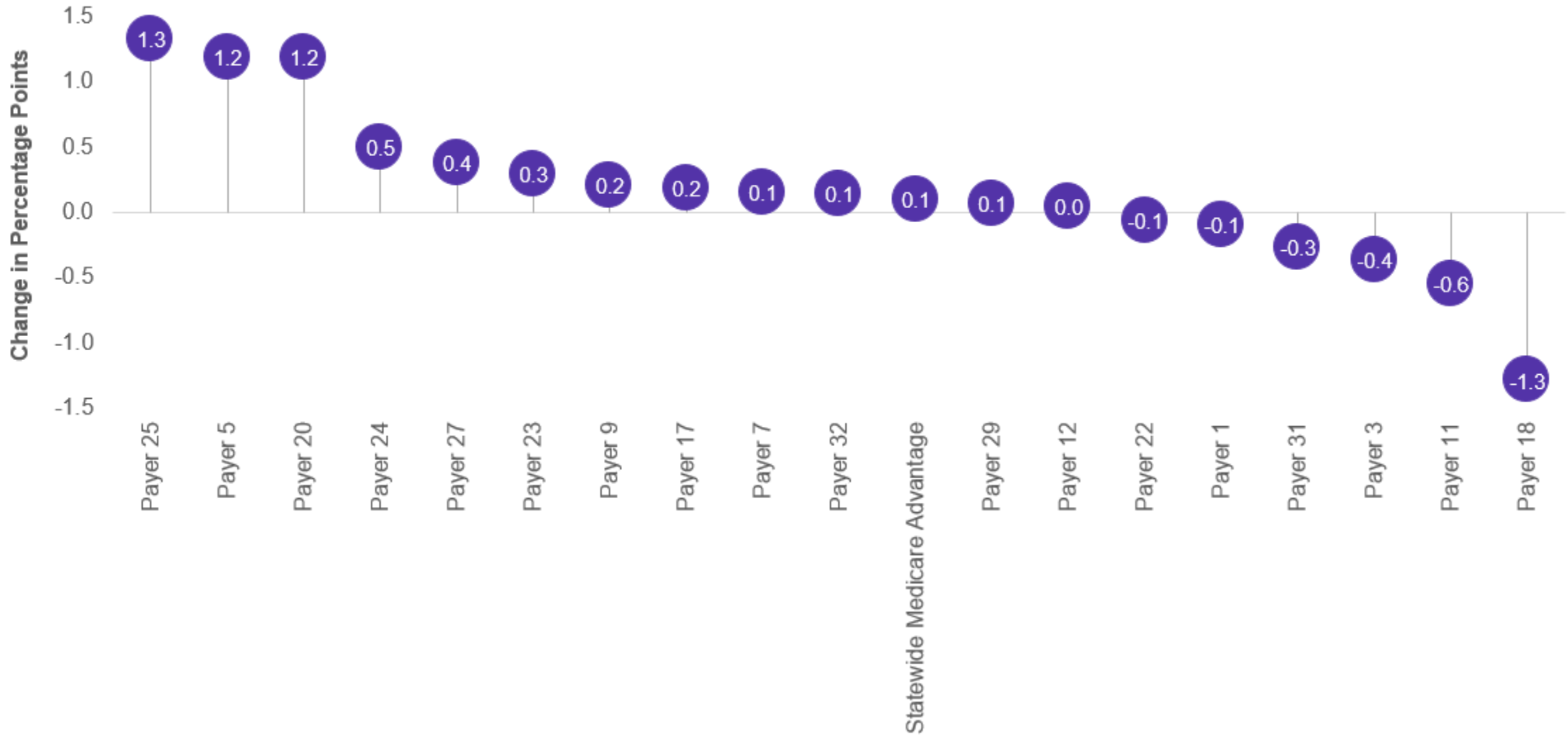
Medicare Advantage - Primary Care Spending as % TME Change in Percentage Points, 2023 to 2024



Annual Improvement Benchmark: 0.5-1 percentage point

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APM Adoption Data, 2023-2024

OHCA APM Adoption Goals

APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer Type				
	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

Baseline established on 2024 data collected in 2025. Data on 2026 goal collected in 2027, reported in 2028.

Alternative Payment Model Standards and Adoption Goals: https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/

Defining APMs for Adoption Goals

OHCA uses the Health Care Payment Learning and Action Network (HCP-LAN) framework to monitor progress towards the APM Adoption Goals.

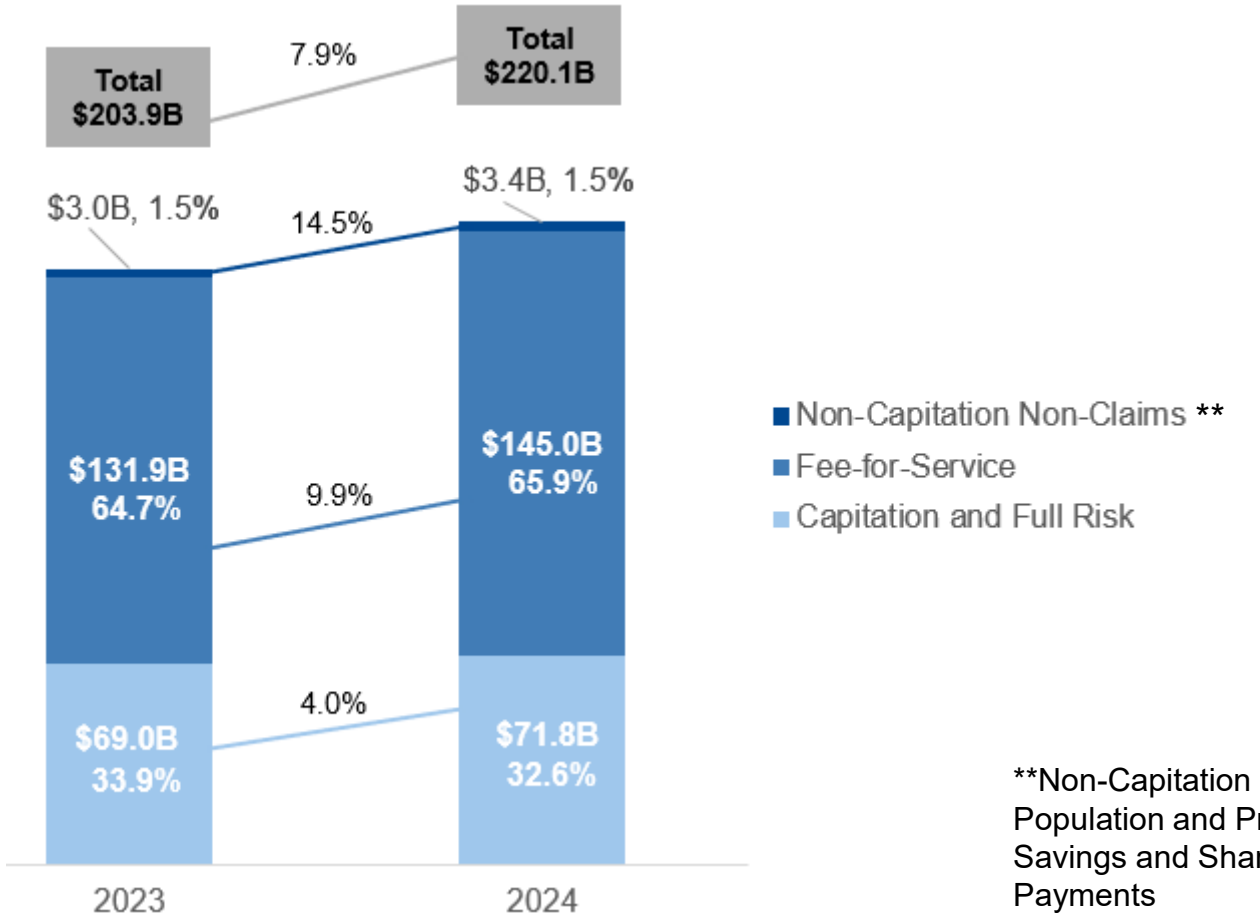
Goals are based on the percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements whose payments are linked to quality:

- 3A: APMs with Shared Savings
- 3B: APMs with Shared Savings and Downside Risk
- 4A: Condition-Specific Population-Based Payment
- 4B: Comprehensive Population-Based Payment
- 4C: Integrated Finance and Delivery System

Note: Data is collected via HCAI's Expanded Non-Claims Payments Framework.

Statewide Total Medical Expense within each Payment Category by Dollars and Percent of Total*

Year-over-year changes represent change in dollars spent



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*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve.

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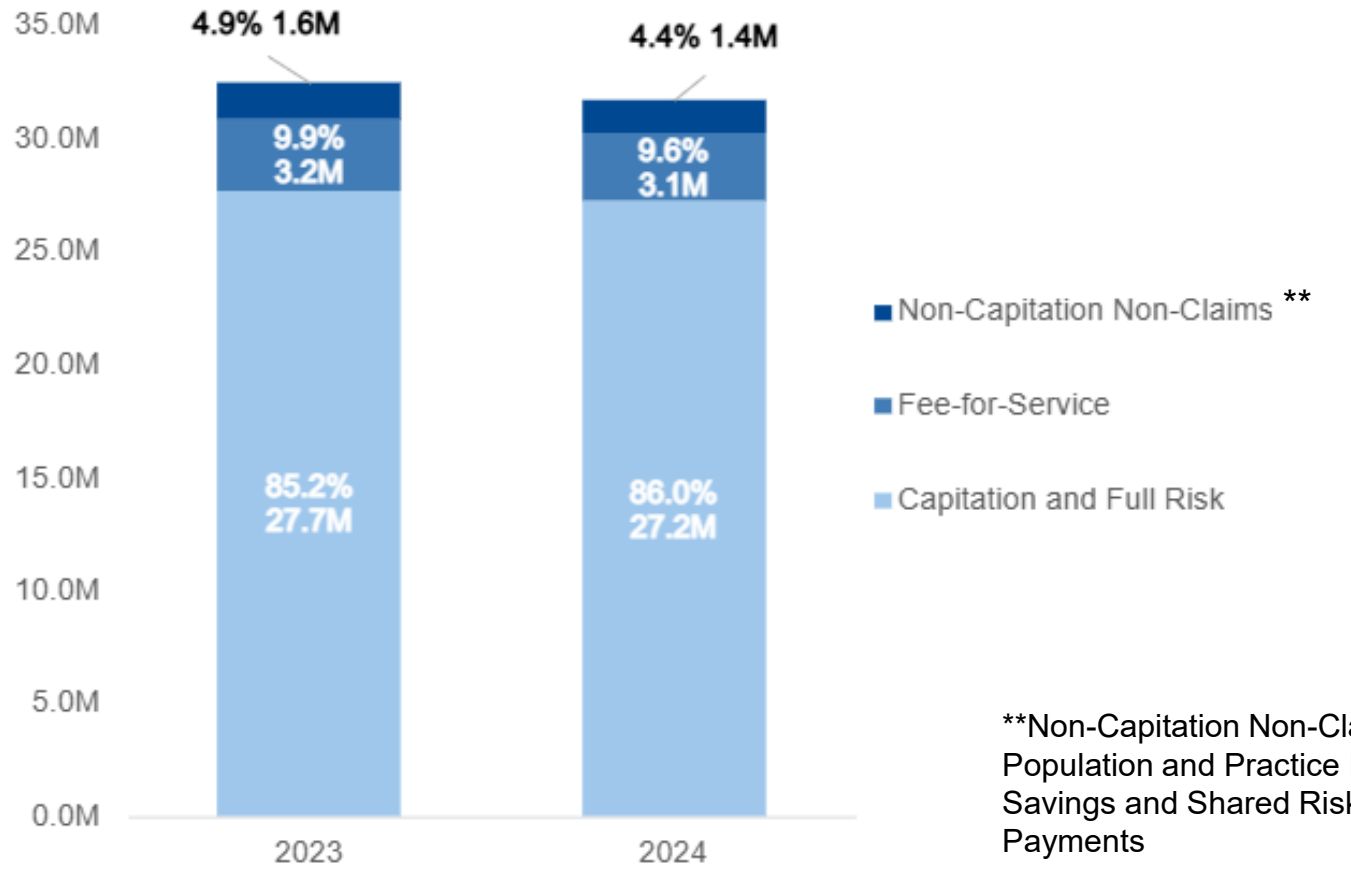
Count and Percent of Statewide Members by Payment Category*



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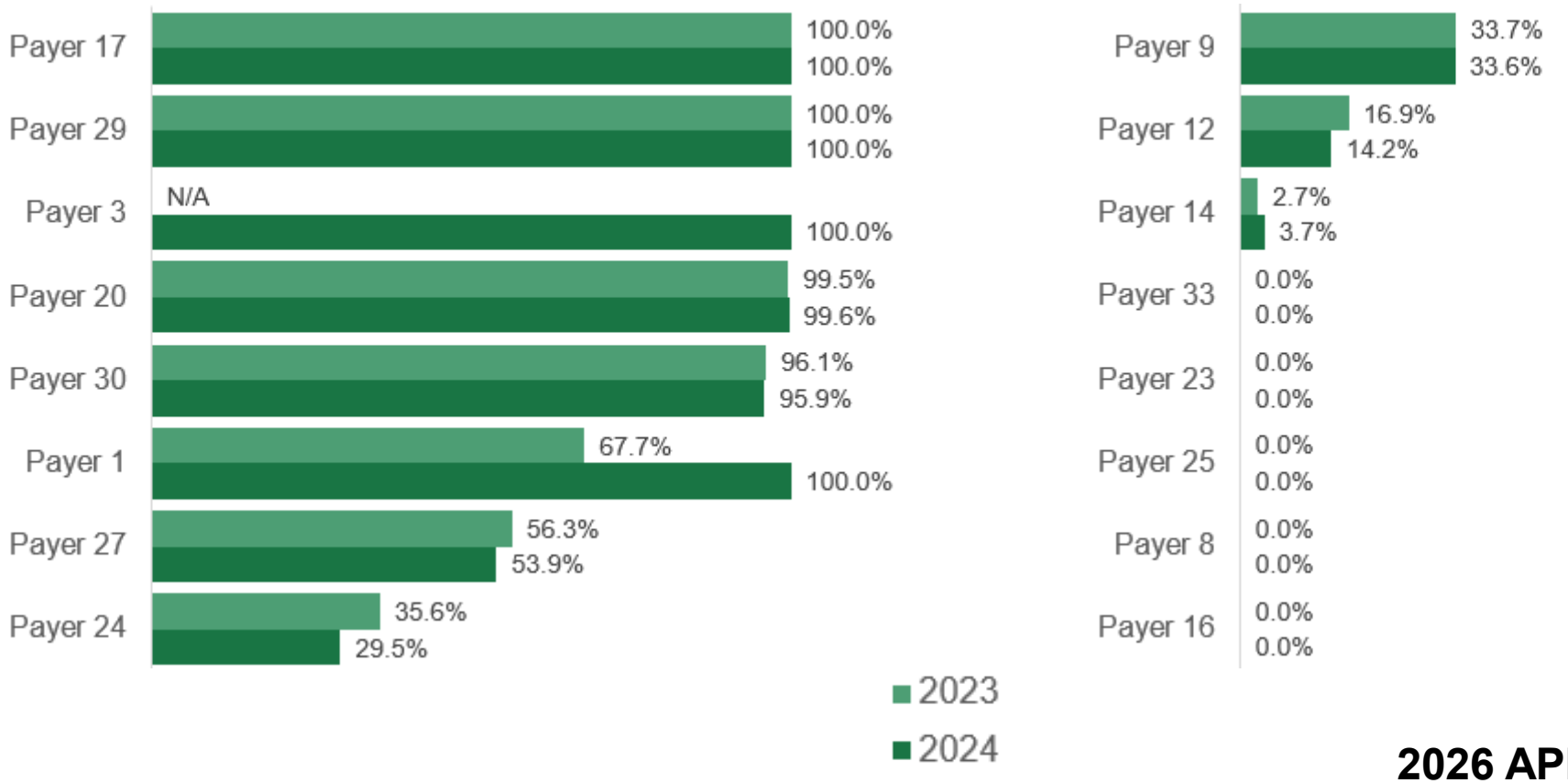
*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve.

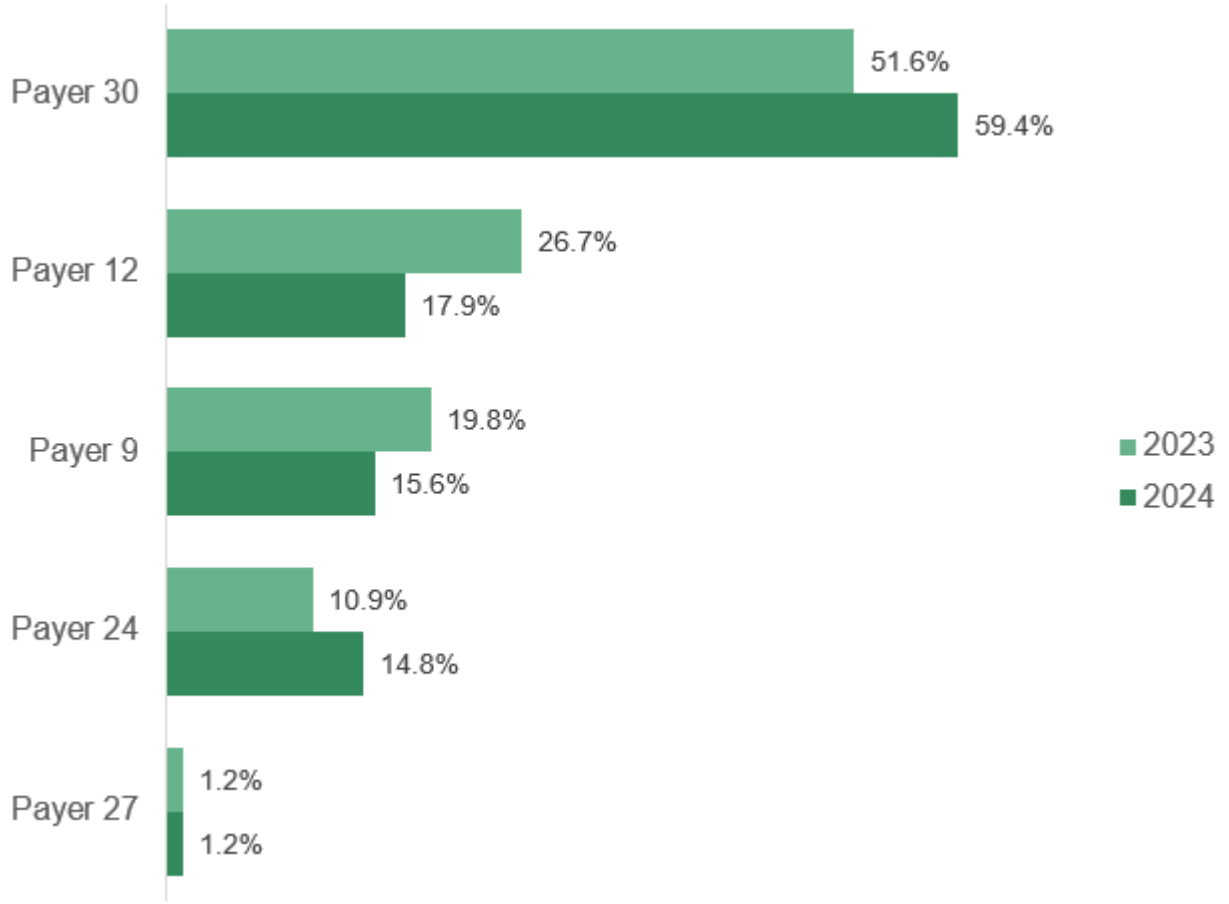
Commercial HMO/POS – Members in Capitation/Full Risk or Shared Savings/Risk Categories Eligible for Quality-Linked Payments*



2026 APM Adoption Goal: 65%

*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve.

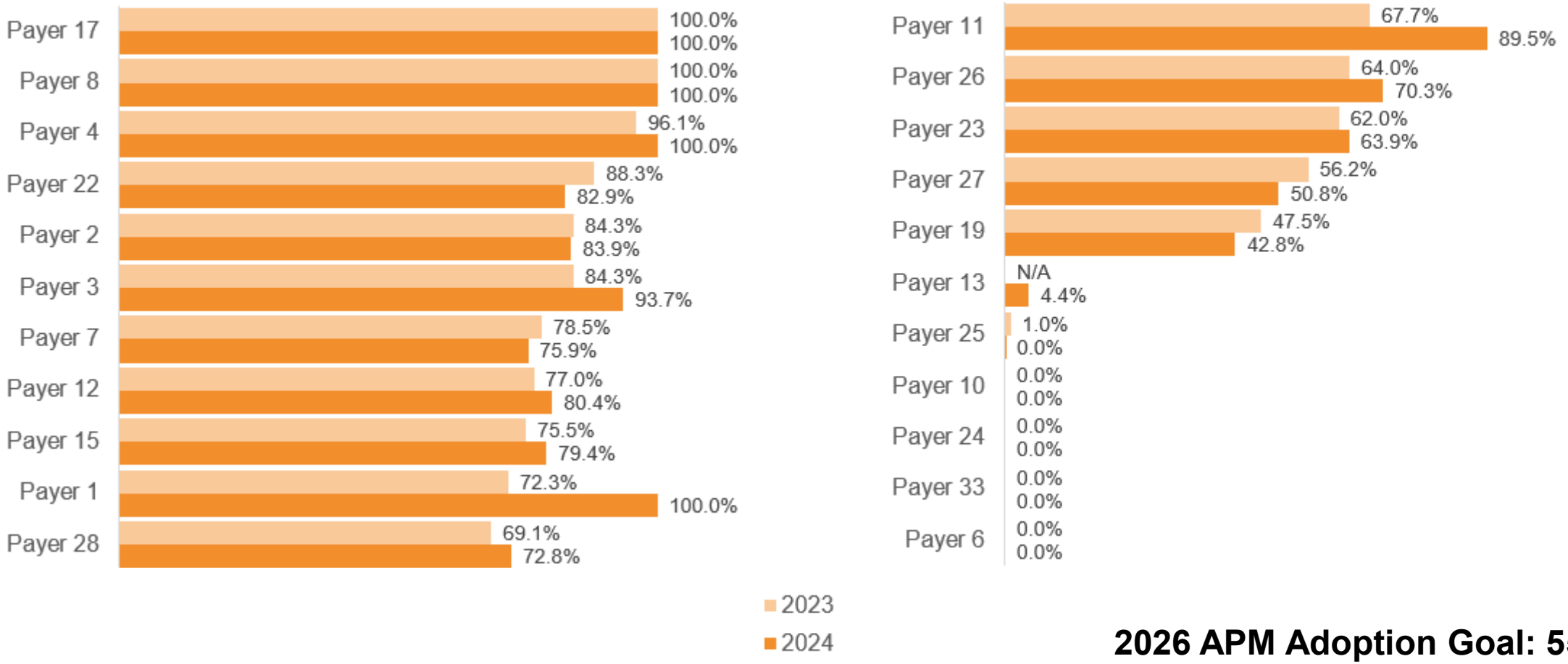
Commercial PPO/EPO – Members in Capitation/Full Risk or Shared Savings/Risk Categories Eligible for Quality-Linked Payments*



2026 APM Adoption Goal: 25%

*Some payers' APM adoption data has been excluded due to data validation concerns which OHCA is working with them to resolve. Some payers data has been excluded due to low member months in this market.

Medi-Cal Managed Care – Members in Capitation/Full Risk or Shared Savings/Risk Categories Eligible for Quality-Linked Payments



2026 APM Adoption Goal: 55%

N/A indicates no data was reported.

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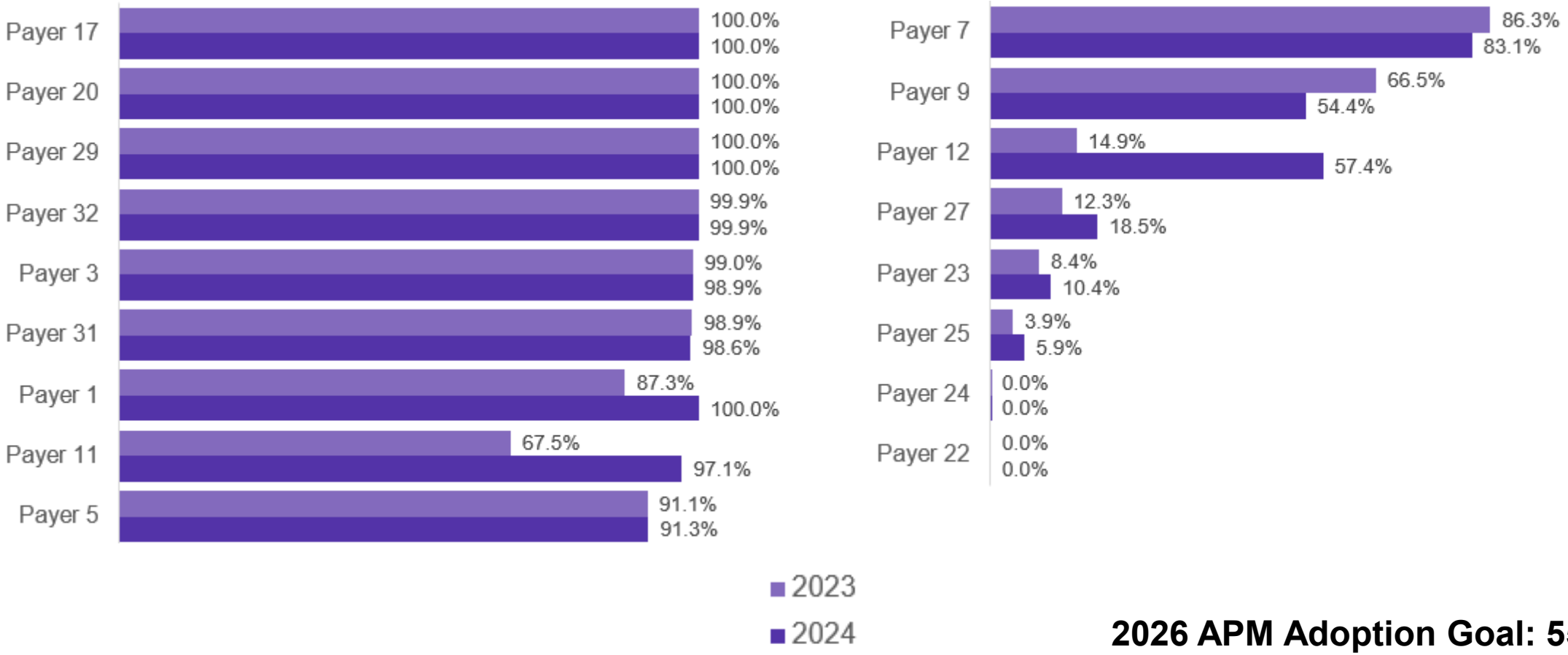
Medicare Advantage – Members in Capitation/Full Risk or Shared Savings/Risk Categories Eligible for Quality-Linked Payments



2026 APM Adoption Goal: 55%

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Discussion

- Do Workgroup members have any initial questions about the de-identified primary care spend and APM adoption data?

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Update on Behavioral Health Spending Analyses and Benchmark Setting

Debbie Lindes, Health Care Delivery System Group Manager

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Planned HPD Behavioral Health Analyses

- Priority analyses for behavioral health investment benchmark development using Health Care Payments Data (HPD)
  - 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 on behavioral health spending measurement
  - What would be the 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?

These analyses will include commercial and Medicare Advantage plans.

Updates and Opportunities

Collaboration between OHCA and Health Care Payments Data (HPD) program to review and understand behavioral health analyses has resulted in several lessons learned that present future opportunities to refine the analyses to inform benchmark development.

Examples of future opportunities include:

- An analysis of spend across payers with non-claims payments, when available
- An analysis of payers with and without behavioral health and/or pharmacy carved out, to understand the full picture of behavioral health spending by payers
- Analysis of Medi-Cal Managed Care Plan (MCP) behavioral health spending can be completed after MCP submissions to OHCA in Fall 2026

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.

Behavioral Health Reporting Categories

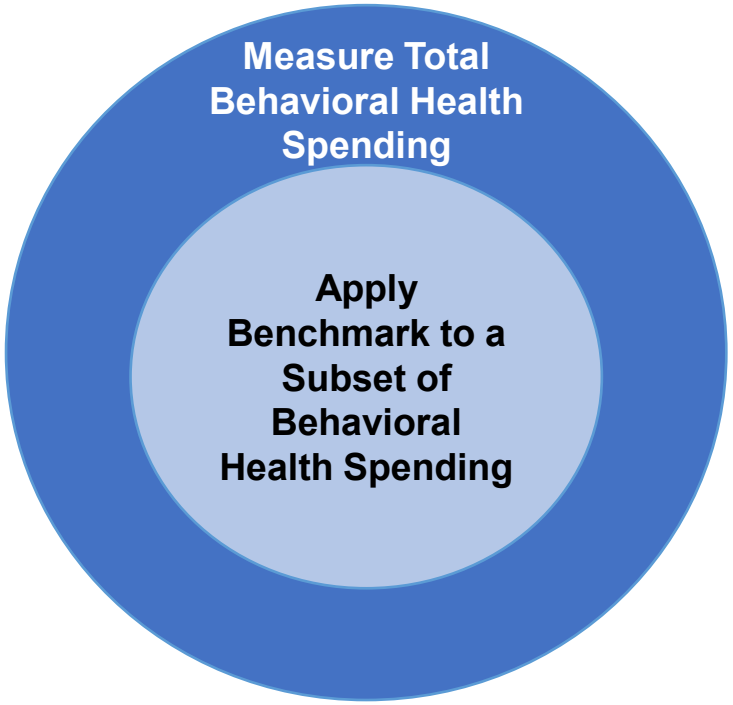
Reporting Categories	Service Subcategories
Outpatient/Community Based	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility
	Emergency Department / Observation; Professional
Inpatient	Inpatient; Facility
	Inpatient; Professional
Residential	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 other subcategories goes to "Other").

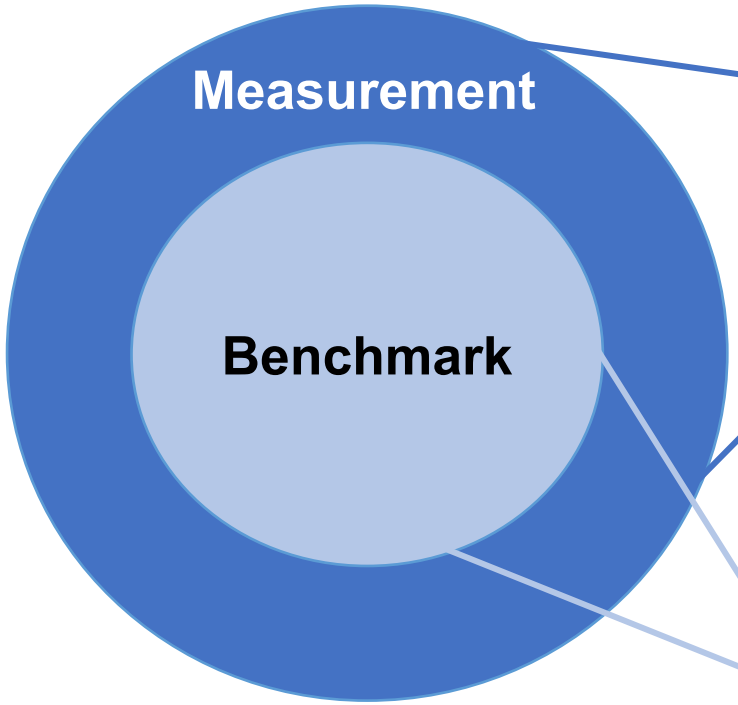
Broad Measurement, Focused Benchmark

- **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



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:

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

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 point increase 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

Key Decisions for Benchmark Structure

- 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?

Key Decisions for Benchmark Structure Considerations

Key Decision	Considerations
Percentage of total medical expenses (TME) or a per member, per month (PMPM) amount?	• **Percentage of TME** aligns with primary care benchmark and communicates increased spending on behavioral health should reallocate rather than increase total spending • **PMPM** better reflects the cost of achieving behavioral health delivery goals and is more consistent with how payers measure health care costs
Incremental, long-term improvement, or a combination?	• **Incremental improvement** recognizes differences across payers and patient population and acknowledges care delivery transformation takes time • **Long-term improvement** can reflect the potential budget needed to develop necessary infrastructure and current thinking on the "right" level of investment • **A combination** allows all to succeed at a reasonable pace and aligns with approach to primary care benchmark
Timeline?	• **Shorter timeline** is aggressive in pursuit of the underlying policy goals • **Longer timeline** reflects reasonable expectations to achieve desired change

Key Decisions for Benchmark Focus

- Should the benchmark be the same across markets or tailored for each?
- Should the benchmark focus only on certain behavioral health service subcategories (e.g., outpatient)?
- Should the benchmark focus only on a specific diagnosis category (mental health or substance use disorder)?
- Should the benchmark focus only on a specific population or age band (e.g., children/youth)?

Key Decisions for Benchmark Focus Considerations

Key Decision	Considerations
The same across markets or tailored for each?	• **Same benchmark across all markets** aligns investment to support care transformation • **Tailored benchmarks** could be responsive to findings from the best available data and better aligns around care delivery and policy nuances for each market
Only certain behavioral health service subcategories?	• **All spend** gives payers flexibility to achieve the benchmark but could result in areas of high investment receiving even more while others fall further behind • **Certain subcategories** gives payers focus areas and an opportunity to target high need subcategories

Key Decisions for Benchmark Focus Considerations

Key Decision	Considerations
Only a specific diagnosis category (mental health or substance use disorder)?	• **Both categories** recognizes co-occurrence of mental health (MH) and substance use disorder (SUD) diagnoses and limitations of identifying a claim as either MH or SUD • **MH or SUD focus** provides an opportunity to target historically underfunded SUD treatment and align with other state initiatives on behavioral health
Only a specific population or age band (e.g., children/youth)?	• **All age bands** aligns with approach to primary care benchmark and recognizes there is no known "right" level of investment for specific age bands • **Specific age bands** provides an opportunity to target an age band with unmet need and align with other state initiatives

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

Challenges in Establishing a Behavioral Health Benchmark

There are several challenges in establishing the behavioral health benchmark that were not present in setting the primary care benchmark:

- Complete, reliable data on behavioral health spending are lacking, particularly at the detailed subcategory level and for certain payer types
- There is no track record of the structures, levels, or effectiveness of behavioral health investment benchmarks in other states
- There is a lack of national and international evidence for what constitutes the "right" or "desired" level of behavioral health spending

Discussion

- Should OHCA consider a benchmark tailored to different markets (commercial, Medicare Advantage, Medi-Cal)?
- How should OHCA think about the appropriate timing for setting a benchmark, based on available data and experience about the “right” level of behavioral health spending?
- What are other considerations for the structure or focus of a behavioral health investment benchmark?

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Next Steps

Margareta Brandt, Assistant Deputy Director

HCAi

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Next Steps

- Next meeting: August 19th, 2026
- Upcoming topics
  - Behavioral health spending analyses
  - Discuss recommendations to OHCA Board for behavioral health investment benchmark
  - Highlights from APM adoption and primary care data collection and reporting
  - APM adoption and primary care investment best practices

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Adjournment

Margareta Brandt, Assistant Deputy Director

HCAI

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