HCAi
Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

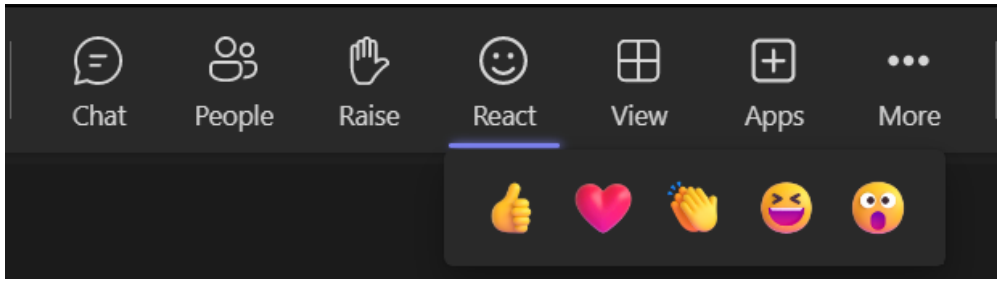
October 16, 2024

Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Discuss Behavioral Health Investment Benchmark Priorities**
10:10 a.m.	**3.**	**Next Steps**
10:30 a.m.	**4.**	**Adjournment**

Meeting Format

- 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: October 16, 2024

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)

Rhonda Chabran, LCSW
Vice President, Behavioral Health & Wellness, Kaiser Foundation Health Plan, Southern CA & HI

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

Vicky 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

Lisa Albers, MD
Assistant Chief, Clinical Policy & Programs Division, 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 Investment Benchmark Approved

Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% 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

Rationale and Considerations:

- Has received strong stakeholder support from Workgroup and public commenters.
- Gives all payers reasonable opportunity to demonstrate immediate progress and long-term success.
- Emphasizes demonstrating annual progress
- Offers gradual glidepath to ambitious but achievable 15% goal.
- Offers some flexibility since OHCA does not have exact measures of current spend using its definition.

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

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.

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

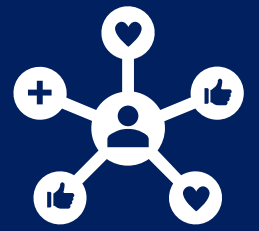
Resulting In

Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total health care expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

Proposed Goals for Improved Behavioral Health Care

				
Accessible	**Comprehensive**	**Coordinated**	**Equitable**	**High Quality**
• Providers and services are available when and where needed • Culturally responsive and linguistically concordant • Affordable	• Services across the continuum • More treatment in community and ambulatory settings, reduced need in emergency departments and correctional facilities	• Services integrated across behavioral health settings and with primary care • Attentive and responsive to health-related social needs	• Reduced disparities in utilization and outcomes • Reduced misinformation, stigma, and discrimination	• Improved behavioral health and overall health outcomes • Low frustration, high satisfaction

Adapted from CalHHS, "Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts." March 2023. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

HCAi
Department of Health Care Access and Information

Discussion of Behavioral Health Investment Priorities

Margareta Brandt, Assistant Deputy Director

Overview and Purpose of Today's Discussion

- OHCA's charge is to measure behavioral health spending.
- Not all behavioral health spending is "equal": while some spending increases are desirable (e.g., office-based care), others are not ideal (e.g., emergency department care).
- The behavioral health investment benchmark should reflect priorities for behavioral health spending.
- The pre-meeting poll was intended to seed a discussion about these priorities.
- Today's discussion is about our benchmark priorities, which will inform how we define and measure behavioral health spending.

About the Poll

- 7 questions
  - 1 ranking question
  - 5 multiple choice questions
  - 1 free text response question (*optional)*
- 24 responses received
  - 7 free text responses received


1. Please rank the following from highest to lowest priority need to address through increased behavioral health investment.

Integrating primary and behavioral health care

Increasing access to specific provider types

Increasing access to the most appropriate care settings

Decreasing out-of-pocket spend for behavioral health care

Increasing access to care for specific populations

2. Should the OHCA behavioral health investment benchmark focus on a specific area of behavioral health care (e.g., conditions, providers, or care settings)?

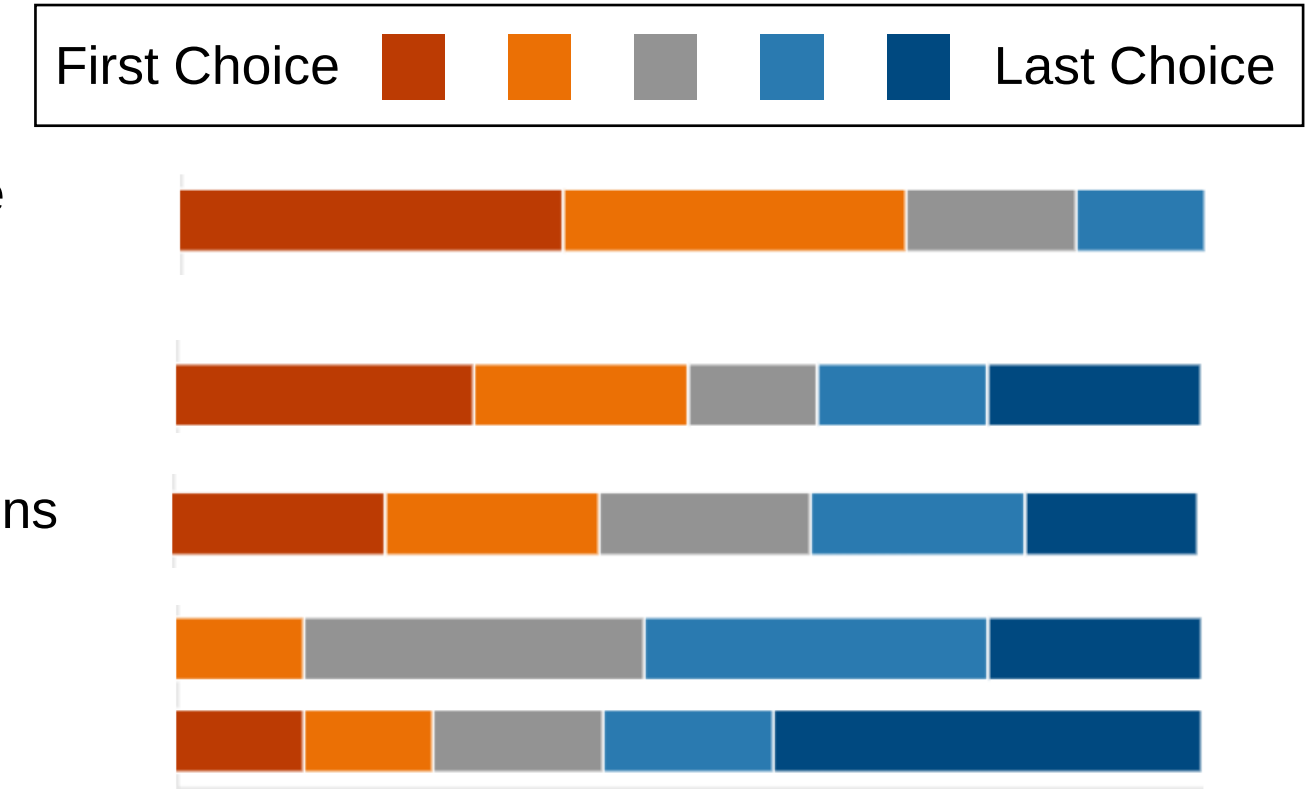
Yes

No

Undecided

Question 1

Order the following from highest to lowest priority needs to address with increased behavioral health investment.



1. Increasing access to the most appropriate care settings
2. Integrating primary and behavioral health care
3. Increasing access to care for specific populations
4. Increasing access to specific provider types
   Decreasing out-of-pocket spend for behavioral health care

Question 2

Should the OHCA behavioral health investment benchmark focus on a specific area of behavioral health care (e.g., conditions, providers, or care settings)?

Results

Yes	50%
No	29%
Undecided	21%

Definition Impact:

- If yes, data submitters would filter claims and non-claims data to report on this area of behavioral health care spending separately using a definition developed by OHCA.

Question 3

Should the OHCA behavioral health investment benchmark focus on certain diagnoses / categories of diagnoses (e.g., mental health, substance use disorders, or more granularly - opioid use disorder, anxiety, or depression)?

Results

Yes	38%
No	38%
Undecided	25%

Definition Impact:

- If yes, data submitters would report behavioral health spending by diagnosis category as defined by OHCA using a set of diagnosis codes.

Question 4

Should the OHCA behavioral health investment benchmark focus on certain care settings (e.g., outpatient, inpatient)?

Results

Yes	67%
No	17%
Undecided	17%

Definition Impact:

- If yes, data submitters would report behavioral health spending by care setting, as defined by place of service codes and revenue codes. OHCA would develop these definitions.

Question 5

Should the OHCA behavioral health investment benchmark focus on certain providers (e.g., psychiatrists, social workers, etc.)?

Results

Yes	25%
No	63%
Undecided	13%

Definition Impact:

- If yes, data submitters would report behavioral health spending by provider type as defined by OHCA using a list of taxonomy codes.

Question 6

Should the OHCA behavioral health investment benchmark focus on certain populations (e.g., adults, adolescents, etc.)?

Results

Yes	33%
No	46%
Undecided	21%

Definition Impact:

- If yes, data submitters would report behavioral health spend for a certain population using data element(s) representing the population characteristics in the definition.

Question 7

Do you have any additional comments or suggestions?

Interest in:

- A benchmark that focuses on spending related to adolescents and early psychosis
- A benchmark that focuses on both conditions and care settings
- A benchmark that focuses on increasing spending on high quality, evidence-based care
- Capturing spending occurring via Employee Assistance Programs as part of behavioral health spending
- Taking a broad approach to measuring behavioral health spend
- Looking at what exists and does not exist now in terms of meeting needs and appropriate care delivery
- Better understanding the relationship between categorizing for measurement versus excluding from a benchmark calculation

Other thoughts?

OHCA Key Takeaways

Strong interest in a benchmark that:

- Prioritizes access to the most appropriate care setting
- Focuses on certain care settings
- Does not focus on certain provider types

Moderate interest in a benchmark that:

- Focuses on certain populations

Mixed interest in a benchmark that:

- Focuses on certain diagnoses or categories of diagnoses
- Focuses on certain populations

Further discussion is needed to:

- Understand data availability for Employee Assistance Programs
- Consider ways to identify evidence-based, high quality behavioral health care

HCAi
Department of Health Care Access and Information

Next Steps

Debbie Lindes, Health Care Delivery System Group Manager

November Workgroup Meeting Preview

Agenda

- Review and discuss OHCA's preliminary draft recommendations for an approach for measuring claims-based behavioral health care spend.

NOTE: November Workgroup meeting has been rescheduled to Thursday 11/21/2024, 9-10:30am.

HCAi
Department of Health Care Access and Information

Adjournment