Office of Health Care Affordability
Proposed Behavioral Health Spending Definition and Measurement Methodology
August 2025

The Office of Health Care Affordability's Mission and Purpose

In 2022, the California Health Care Quality and Affordability Act[1] (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care costs continue to grow, reaching a crisis point for healthcare affordability, OHCA's enabling statute emphasizes that it is in the public interest for all Californians to have access to health care that is accessible, affordable, equitable, high-quality, and universal.

Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015.[2] Californians with job-based coverage face higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020.[3] For the fourth consecutive year, the 2024 California Health Care Foundation California Health Policy Survey reports that more than half of Californians (53%) – and nearly three-fourths (74%) of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months.[4] Among those who reported skipping or delaying care due to cost, about half reported their conditions worsened as a result. Further, high costs for health care disproportionately affect Black and Latino Californians who report they had problems paying or could not pay medical bills (40% and 36%, respectively, compared to White Californians at 25%).[4]

OHCA has three primary responsibilities to achieve its mission of improved consumer affordability:

1. Slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board;
2. Promote high-value health system performance; and
3. Assess market consolidation.

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[1] Health and Safety Code Sections 127500-127507.6.
[2] Centers for Medicare & Medicaid Services. (2022, September 8). *Health Expenditures by State of Residence, 1991-2020.* CMS. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence
[3] Whitmore, H., and Sartorius, J. (2021, August). *California Employer Health Benefits: Are Workers Covered?*. California Health Care Almanac, California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf.
[4] Joynt, J., Rebecca Catterson, R., and Alvarez, E. (2024, January). *The 2024 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/publication/2024-chcf-california-health-policy-survey/.

OHCA promotes high-value system performance through its work in five focus areas: (1) primary care investment, (2) behavioral health investment, (3) alternative payment model adoption goals and standards, (4) quality and equity performance and (5) workforce stability. Across all these areas, the goal is to reorient the health care system towards greater value, with the vision of creating a sustainable health care system that provides high-quality, equitable care to all Californians.

In enacting the California Health Care Quality and Affordability Act, the Legislature declared that "behavioral health needs are common among Californians, with most who need it not receiving treatment. National research finds that persons with mental health or substance use disorders have approximately two to three times higher medical costs than those with no behavioral health diagnosis. This research also shows that total health care spending on mental health and substance use disorder services has remained relatively flat between 2012 and 2017. Models that integrate primary care and behavioral health services have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs."[5]

As part of its work to promote high-value health system performance, OHCA will define behavioral health to measure behavioral health spending, including spending in a primary care setting, and set behavioral health investment benchmarks. OHCA is proposing the behavioral health spending definition and measurement methodology outlined below.

Statutory Requirements

As described in the OHCA enabling statute and summarized here, the statutory requirements related to behavioral health investment include: [6]

- Measure the percentage of total health care expenditures allocated to behavioral health and set spending benchmarks.
- Promote a sustained systemwide investment in behavioral health.
- Build and sustain methods of reimbursement that shift greater health care resources and investments away from specialty care and toward primary care and behavioral health.
- Consider differences among payers and fully integrated delivery systems, including factors such as plan or network design or line of business; the diversity of settings 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.
- Analyze behavioral health spending and growth, and relevant quality and equity performance measures, and incorporate these in the annual report.
- Consult with state departments, external organizations promoting investment in behavioral health, and other entities and individuals with expertise in behavioral health and health equity.

[5] Health and Safety Code Section 127500.5, subdivision (a)(8).
[6] These requirements are summarized from Health and Safety Code Section 127505, subdivisions (a) - (c).

The California Health Care Quality and Affordability Act also specifies that OHCA shall promote improved outcomes for behavioral health including health care entities' investment in or adoption of models that: [7]

- Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support for common behavioral health conditions, such as anxiety, depression, or substance use disorders.
- Leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. Team-based approaches support the sharing of accountability for delivery of care between physicians and nurse practitioners, physician assistants, medical assistants, nurses and nurse case managers, social workers, pharmacists, and traditional and nontraditional primary and behavioral health care providers, such as peer support specialists, community health works, and others.
- Deliver higher value behavioral health services with an aim toward reducing disparities.
- Leverage telehealth and other digital health solutions to expand access to behavioral health services, care coordination, and care management.
- Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

To measure the percentage of total health care expenditures allocated to behavioral health, OHCA is statutorily required to: [8]

- Use the Health Care Payments Data Program (HPD)[9] to the greatest extent possible, to minimize reporting burdens for health care entities.
- Determine the categories of health care professionals who should be considered behavioral health providers and consider existing state and national approaches as appropriate.
- Determine specific procedure codes that should be considered behavioral health services and consider existing state and national approaches, as appropriate.
- Determine the categories of payments to behavioral health providers and practices, including non-claims-based payments, such as alternative payment models, that should be included when determining the total amount spent on behavioral health.

[7] These requirements are summarized from Health and Safety Code Section 127505, subdivision (a).
[8] These requirements are summarized from Health and Safety Code Section 127501.4, subdivision (h)(2).
[9] HPD was established pursuant to Health and Safety Code Division 107, Part 2, Chapter 8.5 (starting with Health and Safety Code Section 127671).

OHCA has decision-making authority for the behavioral health spending definition and measurement methodology. In the future, OHCA will propose recommendations for the behavioral health investment benchmark, which is subject to Board approval.[10]

Background

Evidence indicates that effective treatment for behavioral health conditions, especially in integrated settings, contributes to better behavioral and overall health outcomes and correlates with reduced health care costs.[11] At the same time, many Californians cannot access affordable, in-network behavioral health care they need. A survey of Californians showed that nearly two thirds of those with mental illness did not receive mental health services, many due to the cost of care.[12] California ranks poorly among states on several measures of access to mental health treatment[13] and access to in-network mental health care is a challenge for over half of Californians surveyed.[14] By measuring behavioral health spending by payers across commercial, Medicare Advantage, and Medi-Cal markets, OHCA can focus attention on spending trends to promote improved health outcomes and affordability for consumers, as well as reduced system-wide spending.

OHCA launched the Investment and Payment Workgroup in June 2023, bringing together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans.[15] The Workgroup convenes monthly to provide input as OHCA develops its measurement approach and recommends targets or benchmarks in the areas of alternative payment models (APMs), primary care investment, and behavioral health investment. Since July 2024, the Workgroup has focused on behavioral health. At the outset of its behavioral health work, the Workgroup supported using a set of five goals for improved behavioral health in California, adapted from a California Health and Human Services Agency brief,[16] as the guiding vision to inform OHCA's development of

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[10] Health and Safety Code Section 127501.11, subdivision (b)(3).
[11] See OHCA Investment and Payment Workgroup June 2025 presentation: https://hcai.ca.gov/public-meetings/june-health-care-affordability-board-meeting-3/
[12] Holt, W., and Hahn, T. (2022, July). California Health Care Almanac. *Mental Health in California: Waiting for Care*. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf
[13] Radley, D. C., Baumgartner, J. C., Collins, S. R., & Zephyrin, L. C. (2023, June). *2023 Scorecard on State Health System Performance: Americans' Health Declines and Access to Reproductive Care Shrinks, But States Have Options*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance
[14] Joynt, J., Catterson, R., and Alvarez, E. (2024, January). *The 2024 CHCF California Health Policy Survey*. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf
[15] See OHCA Investment and Payment Workgroup publicly available meetings and materials: https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/
[16] California Health and Human Services Agency. (2023, March). *Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts*. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

its behavioral health spending methodology and benchmark. In addition, the Workgroup used the standardized behavioral health clinical spending measurement methodology developed by the Milbank Memorial Fund and Freedman HealthCare (the Milbank-Freedman methodology)[17] as a guide for its development of OHCA's behavioral health spending definition and measurement methodology.

The proposed definition and measurement methodology described in this memo were informed by months of discussion with the Workgroup and additional stakeholder feedback, including from sibling state departments. During its development, elements of the definition were reviewed by the Health Care Affordability Advisory Committee in October 2024, December 2024, January 2025, and March 2025 and by the Health Care Affordability Board in December 2024 and February 2025. OHCA presented a draft version of the behavioral health spending definition and measurement methodology to the Health Care Affordability Board on July 22, 2025 for review. OHCA will collect public comments on this proposed behavioral health definition and measurement methodology, including the associated code set, in August 2025.

OHCA will incorporate public comments and further input from the Health Care Affordability Advisory Committee and Health Care Affordability Board into the behavioral health definition and measurement methodology that will be included in OHCA's 2026 Data Submission Guide and incorporated into regulation.[18] Following publication of the 2026 Data Submission Guide, OHCA will collect behavioral health spending data from payers beginning in 2026 and report its findings in its annual reports beginning in 2027.

Status of Behavioral Health Investment Benchmark Proposal

In winter and spring 2025, OHCA worked with the Investment and Payment Workgroup and other stakeholders, including sibling state departments, to develop a draft behavioral health investment benchmark. A proposed benchmark was presented to the Workgroup in May 2025, along with preliminary analyses of historical behavioral health spending in California using data from the Health Care Payments Data Program (HPD), Covered California, and CalPERS. Based on input from the Workgroup that historical data are insufficient to set a specific spending benchmark at this time, OHCA recommended to the Health Care Affordability Board at its June 2025 meeting to delay the adoption of a behavioral health investment benchmark until 2028.[19] This approach would allow time to collect and analyze behavioral health spending data from commercial, Medi-Cal, and Medicare Advantage payers and to further study recent spending trends and impacts of behavioral health policies being implemented in California before setting a benchmark. The Board supported delaying benchmark setting for at least one year, requesting that OHCA continue to analyze data from existing sources and revisit readiness to set a benchmark in 2026. OHCA will continue

[17] Sinha, V., Rourke, E., Condon, M. J., & Brandel, W. (2024, April). *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending*. Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2024/04/BH_SPENDING61824.pdf

[18] Total Health Care Expenditures (THCE) Data Submission Guide (DSG) https://hcai.ca.gov/wp-content/uploads/2025/05/THCE-Data-Submission-Guide-v2.0.pdf, incorporated by reference in Cal. Code Regs., tit. 22, § 97445.

[19] See Health Care Affordability Board meeting presentation June 9, 2025: https://hcai.ca.gov/wp-content/uploads/2025/06/June-2025-OHCA-Board-Meeting-Presentation-1.pdf

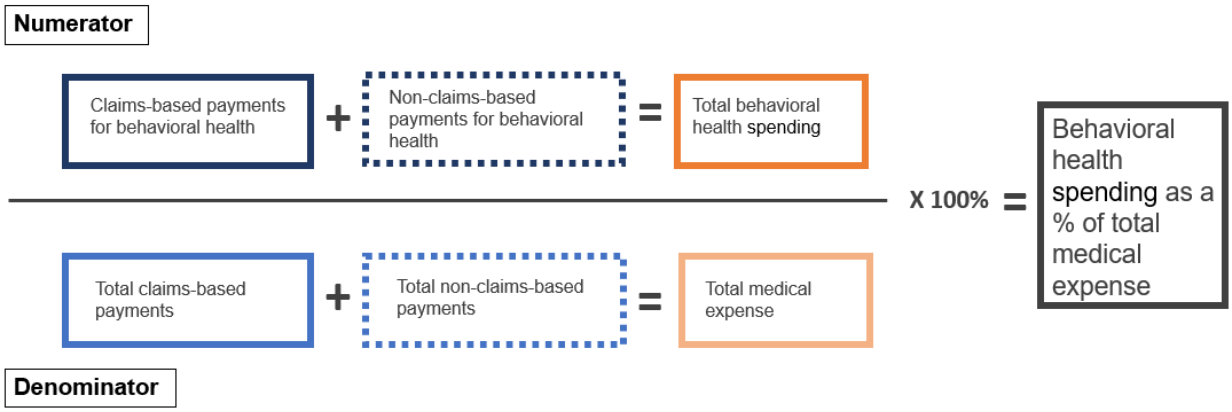
to analyze existing data from the HPD and will continue its collaboration with the Department of Health Care Services (DHCS) to develop a measurement methodology that includes Medi-Cal specialty behavioral health spending. Following the support from the Board, this revised approach to revisit the benchmark in 2026 received additional support from the Advisory Committee and the Workgroup at their subsequent meetings in June 2025.

Behavioral Health Spending Definition and Measurement Methodology

OHCA will measure behavioral health care spending through claims and non-claims payments. The methodology described below, and the accompanying code set, specifies OHCA's proposal for how data submitters will measure behavioral health care spending.[20] A final definition and measurement methodology will be included in the 2026 Data Submission Guide and incorporated into regulation.[21]

A high-level equation showing how OHCA will calculate behavioral health spending as a percentage of total medical expense is shown in **Figure 1**. More detailed information on OHCA's methodology for measuring Behavioral Health Paid via Claims and Behavioral Health Paid via Non-Claims payments can be found in their respective sections below.

Figure 1. Equation for Measuring Behavioral Health Care Spending



Note: The numerator will include patient out-of-pocket responsibility for behavioral health services obtained through the plan i.e., services for which a claim or encounter was generated. The denominator will include pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

Source: Adapted from Erin Taylor, Michael Bailit, and Deepti Kanneganti. Measuring Non-Claims-Based Primary Care Spending. Milbank Memorial Fund. April 15, 2021.

[20] Entities required to submit behavioral health spending data to OHCA are payers and fully integrated delivery systems that provide coverage to minimum of 40,000 lives in the commercial, Medicare Advantage, and/or Medi-Cal managed care markets. See Cal. Code Regs., tit. 22, §§ 97445 and 97449.
[21] Total Health Care Expenditures (THCE) Data Submission Guide (DSG) https://hcai.ca.gov/wp-content/uploads/2025/05/THCE-Data-Submission-Guide-v2.0.pdf, incorporated by reference in Cal. Code Regs., tit. 22, § 97445.

OHCA will measure behavioral health care spending using three modules as shown in **Figure 2**. The modules allow OHCA to monitor each of these types of behavioral health spending separately. The Behavioral Health in Primary Care module, described in more detail below, consists of a limited number of behavioral health services when provided in a primary care setting.

Figure 2. Three Recommended Modules for Behavioral Health Spending Measurement

Claims-Based Behavioral Health Spending

OHCA will measure claims-based behavioral health spending using a methodology informed by the standardized Milbank-Freedman methodology,[22] as shown by the process map in **Figure 3** below. For most claims, the methodology defines behavioral health claims based on the primary diagnosis; behavioral health screening and assessment services and behavioral health pharmacy claims are included regardless of primary diagnosis.

Data submitters will identify claims that are considered behavioral health spending using the **primary diagnosis** on each claim. Any claim with a primary diagnosis code found in the OHCA behavioral health code set will be included in measurement. The diagnoses in the code set are based on the Milbank-Freedman methodology, with modifications for California based on stakeholder input, including input from sibling state departments.

If the primary diagnosis field does not contain a behavioral health diagnosis code, the claim can still be considered behavioral health if it includes a service code for **mental health or substance use disorder screening or assessment** as listed in the OHCA code set. Claim lines with screening or assessment codes are considered behavioral health spending.

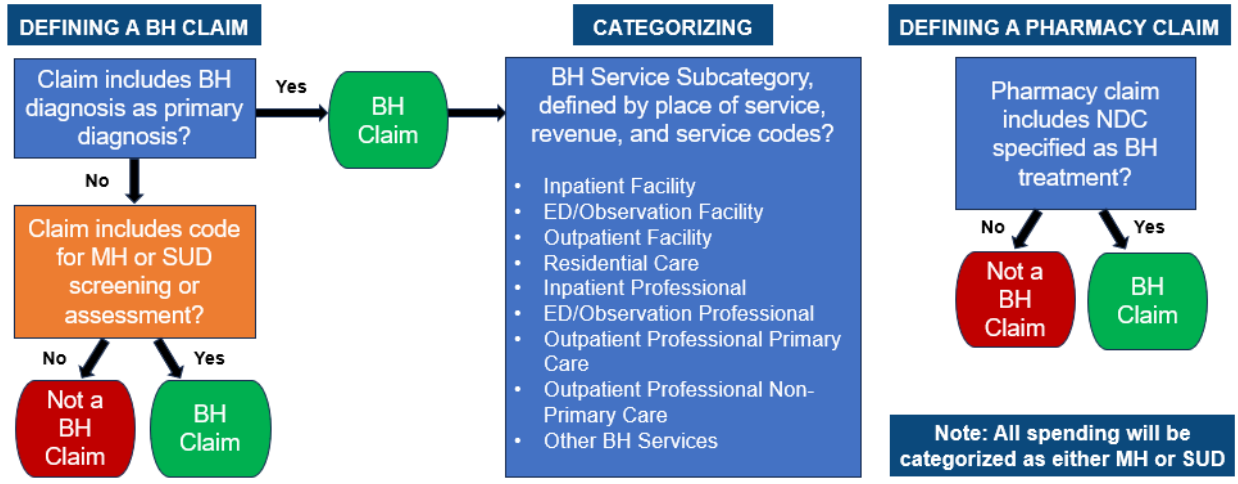
[22] Sinha, V., Rourke, E., Condon, M. J., & Brandel, W. (2024, April). *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending*. Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2024/04/BH_SPENDING61824.pdf

For claims with a behavioral health primary diagnosis, all of which are considered behavioral health spending, the next step is to categorize the service into a specific subcategory using the place of service, revenue, and service codes on the claim. This step allows for analysis of behavioral health spending by care setting. The OHCA code set specifies the codes that define each subcategory. Claims with a behavioral health primary diagnosis that do not fit into any of the defined subcategories are categorized as "Other Behavioral Health Services."

All behavioral health spending will be categorized as either mental health or substance use disorder spending, based on the primary diagnosis on the claim.

To identify pharmacy claims for inclusion in behavioral health spending measurement, payers will use the list of National Drug Codes (NDC) in OHCA's code set to identify medications that are considered behavioral health treatments. If a pharmacy claim contains an NDC in the code set, it is considered a behavioral health claim. All behavioral health pharmacy spending will be categorized as either mental health or substance use disorder spending based on the designation of the medication in OHCA's code set.

Figure 3. Identifying Behavioral Health (BH) Care Paid via Claims



Note: BH = Behavioral Health; MH = Mental Health; SUD = Substance Use Disorder; ED = Emergency Department; NDC = National Drug Code

Non-Claims Behavioral Health Spending

OHCA uses the Expanded Non-Claims Payments Framework (Expanded Framework) to categorize non-claims payment data in its total medical expenses, APM adoption, and primary care spending data collections.[23] OHCA will follow the approach outlined in **Table 1** below to allocate a portion of non-claims payments to behavioral health

[23] See OHCA Expanded Non-Claims Payments Framework: https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

spending. OHCA developed the approach outlined below with input from the Investment and Payment Workgroup and other stakeholders.[24]

Note: Some subcategories of non-claims payments will be fully allocated to behavioral health spending, other categories will be partially allocated to behavioral health spending, and a few categories are not applicable to behavioral health and will not be allocated to behavioral health spending.

Table 1. Allocation of Non-Claims Payments to Behavioral Health

Expanded Framework Category		Full or Partial Allocation to Behavioral Health	Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**		
A1	Care management/care coordination/population health/medication reconciliation	Partial	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	Full	Allocate full primary care and behavioral health integration amount to behavioral health care spending.
A3	Social care integration	Partial	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A4	Practice transformation payments	Partial	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health (see **Figure A1** in the Appendix).
A5	EHR/HIT infrastructure and other data analytics payments	Partial	
B	**Performance Payments**		
B1	Retrospective/prospective incentive payments: pay-for-reporting	Partial	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	Partial	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

[24] See OHCA Investment and Payment Workgroup March 2025, April 2025, and July 2025 presentations: https://hcai.ca.gov/affordability/ohca/#investment-payment-workgroup

Table 1, continued. Allocation of Non-Claims Payments to Behavioral Health

Expanded Framework Category		Full or Partial Allocation to Behavioral Health	Allocation to Behavioral Health Spending
C	**Shared Savings Payments and Recoupments**		
C1	Procedure-related, episode-based payments with shared savings	Not Applicable	
C2	Procedure-related, episode-based payments with risk of recoupments		
C3	Condition-related, episode-based payments with shared savings	Full	Including spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	Full	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable	
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments		
D	**Capitation and Full Risk Payments**		
D1	Primary Care capitation	Not Applicable	
D2	Professional capitation	Partial	Calculate a fee for service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters (see **Figure A2** in the Appendix).
D3	Facility capitation	Not Applicable	
D4	Behavioral Health capitation	Full	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Partial	Calculate a fee for service equivalent based on a fee schedule for behavioral health services multiplied by the number of encounters (see **Figure A2** in the Appendix).
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems		
E	**Other Non-Claims Payments**	Partial	Limit the portion of other non-claims payments** allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health (see **Figure A1** in the Appendix).
F	**Pharmacy Rebates**	Not Applicable	

**May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Behavioral Health in Primary Care Module

Recognizing the high degree of overlap between primary care and behavioral health service delivery, and the improved outcomes associated with integration of behavioral health into primary care, OHCA plans to measure behavioral health care delivered in primary care settings as a discrete module that could be included in analyses of either behavioral health or primary care spending. This module, as shown in **Figure 2,** will include screening and office visits for behavioral health diagnoses delivered by primary care providers, as well as counseling or therapy when provided by a primary care provider or via integrated behavioral health services, where data allow.

As a reminder, the 2025 Data Submission Guide primary care spending allocation methodology specifies primary care provider taxonomies. To identify behavioral health spending in primary care via claims and non-claims payments, OHCA proposes to expand the list of primary care provider taxonomies[25] to include select behavioral health professionals, such as Psychologists, Social Workers, and Marriage and Family Therapists, who commonly deliver services in integrated primary care settings, in its 2026 Data Submission Guide.

Claims Based Behavioral Health Spending in the Module

As illustrated in **Figure 4** below, submitters will identify claims for inclusion in the Behavioral Health in Primary Care module as follows:

- First, submitters will identify claims with a primary behavioral health diagnosis or with a service code for a behavioral health screening or assessment.
- Second, submitters will narrow down to claims with a primary care provider taxonomy using the expanded taxonomy list described above.
- Next, submitters will further narrow down to claims that have a primary care place of service in accordance with OHCA's primary care spending allocation methodology.[26]
- If each of these conditions are met, the final step is to determine whether these claims include service codes in the "Outpatient Professional Primary Care" service subcategory of the behavioral health code set.[27]

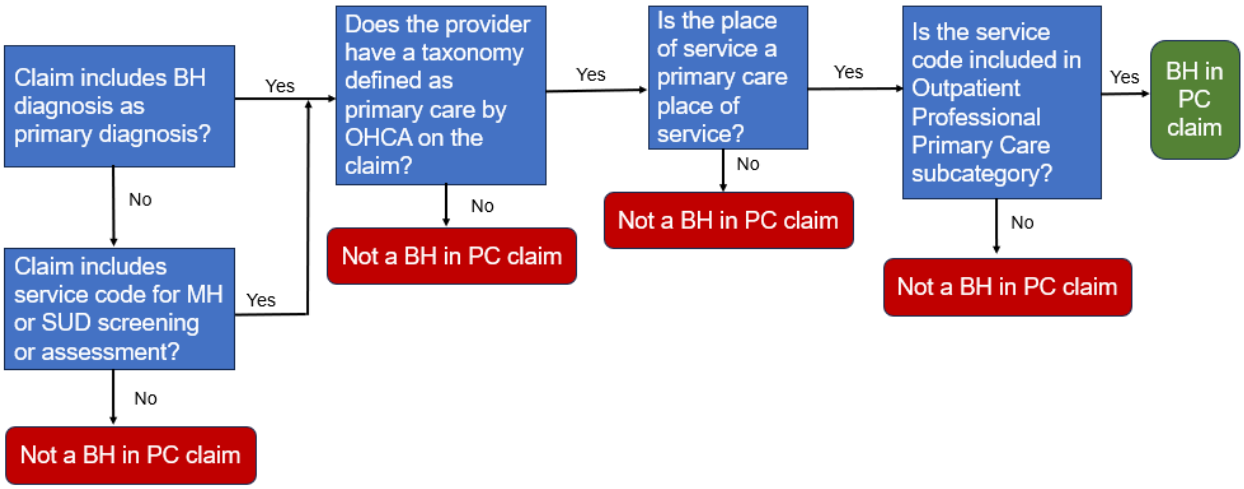
Claims meeting all these requirements will be included in the Behavioral Health in Primary Care module.

[25] OHCA's primary care allocation methodology uses a list of provider taxonomies considered primary care providers to determine whether a claim is considered primary care spending. For further details, see Section 4.9 and Appendix E of Total Health Care Expenditures (THCE) Data Submission Guide (DSG) version 2.0. https://hcai.ca.gov/wp-content/uploads/2025/05/THCE-Data-Submission-Guide-v2.0.pdf

[26] For OHCA Primary Care allocation methodology, see Section 4.9 of Total Health Care Expenditures (THCE) Data Submission Guide (DSG) version 2.0. https://hcai.ca.gov/wp-content/uploads/2025/05/THCE-Data-Submission-Guide-v2.0.pdf

[27] OHCA proposes to expand its existing list of primary care services to include additional services related to integrated behavioral health care.

Figure 4. Process Map for Identifying Behavioral Health in Primary Care Spending



Note: BH = Behavioral Health; MH = Mental Health; SUD = Substance Use Disorder; BH in PC = Behavioral Health in Primary Care

Non-Claims Based Behavioral Health Spending in the Module

The non-claims spending in this module will include:

- All primary care and behavioral health integration payments.
- A subset of the behavioral health portion of capitation and full risk payments (i.e., professional, behavioral health, and global capitation payments and payments to integrated comprehensive payment and delivery systems). Data submitters will identify encounters within these capitation payments with a primary behavioral health diagnosis, a primary care provider taxonomy, a primary care place of service, and a service code in the "Outpatient Professional Primary Care" service subcategory to identify the portion of the capitation payment that will be included in this module using the methodology in **Figure A2** in the Appendix.

Further methodological details for allocating spending to the Behavioral Health in Primary Care module will be included in OHCA's 2026 Data Submission Guide.

Rationale for Select Methodological Decisions

Decisions about whether to include dementia and traumatic brain injury (TBI) as behavioral health diagnoses prompted detailed discussion in the Workgroup. Treatment for these conditions has both behavioral and medical components, and methodological limitations make it difficult to distinguish between medical and behavioral care for any particular diagnosis. The inclusion of medical care for these conditions could overstate behavioral health spending. Other states that measure behavioral health spending take different approaches to including dementia, with some including and others excluding; no state includes TBI as a behavioral health diagnosis. After discussion with the Workgroup and other stakeholders, OHCA proposes to exclude TBI diagnoses from its behavioral health definition, noting that behavioral health care for individuals with TBI is often coded for the associated behavioral health condition (e.g., depression) and would

therefore be included. To minimize inclusion of medical spending for dementia, OHCA proposes to include dementia codes listed in the International Classification of Diseases Version 10 (ICD-10)[28] as mental or behavioral disorders using F codes and to exclude the medical diagnosis codes (G codes in ICD-10) associated with specific types of dementia such as Alzheimer's disease.

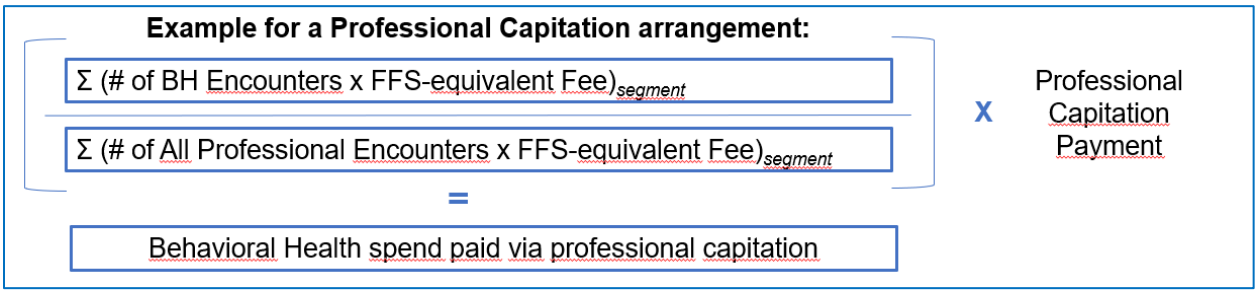
Decisions about how to categorize behavioral health claims spending into service categories also prompted detailed discussion in the Workgroup. The service categories are used to track and trend behavioral health spending in different care settings, but do not impact the total behavioral health spending included in OHCA's measurement (see **Figure 3**). Stakeholders expressed interest in understanding behavioral health crisis care and mobile services utilization. These analyses require more granular data than the OHCA behavioral health data collection can provide. Additionally, preliminary analyses of historical behavioral health spending in California using data from the HPD showed little to no behavioral health spending for mobile services and long-term care for commercial, Medicare Advantage, and Medi-Cal. Therefore, mobile care, crisis care, and long-term care service subcategories are not included in OHCA's service categorization for behavioral health spending. These changes to service categorization also reduce data submitter burden and simplify OHCA's behavioral health spending measurement methodology.

[28] ICD10Data.com. (n.d.). *ICD-10-CM Codes*. Retrieved July 2025, from https://www.icd10data.com/ICD10CM/Codes

Appendix: Non-Claims Payment Allocation Formulas

Figure A1. Apportioning Practice Transformation (A4), EHR/HIT (A5), and Other (E) Non-Claims Payments to Behavioral Health

Figure A2. Apportioning Professional (D2) and Global Capitation (D5) and Payments to Integrated, Comprehensive Payment and Delivery Systems (D6) to Behavioral Health



Note: "Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year, and region or other geography as appropriate. This methodology aligns with OHCA primary care spending allocation methodology.