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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

September 17, 2025

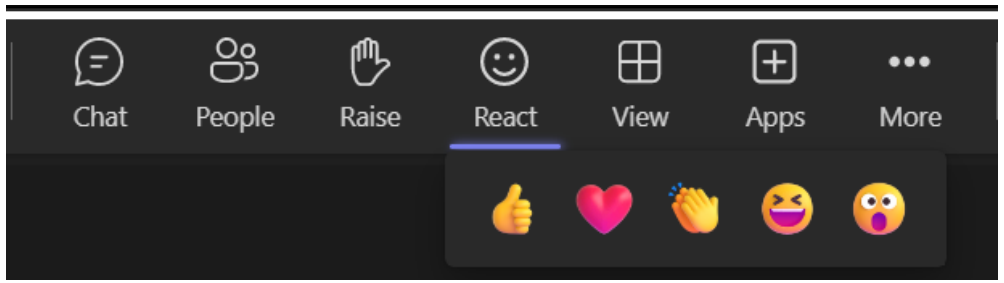
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Behavioral Health Spending Definition: Review of Public Comment**
9:40 a.m.	**3.**	**Revisiting the Behavioral Health in Primary Care Module**
10:10 a.m.	**4.**	**Future Workgroup Meetings and Activities**
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 the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: September 17, 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

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Executive Vice President of Government Affairs, America's Physician Groups

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Chief Executive Officer, California Academy of Family Physicians (CAFP)

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Catherine Teare, MPP
Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)

State & Private Purchasers

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Medical Consultant II, CalPERS

Teresa Castillo
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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

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Behavioral Health Spending Definition: Review of Public Comment

Debbie Lindes, Health Care Delivery System Group Manager

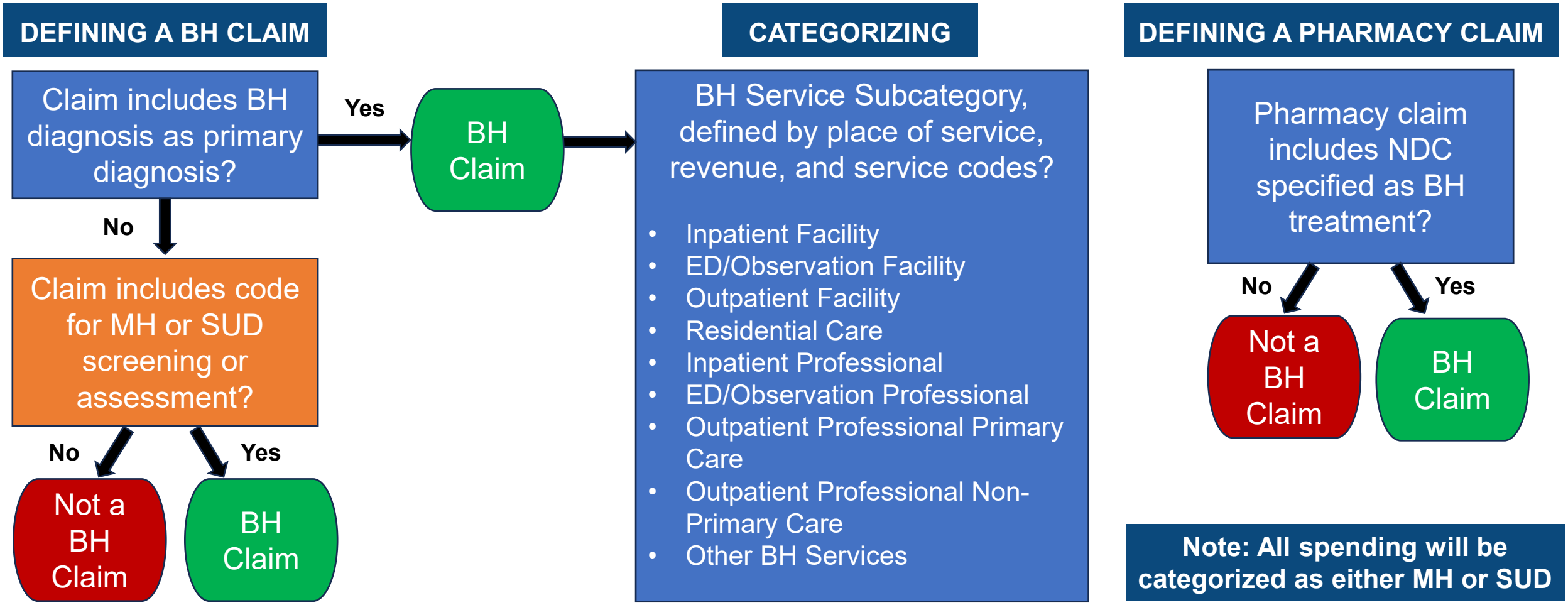
Sources of Public Comments

OHCA received comments on the proposed behavioral health spending definition, measurement methodology, and code set from several types of organizations:

- Consumer advocates and organizations representing specific population groups (5 organizations*)
- Provider organizations (3)
- Quality organization (1)
- Payer organization (1)
- Labor union (1)

*Five organizations submitted a joint comment letter

Milbank-Freedman Process Map for Identifying Behavioral Health (BH) Claims



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

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Measurement Methodology

Feedback (number of comments)	OHCA Response
Diagnoses • Support for using diagnosis codes rather than taxonomy to identify behavioral health claims (1) • The use of primary diagnosis is too restrictive and the definition should include claims with secondary behavioral health diagnoses or other ways to capture all behavioral health services (3) • Include G codes as well as F codes associated with Alzheimer's Disease and Dementia in code set (G codes are more likely to be used under capitation) (1)	• Including all spend on claims with a secondary behavioral health diagnosis would result in significant overcounting of medical spend • Including behavioral health spend for claims with a secondary diagnosis would also result in data submitter burden • OHCA will evaluate inclusion of G codes, including codes' overlap with the relevant HEDIS MY24 value sets
Services • Use specific procedure and service codes to identify a behavioral health claim in absence of primary diagnosis, in addition to screening and assessment (1)	• Expanding the list of services that do not require a primary behavioral health diagnosis will add data submitter burden and increase the risk of overcounting

Measurement Methodology

Feedback (number of comments)	OHCA Response
• Incorporate encounter data into methodology (1)	• Encounter data is used in the non-claims methodology to allocate portions of capitation payments to behavioral health.
• Include partial hospitalization, long-term care, intensive community treatment place of service codes (2)	• OHCA's definition does not limit measurement by place of service. Place of service codes for these facilities are included in service categorization.
• Include mobile clinic services as a subcategory, to encourage this type of care (1)	• OHCA will continue to monitor spending in this category using the Health Care Payments Database (HPD) and is open to including it in the future.
• Collect Medi-Cal data, including County behavioral health services claims, as soon as possible (2)	• OHCA is working with DHCS collect both Managed Care Plan and County behavioral health spending.
• Include paraprofessional providers included in Children and Youth Behavioral Health Initiative (CYBHI) fee schedule (1)	• Provider type is not part of OHCA's definition, so services meeting the diagnosis requirement will be included.

Behavioral Health in Primary Care Module

Feedback (number of comments)	OHCA Response
• General support for the module overall	
• Support for expanding the primary care provider taxonomy list to capture additional integrated behavioral health in primary care spend (1) • Oppose expansion of the list because of potential overcounting of non-integrated care and impact on primary care spend measurement (2)	• OHCA appreciates the potential impact of overcounting non-integrated spend and will use the Health Care Payments Database (HPD) to analyze options for an expanded module in the future • OHCA proposes keeping the module with the original (unexpanded) primary care taxonomies
• To avoid double-counting, count screening and referrals as primary care only and complex diagnoses and treatments as behavioral health (1)	• The module counts these services as both primary care and behavioral health; the modular format allows them to be included or excluded from each

Behavioral Health Investment Benchmark

Feedback (number of comments)	OHCA Response
• Commenters support delay in setting a benchmark (2) • Urge timely action in filling data gaps to inform the benchmark (2)	• OHCA is planning extensive analysis over the next several months, with the intention to propose a benchmark to the Board in Summer 2026.
• Benchmark should encourage investment across the full continuum of care, rather than focus on outpatient and community-based care (1)	• Stakeholders strongly supported an outpatient-focused benchmark in 2025 • Once additional analyses are completed, OHCA will share findings to inform future discussions with stakeholders on the focus on the benchmark

Supplemental Analyses

Some comments went beyond the specifics of OHCA's proposed behavioral health definition and measurement methodology. These suggestions are more appropriately addressed as part of supplemental analyses or research studies. OHCA will evaluate these suggestions along with its other planned analyses of HPD data.

Feedback
• Quickly adopt a plan and timeline for an alternative approach to measuring out-of-plan, out-of-pocket spending for behavioral health care
• Assess spending and utilization using Z codes, including for social determinants of health
• Document preventive and treatment services in various settings to assess access
• Measure spending against unmet needs and desired outcomes
• Measure cost savings associated with modalities of care
• Evaluate payment rates for non-physician professionals

Discussion

- Is there any additional feedback on the OHCA responses to the public comment?

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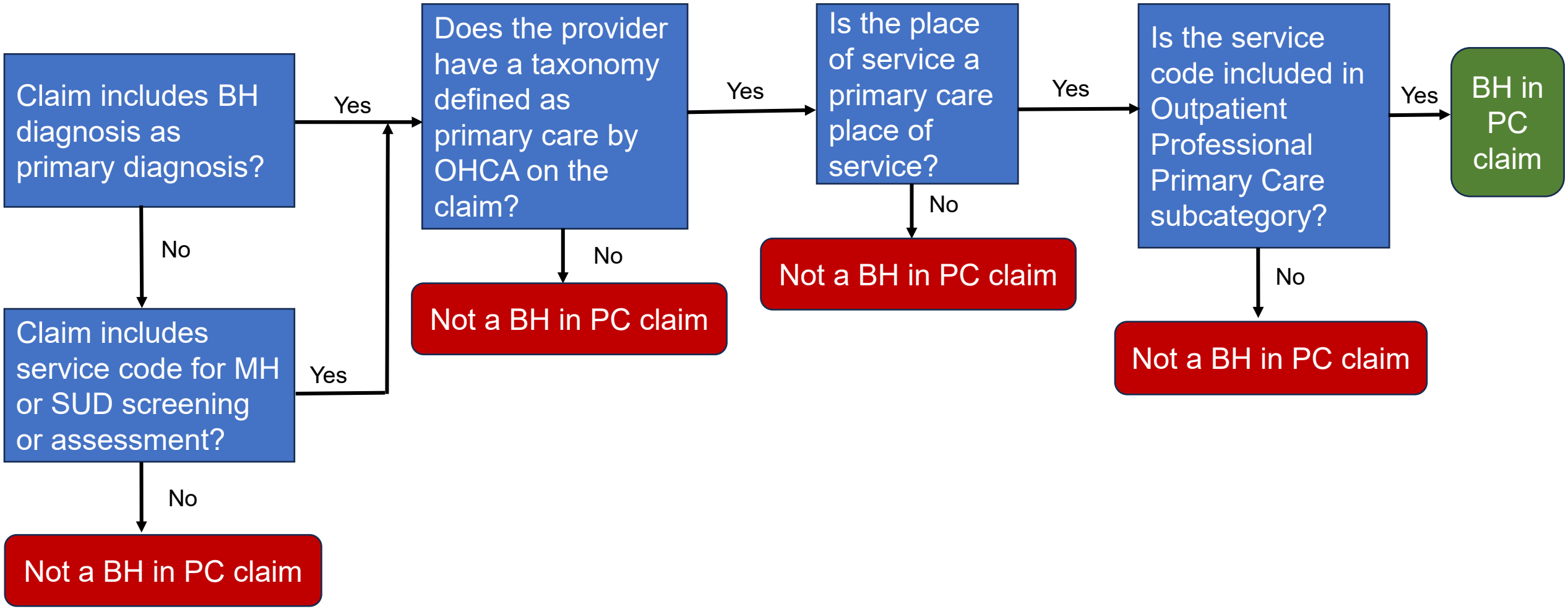
Revisiting the Behavioral Health in Primary Care Module

Robert Seifert, Consultant, Freedman HealthCare

Purpose of the Module

- To capture the overlap of behavioral health services with primary care, without double-counting
- To promote continued integration of behavioral health and primary care

Process Map for Identifying Behavioral Health in Primary Care Claims



Behavioral Health in Primary Care Module: Prior Approach

"Always" BH Services
w/ primary BH Dx and PC POS, Provider

- MH & SUD screening
- Integrated BH

"Sometimes" BH Services
w/ primary BH Dx and PC POS, Provider

Examples:
- Office visits
- Case management

Non-Claims BH

- BH integration (Cat. A2)
- Capitation (Cat. D)

Expand Primary Care Taxonomies
w/primary BH Dx and PC POS, Service

Examples include:
- Social workers
- Psychologists
- BH clinicians

Current Primary Care Definition

- BH in PC module would include certain PC services when a BH diagnosis is present.

Add BH Providers to Primary Care Definition

- To capture their spend for specific BH in primary care codes

Challenges of Implementing the Module

- Limitations of claims data introduce imprecision to the identification of behavioral health in primary care spending
- For non-claims payments, applying the method for allocating a portion of capitation payments to behavioral health a second time for the behavioral health in primary care module will be burdensome to data submitters
- Criterion of “mutually exclusive, collectively exhaustive” (i.e., all spending in the module must also meet the definitions for primary care and for behavioral health) imposes constraints on the methodology

Example of Overcounting in Prior Approach to Behavioral Health in Primary Care Module

- Prior approach expanded primary care provider taxonomy list in order to capture important integrated behavioral health services
  - For example, psychotherapy is an essential element of the Primary Care Behavioral Health model and would be excluded without including psychotherapists as primary care providers
- Psychotherapists, and other BH providers who provide integrated BH services, also provide many non-integrated services
  - Data limitations do not allow submitters to identify integrated PC settings distinct from other office settings
  - Prior approach would over-count integrated services provided by BH providers on the expanded taxonomy list
- Revised approach would count these services as behavioral health, but not behavioral health in primary care

Proposed Way Forward

1. **Short term** (2026 Data Collection): Capture a portion of behavioral health in primary care spending in OHCA's Total Health Care Expenditure (THCE) data collection
   - Primary care taxonomies list not expanded (see Appendix for previously proposed list of expanded primary care taxonomies)
2. **Longer term:** Analyze HPD data to measure integrated behavioral health provided by behavioral health clinicians with methodological nuance
   - Expanded taxonomies, integrated psychotherapy and other services, etc.
   - Refine methodology for future THCE data collection, perhaps in concert with benchmark development

Behavioral Health in Primary Care Module: Revised Approach

Payment Type	Spending Included
Claims	Outpatient Professional Primary Care subcategory • Existing set of primary care provider taxonomies, places of service • Service list includes screening and assessment, Collaborative Care Model and other integrated behavioral health codes
Non-Claims	Primary Care and Behavioral Health Integration payments (subcategory A2)

Discussion

- What are your thoughts about OHCA's proposed way forward on measuring behavioral health in primary care?

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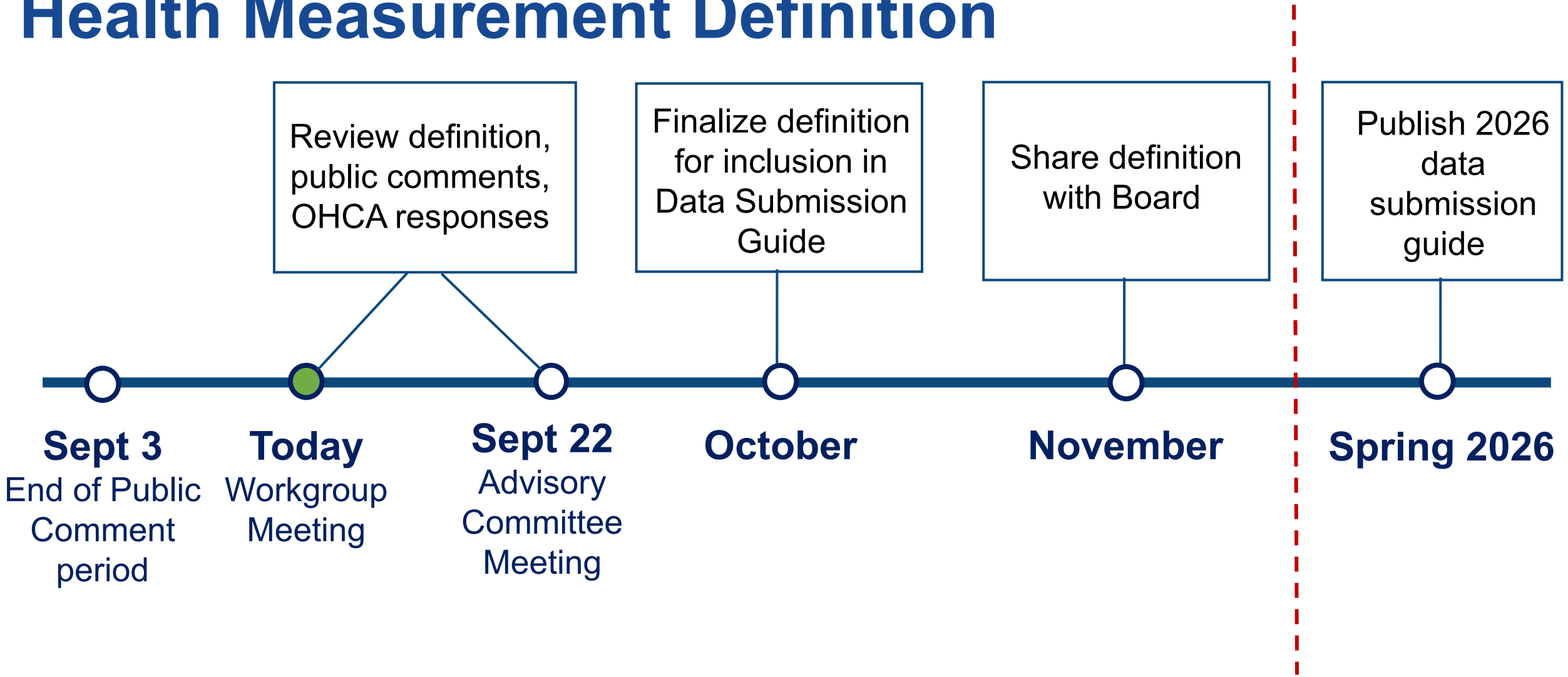
Future Workgroup Meetings and Activities

Debbie Lindes, Health Care Delivery System Group Manager

Detailed Timeline for Finalizing Behavioral Health Measurement Definition



Future Workgroup Structure and Approach

- Quarterly convening, beginning in December
- Broad range of topics
- Refreshed membership
  - Current members have opportunity to continue
  - Re-engage members from Primary Care and Alternative Payment Model workstreams
  - Agendas distributed well in advance to support member's attendance based on the agenda topics and their expertise and interests; not all members expected to attend all meetings

Quarterly Workgroup Meetings: Potential Topics

- Introduce HCAI “Health of Primary Care in California Snapshot” project including vision, purpose, and timeline
- Discuss behavioral health spending definition in 2026 OHCA Data Submission Guide
- Preview of primary care and alternative payment model (APM) data analyses
- APM adoption and primary care investment best practices
- Additional behavioral health spending analyses
- Discuss recommendations to Board for behavioral health investment benchmark

Dates of Upcoming Workgroup Meetings

December 17, 2025

March 18, 2026

May 20, 2026

August 19, 2026

October 21, 2026

Meetings occur on the third Wednesday of the month, from 9:00-10:30 AM Pacific Time

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Adjournment

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Appendix

Previously Proposed Additions to Primary Care Provider Taxonomies

Taxonomy	NUCC Name*
101Y00000X	Counselor (General)
101YA0400X	Addiction (Substance Use Disorder) Counselor
101YM0800X	Mental Health Counselor
103T00000X	Psychologist
103TA0400X	Addiction (Substance Use Disorder) Psychologist
103TA0700X	Adult Development & Aging Psychologist
103TC0700X	Clinical Psychologist
103TC1900X	Counseling Psychologist
103TC2200X	Clinical Child & Adolescent Psychologist
103TF0000X	Family Psychologist
103TH0004X	Health Psychologist
103TH0100X	Health Service Psychologist
103TP0016X	Prescribing (Medical) Psychologist

Taxonomy	NUCC Name*
103TP2701X	Group Psychotherapy Psychologist
103TS0200X	School Psychologist
104100000X	Social Workers
1041C0700X	Clinical Social Worker
1041S0200X	School Social Worker
106H00000X	Marriage and Family Therapist
136A00000X	Dietetic Technician, Registered
167G00000X	Licensed Psychiatric Technician
171M00000X	Case Manager/Care Coordinator
235Z00000X	Speech-Language Pathologist
101YS0200X	School Counselor
363LP0808X	Psychiatric/Mental Health Nurse Practitioner

*National Uniform Claim Committee