HCAi Department of Health Care Access and Information

LONG-TERM FUNDING OPTIONS FOR THE HEALTH CARE PAYMENTS DATA PROGRAM

MARCH 2023

2020 WEST EL CAMINO AVENUE, SUITE 1200 • SACRAMENTO, CA 95833
PHONE: (916) 326-3700 • EMAIL: hpd@hcai.ca.gov

"A healthier California where all receive equitable, affordable, and quality health care"

State of California
Gavin Newsom, Governor

Health and Human Services Agency
Mark Ghaly MD, MPH, Secretary

Department of Health Care Access and Information
Elizabeth Landsberg, Director

Appreciation to all who contribute to the Health Care Payments Data Program's success

Executive Summary

By providing $60 million in initial funding for a state All-Payer Claims Database (APCD) in 2018, California made an important step toward increasing transparency for California's healthcare spend and improving affordability and health outcomes for Californians. With that investment, the Department of Health Care Access and Information (HCAI) established a new Health Care Payments Data (HPD) Program that collects detailed healthcare claims, utilization, enrollment, and provider data on insured Californians. Set for initial implementation in 2023, the HPD will be invaluable as a reporting tool and research database, especially as the data and analytic functionality matures over time. With the initial funding expiring in June 2025, legislative and budget actions are required to provide the HPD Program with a sustainable funding model to fulfill its legislative intent. **HCAI recommends that state policy makers support an annual total funds budget of $22 million for the HPD Program, including $15.4 million in state funds, starting with Fiscal Year 2025-26**.

Considerable success and progress in the development of the HPD Program has occurred since the 2018 enabling legislation. HCAI is on track to substantially complete the database by July 2023. Key stakeholder groups, including the HPD Advisory Committee, meet regularly on program policies and technical requirements for data submission. Several years of detailed healthcare data, starting with calendar year 2018, have been collected on services provided by California's commercial health plans and insurers, Medi-Cal, and Medicare. An ongoing federal funding process has been established in collaboration with the Department of Health Care Services, covering approximately one-fourth of the total costs of the Program. Technical solutions for data collection, integration, and reporting have been implemented.

Sustaining a reliable HPD Program to better understand the more than $400 billion spent annually on health care for Californians[1] requires investment and ongoing maintenance to fund many essential activities, including:

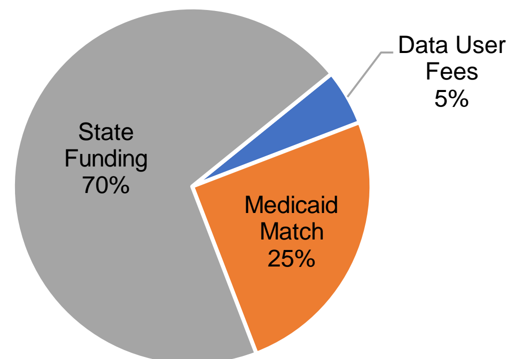
- Collect core data from public and commercial health plans and insurers, including monthly medical and pharmacy claim payments, enrollment, and provider information
- Support the addition of other data sources, such as non-claims payment data (including capitation and payments under other alternative payment models)
- Develop and maintain policies and practices to ensure the privacy, security, and confidentiality of consumers' individually identifiable health information
- Integrate, and make ready for analysis, data from California's disparate submitters
- Use data analysis and visualization capabilities to produce reports and data sets on healthcare payments and utilization
- Develop and maintain processes and a technical environment to support secure access to non-public data by researchers and other approved users
- Respond to the demand for additional data, uses, and users over time

- Analyze cost drivers for the newly formed Office of Health Care Affordability

HCAI estimates that Medicaid match will provide approximately 25% of the annual ongoing HPD operational costs, data user fees will provide up to 5% of the needed revenues, and direct, or state, funding will be required for approximately 70% of ongoing operating costs.

HPD Annual Funding Sources Estimates Based on Projected Operating Costs

	MEDICAID MATCH (25%)	USER FEES (5%)	DIRECT (STATE) FUNDING (70%)	TOTAL
Annual Operating Costs	$5.5M	$1.1M	$15.4M	**$22.0M**



Based on the experience of other states, discussions with the HPD Advisory Committee, and examples of funding methods used in California for other healthcare programs, the most likely state funding options for the roughly 70% of needed revenue (or $15.4 million per year) are General Fund, special funds from industry assessments, or some combination of those sources.

Special funds, funded by assessments on health plans and insurers, are used in California for various oversight, reporting, and transparency purposes and provide some significant advantages in stability and flexibility over reliance on the General Fund. Such an assessment would be on top of costs already incurred by health plans and insurers to provide required data to the HPD Program.

The amount of a health plan and insurer assessment could be reduced by amounts from the General Fund or by amounts contributed by other participants in California's healthcare industry.

Although current law prevents use of the General Fund for the HPD beyond June 2025, a change to the law and an accompanying budget change could support an ongoing General Fund appropriation.

Recommendation: HCAI recommends that state policy makers:

1. Support an annual total funds budget of $22 million for the HPD Program,
2. Establish a state funding model, using General Fund, special funds, or some combination thereof, that provides $15.4 million in annual state funds, and
3. Ensure the above funding provisions are in place with Fiscal Year 2025-26 to avoid disruption to HPD Program operations.

Additional Resources about HCAI and the HPD Program

California Department of Health Care Access and Information
Health Care Payments Data Program
HPD Program Goals
HPD Program Advisory Committee
Health Care Payments Data (HPD) Program Frequently Asked Questions
HPD Program Data Submitters
HPD Data Release Committee

HCAi
Department of Health Care Access and Information

Introduction

This Report evaluates options for long-term funding of the Health Care Payments Data (HPD) Program. In June 2018, the Governor signed Assembly Bill 1810 (Chapter 34, Statutes of 2018) which added Chapter 8.5, Health Care Cost Transparency Database, to the Health and Safety Code (HSC) (hereinafter referred to as "HSC Chapter 8.5"). Subsequently amended (AB 80, Chapter 12, Statutes of 2020), HSC Sections 127671-127674 require the Department of Health Care Access and Information (HCAI) to plan for, develop, and administer an HPD System, often referred to as an all-payer claims database (APCD) in the 19 states that have implemented such a program.[2]

The Legislature provided $60 million in one-time funding (SB 840, Chapter 29, Statutes of 2018) to establish the HPD Program and HSC Chapter 8.5 requires that HCAI, "on or before March 1, 2023 . . . submit a report to the Legislature on recommendations for funding options for the program." The HPD Program will likely expend the initial $60 million during state Fiscal Year (FY) 2024-25. Regardless, without a legislative change, spending authority for the initial $60 million expires at the end of June 2025.

The HPD Program's 2020 Report to the Legislature (hereinafter referred to as the "2020 Report") included a thorough discussion of funding options and initial recommendations.[3] This Report builds upon and updates the information provided in that 2020 Report. After a brief background and status of the HPD Program, this Report presents estimated costs to administer the HPD Program, provides an overview of typical APCD funding types and progress to date, and discusses considerations for the two most likely sources of ongoing funding: 1) state General Fund, and 2) assessments/special funds. Examples and learnings from other state APCDs and other programs within California are included throughout the Report.

Background on the HPD Program

With the passage AB 1810 in 2018, the California State Legislature took a crucial step forward in enabling a more efficient and effective, and thus more affordable, healthcare system in California. The Health Care Payments Data (HPD) Program, including the necessary planning, processes, resources, and system ("HPD System"), was established. In gathering, integrating, and organizing information about health plan and insurer payments for services, the HPD System offers an unprecedented opportunity to understand and address healthcare costs and drive improvement in California's healthcare system. The HPD Program will also play an important role in the new Office of Health Care Affordability (OHCA). The California Health Care Quality and Affordability Act requires that OHCA use the HPD Program "to the greatest extent possible" to support the calculation of total healthcare expenditures (SB 184, Chapter 47, Statutes of 2022).

Considerable progress in the development of the HPD Program has occurred since the 2018 legislation. HCAI is on track to substantially complete the database by July 2023 as required. Key milestones and accomplishments for the HPD Program are summarized below:

Exhibit 1. Key HPD Program Milestones

DATE	MILESTONE	DESCRIPTION
June 2018	• Initial Legislation (AB 1810, Chapter 34, Statutes of 2018)	• Outlines HPD Program intent and requires planning effort. • Requires the state to plan for, develop, and administer a "Health Care Cost Transparency Database," often referred to as an all-payer claims database (APCD) in other states. • Establishes the legislative intent of the HPD Program: – Establish a system to collect information regarding the cost of health care and a process for aggregating such information from many disparate systems, with the goal of providing greater transparency regarding healthcare costs. – Improve data transparency to achieve a sustainable healthcare system with more equitable access to affordable and high-quality health care for all. – Encourage use of such data to deliver health care that is cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.
March 2019 through February 2020	• HPD Review Committee	• Healthcare stakeholders and experts meet and advise the state on the establishment, implementation, sustainability, and ongoing administration of the HPD Program.
March 2020	• Legislative Report	• HPD Program submits statutorily required report to the Legislature. • The report includes background and learnings from other state APCDs, as well as 36 specific recommendations, discussed and voted on by Review Committee members, for the successful operation of the HPD Program in California, across nine areas: – APCDs and Use Cases

DATE	MILESTONE	DESCRIPTION
		– Data Categories and Formats – Linkages – Submitters – Funding and Sustainability – Privacy and Security – Technology Alternatives – Data Quality – Governance
July 2020	• Updated Legislation (AB 80, Chapter 12, Statutes of 2020)	• Authorizes data collection from health plans and insurers. • Requires the establishment of an HPD Program Advisory Committee to assist and advise the state in formulating program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the program. • Identifies the types of data to be collected by the HPD Program, including detailed payment and healthcare utilization information. • Requires the state to develop guidance (i.e., regulations) for required and voluntary data submissions from California's health plans, insurers, and other healthcare organizations.
October 2020	• Advisory Committee	• The Advisory Committee begins quarterly meetings. • The committee is comprised of healthcare stakeholders and experts to assist and advise the HCAI Director in formulating program policies regarding data collection, management, use, access, and development of public information to meet the goals of the HPD Program. • The committee does not have decision-making authority related to the administration of the database but serves as a forum for stakeholder and public engagement on policy decisions, while fostering accountability and transparency.
July 2021	• Submitter Group	• The Submitter Group, comprised of representatives from California's health plans and insurers, begins quarterly meetings. • Provides a forum for HPD Data Submitters to receive up to date information on submission requirements, troubleshoot data submissions, and address any other technical issues related to data submission.
December 2021	• Emergency Regulations	• Initiates the first stage of the HPD Data Program, including collecting core healthcare data, by identifying submitters, specifying data to be collected, creating a process for data submission, and establishing a timeline for data collection (California Code of Regulations, Title 22, Sections 97300-97370).
May 2022	• Plan and Submitter Registration	• Completes registration process for California's required submitters. • Health plans and insurers identify key contacts, product offerings and attributes of plans, and relationships with other organizations responsible for submitting data.

DATE	MILESTONE	DESCRIPTION
June 2022	• Data Collection Begins	• Submitters begin sending detailed data, including healthcare claims and encounters, eligibility, and provider information.
December 2022	• Data Release Committee	• Eleven-member committee begins regular meetings to advise on criteria, policies, and procedures for access to and release of HPD data.
February 2023	• Initial Data Collection Completes	• Submitters complete delivery of data covering calendar years 2018-2022.
June 2023 (Planned)	• Initial Data Quality Analysis Completes	• Complete user acceptance testing of HPD System functionality: data collection, data quality evaluation, analytic dataset generation, report creation.
July 2023 (Planned)	• HPD System Public Reporting Begins	• The HPD System public reporting begins, with data from the state's commercial health plans and insurers, Medi-Cal, and Medicare integrated into a single platform.

The HPD Program, if sufficiently funded, can provide tremendous value for the public, researchers, policymakers, practitioners, and others interested in health care in California. The HPD Program will:

Provide a window to California's $400 billion[1] healthcare spend. Approved users will be able to explore price variation for specific conditions, services, and procedures, statewide and by geographic area. The uniform structure of the HPD System's data will allow easier comparisons among Medicare, Medicaid, and commercial health plans and insurers. The service-level detail of the HPD data will help policymakers and OHCA identify the elements of California's healthcare system that are driving up costs and support design of targeted interventions.

Allow users to identify and act on opportunities to improve California's healthcare system. California has a complex healthcare landscape that, to date, has lacked a comprehensive overview of system performance. The HPD will allow assessments of the results of health initiatives and track changes in utilization, cost, and quality. Analyses using the HPD will support learning from the success of high-performing plans, models of care, and regions. The HPD will help streamline access to state-wide data across the California Health and Human Services Agency and other agencies.

Support healthcare research that directly benefits Californians. The HPD System will become one of the largest research databases of its kind, enabling a wide range of projects that align with the program's purposes. As understanding grows of the key role played by social drivers in health outcomes, the ability to link healthcare services data to social services and other data becomes increasingly important. The HPD will facilitate linkages with other datasets (e.g., economic, environmental, social, clinical), creating

opportunities to improve state programs informing the development of new healthcare policies, initiatives, and delivery systems.

Only with a reliable source of ongoing funding can the HPD Program meet its intended statutory and program goals. The HPD Program Goals were discussed with the HPD Advisory Committee at the April 28, 2022 meeting:

HPD Program Goals[4]

1. Provide public benefit for Californians and the state while protecting individual privacy.
2. Increase transparency about healthcare costs, utilization, quality, and equity.
3. Inform policy decisions on topics including the provision of quality health care, improving public health, reducing disparities, advancing health coverage, reducing healthcare costs, and oversight of the healthcare system and healthcare companies.
4. Support the development of approaches, services and programs that deliver health care that is cost effective, responsive to the needs of Californians, and recognizes the diversity of California and the impacts of social determinants of health.
5. Support a sustainable healthcare system and more equitable access to affordable and quality health care for all.

Estimated HPD Operations Costs

Sustaining and supporting a reliable HPD Program to better understand the more than $400 billion spent annually on health care for Californians[3] requires investment in an array of activities essential for a successful HPD Program, including:

- **Medical claim payment and utilization data collection**: support the ongoing submission of detailed healthcare utilization and payment data from:
  - California's commercial health plans and insurers. In some cases, plans and insurers coordinate the submission of separate feeds from within their organization and/or from sub-contracted entities. Most commercial submitters provide data monthly. The HPD provides analysis and feedback on data quality.
  - California's Medi-Cal program, covering approximately thirty-eight percent of the state's population.[i] This process requires monthly data feeds and ongoing coordination with the Department of Health Care Services (DHCS) to ensure that services are not duplicated in the feeds from commercial health plans and insurers.
  - The Centers for Medicare & Medicaid Services, for Californians with Original Medicare (note that Medicare Advantage data comes from California's commercial health plans).
  - Voluntary submitters, including organizations that administer healthcare benefits for self-funded employers.
- **Additional data collection**: support the addition of other data sources, such as non-claims payment data (including capitation and payments under other alternative payment models), dental data, and vital records.
- **Privacy and security**: develop and maintain policies and practices to ensure that the privacy, security, and confidentiality of consumers' individually identifiable health information is protected, consistent with state and federal privacy laws. This includes the process for collecting and storing data securely.
- **Data quality, aggregation, and enhancement**: integrate, and make ready for analysis, data from California's disparate submitters. This includes analysis and monitoring of data quality as well as complex technical processes to help reconcile the various data feeds and identifiers for individuals, hospitals, and providers used by California's health plans and insurers.
- **Analytics and public reporting**: use business intelligence and other built-in analysis capabilities to produce visualizations, reports, and data sets on healthcare payments and utilization.
- **Research enclave**: develop and provide processes and a technical environment to support secure access to non-public data by researchers and other approved users.

[i] Calculated, based on 14.9 million Medi-Cal enrollees[5] and 39.2 million Californians.[6]

- **Stakeholder engagement**: support the HPD Advisory Committee, including preparation of meeting materials, presenters, and public comment; adhere to requirements for public meetings in California.
- **Data request and release**: support a process, including review of requests and data use agreements, to manage access to non-public data, including a new Data Release Committee for HPD data.

Developing a sustainable funding plan for ongoing operating costs requires an estimation of those future operating costs. The 2020 Report included an estimate of approximately $15 million in ongoing annual costs for an initial, or “basic” HPD, based on the experience of other states, results from a request for information process with the vendor community, and an assessment of current staffing levels and resources.

HCAI subsequently developed a plan and budget to build the HPD System, and operate it through June 30, 2025, using the original $60 million appropriation from 2018. The California Department of Technology (CDT), as part of their oversight role for state IT projects, reviewed and approved the spending plan for the HPD System. HCAI is on track expending the original appropriation against planned project activities to develop the HPD System and will meet the core requirements of the HPD with the one-time budget provided. The CDT-approved project budget also includes an estimate of $16.2 million to maintain and operate the HPD Program in the first year following the initial implementation. This estimate was intended to cover the basic HPD operating costs, including technical infrastructure, initial data collection, program administration, the data request program, and technical support.

Considerable progress and experience since the development of these initial budgets have helped inform a more up to date estimate of ongoing costs, including:

- Updates to the high-level HPD System Design, including defining roles for vendor and state organizations.
- Completion of several procurements of experienced vendors to assist in the development of the HPD Program.
- Identification and onboarding of state positions (and associated costs) required to support the HPD Program.
- Development, testing, and implementation of many of the IT functions of the HPD System, including the data collection and data aggregation processes necessary to analyze healthcare payment and utilization data across California’s health plans and insurers.
- Discussion and identification of data or functionality that can be added over time, including new data collection streams, integration with other programs, new and more complex use cases, additional analytics, and expanded access to researchers.

The HPD Advisory Committee, over the course of numerous meetings through October 2021, has acknowledged that a higher level of funding will be required to fully meet the legislative vision for the HPD Program. Other state APCD programs typically build upon the core data sources and functionality of the system over time, and similar growth is envisioned for California’s program. The 2020 Report anticipated such a trajectory,

describing the types of use cases, data sources, linkages, and support for researchers that could logically be added over time (see Exhibit 2, Data and Reporting Through the HPD). The approach has always been to launch with a core system and add to it over time.

Exhibit 2. Data and Reporting Through the HPD (from 2020 Report)[a]

	TIER 1: CORE	TIER 2: EXPANSION	TIER 3: MATURITY
Data Categories	• Claims and encounters (medical and pharmacy) • Member enrollment • Provider information	• Capitation: alternative payment models (APMs), pharmacy rebates, pay for performance, etc. • Dental claims, encounters, member enrollment, and provider information	• Lab values and other clinical information through electronic medical records (potentially)
Leveraging Other Data Sources: Examples	• Census data elements (such as race/ethnicity, income, and housing)	• Hospital discharge data (HCAI) • Vital statistics (birth and death records) • Surveys (e.g., California Health Interview Survey, Behavioral Risk Factor Surveillance System) • CA's open data portal (e.g., air and water quality) • Other public sources	• Immunization registries • Chronic disease registries • CA Reportable Disease Information Exchange (infectious disease, CalREDIE) • California Cancer Registry • Controlled Substance Utilization Review and Evaluation System (CURES)
Output Examples	• Web displays, including maps and dashboards • Predefined reports on de-identified aggregate data	• Interactive reports • Access to data by application through a data enclave • Custom datasets (one-time data extracts)	• Web or enclave-enabled data analysis
Reporting Level and Capabilities	Summary statistics, statewide and regional by age, gender, race/ethnicity	By payer (Medi-Cal, Medicare, commercial) and product (HMO, PPO, ACO)	Patterns of care over time, such as episodes of care, longitudinal analyses (e.g., cost in last six months of life)

	TIER 1: CORE	TIER 2: EXPANSION	TIER 3: MATURITY
Use Case Examples	• Utilization, Spending, and Total Cost of Care (utilization and spending components) • Quality Comparisons • Coverage Trends by Region and Payer (region component) • Regulatory Oversight of Insurance • Prevalence, Management, and Cost of Chronic Conditions (prevalence component)	• Utilization, Spending, and Total Cost of Care (total cost of care component) • Identify and Reduce Low-Value Care • Quality and Continuity of Care Through Coverage Transitions • Coverage Trends by Region and Payer (payer component) • Prevalence, Management, and Cost of Chronic Conditions (management and cost components) • Understanding the Opioid Epidemic • Report on Statewide System Performance • Effect of Consolidation on Quality and Cost	More complex analysis and sophisticated reporting on all use cases (e.g., episodes of care for a chronic condition such as diabetes—Use Case Example 4.1).

[a] Office of Statewide Health Planning and Development. *Health Care Payments Data Program Report to the Legislature,* 2020. Accessed at https://hcai.ca.gov/wp-content/uploads/2020/12/HPD-Legislative-Report-20200306.pdf.
Note that subsequent discussions and technological changes have occurred since this Exhibit was included in the 2020 Report. For example, web or enclave-enabled data analysis, originally targeted for Tier 3, are now planned for earlier tiers.

The HPD Advisory Committee discussed one of the key components of this planned growth—increasing the complexity of analytic capabilities and adding new data sources over time to meet public reporting priorities (see Exhibit 3, Framework for Public Reporting Priorities).

Exhibit 3. Framework for Public Reporting Priorities[a]

TIER 1: CORE	TIER 2: EXPANSION	TIER 3: MATURITY
• Initial cost and utilization statistics, statewide and: ○ By geography, age, gender ○ By payer (Medi-Cal, Medicare, commercial) • Component cost and utilization (e.g., inpatient, outpatient, professional, prescription drug) • Out of pocket costs • Chronic condition prevalence by geography and payer, age, and gender • COVID-19 utilization, cost	• Increasingly robust cost and utilization statistics • Cost for common episodes of care/procedures • Quality of care • Health disparities (race/ethnicity Census overlay) • Low value care: sources, volume, cost • Chronic conditions: costs to treat, utilization • Prescription drug spending • Primary care spending • Behavioral health utilization	• Prevalence of capitation and alternative payment models • Statewide health system performance • Total cost of care • Provider comparisons on cost and quality • Primary care spending (including non-claims payments) • Behavioral health spending (including non-claims payments) • Enhancing race/ethnicity/ language reporting through linkage to other sources

[a] Source: Department of Health Care Access and Information, HPD Advisory Committee, October 2021 meeting. Note that headings have been changed from “Sooner,” “Next,” and “Longer Term” to align with the Tier headings in Exhibit 2.

In summary, to achieve a mature HPD Program described above requires the following pursuits:

- **Support demand for linkages and incorporating more data into the system.** Stakeholders have routinely expressed the desire to link, or incorporate into the HPD System, data outside of health claims, utilization, and cost data, including survey data, surveillance, and registry data, infectious disease data, lab data, and other clinical data sources. The 2020 Report includes a recommendation from the HPD Review Committee about this area. Linking, or adding a wide range of additional data sources to the HPD System, is necessary to meet the full breadth of use cases so that future and emerging research and analysis can be performed across time, sources, and populations.
- **Support demand for access by a wide range of users.** While acknowledging the HPD may need to levy a user fee for access, stakeholders have also expressed that HPD data be broadly available to approved users, including those representing vulnerable populations, such as patient advocacy organizations and regional community-based organizations serving local public health needs, as well as to qualified students. Mature-level funding will allow HCAI to subsidize the cost of accessing the HPD Program's data and make it more available to users by keeping access affordable.
- **Support demand for addition of voluntary submitters to the HPD.** Stakeholders have expressed the desire for HCAI to work with voluntary submitters that are not health plans, insurers, and other mandatory submitters. Enabling statute contemplates the HPD encouraging voluntary submission from such entities to maximize the data completeness. Though HCAI is actively engaged in encouraging voluntary submission from ERISA-governed self-funded entities, maturity-level funding would be required to support processing voluntary data submission from other entities, including provider organizations such as Risk Bearing Organizations as defined by the Department of Managed Health Care (DMHC).[7]
- **Support the demand for use cases and public reporting.** Stakeholders have demonstrated, through surveys, focus groups, and public meetings, the regular, ongoing demand for use cases[8] and public reporting[9] on a volume of topics and complex areas—including those described in Exhibit 3—at a frequency that cannot be met with base funding.

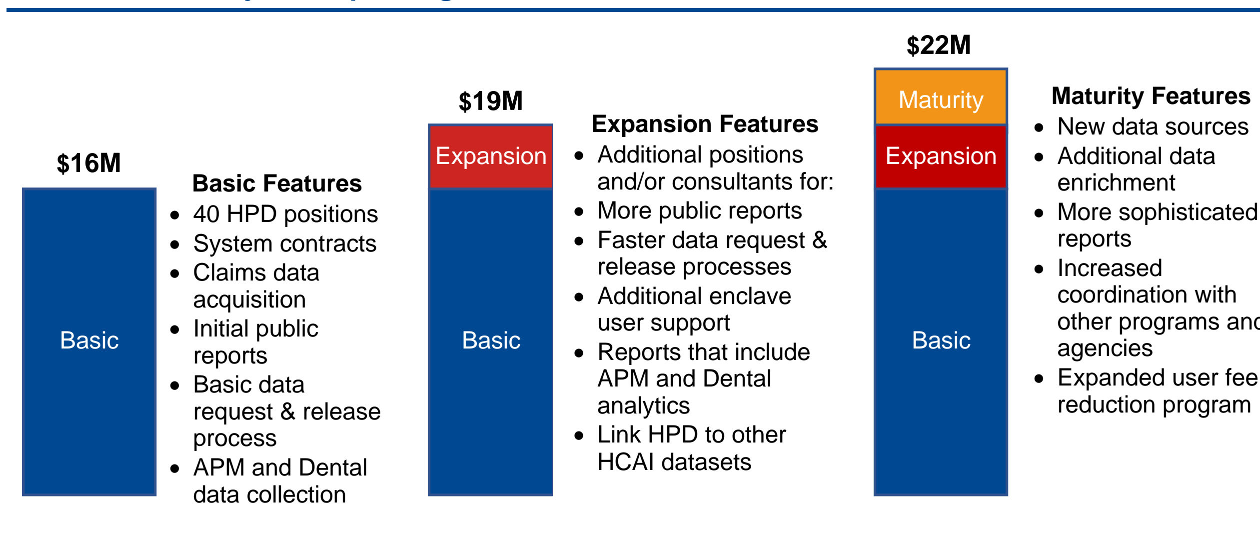
Updated estimates of annual operating costs, informed by the planned trajectory described above, are summarized in Exhibit 4, HPD Projected Operating Costs Over Time. A $16 million budget supports continued operations of the initial, or basic system. It covers state staff position, contract, and data acquisition costs that will yield the initial public reports, the data access program, and the upcoming Alternative Payment Model (APM) and dental data collection.

Exhibit 4 also displays two more levels of funding, with estimates for expansion- and maturity-level budgets. Expanding the operations budget to approximately $19 million increases HPD's operational capacity. It would allow HCAI to produce more public reports, support faster turnaround time on data requests, provide additional enclave

support, develop data products that use the upcoming APM and dental datasets, and develop linkages to other department data.

At the October 27, 2022 HPD Advisory Committee Meeting,[10] members supported HCAI's proposal to pursue an estimated annual budget of $22 million, starting in FY 2025-26, recognizing that this funding amount was necessary to provide the needed resources to continue the HPD Program and ensure there is funding to support programmatic needs as the HPD Program grows. Moving to the required level of funding for a mature program, $22 million would be required for the HPD to invest in new capabilities. It would be required for HCAI to pursue new and complex data sources, further enrich the analytic datasets available to users, provide more sophisticated reports, support HPD's coordination with other state programs and agencies, and help keep access affordable by expanding the user fee reduction program. To maximize the usefulness of the HPD, the long-term funding should account for these planned areas of growth.

Exhibit 4. HPD Projected Operating Costs Over Time



Three other factors may increase the need for funds over time: data volume, inflation, and experience with actual use. The amount of data in the HPD System will grow over time, from three to ten years of historical data. Additional data translates to increased IT costs for storage, software licensing, and computing. The program budget and cost estimates, made prior to the completion and roll-out of the HPD System, have not accounted for recent inflationary increases in wages and other costs. Finally, despite considerable planning and HCAI's focus on managing a cost-efficient implementation, actual experience from the final stages of implementation and early use of the HPD System may uncover unforeseen issues or opportunities. Adequate funding will allow the program to manage risks and cope with scenarios that might otherwise interrupt operations.

Exhibit 5 displays a break-down of the $22 million in ongoing funded needed to sufficiently fund the "maturity" vision for the HPD Program.

Exhibit 5. Estimates of Future HPD Program Operating Costs (in millions)

CATEGORY	ANNUAL COSTS AT MATURITY
Staff	$6.50
Interdepartmental Services	$0.89
Consulting & Professional Services	$4.55
Information Technology	$9.35
Other	$0.71
Total	**$22.00**

Based on experience to date, planned growth in data and functionality over time, and accounting for unanticipated costs that may arise during the initial years of operation, HCAI recommends an annual budget of $22 million, starting in state FY 2025-26, to operate the HPD Program. The HPD Advisory Committee concurred that fully funding HPD with an annual budget of $22 million would allow the development of capabilities to meet the long-term legislative intent of the program.

Potential Funding Sources for the HPD Program

This section evaluates potential sources to fund the future operating costs of the HPD Program. The Legislature appropriated $60 million on a one-time basis to support the HPD initiative, including planning, development, and build through June 2025. For ongoing operations, the Legislature required development of a sustainability plan.

The HPD Review Committee discussed a wide range of funding options in 2019 for the HPD Program and landed on four recommendations. Two of these recommendations, Medicaid match and creation of a special fund, have been successfully initiated. A third, a user fee schedule, was discussed at the July 2022 Advisory Committee meeting and work is ongoing to develop and refine specifics. The last, related to evaluating other revenue sources, is covered in this Report. Exhibit 6 includes those funding recommendations and provides a brief progress update.

Exhibit 6. Status of Funding-Related Recommendations from 2020 Report

RECOMMENDATION	PROGRESS UPDATE
1. *Pursue CMS Medicaid Matching Funds*: Maximum possible Centers for Medicare & Medicaid (CMS) Medicaid matching funds, or other federal funds, should be pursued to support the HPD Program.	• The California Department of Health Care Services, in concert with HCAI, successfully requested and received advance approval for Medicaid IT System funding starting in federal FY 2021-22. • Ongoing federal funding is available for approximately 25% of ongoing operating costs, subject to several conditions.
2. *Establish User Fee Schedule to Support the HPD Program*: Develop a fee schedule and charge data user fees for data products to support the HPD Program and stakeholder access to data.	• HCAI discussed with the HPD Advisory Committee at the July 2022 and October 2022 meetings. • HCAI estimates that user fees will provide no more than 5% of the needed revenues; this amount will be less in the early years of the HPD Program.
3. *Explore Other Revenue Sources*: For the remainder of HPD Program operational expenditures, other revenue sources should be considered in collaboration with stakeholders.	• Funds from federal grants and private foundations may occasionally become available and be worth pursuing, but as discussed at the October 2022 Advisory Committee meeting, they are unlikely to provide a significant or stable source of ongoing funding. • After accounting for 25% from Medicaid IT funds and 5% from user fees, some type of state funding will be required for approximately 70% of ongoing operating costs.
4. *Special Fund for the HPD Program*: A special fund should be created for the HPD Program, and revenue to support the HPD Program should be directed to that fund. Any funds not used during a given year will be available in future years, upon appropriation by the Legislature.	• 2020 legislation created the Health Care Payments Data Fund (AB 80, Chapter 12, Statutes of 2020), but funding sources and appropriates still need to be determined. • Potential revenue sources for a special fund were discussed with the HPD Advisory Committee at the October 2022 meeting.

The 2020 Report also provided an analysis of typical APCD funding sources; these are summarized in Exhibit 7.

Exhibit 7. Summary of APCD Funding Sources[a]

SOURCE	DESCRIPTION
Medicaid Match	• The federal Centers for Medicare & Medicaid Services provides matching funds for states that demonstrate the APCD is part of the state's Medicaid IT systems. • Medicaid funds are limited to the portion of APCD costs attributable to Medicaid. • Almost half of state APCD programs have pursued Medicaid funds.
Data User Fees	• Fees are charged to access the data, including reports, data sets, and direct access. • Most states have a data request process and fees vary considerably by state. For most states, user fees offset only a small portion (0-10%) of APCD operating costs.
State Funds	• Includes general state appropriations and special fund sources such as from industry assessments. • Primary source of funding for most state APCD programs; the majority of APCDs have some core funding from general state appropriations.

[a] Office of Statewide Health Planning and Development. *Health Care Payments Data Program Report to the Legislature,* 2020. Accessed at https://hcai.ca.gov/wp-content/uploads/2020/12/HPD-Legislative-Report-20200306.pdf.

The 2020 Report also discussed grant funding as a potential fund source. Funds from federal grants and private foundations may occasionally become available and be worth pursuing, but they are unlikely to provide a significant or stable source of ongoing funding. While other APCDs have received grant funding from government and private sources, grant funding has not been a major or sustainable source of funding for those programs, which are considerably smaller enterprises than the HPD, given the relative population size of those states. Grant funding could be a source for one-time investments or special projects—but not for annual operations.

The following sections provide additional detail on the progress and status of the most common and likely funding sources for the HPD Program: Medicaid matching funds, data user fees, and state funds.

Medicaid Match

States may receive federal matching Medicaid funds for costs associated with implementing and maintaining an APCD, assuming the state meets certain conditions described in federal regulations. Among those conditions, the state Medicaid agency must request and receive approval in advance and demonstrate that the data collected and maintained by the APCD will support the Medicaid program. Only the costs of the system that relate to Medicaid are eligible for federal match. Federal approval is also required before executing IT contracts that will be paid with matching federal dollars. If approved, the Centers for Medicare & Medicaid Services (CMS) funding is retrospective—states must expend state funds before they request the corresponding federal share. The specifics are described in the Code of Federal Regulations (CFR) Title 42, Part 433, Subpart C, Mechanized Claims Processing and Information Retrieval Systems (referred to as the Medicaid Management Information System, or MMIS). States use the Advance Planning Document (APD) process to request prior approval of

Medicaid match funding from CMS. The federal regulations refer to this type of funding as Federal Financial Participation (FFP).

DHCS, in consultation with HCAI, successfully requested and received advance approval for up to $22 million in Medicaid FFP for federal FYs 2021 through 2024. Requests will need to be kept up to date through an annual APD update process. The requests approved to date include system implementation costs, which are eligible for 90% federal match. To be eligible for long-term funding of systems operations costs, the HPD System must successfully complete an outcomes-based system certification process planned for August 2024. If the certification process is successful, federal funding can provide a 75% match on operations and maintenance costs for the Medi-Cal share of enrollment in the HPD System (Medi-Cal covers approximately 1/3 of the state's population). HCAI and DHCS continue to coordinate and plan for a successful certification, ongoing APD requests, and maximum allowable federal funding. **HCAI estimates Medicaid match will provide approximately 25% of the annual ongoing HPD operational costs.**

Data User Fees

Most state APCD programs charge fees to access the data, including for reports, data sets, and direct access. Fees, types of access, amounts collected by year, and the proportion of operating costs offset by user fees vary considerably by state. The percent of operating costs contributed from user fees in other states ranges from 0% to 17%, with early years of operation near zero.[11] The 17% figure is from Colorado and is an outlier, achieved over time with a heavy focus on data sales by a dedicated sales team. For all other state APCDs, user fees offset only a small portion of APCD operating costs.

A key consideration in establishing user fee amounts is the ongoing need to balance the importance of generating revenue for long-term funding with providing affordable access to a wide range of approved users. HCAI has considerable experience setting and collecting fees for accessing data, including the patient discharge, ambulatory surgery, and emergency department data collected from California's healthcare facilities. In FY 2021-22, HCAI collected $160,000 from data sales, approximately 0.4% of the Health Data and Planning Fund revenue. HPD Advisory Committee members, during the October 2022 meeting, cautioned against counting on anything more than a marginal amount for user fees, citing concerns about variability year-to-year and the relatively small share that they contribute to the existing HCAI Data Fund.[10] A detailed user fee schedule for the HPD Program is under development.

HCAI obtained input from the HPD Advisory Committee to adopt the following guidelines for establiing HPD data user fees:

1. Fee amounts should vary with the complexity of the request.
2. Data user fees should cover a portion of operating costs, not just the marginal cost of creating data files and products.
3. Fees should be affordable—HPD data, appropriately used, is a public asset.
4. User fees should not be so low as to encourage more requests than a reasonably staffed HPD Program can handle in a timely manner.

5. The fee schedule should accommodate fee reductions and/or waivers for certain types of requesters, such as consumer organizations specified in the HSC,[ii] students, and those using data for purposes encouraged by the state (e.g., reducing health disparities).
6. The user fee structure should be revisited and updated over time based on experience and feedback from stakeholders.

Given the above framework and the experience of other states, **HCAI estimates that user fees will provide no more than 5% of the needed revenues; this amount will be lower in the early years of the HPD Program.**

State Funds

Like other state APCDs, state funds will be required to provide the primary funding for California's HPD Program. As outlined above, after accounting for 25% from Medicaid IT funds and 5% from user fees, **some type of state funding will be required for approximately 70% of ongoing operating costs, or $15.4 million per year starting in state FY 2025-26.**

Similar to other states, California has two primary state fund types—General Fund and special funds. The 2022 state budget totaled $303 billion, including $234 billion in General Fund and $69 billion in special funds.[12] Here's how the California Department of Finance describes these two fund types:[13]

- ***<u>General Fund</u>**: Used to account for all revenues and activities financed therefrom which are not required by law to be accounted by any other fund. Most state expenditures are financed from the General Fund. Normally, the only difference between the General Fund and the other governmental costs funds is the restriction placed on the use of the other governmental cost funds.*
- ***<u>Special Funds</u>**: Consists of governmental cost funds used to account for taxes and revenues which are restricted by law for particular functions or activities of government. The funds included in these classifications are primarily for the regulation of businesses, professions, and vocations; transportation, law enforcement, and capital outlay. In either case, subsequent legislation would be required to formalize the funding source and specifics.*

Although current law prevents use of the General Fund for the HPD beyond June 2025, a change to the law could allow for an ongoing General Fund appropriation. A $15.4 million General Fund increase equates to 39 cents per Californian per year.[iii] For comparison, the Office of Health Care Affordability, a separate healthcare transparency and reporting initiative established within HCAI in 2022 that will rely on HPD as an important data source, is funded with annual ongoing General Fund revenues of $31.6 million per year.[14]

As described in the 2020 Report, 13 of the 19 state APCDs receive general fund-type appropriations to support APCD operations, in full or in part. For example, Minnesota's

---

[ii] See Health and Safety Code Section 127674 (f) (2): "consumer organizations certified for the Consumer Participation Program administered by the Department of Managed Health Care pursuant to Section 1348.9 that have been awarded reasonable advocacy and witness fees in a proceeding or proceedings of the department."

[iii] Calculated, based on 39.2 million Californians.[6]

APCD receives some funding from the state to support healthcare transformation, including research and reporting on quality improvement. Minnesota also receives an ongoing appropriation for required activities conducted by the Department of Health from funds derived from Minnesota's Health Care Access Fund, which generates revenue from a tax on providers in Minnesota that dates to the early 1990s. Colorado's APCD has a wide range of funding sources that initially did not include general funds but now includes state support. Similarly, Virginia's APCD transitioned from reliance on voluntary industry assessments to state general funds in 2019.

In addition to General Fund appropriations, special funds such as revenue generated by industry assessments provide a stable source of funding for five state APCDs. States that use special fund-type assessments for their APCD apply those assessments to a variety of healthcare industry participants including submitters, plans, insurers, third-party administrators, hospitals, nursing homes, pharmacies, home health agencies, and health occupation boards. States determine assessment amounts for each segment in various ways, including revenues, operating expenses, premiums, and covered lives. The most commonly assessed organizations in other state APCD programs include payers, hospitals, and nursing homes.

Special funds are used in California for various healthcare reporting, transparency, and oversight purposes. Exhibit 8 describes four such programs: HCAI's existing data program for facilities, the Office of the Patient Advocate, the California Health Benefits Review Program, and a prescription drug cost transparency initiative.

Exhibit 8. Special Fund Support for Selected Health Care Transparency Programs

SPECIAL FUND OR PROGRAM	2022-23 AMOUNT	DESCRIPTION
Health Data and Planning Fund (Fund 0143)	$42.2 million[a]	Hospitals, certain long-term care facilities, and certain ambulatory surgery clinics (ASCs) licensed by the State of California pay fees that HCAI uses to collect and disseminate performance, financial, utilization, patient characteristics, and service data. The fee for hospitals and long-term care facilities is set annually in regulations but cannot exceed 0.035% of the gross operating cost of the facility for the prior year. ASCs pay an amount based on the number of data records submitted to HCAI in the prior year; ASCs currently pay 50 cents per record, the maximum allowed by Health and Safety Code. For the FY 2022-23, the facility fee was 0.027% for hospitals and 0.025% for long-term care facilities.
Health Plan Improvement Trust Fund (Fund 3209)	$2.2 million[b]	The Center for Data Insights and Innovation, formerly the Office of the Patient Advocate, collects and publishes information about health care provided by California's plans and insurers, including an annual publication that includes a quality-of-care report card and other information intended for the healthcare consumer.[c] These activities are funded by transfers from DMHC's Managed Care Fund and CDI's Insurance Fund.
California Health Benefits Review Program	$2.2 million[d]	The California Health Benefits Review Program (CHBRP) responds to requests from the State Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.[e] Funding for CHBRP comes from an assessment amount, determined through regulation, on DMHC health plans and CDI insurers.
Prescription Drug Cost Transparency	$1.5 million[f]	California Health and Safety Code (HSC) Section 1367.243 (SB 17, 2017) requires health plans and health insurers to annually report specific information related to the costs of prescription drugs. Funding for HCAI's responsibilities for this program is provided by transfers of moneys from DMHC's Managed Care Fund and CDI's Insurance Fund, in proportion to the total number of all covered lives in the state.

[a] State of California Department of Finance, 2022-23 State Budget, Fund Condition Statement, Fund 0143, revenues from 4129200, "Other Regulatory Fees"
[b] State of California Department of Finance, 2022-23 State Budget, Fund Condition Statement, Fund 3209, sum of revenue transfers from the Insurance Fund ($80,000) and the Managed Care Fund ($2,151,000)
[c] State of California Department of Finance, Manual of State Funds, Health Plan Improvement Trust Fund
[d] Assembly Bill 1082 (Chapter 592, Statutes of 2021)
[e] California Health Benefits Review Program, About CHBRP, accessed December 29, 2022, available at https://www.chbrp.org/about_chbrp/index.php
[f] State of California Department of Finance, 2022-23 State Budget, Fund Condition Statement, Fund 0143, sum of revenue transfers from the Insurance Fund ($54,000) and the Managed Care Fund ($1,446,000) per Health and Safety Code Section 127683

Special funds provide the primary funding mechanism for California's regulatory oversight of California's health plans and insurers, as well as for the operation of the state's health insurance marketplace. Exhibit 9 displays the tax or assessment amounts collected from health plans and insurers to operate the Department of Managed Health Care, the California Department of Insurance, and Covered California.

Exhibit 9. Special Fund Support for DMHC, CDI, and Covered California

SPECIAL FUND	2022-23 AMOUNT	DESCRIPTION
Managed Care Fund (Fund 0933)	$135 million[a]	The Managed Care Fund supports the operation of DMHC, which regulates most commercial health plans and products in the large group, small group, and individual markets, including the health plans that participate in Covered California. The DMHC also regulates most Medi-Cal managed care plans, Medicare Advantage plans, and specialized health plans, including dental and vision plans).[b] Overall, plans regulated by DMHC covered 97.2 percent of Californians enrolled in commercial coverage in 2022.[c] Health plans are annually assessed a base fee of $10,000 per plan and an annual assessment per enrollee, currently set at $2.76 for full-service plans and $1.17 for specialized plans.[d]
Insurance Fund (Fund 0217)	$333 million[e]	The Insurance Fund provides the primary funding for the California Department of Insurance (CDI), which oversees all types of insurers doing business in the state, including enforcement of insurance laws and regulations and assistance to consumers in their dealings with insurance companies.[f] Fees and assessments on California's insurers provide the moneys for the Insurance Fund. Overall, commercial health insurers regulated by CDI covered 2.8 percent of Californians enrolled in commercial coverage in 2022.[g]
Covered California Enterprise Fund	$405 million[h]	The Covered California Enterprise fund supports the operation of the state's health insurance marketplace established under the federal Patient Protection and Affordable Care Act. Covered California receives no state General Fund for operations, instead relying on assessment fees it collects from health plans (3.25 percent of gross premiums for the individual market and 5.2 percent of gross premiums for the small business market during FY 2022-23).

[a] Department of Managed Health Care (DMHC), November 20, 2022 email, "questions about health plan assessments to inform HPD funding options report." Amount reflects total of assessment amounts from licensed health plans.
[b] DMHC, *Prescription Drug Transparency Report*, Measurement Year 2020, accessed December 29, 2022, available at https://www.dmhc.ca.gov/portals/0/Docs/DO/SB17-2020ReportAccessible.pdf
[c] DMHC email, November 20, 2022
[d] DMHC email, November 20, 2022
[e] State of California Department of Finance, 2022-23 State Budget, Fund Condition Statement, Fund 0217, Total Revenues, Transfers, and Other Adjustments
[f] State of California, Department of Insurance, About the Department, accessed December 29, 2022, available at http://www.insurance.ca.gov/0500-about-us/02-department/index.cfm
[g] DMHC email, November 20, 2022
[h] Covered California, Fiscal Year 2022-23 Budget, June 16, 2022, available at https://hbex.coveredca.com/financial-reports/PDFs/2022/fy-2022-23-annual-report-final.pdf

Exhibit 10 displays the estimated financial impact to the Managed Care and Insurance funds from a potential new HPD assessment, assuming a proportional assessment on DMHC and CDI plans for the entire state-funded portion of the HPD Program, like the mechanisms used today for CHBRP, the Center for Data Insights and Innovation, and the Prescription Drug Price Transparency Initiative. A new HPD assessment would increase the amounts from DMHC-regulated plans by $15 million, or 11%. The per member assessment would increase by 31 cents and 13 cents per member per year, respectively, for full service and specialized plans. Amounts from the Insurance Fund would total $431 thousand.

Exhibit 10. Estimated Impact to Health Plans and Insurers from a New HPD Assessment

SOURCE	CURRENT ASSESSMENT[a]	ESTIMATED HPD ASSESSMENT	PERCENT INCREASE
DMHC (97.2%)	**$134.7M**	**$15.0M**	**11%**
FULL-SERVICE PLANS (REVENUE)	$87.6M	$9.7M	
FULL-SERVICE PLANS (PER ENROLLEE PER YEAR)	$2.76	$0.31	
SPECIALIZED PLANS (REVENUE)	$47.1M	$5.2M	
SPECIALIZED PLANS (PER ENROLLEE PER YEAR)	$1.17	$0.13	
CDI (2.8%)	**N/A**	**$431.2K**	

[a] Current DMHC assessment amounts and the split of DMHC vs. CDI reflect amounts for Fiscal Year 2022-23 and were provided by DMHC, in a November 20, 2022 email, “questions about health plan assessments to inform HPD funding options report.”

The amount of a health plan and insurer assessment for the HPD Program could be reduced by amounts contributed by other participants of California’s healthcare industry. As described above, licensed healthcare facilities pay into the Health Planning and Data fund, which supports various HCAI offices including Health Care Information and Quality Analysis, Workforce, and Administration. The fee for hospitals and long-term care facilities is set annually in regulations but cannot exceed 0.035% of the gross operating cost of the facility for the prior year. ASCs pay an amount based on the number of data records submitted to HCAI in the prior year; ASCs currently pay 50 cents per record, the maximum allowed by Health and Safety Code. For FY 2022-23, the facility fee was 0.027% for hospitals and 0.025% for long-term care facilities. Current law allows HCAI to use these funds “to pay for any other health-related programs administered by the department” (HSC Section 127280), so HCAI could increase such assessments without changing the upper limit and the use such funds to support the ongoing operations for the HPD Program.

The above examples depend on existing regulatory and fee collection processes for health plans, insurers, and facilities. The State could consider assessing other parts of the healthcare industry as well, including physician organizations, pharmacies, pharmacy benefit management companies, drug manufacturers, employers and their third-party administrators for self-funded health plans, home health agencies, and others, but such assessments would likely require new and significantly complex legal and regulatory processes.

Finally, the above examples focus primarily on a single source (e.g., General Fund or industry assessment) for the direct funding necessary to support ongoing operations of the HPD Program. Combinations of the above direct sources are also possible. Any special fund assessment amounts could be reduced by combining a general fund portion share into the HPD Program’s funding model.

Other Considerations When Evaluating State Funding Options

This section outlines some additional considerations for the state-funding options, all of which were discussed during the October 2022 meeting of the HPD Advisory Committee.[iv]

Alignment to HPD Program Goals

One consideration in evaluating the use of General Fund versus a special fund from an industry assessment is how closely each approach aligns to the intent of the HPD Program. Is the intent of the HPD Program more about providing a public benefit, in which case a general broad-based tax is most appropriate? Or is the intent more about oversight of the healthcare industry, in which case an industry assessment makes more sense? The legislation references both "public benefit" and "oversight of the healthcare system" among the intents, and Advisory Committee members were similarly split on their preferences for use of General Fund versus special fund.

Data Preparation and Submission Costs

Health plans and insurers, as the primary suppliers of HPD data, already invest resources to comply with HPD Program requirements. Any new assessment would add to the monthly data submission and other HPD-related costs that health plans and insurers already expend to meet the requirements of the HPD Program.

Stability and Flexibility

Both General Fund and special fund approaches provide a manageable and stable source of funding, especially when compared to data user fees, grants, or other funding options. Special funds, however, provide some significant advantages in stability and flexibility over General Fund approaches, including:

- **Special funds are not impacted by California General Fund budget limits.** The state spending limits and guaranteed education spending formulas in the California Constitution (e.g., Gann Limit and Proposition 98) can sometimes lead to reductions in General Fund appropriations for a program such as the HPD. Special funds are not subject to these limits.
- **Special funds are (more often) insulated from budget cuts or changes in the priority of the Administration**. Since statute defines the specific purpose for special funds, they are usually insulated from budget cuts that sometimes occur in difficult budget years or changes in Administration.
- **Special funds allow surpluses to roll over.** Unlike the use-it-or-lose-it nature of General Fund appropriations, unused special funds are available in future years. This would be especially beneficial to the HPD Program, given the likely year-to-year variability in data user fees and operating costs.

[iv] HPD Advisory Committee members acknowledged during the October 2022 meeting[10] that there were few other viable options for direct funding beyond General Fund or a special fund assessment. Suggestions included requiring data (and assessment fees) from the approximately 200 Risk Based Organizations, applying for Centers for Medicare & Medicaid Innovation (CMMI) federal grants, and pursuing funds from the No Surprises Act. Members acknowledged that these sources were unlikely to provide significant ongoing revenue.

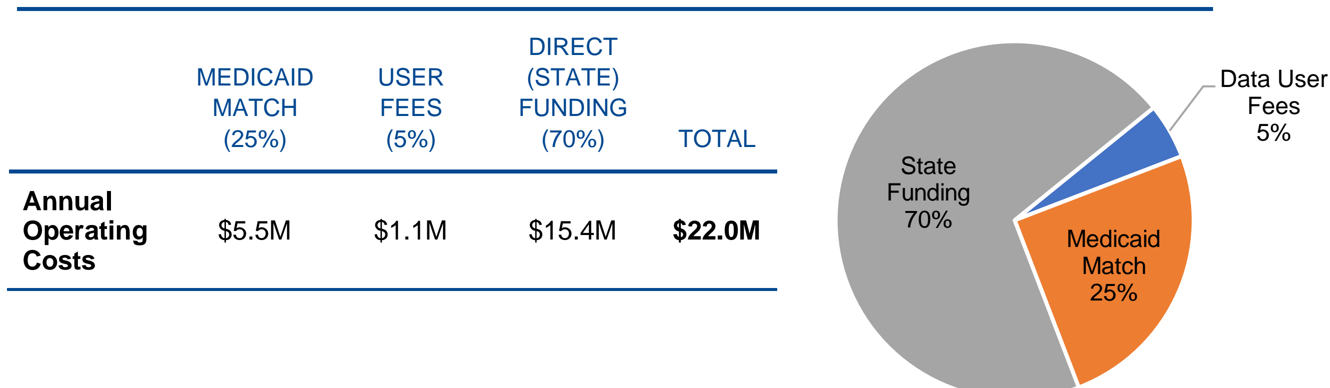
- **Special fund amounts can be adjusted year-to-year.** The statute that creates the special fund can define an upper limit, with annual amounts up to the upper limit adjusted accordingly through the regulations process. This also helps shield from expected variability in other revenue sources.

Summary and Recommendations

By providing $60 million in initial funding for a state APCD in 2018, California made an important step toward improving transparency around California's healthcare spend and, ultimately, improving affordability and health outcomes for Californians. With that investment, HCAI has established a new HPD Program that collects detailed healthcare claims and utilization data from Medicare, Medi-Cal, and commercial health plans and insurers. Set for an initial implementation in 2023, the HPD will be invaluable as a reporting tool and research database, especially as the data and analytic functionality matures over time. With the initial funding expiring in June 2025, legislative and budget actions are required to provide the HPD Program with a sustainable funding model to fulfill its legislative intent.

1) ***Operating Costs***. Based on experience to date, planned growth in data and functionality over time, and accounting for unanticipated costs that may arise during the initial years of operation, HCAI recommends an annual budget of $22 million, starting in state FY 2025-26, to operate the HPD Program. The current General Fund appropriation for the HPD Program expires at the end of June 2025, and HCAI is on track to expend all of the original appropriate by then as planned.
2) ***Sources of Funding***. Based on the experience of other state APCD programs, the goals of the HPD Program, and success to-date in pursuing federal funding, HCAI estimates the following distribution of funding:
   a) Medicaid match will provide approximately 25% of the annual ongoing HPD operational costs; this amount assumes that HCAI and DHCS continue to collaborate on federal requests and meet other federal requirements around use of the system to support Medi-Cal.
   b) Data user fees will provide no more than 5% of the needed revenues; this amount will be less in the early years of the HPD Program.
   c) Direct, or State, funding will be required for approximately 70% of ongoing operating costs. Such funding will require Administration and/or state legislative action.

Exhibit 11. HPD Annual Funding Sources Estimates Based on Projected Operating Costs



	MEDICAID MATCH (25%)	USER FEES (5%)	DIRECT (STATE) FUNDING (70%)	TOTAL
Annual Operating Costs	$5.5M	$1.1M	$15.4M	**$22.0M**

3) ***State Funding Options***. Based on the experience of other states, discussions with the HPD Advisory Committee, and examples of funding methods used in California

for other healthcare programs, the most likely state funding options for the roughly 70% of needed revenue (or $15.4 million per year) include:

a) General Fund. Although current law prevents use of the General Fund for the HPD beyond June 2025, a change to the law and an accompanying budget change could support an ongoing General Fund appropriation. A $15.4 million General Fund increase equates to 39 cents per Californian per year.

b) Special Funds. Assessments on health plans and insurers are used in California for various oversight, reporting, and transparency purposes and provide some significant advantages in stability and flexibility over General Fund. Assuming a proportional assessment on DMHC and CDI plans for the entire state-funded portion of the HPD Program ($15.4 million), like the mechanisms used today for the California Health Benefits Review Program (CHBRP), the Center for Data Insights and Innovation, and the Prescription Drug Price Transparency Initiative, a new HPD Assessment would increase existing amounts by approximately 11%. The per member per year assessment would increase by 31 cents and 13 cents, respectively, for the full service and specialized plans regulated by DMHC.

   The amount of a health plan and insurer assessment could be reduced by amounts contributed by other participants of California's healthcare industry. For example, hospital and nursing home assessments already collected by HCAI could be increased without changing the upper limit in current law (0.035% of operating costs). The State could also consider assessing other parts of the healthcare industry, including physician organizations, pharmacies, pharmacy benefit management companies, drug manufacturers, employers and their third-party administrators for self-funded health plans, home health agencies, and others, but such assessments would likely require new and significantly complex legal and regulatory processes.

c) Combination of General Fund and Special Funds. Combinations of the above direct sources are also possible and would serve to reduce the share of funding provided by General Fund or special fund sources.

Recommendation: HCAI recommends that state policy makers:

1. Support an annual total funds budget of $22 million for the HPD Program,
2. Establish a state funding model, using General Fund, special funds, or some combination thereof, that provides $15.4 million in annual state funds, and
3. Ensure the above funding provisions are in place with Fiscal Year 2025-26 to avoid disruption to HPD Program operations.

References

1. The Centers for Medicare & Medicaid Services. Health Expenditures by State of Residence, 1991-2020. Accessed December 19, 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence

2. APCD Council. APCD Legislation by State. Published 2022. Accessed December 16, 2022. https://www.apcdcouncil.org/apcd-legislation-state

3. Office of Statewide Health Planning and Development. *Health Care Payments Data Program Report to the Legislature*.; 2020. https://hcai.ca.gov/wp-content/uploads/2020/12/HPD-Legislative-Report-20200306.pdf

4. Department of Health Care Access and Information. Health Care Payments Data (HPD). Accessed December 19, 2022. https://hcai.ca.gov/data-and-reports/cost-transparency/healthcare-payments/

5. California Health and Human Services. Medi-Cal Enrollment by Eligibility Group. - California Health and Human Services Open Data Portal. Accessed December 19, 2022. https://data.chhs.ca.gov/dataset/medi-cal-enrollment-by-eligibility-group

6. California Department of Finance. Slowing State Population Decline Puts Latest Population at 39,185,000. Published May 2, 2022. Accessed December 19, 2022. https://dof.ca.gov/wp-content/uploads/Forecasting/Demographics/Documents/E-1_2022PressRelease.pdf

7. California Department of Managed Health Care > Licensing & Reporting > Risk Bearing Organizations. Accessed January 17, 2023. https://www.dmhc.ca.gov/licensingreporting/riskbearingorganizations.aspx

8. Department of Health Care Access and Information. Meeting Presentation. Presented at: HPD Program Advisory Committee; January 28, 2021. https://hcai.ca.gov/wp-content/uploads/2021/01/HPD_Advisory_Committee_Meeting_Slidedeck_1.28.2021_FINAL_ADA.pdf

9. Department of Health Care Access and Information. Establishment of General Principles and Priorities for HPD Public Reporting. Presented at: HPD Advisory Committee; October 28, 2021. https://hcai.ca.gov/establishment-of-general-principles-and-priorities-for-hpd-public-reporting-ada/

10. Department of Health Care Access and Information. Meeting Minutes HPD Advisory Committee. Published online October 27, 2022. Accessed February 3, 2023. https://hcai.ca.gov/wp-content/uploads/2023/01/Approved-Oct-27-Meeting-Minutes.pdf

11. Department of Health Care Access and Information. Funding Options for HPD Long Term Sustainability. Presented at: HPD Program Advisory Committee; October 27, 2022. https://hcai.ca.gov/?post_type=document&p=143207&preview=true

12. Legislative Analyst's Office. *The 2022-23 Budget: Overview of the Spending Plan*.; 2022. Accessed December 19, 2022. https://lao.ca.gov/Publications/Report/4616

13. California Department of Finance. Description of Fund Classifications in the Treasury. Accessed December 30, 2022. https://dof.ca.gov/wp-content/uploads/budget/budget-analyst-guide/fundclassifications.pdf

14. Department of Health Care Access and Information. Budget Change Proposal 4140-076-BCP-2022-A1.