THE DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

HCAI Technical Note for Producing Healthcare Payments Data (HPD) Services Report

2018 - 2023 Data

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Healthcare Payments Database Overview

The Healthcare Payments Database (HPD) serves as California's All Payer Claims Database (APCD), a research database consisting of healthcare administrative data such as claims and encounters. The records contained within the HPD are generated from transactions between payers and providers for insured individuals and collected from California plans and insurers. The Healthcare Payments Data (HPD) Services Report uses HPD data from 2018-2023. For additional information on the health plans and insurers that have submitted data to HCAI, see the HPD Snapshot Technical Notes document found on the California Health and Human Services (CalHHS) Open Data Portal (ODP).

Visit the HPD Program Overview webpage for more information on the program's goals, current stakeholder engagement, and additional public reporting initiatives.

Reporting Methodology

The Healthcare Payments Data (HPD) Services Report allows for the exploration of the types of healthcare services provided to Californians each year. "Services" refer to individual procedures, encompassing everything from consultations with specialists to routine mammograms and anesthesia administration during surgery. Each service corresponds to a single service line on a claim or encounter and is categorized based on the Healthcare Common Procedure Coding System (HCPCS) codes associated with that service line.

Services Categories and Subcategories

The Healthcare Payments Data Services Report groups services into a hierarchy of broader categories and more granular subcategories using the Restructured Berenson-Eggers Type of Services (BETOS) Classification System (RBCS), provided by the U.S. Centers for Medicare and Medicaid Services (CMS).

Major Categories are the highest level of the RBCS taxonomy and comprise eight general concepts: Anesthesia, Durable Medical Equipment (DME), Evaluation and Management (E&M), Imaging, Procedure, Test, and Other. The Service Home view reports various metrics for services at this level.

RBCS Subcategories are the next level of granularity in the RBCS taxonomy. The RBCS Subcategories divide the major categories further into specific service groupings based on the type of care or organ systems, as relevant. For example, the major "Imaging" category contains subcategories specific to the type of imaging received, such as "Standard X-Ray" or 'Ultrasound". The "Procedures" category is divided into subcategories specific to the organ system being treated, such as "Cardiovascular" or "Digestive/Gastrointestinal". The Service Drill-Down view reports various metrics for services at this level.

More information on the taxonomy, as well as specific descriptions of the methodology behind the categorizations, can be found on the CMS website for the Restructured BETOS Classification System.

Payer Types
Payers: The companies, programs, and organizations that oversee insurance plans and reimburse healthcare providers. Three main types of payers make up the majority of the insurance market: Medicare, Medi-Cal, and commercial.

The payer type assignments for the services that appear in the HPD Services Report are determined based on the payer reported on each medical claim service line. The payer type assignment for each individual whose data appears in the HPD Services Report is determined based on the primary medical insurance coverage (payer) reported on their monthly member enrollment. Each individual is assigned to one primary payer type for each month of enrollment. Individuals enrolled in multiple plans in the same month will only be assigned to the payer type that is identified as the primary payer. In cases of a discrepancy in the reported data for which payer is primary, the order of assignment is commercial payers, followed by Medicare, and then Medi-Cal. Because Medi-Cal is the payer of last resort, dual-eligible individuals will typically be assigned to the Medicare primary payer group. To estimate the average number of members associated with each payer during a full calendar year, the monthly enrollments for each payer type are summed and divided by 12.

Claims incurred by a member with a missing or invalid insurance code are excluded from reporting.

Data De-Identification
The HPD Services Report follows the California Health and Human Services Agency Data De-Identification Guidelines. Data from any group with less than 30 individuals are removed from the analyses and suppressed in the visualizations before calculating metrics or aggregating across groups. Totals in the dashboards only include values from unsuppressed records. Values of zero are unsuppressed in both the data and the dashboards.

Implications: Suppression will result in some error in the reported rates, especially in counties with small populations or for services with lower utilization rates. Use caution when interpreting results for individual counties with less than 30,000 residents.

Definitions

Metrics

- Total Services: The total number of services received by members during the reporting year. If multiple services in a category are reported for the same member on the same day, those are counted as one service.
- Member Count: The total number of unique individuals who received at least one service during the reporting year.
- Service Rate per 1,000 Members: Calculated by dividing the total number of services during the reporting year by the total sum of monthly member enrollments and then multiplying the result by 12,000. This methodology adjusts for differences in population or situations where a member was enrolled in an insurance plan for only a part of a reporting year.

Data Elements: The following characteristics can be used to group and filter the data displayed in the Service Drill-Down view.

- Reporting Year: Based on the year of the first service date on which a member received the service; January 1 – December 31.
- Age Band: Based on the member's age at the end of the reporting year in which they received the service.
- Sex: Based on the member's sex at the end of the reporting year in which they received the service.
- County of Residence: Based on the member's ZIP code of residence during the reporting year in which they received the service. If the "LA + Service Planning Area" option is selected as the County Granularity, the data for Los Angeles (LA) County will be displayed broken down by the eight LA Service Planning Areas (SPAs), which are also based on the member's ZIP code of residence (see the below section on Los Angeles County Service Planning Areas).
- Covered California Region: Based on the member's county of residence during the reporting year in which they received the service.

Los Angeles County Service Planning Areas (SPAs)

- Due to Los Angeles County's large population, the LA County Department of Public Health has divided it into eight different geographic areas, called Service Planning Areas (SPAs), based on ZIP codes: Antelope Valley, San Fernando Valley, San Gabriel Valley, Metro, West, South, East, and South Bay.
- Users can select between two different County Granularity views that show LA County data for either the entire county or broken down by the eight SPAs. The underlying data is separated between two distinct columns in order to prevent any double counting when aggregating data across rows.

Exclusions

- Medical records for which the payer is indicated to be the secondary or tertiary (etc.) payer are excluded.
- Orphaned records, which are adjustments to records that were initially not reported to the APCD, are excluded.
- All records associated with a member reported without a valid age are excluded.
- All records associated with a member reported with a missing or invalid reported sex are excluded.
- All records associated with a member reported with a missing, invalid or non-California ZIP code are excluded.