OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

# Health Care Affordability Board Meeting

March 25, 2025

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# Welcome, Call to Order, and Roll Call

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# Agenda

Item #1 **Welcome, Call to Order, and Roll Call**

*Secretary Kim Johnson, Chair*

Item #2 **Executive Updates**

*Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director*

Item #3 **Action Consent Item**

*Vishaal Pegany*

a) Vote to Approve February 25, 2025 Meeting Minutes

Item #4 **Informational Items**

*Vishaal Pegany; CJ Howard, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager; David Seltz, Executive Director, Massachusetts Health Policy Commission; Sarah Bartelmann, Cost Growth Target & Health Care Market Oversight Program Manager, Oregon Health Authority; Michael Valle, Deputy Director and Chief Information Officer; Dionne Evans-Dean, Chief Data Officer; Chris Krawczyk, Chief Analytics Officer; Margareta Brandt, Assistant Deputy Director*

a) Follow up - Sector Target Methodology and Values including Advisory Committee Feedback

b) Massachusetts and Oregon Cost Target Program Update Presentations

c) Proposed Emergency Regulation on Hospital Sector Definition including Summary of Public Comment Feedback

d) Healthcare Payments Data Program Update

Item #5 **General Public Comment**

Item #6 **Adjournment**

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# Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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# With Appreciation

- Dr. Carlisle was appointed to the Health Care Affordability Board by Governor Newsom.
- Presently serving since 2011 as the President and Chief Executive Officer of Charles R. Drew University of Medicine (CDU) and Science in the Watts-Willowbrook area of Los Angeles County, Dr. Carlisle is a published author in health policy, quality of care, medical education diversity and eliminating health disparities. A board-certified Internal Medicine specialist, his clinical work has always revolved around caring for the underserved.
- Dr. Carlisle has been affiliated with the UCLA Department of Medicine for over 30 years, becoming a tenured Associate Professor in 1998. He is presently a Professor of Medicine and Public Health at CDU and an Adjunct Professor of Medicine at UCLA.
- President Carlisle served as Director of the Office of Statewide Health Planning and Development for eleven years (2000-2011) under Governors Gray Davis, Arnold Schwarzenegger, and Jerry Brown. Under his leadership, OSHPD released its first-ever health disparities reports, increased scholarship and loan repayment opportunities for health providers committed to practice in underrepresented, under-resourced and underserved communities, and successfully administered hospital seismic safety as well as health facility loan insurance programs.

# Milbank Report on Primary Care Spending

- To address primary care workforce shortages and help keep care more affordable, a growing number of states are engaged in efforts to strategically invest in primary care.

- Milbank's March 2025 report looked at efforts to increase primary care spending across five states:
  - **California (15% by 2034)** – Established a benchmark of 15% investment in primary care by 2034 for all payers and a 0.5% to 1% annual improvement benchmark through 2033. This is paired with a statewide health care spending target of 3.5%. Primary care spending benchmarks are not enforceable, but there is flexibility to not apply enforcement measures on the statewide health care target if plans achieve primary care target.

  - **Connecticut (10% by 2025)** – Established a primary care spending target of 10% by 2025 for commercial health plans, Medicare, and Medicaid in 2020 via executive order and codified by General Assembly in 2022. The state has increased spending but missed targets thus far, including 4.9% in spending against a 5.3% target in 2022. 2023 data will be released in March 2025. There are currently no enforcement mechanisms.

Source: Foubister V. *Five States Leading Efforts to Increase Primary Care Spending*. The Milbank Memorial Fund. March 12, 2025. Five States Leading Efforts to Increase Primary Care Spending | Milbank Memorial Fund

# Milbank Report on Primary Care Spending

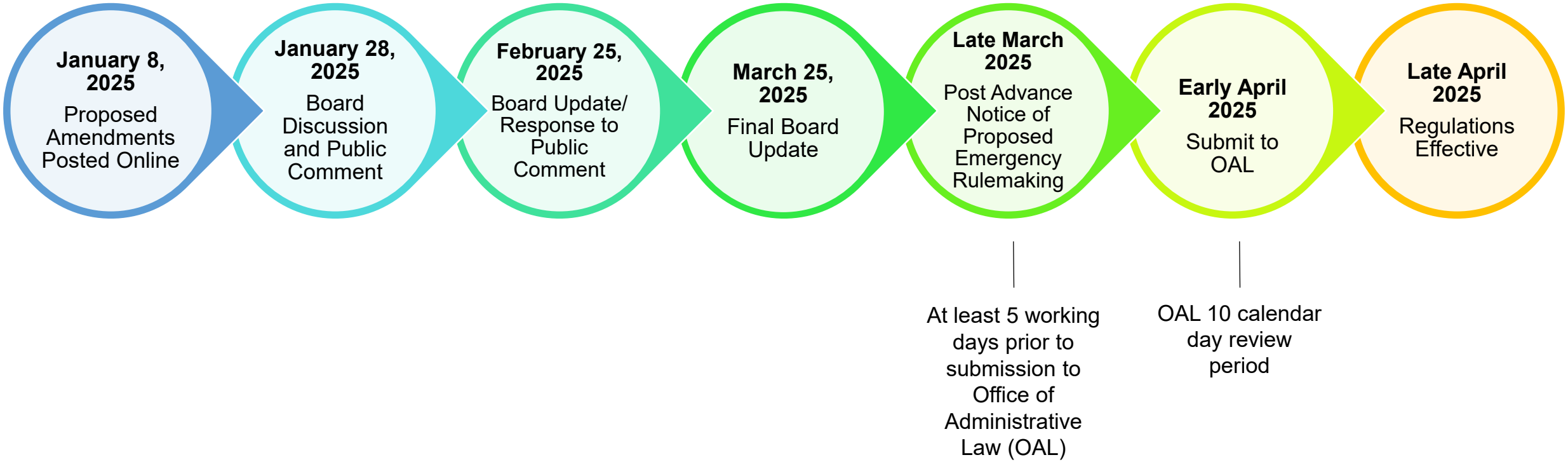
- **Oklahoma (11% by 2028)** – Transitioned about 50% of state's Medicaid enrollees to a managed care model called SoonerSelect, which launched in April 2024. SoonerSelect has a primary care spending target of 11% within 4 years of launch. They are currently spending 5% of health care budget on primary care. The spending target does not apply to other health plans.

- **Rhode Island (10%)** – First state to set a primary care spending target in 2010 of 1% annual increases to achieve 10.7% by 2014. In 2023 Rhode Island recalibrated by publishing a report, redefining "Primary Care Expenditure" to include physicians practicing outside of Rhode Island, and set a new target of 10%. Most commercial health insurers meet the target and they have never taken enforcement action.

- **Virginia (target coming soon)** – Public-private partnership task force work began in 2020 and they have released an annual scorecard to track investment, regional clinician capacity, utilization, outcomes, access to primary care, and compares with national benchmarks. The 2024 scorecard reported that Virginia spent 2.3% to 4.1% of the state's total health care dollars on primary care services. The task force plans to recommend a spending target and enforcement mechanism to the state's General Assembly in 2025.

Source: Foubister V. *Five States Leading Efforts to Increase Primary Care Spending*. The Milbank Memorial Fund. March 12, 2025. Five States Leading Efforts to Increase Primary Care Spending | Milbank Memorial Fund

# THCE Rulemaking Timeline



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# Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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# Public Comment

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# Action Consent Item: Vote to Approve February 25, 2025 Meeting Minutes

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# Informational Items

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# Sector Target Methodology and Values including Advisory Committee Feedback

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Andrew Feher, Research and Analysis Group Manager

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# Board Follow-Up Items

# Board Follow-ups

1. Additional feedback from meetings with hospitals.
2. One Board member noted that the distribution of Commercial to Medicare Payment to Cost Ratio included two modes and asked if there's something different about the hospitals in one peak compared to hospitals in the second peak.
3. Board members asked for more information about Northbay Medical Center's trend across unit and relative price measures (i.e., is there a "data problem") and more broadly, "what do we do when we see an improving trend in more recent years?"
4. One Board member asked for a typology of hospital systems.

# 1. Hospital Feedback

**Question:** Can OHCA meet with hospitals and collect feedback on the presented methodology for identifying high-cost hospitals?

**Approach:**

- As a reminder, OHCA met with 5 hospitals between the January 2025 Board meeting and the February 2025 Board meeting: Community Hospital of the Monterey Peninsula, Salinas Valley Health, Sharp HealthCare, Stanford Tri-Valley, and Stanford HealthCare.
- OHCA met with an additional 7 hospitals between the February 2025 Board meeting and the March 2025 Board meeting: Barton Memorial Hospital, Washington Health, Marshall Medical Center, Dominican Hospital, Doctors Medical Center-Modesto, Northbay Medical Center, and Cottage Health (Santa Barbara and Goleta Valley Cottage Hospitals) .

**Discussion included:**

- Overview from the hospitals on their facilities and programs.
- Feedback on the proposed options for identifying disproportionately high-cost hospitals that may merit a lower spending target value.
- Suggestions for different measures OHCA could consider to identify disproportionately high-cost hospitals.

# 1. Hospital Feedback

**Identification of High-Cost Hospitals:**

- **Discharge Threshold:** Multiple hospitals asked why the discharge threshold presented in January was removed from the recommendation and expressed support for bringing back a discharge threshold. One hospital suggested we use the 25$^{th}$ or 50$^{th}$ percentile as it would account for hospitals that have low discharges, but do not have the ability to spread their fixed costs across a larger system.
- **Margins:** Incorporate operating margins into the identification of these hospitals. Use operating margins for health systems to identify outliers, not operating margins of individual facilities.
- Evaluate at a health system level rather than individual hospital; a hospital may have high margins, yet the hospital may incur costs outside of the hospital but within its system (e.g., clinics) that potentially have much lower margins.
- Incorporate rates of charity care into the analysis.

# 1. Hospital Feedback

- **Unit Price Measure:** Use average net patient revenue per case mix adjusted discharge (instead of using commercial-only) to account for the total cost of care.
- **Relative Price Measure:** This measure is not an appropriate point for comparison because of different circumstances of hospitals, such as those that have higher Medicare reimbursement rates or Graduate Medical Education payments. The ratio favors academic medical centers that get more reimbursement.
- **Repeat Outlier:** One hospital suggested looking at years that did not include the COVID years but acknowledged that only looking at pre-COVID years wouldn't capture accurately the situation today.
- **Payer Mix Threshold:** One hospital suggested exempting any hospital whose commercial payer mix is under 20%. This would eliminate many safety net hospitals from consideration.

# 1. Hospital Feedback

**Other feedback and comments:**

- Smaller Hospitals:
  - Volatility in inpatient discharges.
  - Inadequate commercial reimbursements for physician services delivered by medical foundations.
  - Fixed costs for smaller hospitals/systems can’t be spread out across multiple facilities as they are for larger systems.
  - Less negotiating leverage on high-cost drugs, medical device implants, etc. They use a group purchasing organization, but do not have as much negotiating leverage as large systems.
- District hospitals: Survive on their own operations and currently have a negative margin. Have had to engage in cost savings measures, such as closing service lines and early retirements.

# 1. Hospital Feedback

**Other feedback and comments:**
Consideration is needed for:

- Unintended consequences affecting access to care due to aggressive pricing caps
- Clinical innovation, investments, and expansion of services resulting in high up-front costs.
  - Investments made in lower cost outpatient settings so that members use our system later and ensuring hospitals have an incentive to make these investments.
- Workforce
  - High-cost living areas resulting in increased compensation and benefits for employees of facilities.
  - Health care workforce shortages and ability to attract and retain physicians to provide needed specialty care in geographically isolated areas.
  - Labor costs are driven by union contracts.
- Finances
  - Payer mix as this is biggest factor that increases the delta between government rates and commercial rates.
  - To break even, hospitals must cover costs from uninsured and charity care.
  - Medicare compensation: Geographic regions where Medicare compensation is lower than other parts of the state and declining. Medicare Advantage may have a higher base rate, but there is expense for appealing claim denials.
  - The impact of federal actions, such as increased tariffs, proposed cuts by Congress that may impact Medi-Cal/Medicare funding and ultimately payments to hospitals.

# 1. Hospital Feedback

**Other feedback and comments:**

Consideration is needed for:

- Commercial revenue and payment to cost ratio measures alone do not account for value. Propose that OHCA explain high-cost hospitals using the following seven criteria: 1) access; 2) payer mix; 3) graduate medical education, including slots not funded by CMS; 4) cost of living; 5) seismic status; 6) quality of care; and 7) scope of services delivered.
- Growing share of aging compared to younger population.
- Seismic standard requirements.
- Hospitals that are the safety net hospitals where there is not a county hospital.
- Damaging the reputation of the hospitals by placing them on a high-cost hospital list.
- Affordability efforts should be focused on greater price transparency.

# 2. Distribution of Relative Price Among Comparable Hospitals

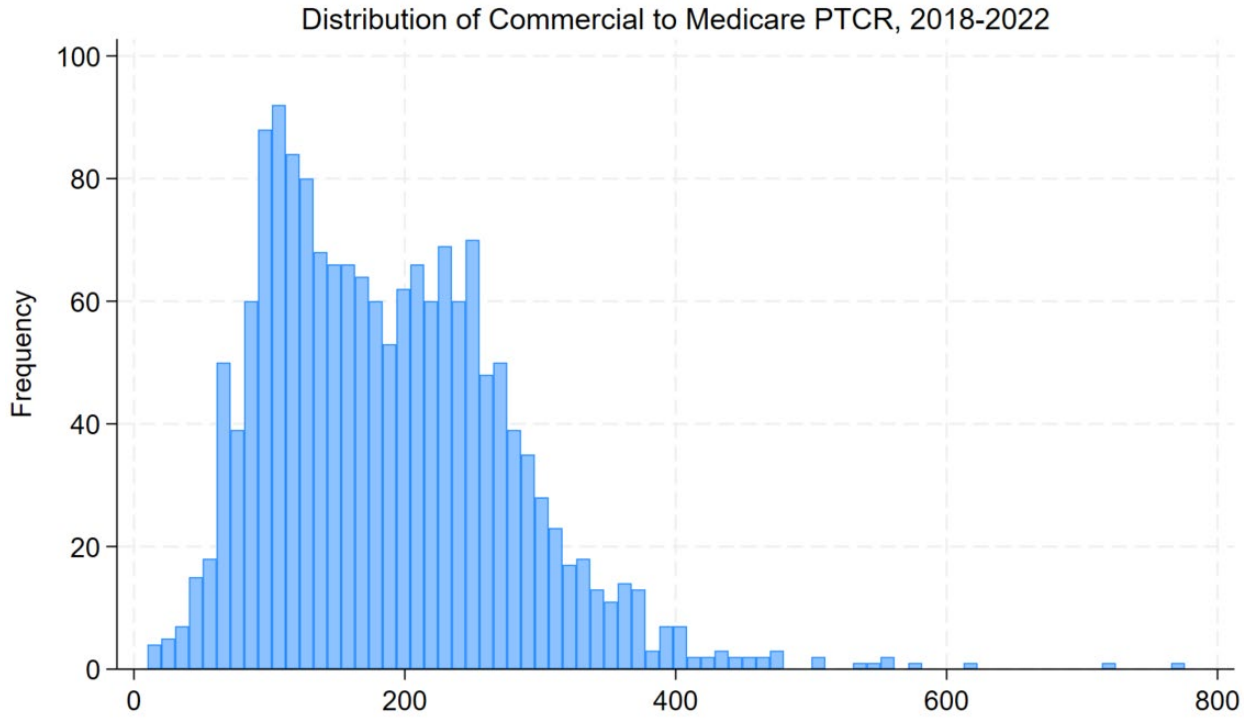
**Question:** Is there something different about the hospitals in one peak compared to hospitals in the second peak?

**Approach:** Based on 2018-2022 HCAI Hospital Annual Financial Disclosure data, OHCA

a. Compared the share of public hospitals* in each peak.

b. Compared the share of hospitals in competitive markets** (HHI <1500) in each peak.

c. Compared the share of hospitals in Southern vs Northern regions*** in each peak.




*To identify public hospitals, OHCA used a member list of California Association of Public Hospitals & Health Systems available at https://caph.org/about/members/.

**Herfindahl-Hirschman Index (HHI) is calculated as the sum of squared market shares for each county and year. A hospital's market share is defined as total discharges divided by county-level total discharges by year.

***OHCA defined Southern California as five counties: Los Angeles, Riverside, San Bernardino, Orange, San Diego.

# 2. Distribution of Relative Price Among Comparable Hospitals

Compared to hospitals with higher Commercial to Medicare Payment to Cost Ratios (PTCR) (high peak), hospitals with lower Commercial to Medicare PTCR (low peak) were:

- Marginally more likely to be public hospitals (7.7% vs 7.2%).
- More likely operate in competitive markets (58% vs 45%).
- More likely to operate in Southern California (56% vs 40%).
- Similar in terms of their public payer mix (71.7% vs. 71.3%).

# 3. Northbay's Trend Across Unit and Relative Price Measures

**Question**: Is there a data issue with Northbay's numbers on both measures?

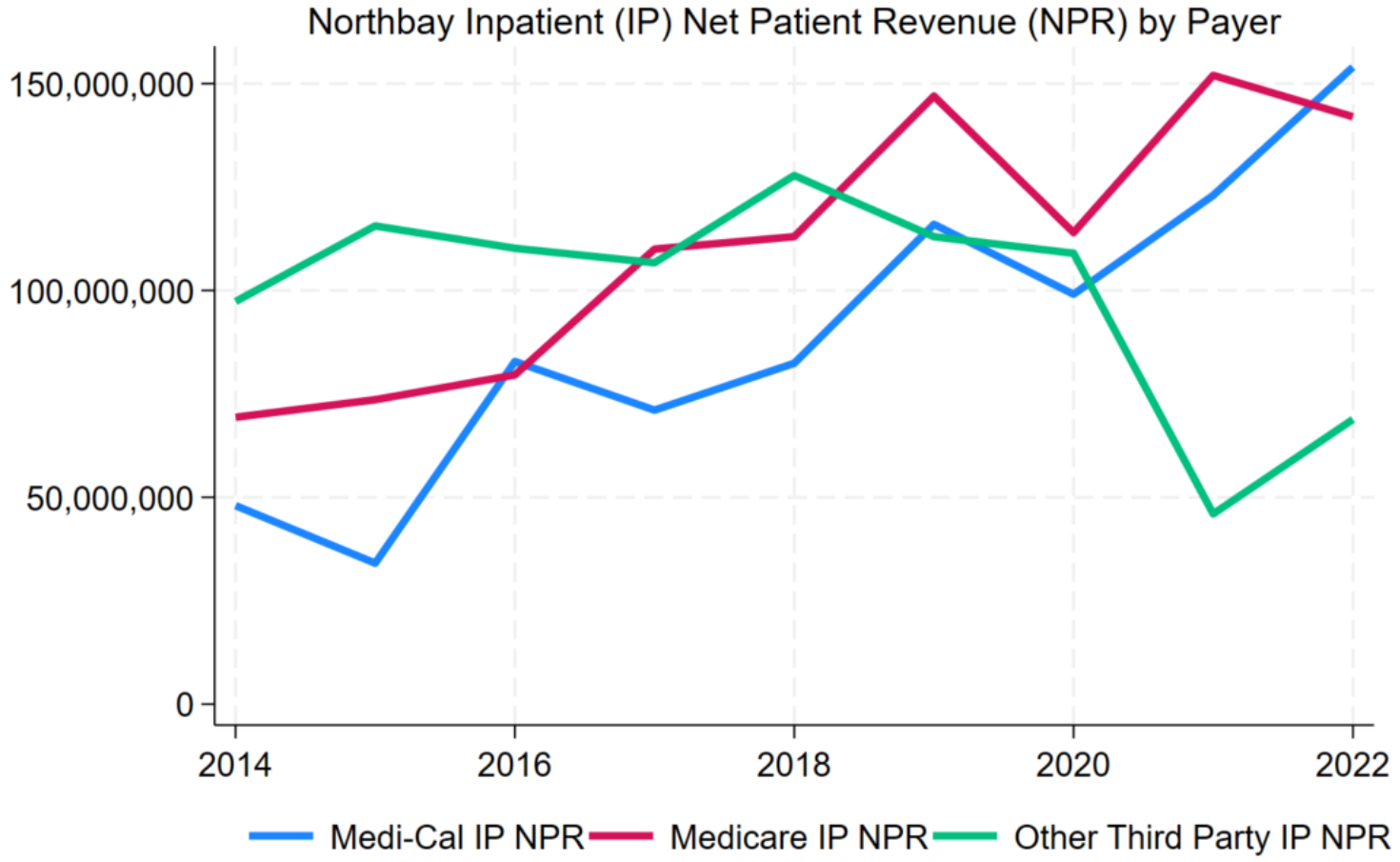
**Discussion:** OHCA verified its code accurately calculated the unit and relative price measures. OHCA can confirm that the data used in the calculations matches the data Northbay submitted to HCAI. OHCA also met with Northbay staff to understand what contributed to the steep decreases in unit and relative prices in more recent years.

**Conclusion**: Northbay's unit and relative price measures reflect what they submitted in their annual financial disclosure reports.

# 3. Northbay's Trend Across Unit and Relative Price Measures

Question: What contributed to Northbay's steep decreases in unit and relative prices in more recent years?

Discussion: Northbay staff informed OHCA that (1) they changed report preparers in early 2021 and (2) as part of that change, they began shifting Other Third Party (Commercial) net patient revenue to Medicare, Medi-Cal and Other Categories.



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# 3. Northbay's Trend Across Unit and Relative Price Measures

**Question**: What do we do when we see an improving trend in more recent years?

**Discussion:** The board has ultimate decision-making authority on establishing the methodologies for target setting and establishing target values. As the Northbay example highlights, in cases of dramatic changes in trend, the first step is a deeper inquiry into the underlying causes or explanations of the trend.

**Conclusion:** On a case-by-case basis, the board can determine whether the factors driving the recent trend merit changes for a particular facility, or modification to the Board's methodology for target setting.

# 4. Overview: Health Systems Have Substantial Variation and Complexity

**Question**: Can OHCA provide a typology of what health care systems in California?

**Summary:**

- While there are multiple definitions of health systems, there is not currently one in state law except for fully integrated delivery system and hospital systems.
- There is substantial variation and complexity in health systems.

# 4. OHCA Statute: Fully Integrated Delivery Systems

- One definition of a system that is included in OHCA's enabling statute is for Fully Integrated Delivery Systems (FIDS).
- In a FIDS, all members can be attributed to the system.
- All systems meeting the FIDS definition (at present, only Kaiser Permanente) will be assessed using a FIDS-specific measure.

**§127500.2(h) Fully Integrated Delivery System**

"Fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.

# 4. HCAI Definition: Hospital Systems

HCAI promulgated a definition of  a “hospital system” for the purposes implementing the Hospital Equity Measures Reporting Program.

**HCAI Title 22, Division 7, Chapter 8.4 § 95300:**

“Hospital system” means an entity or system of entities that includes or owns two or more hospitals within the state, of which at least one is a general acute care hospital, as defined in Health and Safety Code section 1250, subdivision (a). Hospital system also includes a single corporation or entity that controls two or more hospitals and an integrated system as defined in Health and Safety Code section 127371, subdivision (f)…

# 4. AHRQ Compendium of U.S. Health Systems

- The Agency for Health Research and Quality (AHRQ) created a definition of health system in 2016 based in part on work of three System Performance Initiative "Centers of Excellence" (Dartmouth, National Bureau of Economic Research, and RAND).
- Based on that definition, AHRQ releases a dataset of national health systems annually.
- The definition excludes some types of systems that OHCA may want to consider, e.g., hospital-only systems.

**AHRQ Compendium Definition:**

A health system includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management.

The definition requires that a system include:

1. At least one nonfederal acute care hospital
2. At least 50 physicians (in total)
3. At least 10 primary care physicians

# 4. Pending Legislation: Health System Definition

**AB 1415 Definition:**

(l) "Health system" includes any of the following entities, under common ownership or control, in whole or in part:

(1) A hospital system, as defined in subdivision (e) of HSC section 127371.

(2) A combination of one or more hospitals and one or more physician organizations.

(3) A combination of one or more hospitals, one or more physician organizations, or one or more health care service plans or health insurers.

- AB 1415 (Bonta, introduced 2/21/25) would amend existing Health and Safety Code to define "health system" and add health systems to OHCA's "provider" definition.
- If passed into law, OHCA would consider performance and enforcement at both the individual health care entity and health systems level.
- The definition is comprehensive and OHCA would need to implement a process to identify which entities meet the health system definition.

Assembly Bill 1415, California Legislative Information

# 4. Health Systems Have Substantial Variation and Complexity

***RAND: "If you've seen one health system, you've seen one health system."***
Systems span the continuum from a single legal entity to very complex multi-layered systems that operate or manage multiple hospitals and multiple physician organizations and also provide care through clinically integrated networks and other affiliation arrangements with private practice physicians.

**Health Systems Vary Across Multiple Dimensions:**

- **Scale:** Number of facilities, size of facilities, geographic footprint
- **Ownership structure**: Academic, public, for-profit, non-profit
- **Financial Arrangement/Support:** Payer Mix, Public Support, Integrated Health Plans, Contracted Health plans
- **Services Types and Composition offered**: Acute/Sub Acute care, Primary Care, Specialty Care, Children's, Psych, Imaging, Laboratory, etc.
- **Facility Types and Facility Composition**: General Acute Care Hospitals, Hospital Outpatient, Ambulatory Surgery Clinics, Skilled Nursing Facilities, Urgent Care, Clinics, Mobile clinics, etc.
- **Physician Affiliations**: Medical groups, IPAs, Medical Foundations
- **Control and Decision Making**: the degree to which system executive leadership controls constituent entities centrally or whether entities have greater autonomy

RAND Health Care. (n.d.). *If you've seen one health system, you've seen one health system.* rand.org. Retrieved March 13, 2025 from https://www.rand.org/health-care/centers/health-system-performance/what-have-we-learned/health-systems.html#if-youve-seen-one-health-syste-

# Advisory Committee Feedback

# Advisory Committee Feedback

- Many Advisory Committee members supported the proposed methodology highlighting the respective changes and considerations that have been integrated from previous board and AC discussions.
- Many AC members support the proposed 3 out of 5 years analysis of the high-cost hospitals.
  - One member suggested a rolling three-year examination to capture more recent figures.
- One member suggested including a geographic examination of Northern vs. Southern California to ensure high-cost outlier hospital are geographically represented.
  - Additionally, consideration should be given to the lack of competition based on geography.
- One member suggested a broader system analysis for some of the outlier hospitals that are operating under a larger healthcare system noting opportunities to shift revenues and expenses.

# Advisory Committee Feedback

- Some members expressed concern over the methodology of the first measure potentially missing or under-accounting for hospital-based outpatient services and want to explore outpatient intensity adjustments in the future.
  - Commercial payment is not independent of Medicare and Medi-Cal.
- A member was concerned that the approach using two measures to get on the list eliminates several hospitals that were high cost on just the Commercial measure.
- Some members expressed concern over the Payment to Cost Ratio being dependent on Medicare – not equitable and reimburses hospitals differently.
- Two members suggested considering how capitation and Medicare Advantage impact net patient revenue reporting when developing sector target methodology.
- Some members suggested that learnings could be made from hospitals who are “low-cost outliers,” such as the 11 hospitals with the lowest cost.
- Some members urged that consideration needs to be given to future Medicaid cuts and those impacts.

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# Massachusetts and Oregon Cost Target Program Updates

Vishaal Pegany, Deputy Director

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Department of Health Care Access and Information

MASSACHUSETTS
HEALTH POLICY COMMISSION

# The Massachusetts Health Care Cost Growth Benchmark

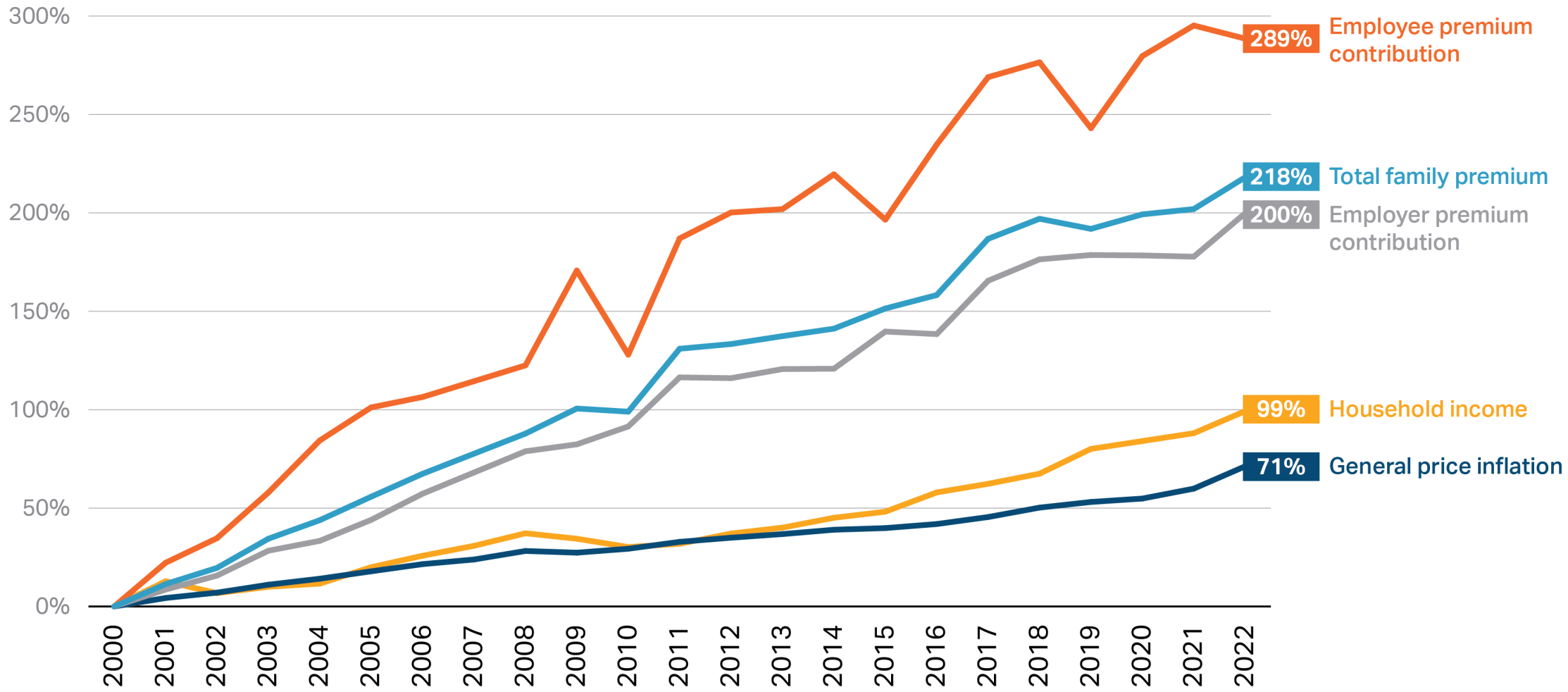
## Update on Spending Trends, Implications for Affordability, and New Tools for Accountability

March 2025

# Presentation Outline

1. **Overview of the Health Policy Commission and the Health Care Cost Growth Benchmark**
2. Recent Spending Trends
3. Implications for Affordability of Health Care
4. Recently Passed Legislative Improvements

# The Motivating Challenge: In Massachusetts, the growth in health care costs exceeds increases in income or general inflation, resulting in less affordable and accessible care.



# In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

## CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

## GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

## VISION

A **transparent**, **innovative, and equitable** health care system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

# The Massachusetts Health Care Cost Growth Benchmark

- Sets a target for **moderating the growth** of total health care expenditures across all payers (public and private) and is set to the state's long-term economic growth rate.

  The health care cost growth benchmark:

| 2013 - 2017 | 2017 - 2021 | 2022 on |
|---|---|---|
| 3.6% | 3.1% | Defaults to 3.6% |

- The law does not currently allows for sector specific benchmarks.
- If target is not met, the HPC can require certain health care providers and health plans to implement Performance Improvement Plans and submit to strict public monitoring.

## TOTAL HEALTH CARE EXPENDITURES

**Definition:** Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

**Includes:**

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

# Background on the Massachusetts Health Care Cost Growth Benchmark

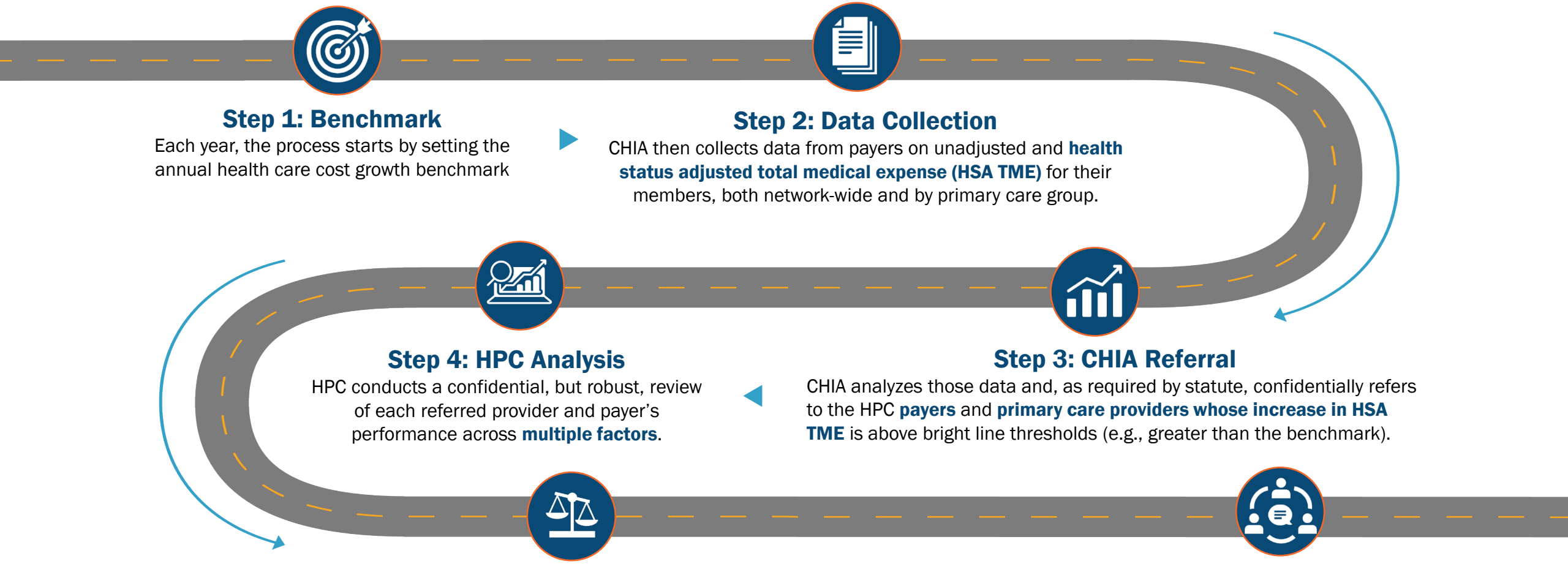
## WHAT THE BENCHMARK IS

- **A target** to track and evaluate the **growth** of total health care expenditures in the state and the long-term overall performance of the health care system.
- **A measurable goal** to catalyze public and private collective action to improve **health care affordability and access.**
- A method for **enhancing transparency of the health care system** so that market participants, policymakers, and the general public can examine what is contributing to higher health costs for government, businesses, and residents.
- A **long-term framework** to track and identify unsustainable *spending growth* and opportunities for improvement. The overall goal is to improve health outcomes and **promote high-quality, affordable, and accessible health care for all residents**.

## WHAT THE BENCHMARK IS NOT

- **A cap** on total health care spending, prices, premiums, or payments. It is a target for sustainable spending growth.
- **A punitive measure**. THCE growth above benchmark alone does not automatically trigger penalties or other negative consequences to the health care system or individual organizations. The HPC may require a performance improvement plan of an individual health care provider or plan only after a comprehensive, multi-factor review of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.
- A measure of **internal costs or operating expenses** of health care providers. It is a measure of health care spending for patients.
- A single solution to addressing health care affordability challenges within Massachusetts. The benchmark process provides **critical information and data** to inform other policy initiatives to improve affordability and access.

# Accountability for the MA Health Care Cost Growth Benchmark: An Overview



## Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

## Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

## Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC **payers** and **primary care providers whose increase in HSA TME** is above bright line thresholds (e.g., greater than the benchmark).

## Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**.

## Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

## Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

# CHIA's referral of entities is based on a bright-line test of their spending growth, whereas the HPC is charged with contextualizing that growth for each referred entity.

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan (PIP) if, after a review of regulatory factors, it identifies **significant concerns** about the entity's costs and determines that a PIP could result in **meaningful, cost-saving reforms**.

| REGULATORY FACTORS | |
|---|---|
| a | Baseline spending and spending trends over time, including by service category; |
| b | Pricing patterns and trends over time; |
| c | Utilization patterns and trends over time; |
| d | Population(s) served, payer mix, product lines, and services provided; |
| e | Size and market share; |
| f | Financial condition, including administrative spending and cost structure; |
| g | Ongoing strategies or investments to improve efficiency or reduce spending growth over time; |
| h | Factors leading to increased costs that are outside the CHIA-identified Entity's control; and |
| i | Any other factors the Commission considers relevant. |

# In December 2024, the HPC determined that the first-in-the-nation state-mandated performance improvement plan for health care spending was successful.

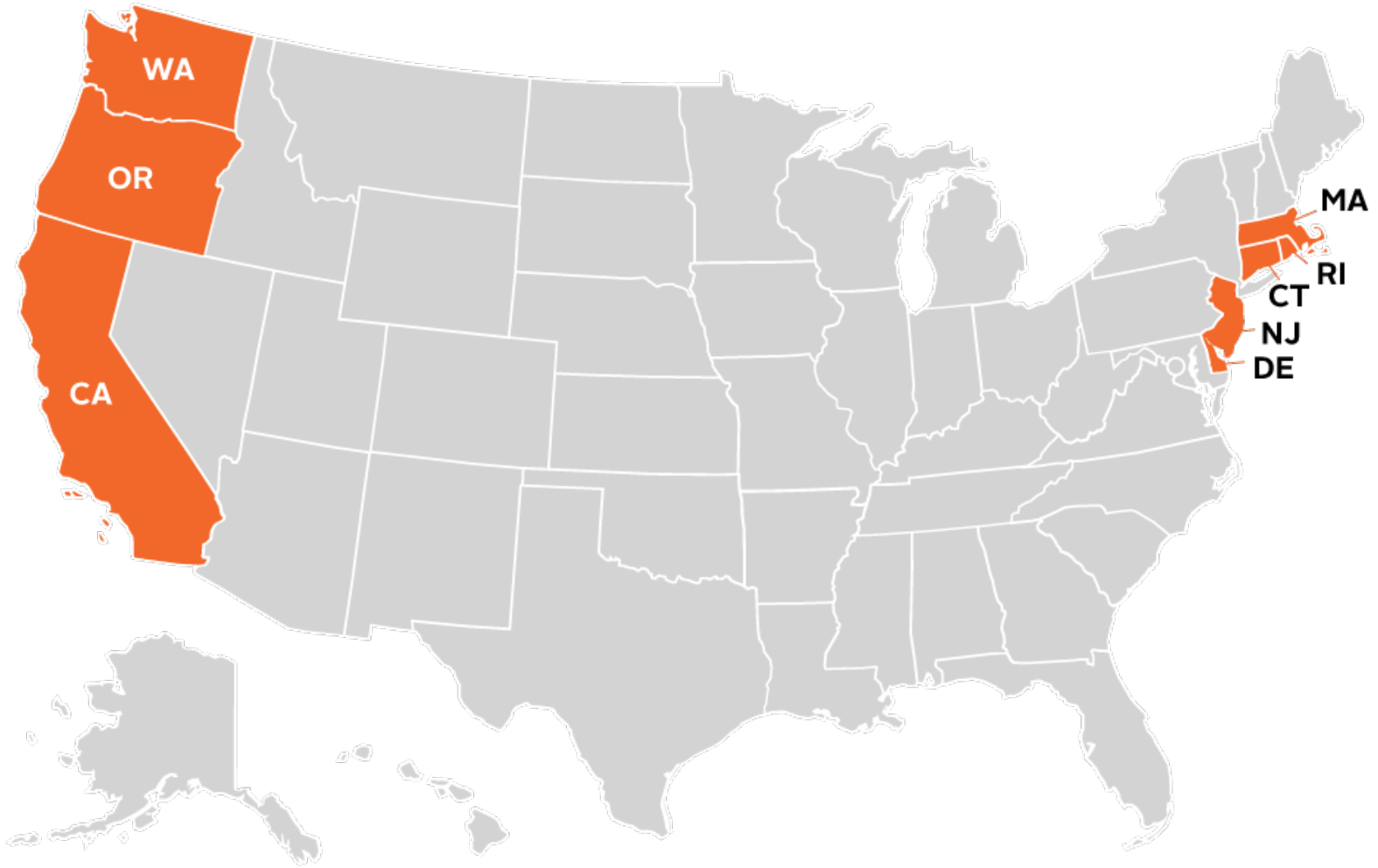
- In January 2022, the HPC Board **voted unanimously** to require Mass General Brigham (MGB) to develop a PIP to reduce cost growth, finding:
  - MGB **regularly had spending growth above the benchmark** and higher absolute spending levels for its patients than most other systems.
  - **Price and mix** were the primary drivers of MGB's spending growth, not utilization.
- MGB's PIP included **ten strategies** and a total savings target of $176.7 million over the 18-month period.
- In December 2024, the HPC voted to conclude MGB's PIP, finding that MGB **achieved its savings target** and that MGB's spending growth was meaningfully reduced.

| MGB Strategy | PIP Savings Target ($M) | Reported Total Savings by MGB ($M) |
|---|---|---|
| **Price Reductions** | | |
| Reducing Outpatient Rates | $86.8 | $85.3 |
| Mass General Waltham Rates | $19.2 | $24.8 |
| Reducing ConnectorCare Rates | $17.9 | $29.5 |
| Other Insurance Discount | $1.5 | $3.3 |
| **Reducing Utilization** | | |
| Integrated Care Management Program | $23.0 | $24.9 |
| SNF Utilization Reduction | $13.4 | $7.3 |
| MGB Health Plan Utilization Management | $1.5 | $1.5 |
| MRI and CT Utilization | $6.5 | $14.4 |
| **Shifting Care to Lower Cost Sites** | | |
| Home Hospital | $1.9 | $0.9 |
| Virtual Care Discount | $5.1 | $5.4 |
| **Total** | **$176.7** | **$197.1** |


47

**Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.**

**Many states are innovating with complimentary policies (e.g. primary care spending targets).**



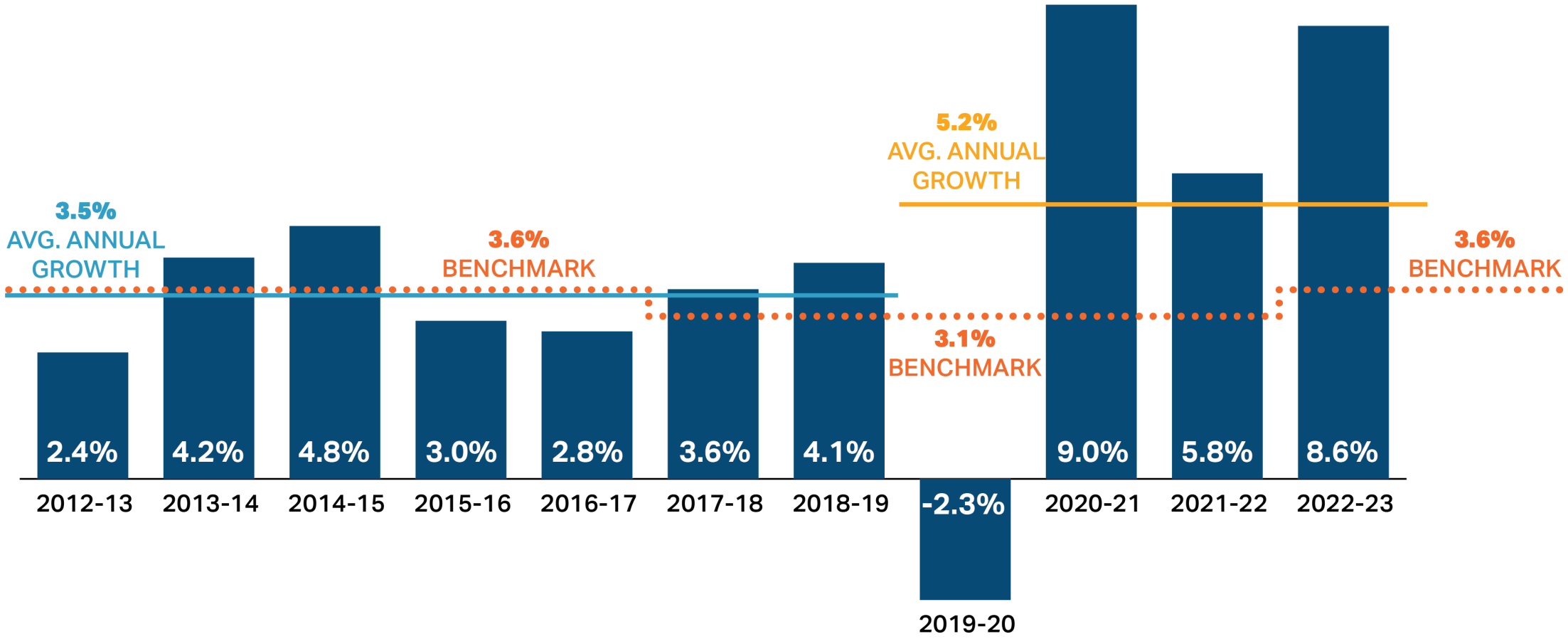

How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

# Presentation Outline

1. Overview of the Health Policy Commission and the Health Care Cost Growth Benchmark
2. **Recent Spending Trends**
3. Implications for Affordability of Health Care
4. Recently Passed Legislative Improvements

# Health care spending growth in Massachusetts averaged 4.1% from 2012 to 2023. Recent years have seen an acceleration of spending growth.

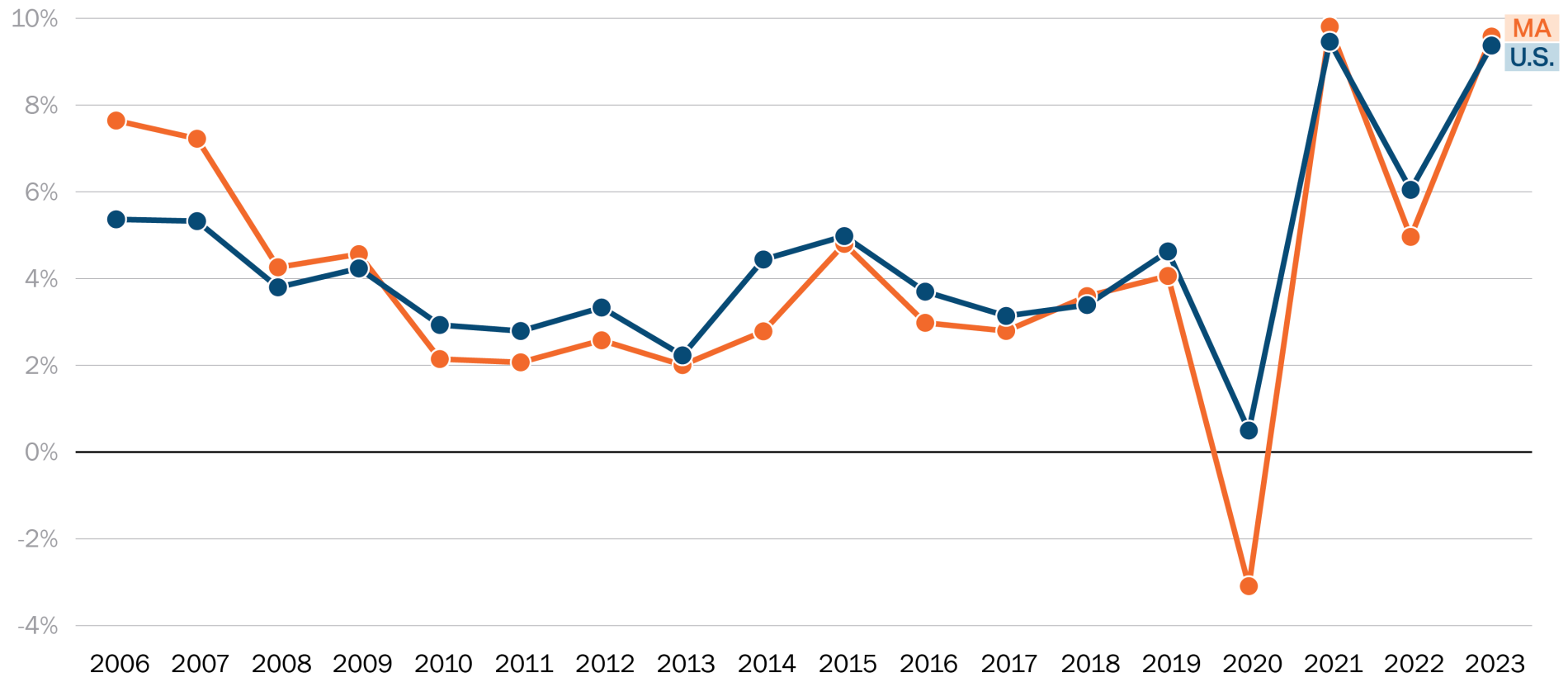
*Annual growth in total health care expenditures per capita in Massachusetts, 2012-2023*




Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System 2013-2025.

# Massachusetts' total health care spending growth has been below the national rate in 7 of the past 10 years.

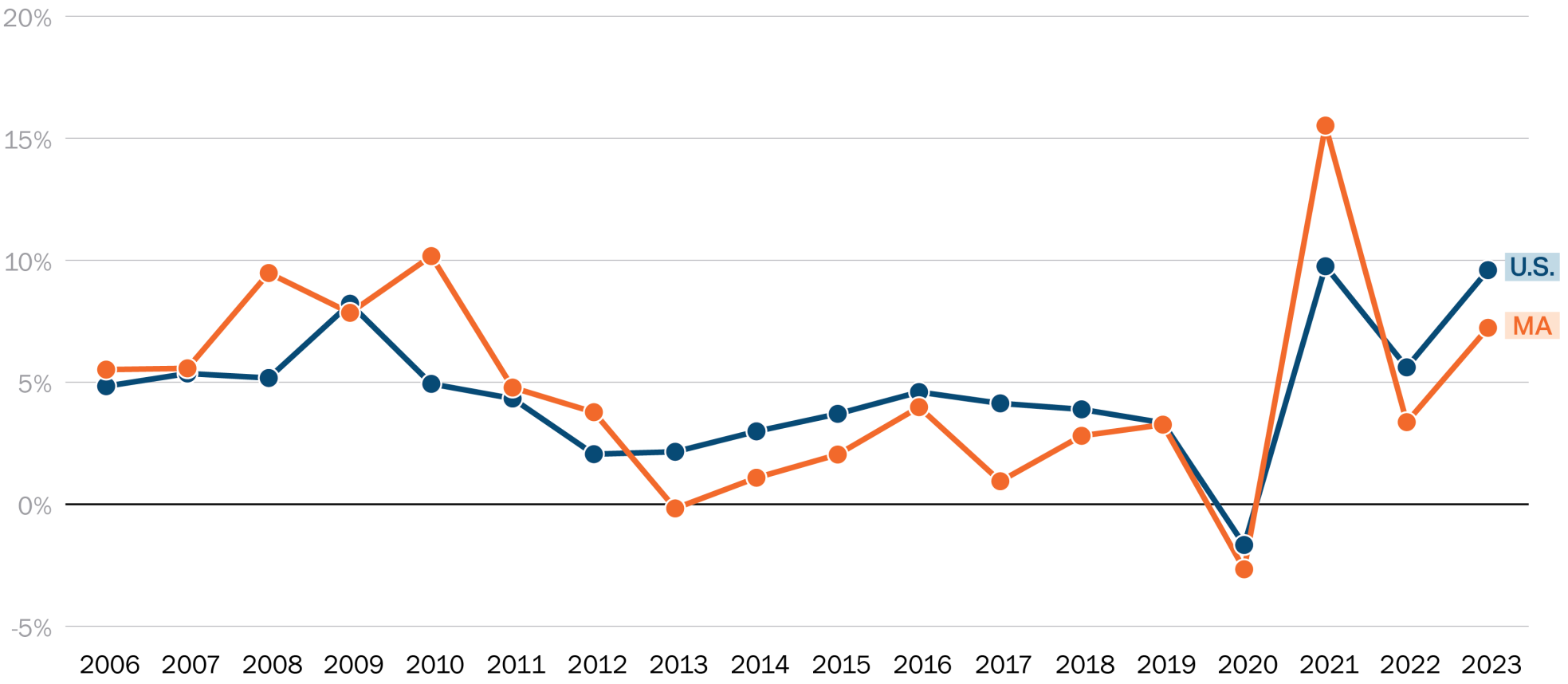
*Annual growth in per capita health care spending from the previous year to the year shown, Massachusetts and the U.S., 2006-2023*




Notes: U.S. data includes Massachusetts. Massachusetts and U.S. data exclude federal and state supplemental COVID-19 relief funding.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2023 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis (CHIA), Total Health Care Expenditures, 2014-2023.

# Massachusetts commercial spending has been at or below the national rate in 9 of the past 10 years.

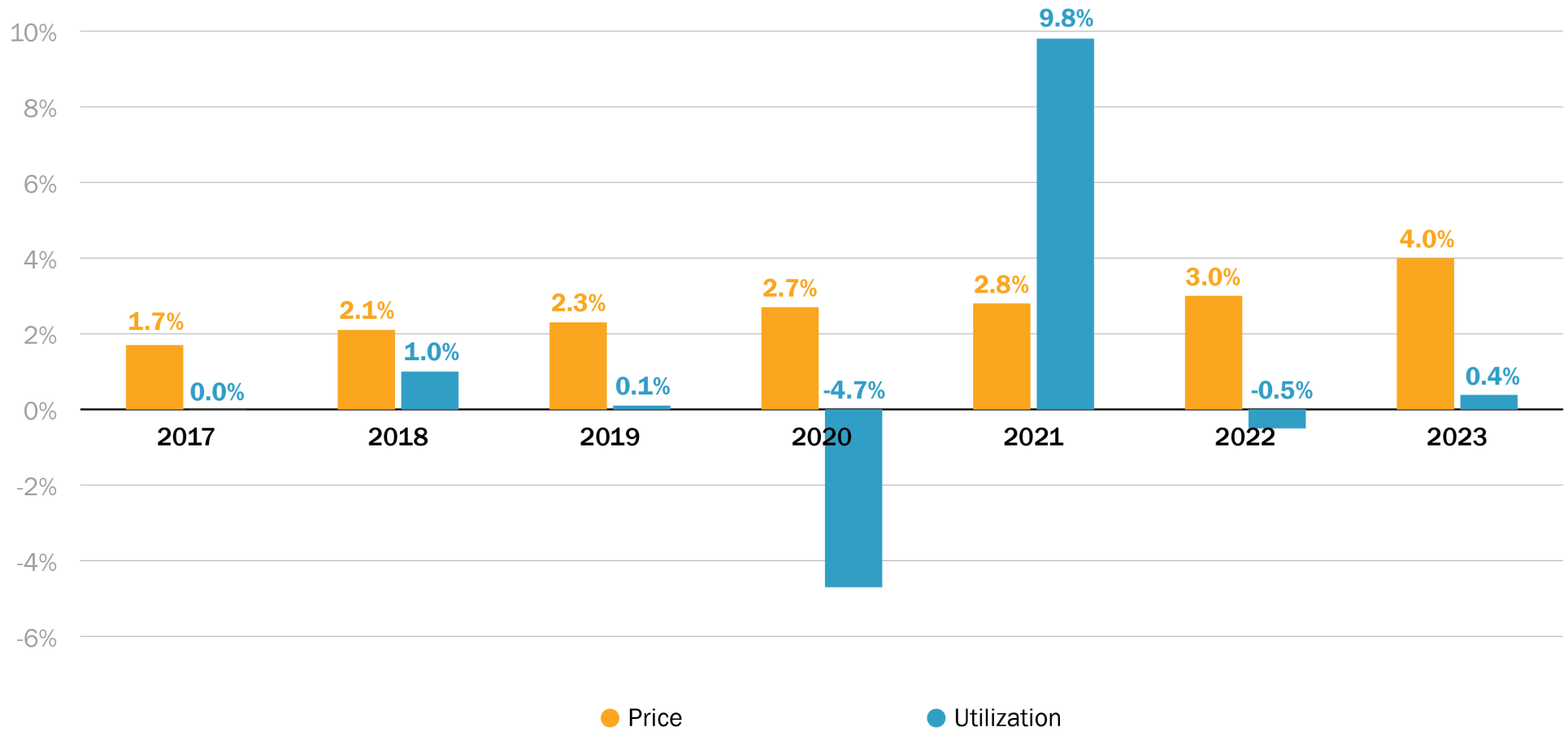
*Annual growth in per-enrollee commercial health care spending, Massachusetts and the U.S., 2006-2023*




Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2023 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis Annual Report on the Performance of the Massachusetts Health Care System 2014-2023.

# Commercial spending growth continues to be driven by prices more than utilization overall, with accelerating prices each year according to one large payer.

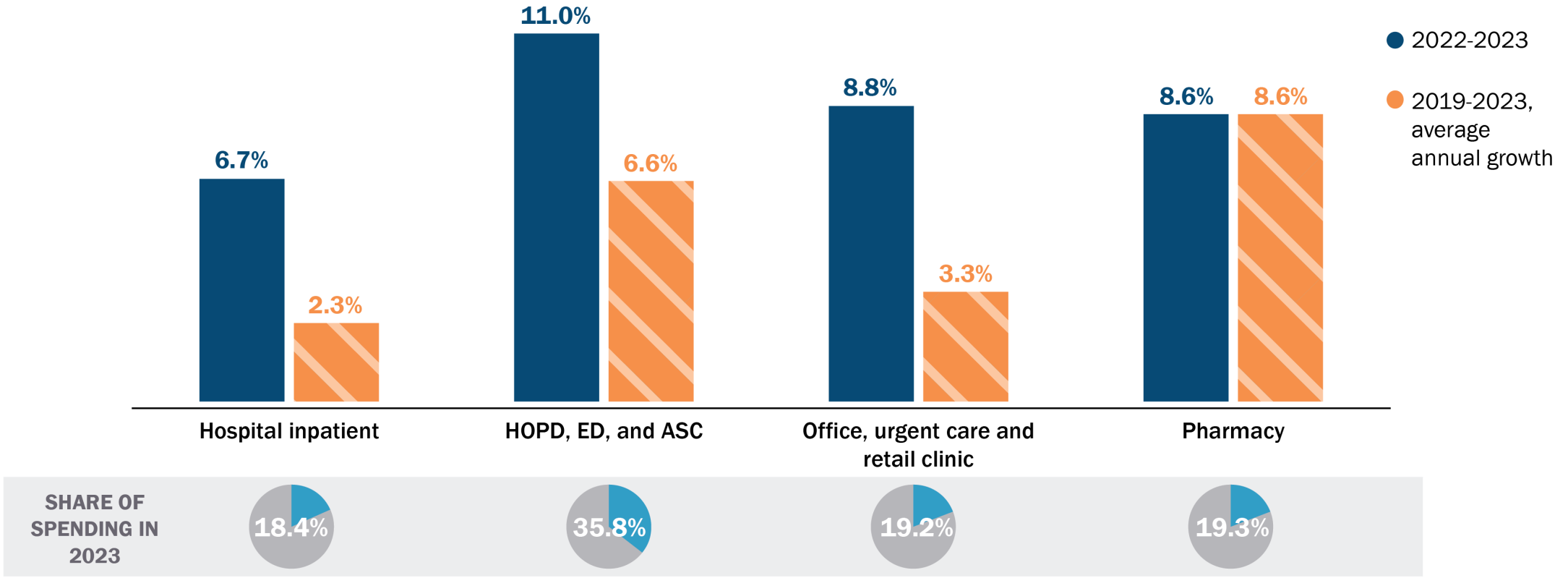
*Payer-reported percent change in commercial prices (unit cost) and utilization for a large Massachusetts insurer from previous year to year shown*




Sources: Pre-Filed testimony submitted to the HPC in advance of the 2021, 2022, 2023 and 2024 Annual Cost Trends Hearings.

# Spending increased substantially for all major categories of care in 2023, with hospital outpatient (HOPD) and pharmacy being the top drivers from 2019-2023.

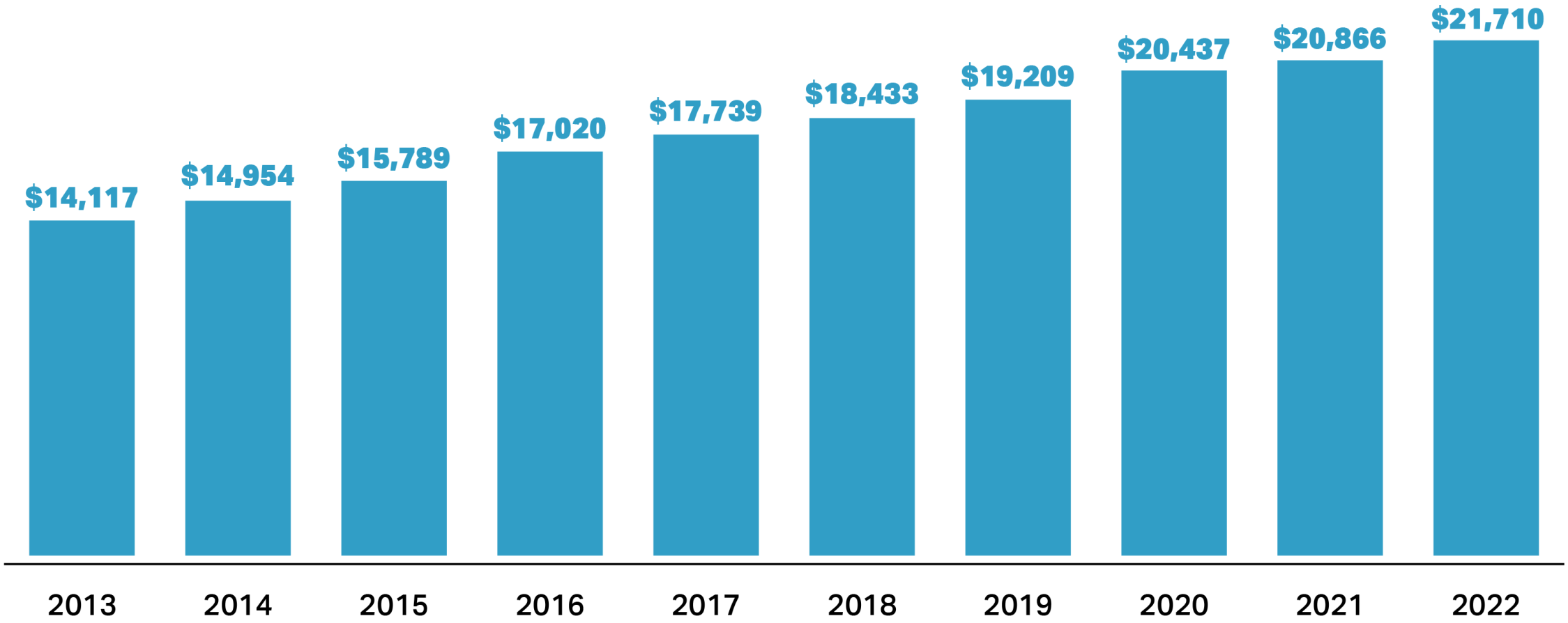
*Average annual growth in commercial spending per enrollee by site of care, 2022-2023 and 2019-2023*




Notes: Pharmacy spending is net of rebates. Share of spending does not sum to 100% as sites of care with smaller spending amounts are not shown. Spending amounts in all hospital categories include both professional and facility spending.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA), Total Medical Expenditures, 2019-2023 (pharmacy spending, full claims only). HPC analysis of CHIA All-Payer Claims Database V2023, 2019-2023 (spending at other sites).

# Over the past ten years, the price paid per commercial hospital stay increased 54%, double the rate of inflation during this period (25%).

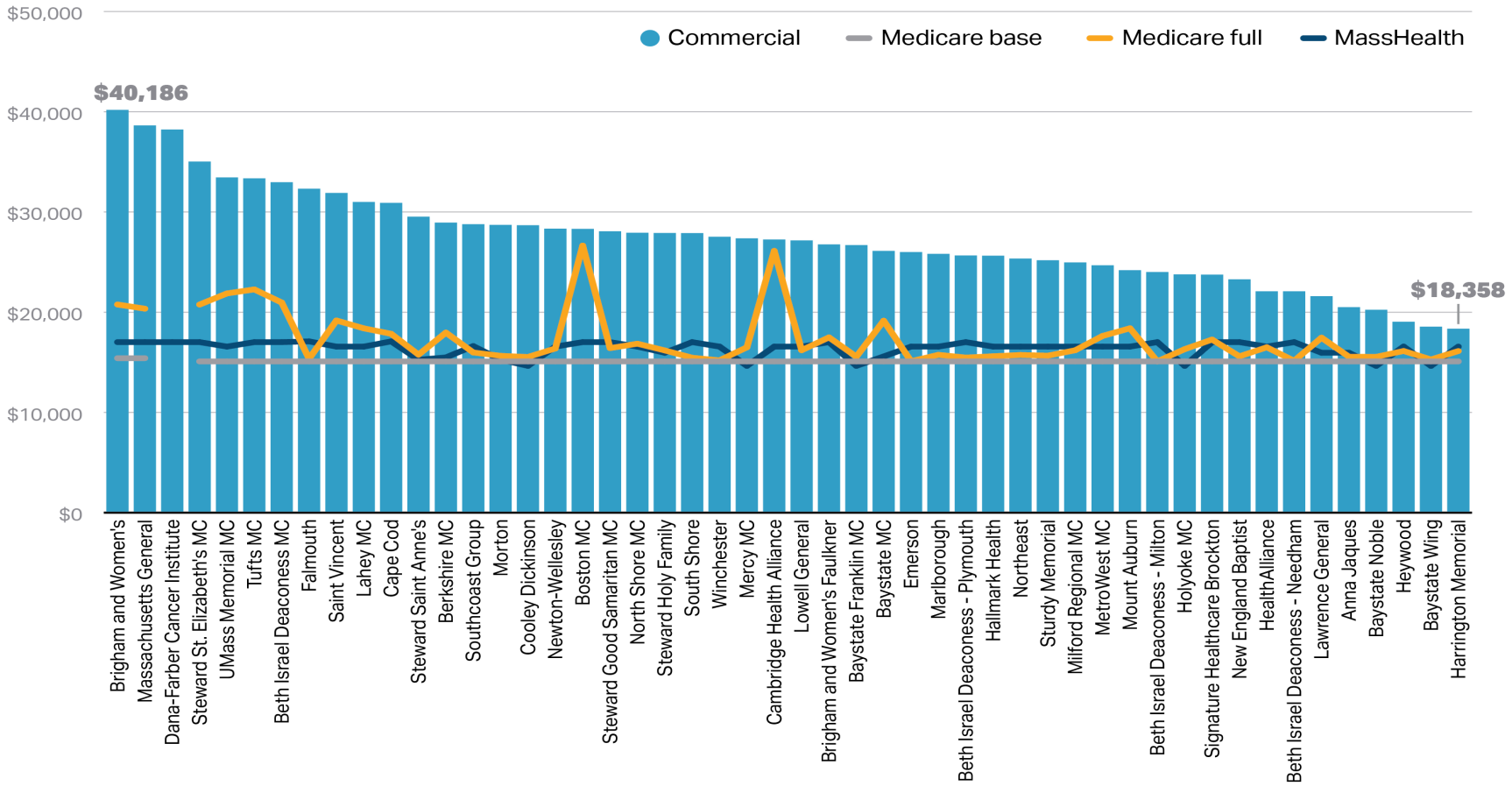
*Average inpatient spending per commercial discharge, 2013-2022*




Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge database, 2013-2022 and Annual reports, 2015-2024; Bureau of Labor Statistics, CPI-U for the greater Boston metro area. Inflation averaged 2.5% annually from 2013 to 2022.

# Commercial hospital prices for the same inpatient stay varied from $18,000 to $40,000 in 2022. MassHealth and Medicare rates are similar to each other.

*Average price paid to each hospital by commercial insurers, MassHealth and Medicare for an equivalent stay, excluding maternity and psychiatric stays, 2022.*

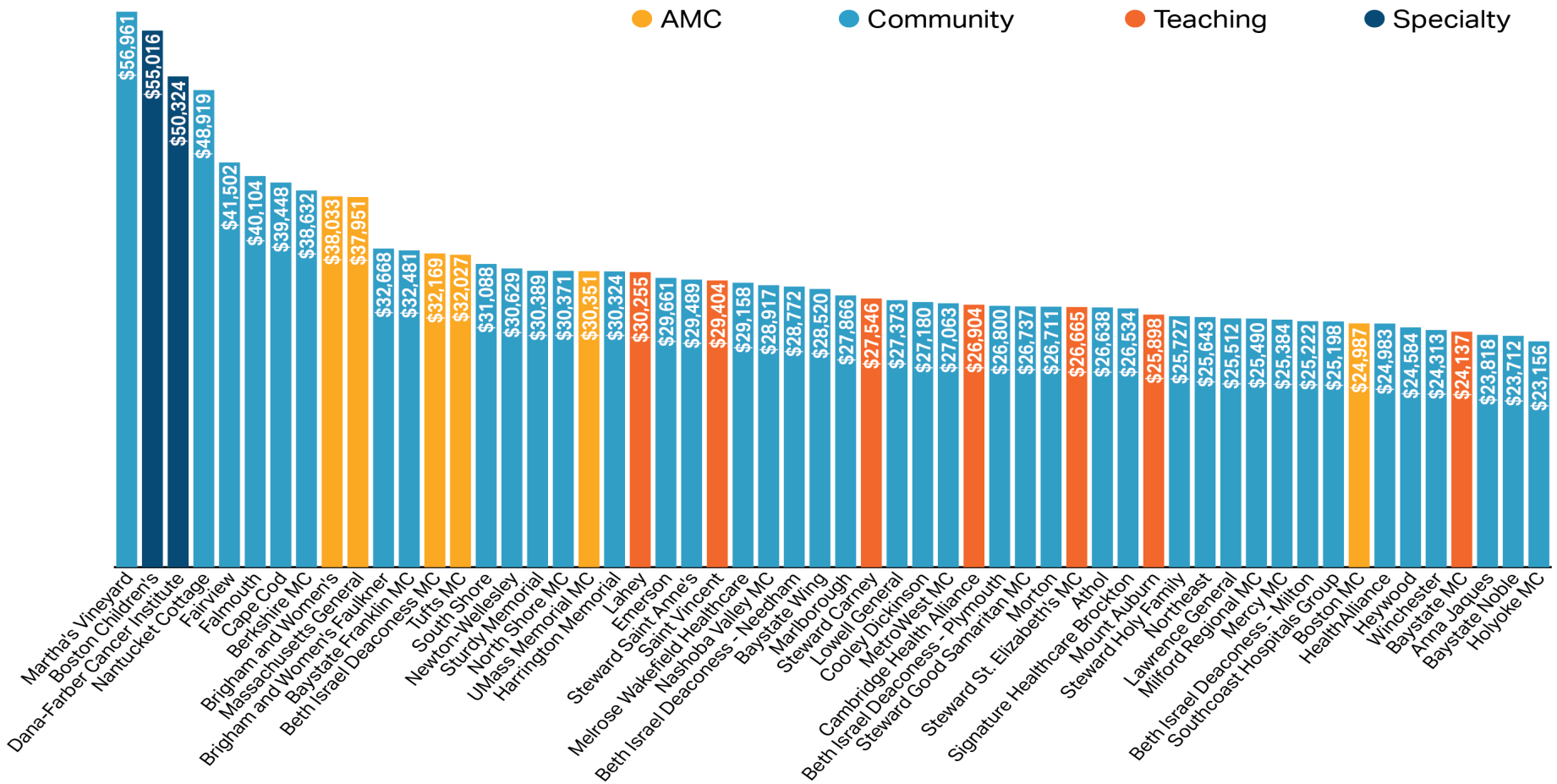



- "Full" Medicare prices are higher for teaching hospitals and those serving a high proportion of uninsured and MassHealth patients.

Notes: Exhibit includes the top 50 acute care hospitals by volume of adult non-maternity and non-psychiatric patients in 2022. Stays that are outliers in payment and length of stay within their APR-DRG as well as transfers are excluded to ensure comparable prices. Commercial prices are adjusted for the APR-DRG commercial weight of each admission and include both facility and professional payments and multiplied by average commercial DRG weight. See technical appendix for details.
Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, V2022, 2022; 3M commercial APR-DRG weights, version 38; Medicare IPPS Final rule and correcting amendment documentation 2022.

# The price of a market basket of 50 common hospital outpatient services such as labs and imaging ranged from $23,000 to $57,000 across hospitals in 2022.

*Total spending for a market basket of 50 hospital outpatient services for 100 average Massachusetts residents by hospital, 2022*

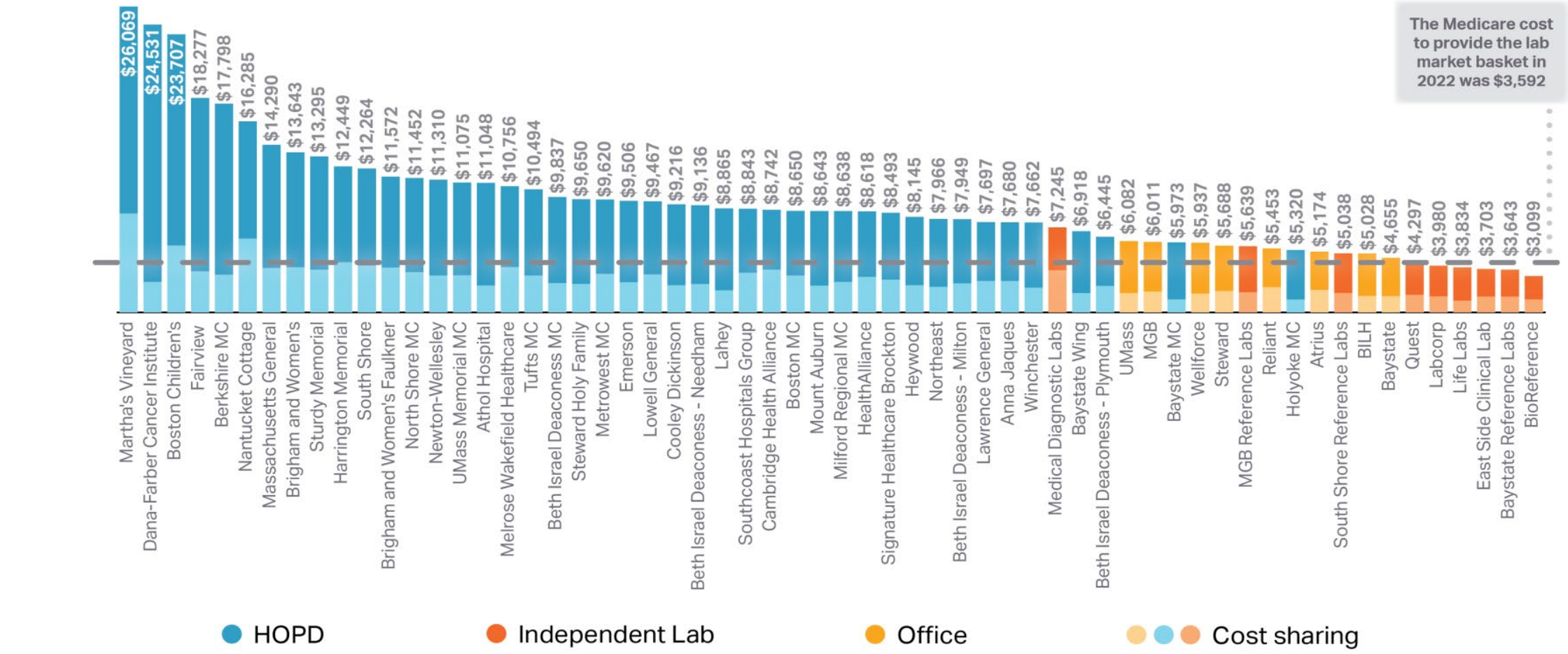



Notes: Academic medical center (AMC). For each hospital, the same 50 procedure codes are evaluated using a fixed statewide volume (computed using 2022 data) and hospital-specific average service prices in 2022 for each procedure code. Hospitals with fewer than 20 service encounters for any individual procedure code have imputed values for that procedure code and are not included if more than 20 procedure codes would have to be imputed.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2022, V2022.

# The price of a market basket of 50 common lab tests varied from $3,000 to $26,000 by provider. Patient cost sharing for these labs varied proportionally.

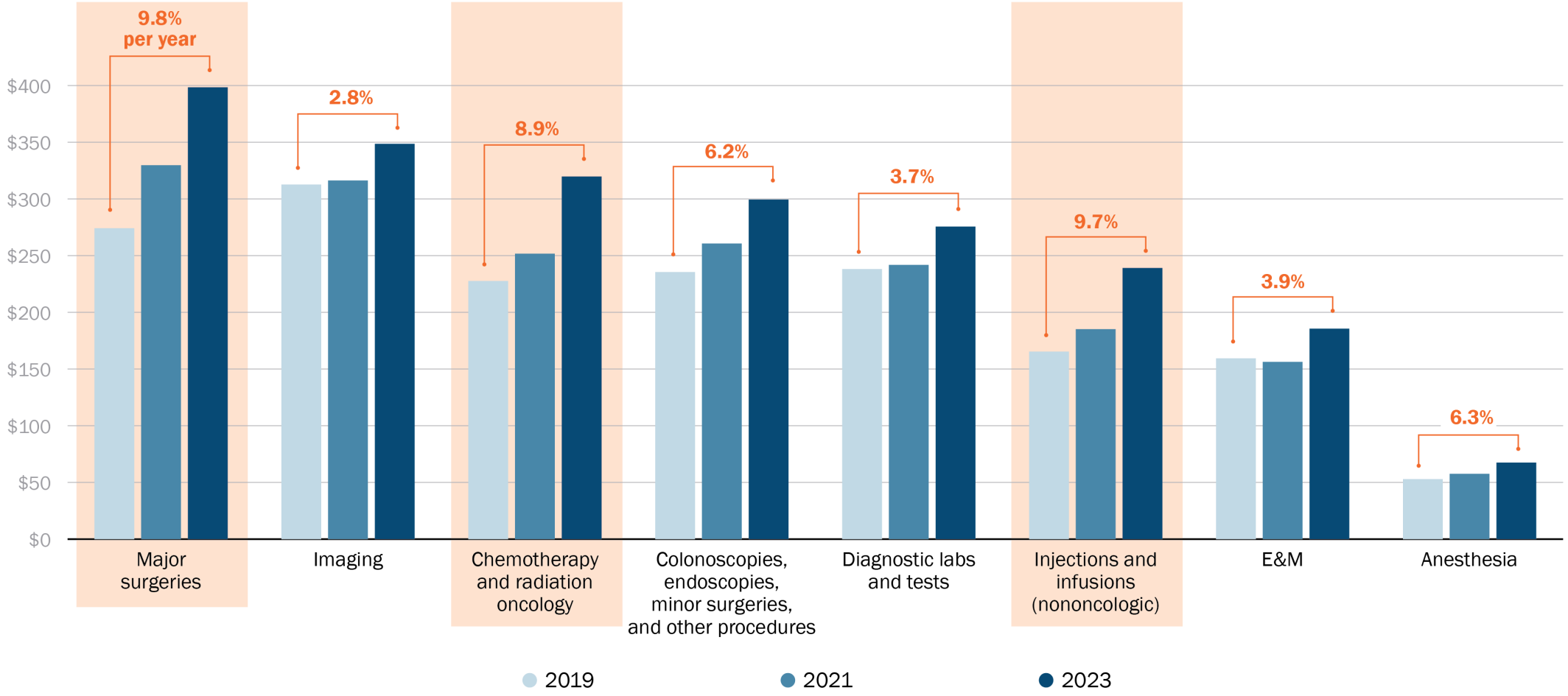
*Total spending for a market basket of 50 lab tests for 100 average Massachusetts residents by provider, 2022*




Notes: The lab market basket reflects the quantity and type of lab tests ordered per 100 members in 2022. For each provider, the same 50 highest-aggregate-spending procedure codes are evaluated using a fixed statewide volume (computed using 2022 data) and provider-specific mean service prices in 2022 for each procedure code. Providers with fewer than 20 service encounters for any individual procedure code have imputed values for that procedure code and are not included if more than 25 procedure codes would have to be imputed. See technical appendix for more details on methodology.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2022, 2022.

# Within HOPD spending categories, the biggest drivers were major surgeries (9.8% annual growth from 2019-2023), chemotherapy (8.9%) and injections and infusions (9.7%).

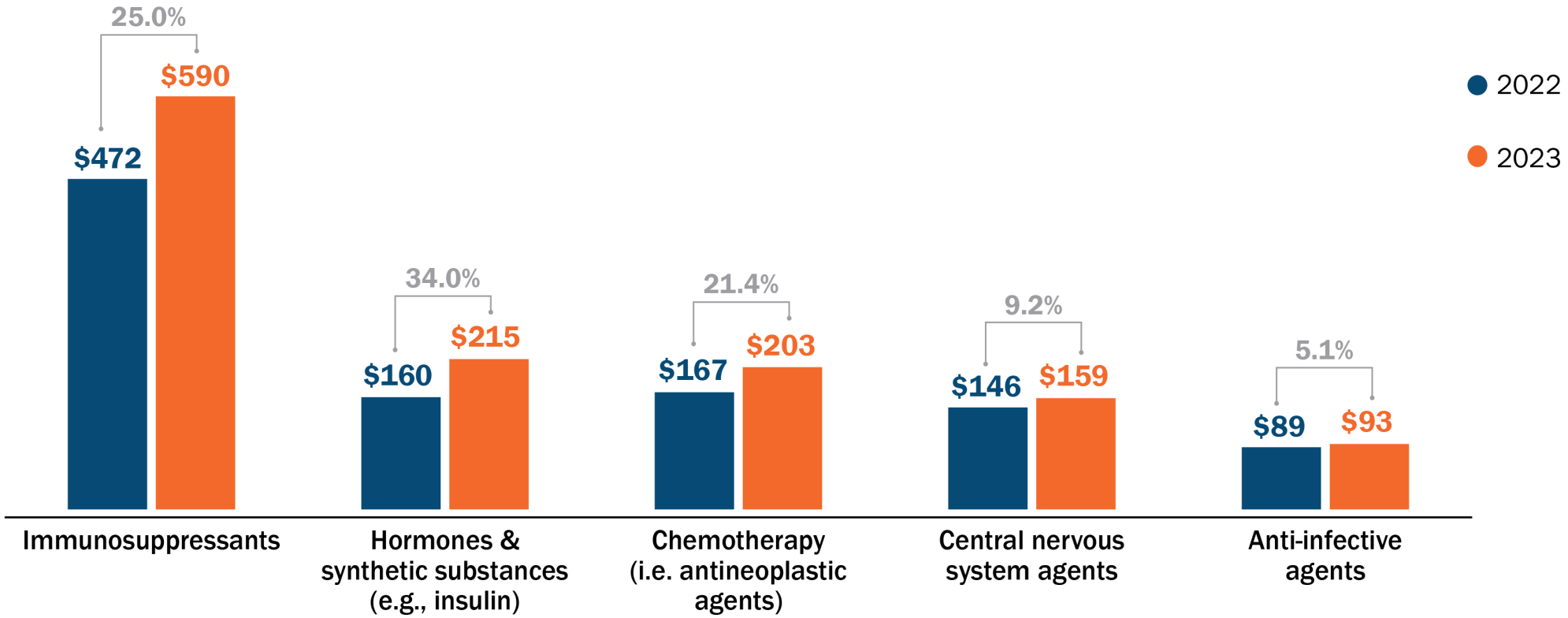
*Commercial spending per member per year for HOPD services by type of service, 2019-2023*




Notes: E&M = evaluation and management services. Includes spending from Massachusetts acute hospitals only. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. Categories with small spending amounts are omitted (e.g., durable medical equipment). Spending on COVID tests and vaccines are excluded.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2023, 2019-2023.

# Increasing prescription drug spending in 2023 was primarily due to immunosuppressants, with large contributions from the hormone classes and chemotherapy.

*Estimated per member per year net spending by therapeutic classes with the highest total spending, 2022-2023*



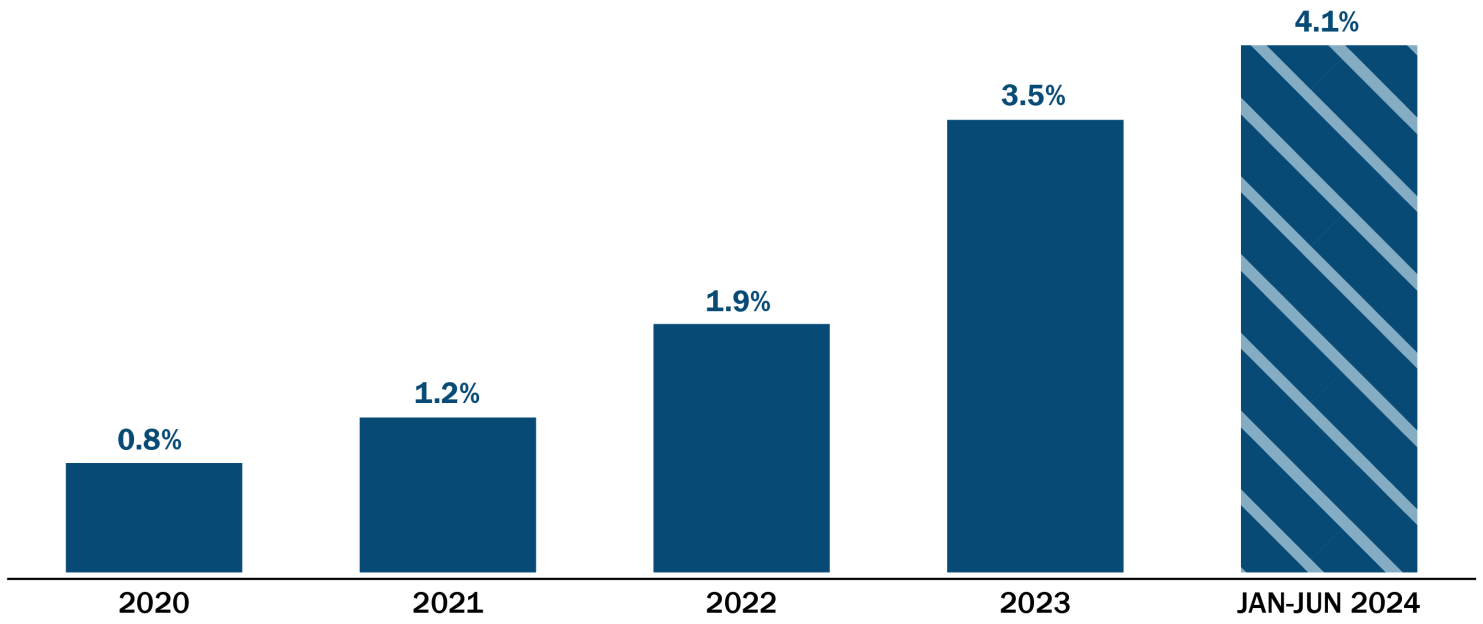

| | | | | | |
|---|---|---|---|---|---|
| SHARE OF CLAIMS IN 2023 | 1.3% | 16.0% | 0.7% | 31.6% | 10.1% |

Notes: Therapeutic class based on Red Book. Spending is net of rebates. Rebates were sourced from The Medicare Payment Advisory Commission July 2024 Data Book, Section 10: Prescription drugs. Available at: https://www.medpac.gov/document-topic/part-d/

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims database, V2023 2022-2023.

# The percentage of Massachusetts residents using GLP-1 medications has grown 5-fold since 2020, from 0.8% to 4.1%.

*Percent of commercially-insured adults who had at least one GLP-1 prescription that year, January 2020 to June 2024*




- In 2023, **5.5% of all commercial prescription drug spending** (net of rebates) was attributable to GLP-1 medications.
- The **increase in spending for GLP-1 medications** between 2022 and 2023 added 3 percentage points to commercial prescription drug spending growth (net) and 0.6 percentage points to overall commercial spending growth.

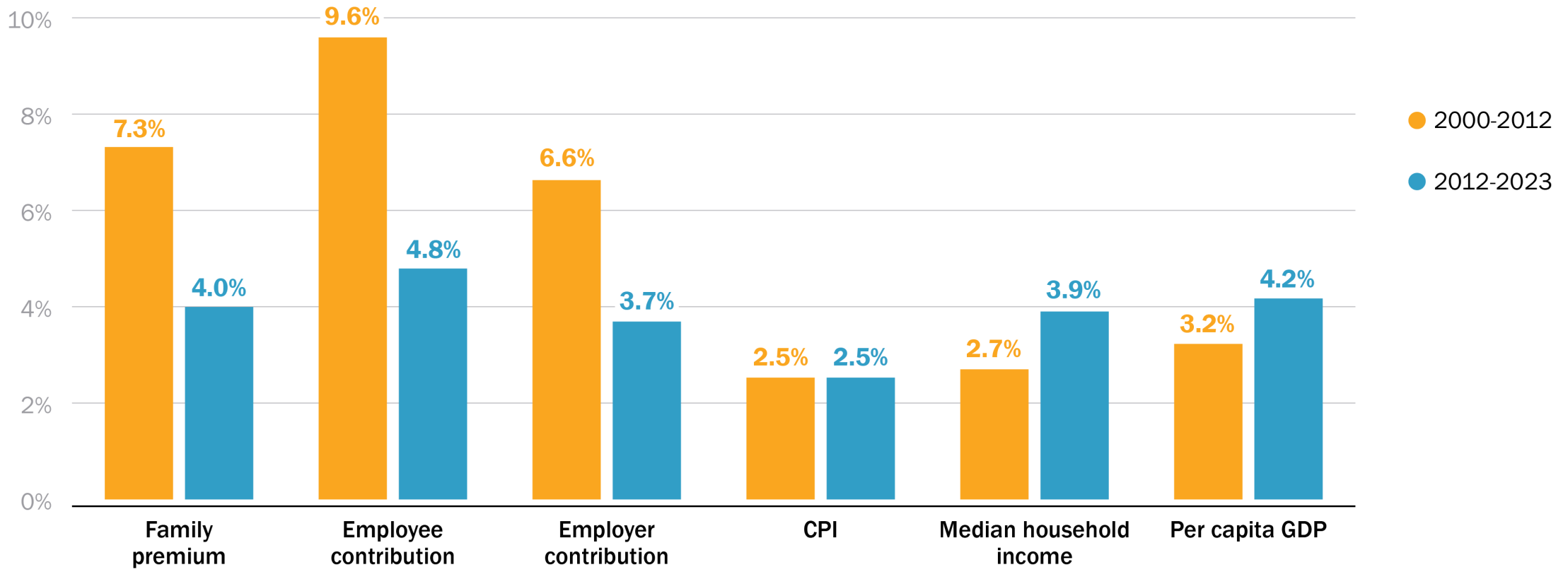
Notes: The following medications were included: Victoza, Saxenda, Trulicity, Ozempic, Rybelsus, Wegovy, and Mounjaro. Exhibit includes prescriptions among commercially-insured members between 18 and 64 years of age and with 12 months of medical and pharmacy coverage that year (6 months in 2024). Analysis for the sidebar texts includes commercially-insured members of all ages. Pharmacy spending is net of rebate.
Sources: HPC analysis of Massachusetts Enhanced All-Payer Claims Database, 2020-2024 (for exhibit). HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database, V2023 2022-2023 (for sidebar statistic). CHIA Annual Report on the Performance of the Massachusetts Health Care System 2024 (for commercial spending and average commercial rebates). GLP-1 rebates were sourced from the following two publications: Hernandez I, Sullivan SD. Net prices of new antiobesity medications. Obesity. 2024 Mar;32(3):472-5. Ippolito BN, Levy JF. Estimating the cost of new treatments and diabetes and obesity. American Enterprise Institute. Sep 2023. Available at: https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208

# Presentation Outline

1. Overview of the Health Policy Commission and the Health Care Cost Growth Benchmark
2. Recent Spending Trends
3. **Implications for Affordability of Health Care**
4. Recently Passed Legislative Improvements

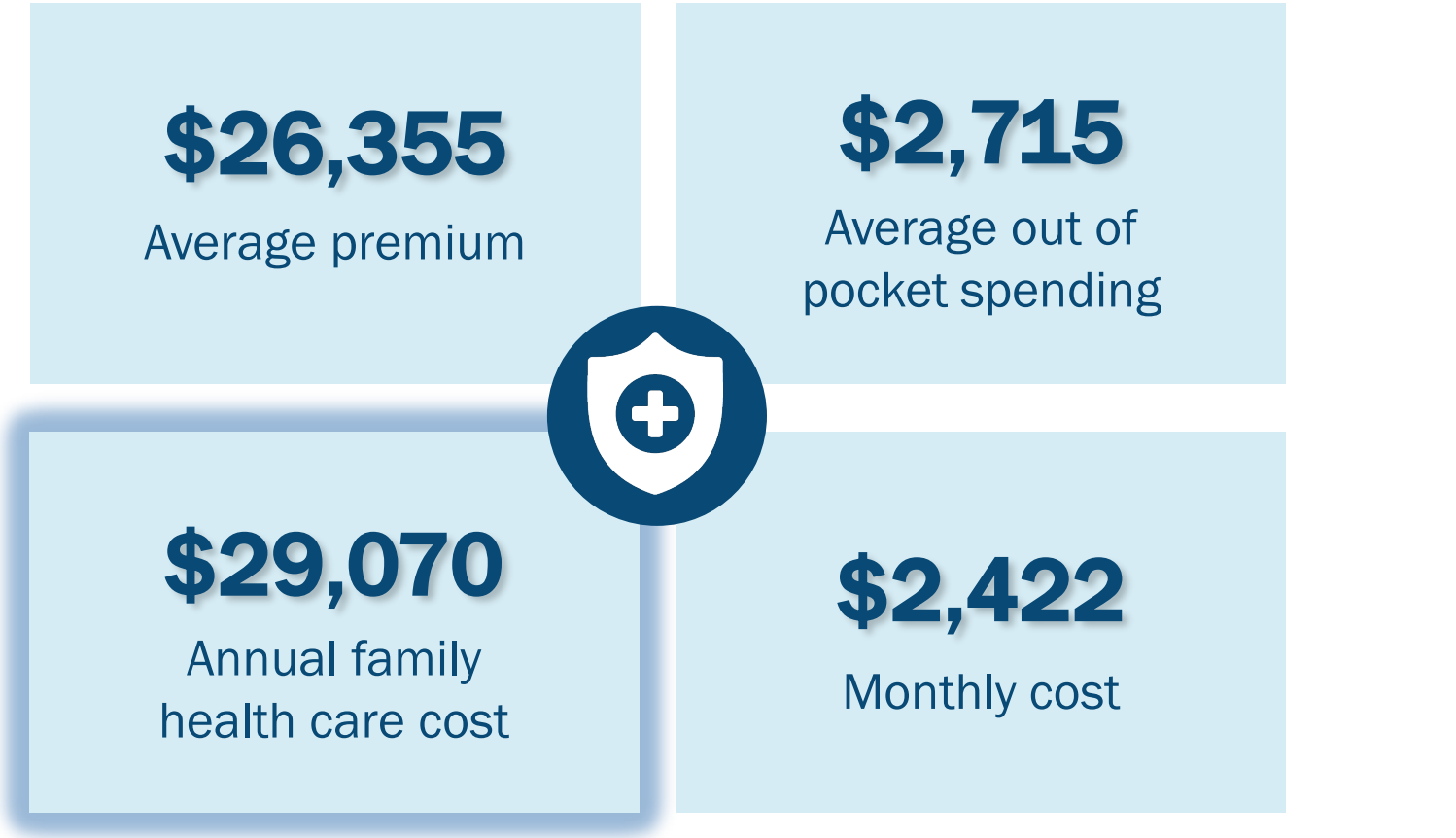
# Since the benchmark was established in 2012, growth in the cost of health insurance for families in MA has slowed significantly. However, the growth of total premium and employee contribution costs still outpaced inflation and household income growth.

*Average annual growth of various quantities in Massachusetts from 2000-2012 and 2012-2023.*




Sources: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, American Community Survey, and Bureau of Labor Statistics

# Including out of pocket spending, the average cost of health care for a Massachusetts family exceeded $29,000 in 2023.

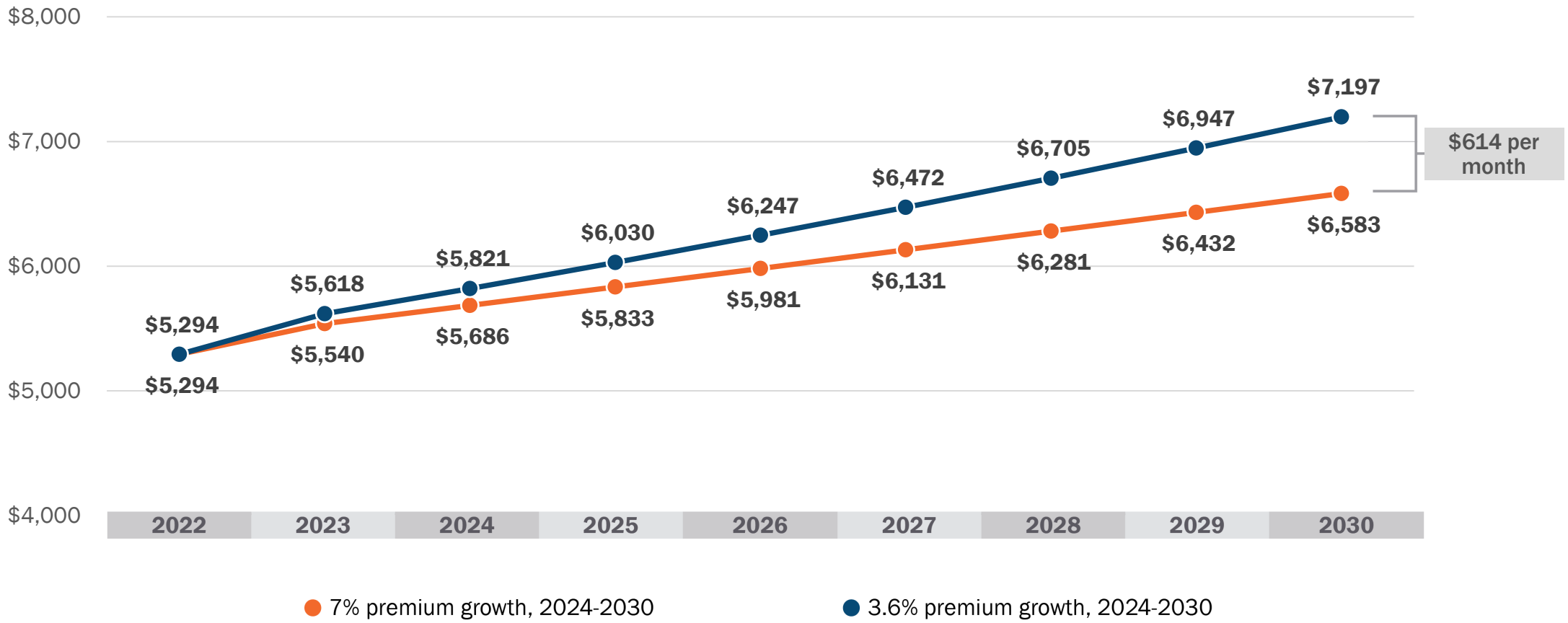



**Family premiums grew an additional 7% nationally in 2024**

Notes: Cost sharing amount based on data on cost sharing relative to premium payments in from CHIA's Annual Report, 2024. Source: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey-Insurance Component and Center for Health Information and Analysis, Annual Report, 2024; Kaiser Family Foundation/HRET Annual employer health benefits survey.

# If commercial spending continues to grow at the current rate, an average family would see a reduction in take-home pay of more than $600 per month by 2030.

*Projected monthly take-home pay after taxes and health care costs for an average Massachusetts household with employer-based coverage and 3.6% annual growth in total compensation from their employer under two scenarios of premium growth.*




Notes: This analysis assumes out of pocket spending also grows at the rate of premium growth shown. Assumes that an employee taking up family coverage from their employer bears the full cost of the employee premium contribution and 75% of the employer contribution to their premium as reduced wages (with the remainder spread across the employer's workforce in general).

# Presentation Outline

1. Overview of the Health Policy Commission and the Health Care Cost Growth Benchmark
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4. **Recently Passed Legislative Improvements**

# In January, Massachusetts adopted new legislation that marks the most significant advancement in the state's cost containment approach since the initial law.

## An Act relative to pharmaceutical access, costs, and transparency

- Improves state oversight of the pharmaceutical industry, including pharmacy benefit managers (PBMs)
- Caps out-of-pocket costs for drugs to treat asthma, diabetes, and certain common heart conditions

## An Act enhancing the market review process

- Strengthens state oversight of private equity investment in health care
- Requires statewide health planning with increased data collection and agency coordination

# Key Legislative Components

AFFORDABILITY STANDARDS

STRENGTHENS MARKET OVERSIGHT AUTHORITY

REVITALIZES STATE HEALTH PLANNING

CREATES PHARMACEUTICAL OVERSIGHT

ENHANCED INTERAGENCY COORDINATION

ESTABLISHES INTERAGENCY PRIMARY CARE TASK FORCE

# Questions?


## David Seltz

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tinyurl.com/hpc-linkedin

tinyurl.com/hpc-video

March 2025

# Oregon's Health Care Cost Growth Target Program: Implementing Accountability Measures

Sarah Bartelmann | Cost Programs Manager
HealthCare.CostTarget@oha.oregon.gov

# Oregon's Cost Growth Target Program Development

**2017-18**

- Joint Legislative Taskforce on Health Care Costs (SB419)
- Recommended cost growth target model (based on Mass.)

**2019**

- SB 889 created program and Implementation Committee

**2020**

- Committee developed program and set target (3.4%)

**2021**

- Implementation Committee published recommendations
- HB 2018 codified accountability measures
- Baseline data (2018-2020) collection

**2022**

- First public hearing on cost impacts
- State and market level public reporting begins

**2023**

- Payer and provider organization public reporting begins
- First public hearing on performance

# Oregon's Cost Growth Target Applies Broadly

By statute, Oregon's cost growth target applies to "**all** providers and payers in the health care system in this state."

Operationally, in 2024, the cost growth target applied to 30 payers and 52 provider organizations.

Oregon does not have sector specific targets. All payers and provider organizations are accountable to the statewide target.

**Payers**

- 9 commercial health plans
- 12 Medicare Advantage plans
- 17 Medicaid plans

**Provider Organizations**

- 7 large (more than 20k patients)
- 10 midsize (10-20k patients)
- 12 small (<10k patients)
- 8 pediatric practices
- 15 FQHCs

# Oregon's Cost Growth Accountability Measures

1. **Transparency**
   public reporting and public hearings

2. **Performance Improvement Plans (PIPs)** for payers and provider organizations who exceed the cost growth target with statistical confidence and without an acceptable reason

3. **Financial Penalties**
   for payers and provider organizations who exceed the cost growth target with statistical confidence and without an acceptable reason in any 3 of 5 years

- Only payers and provider organizations that exceed the cost growth target **with statistical confidence** may be held accountable.
- Only payers and provider organizations that exceed the cost growth target **without an acceptable reason** may be held accountable.

# Oregon has a process and criteria for determining whether cost growth above the target is for an acceptable reason

If payers and provider organizations are found to have an acceptable reason for their cost growth, no accountability measures apply.

The list of acceptable reasons and determination process were codified in administrative rule summer 2024.

- Changes in federal or state law
- Changes in mandated benefits
- New pharmaceuticals or treatments
- Changes in taxes (or other admin)
- “Acts of God”
- Investments to improve health/ health equity
- Macro-economic factors
- Frontline workforce costs (as per HB 2045)
- High-cost outliers

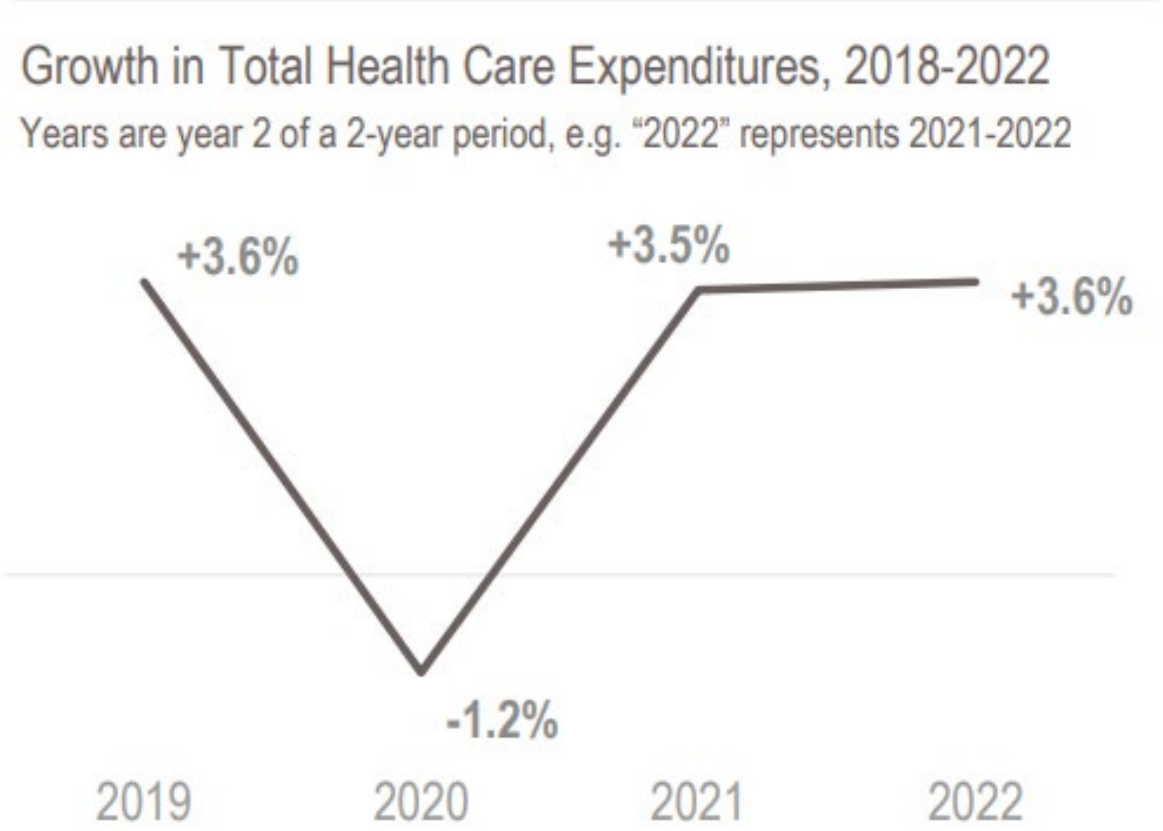
https://www.oregon.gov/oha/HPA/HP/Pages/cgt-accountability.aspx

# Cost Growth Target Accountability Phases in Over Time

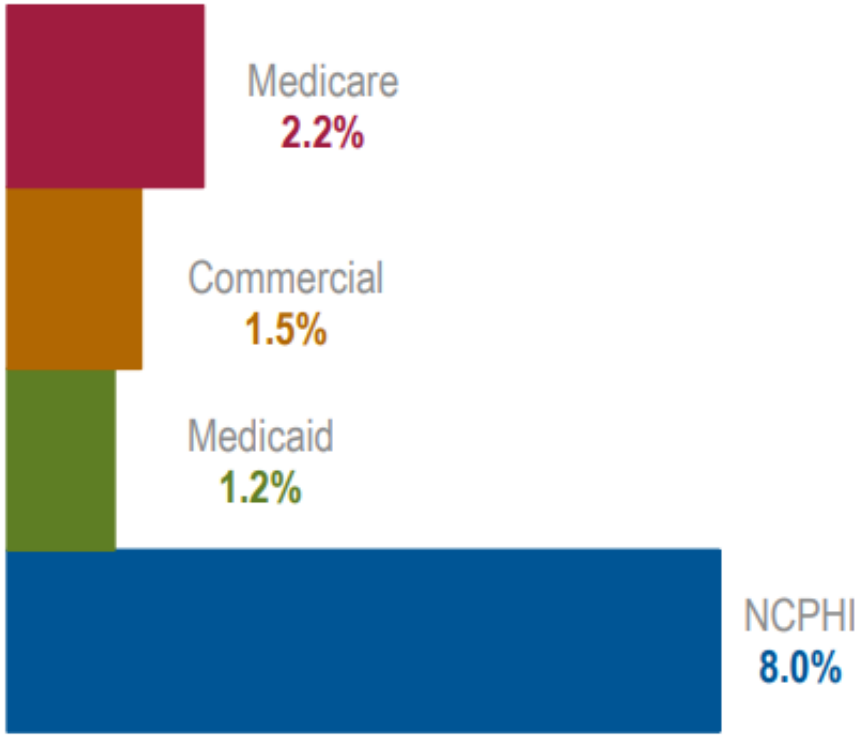
| CGT Year | 0 | 1 | First Year of Accountability | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Cost growth between | 2018 – 20 | 2020 – 21 | 2021 – 22 | 2022 – 23 | 2023 –24 | 2024 – 25 |
| Data submitted in | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Report published in | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
| Are payers/providers publicly identified? | No | Yes | Yes | Yes | Yes | Yes |
| Determination of reasonableness? | No | No | **Yes** | Yes | Yes | Yes |
| Do PIPs apply? | No | No | No | Yes | Yes | Yes |
| Applies to a potential $ penalty in 2028? | No | No | Yes | Yes | Yes | Yes |

# Oregon Cost Growth, 2021-2022

# Total Health Care Expenditures grew 3.6% in 2022, but with different experiences by market



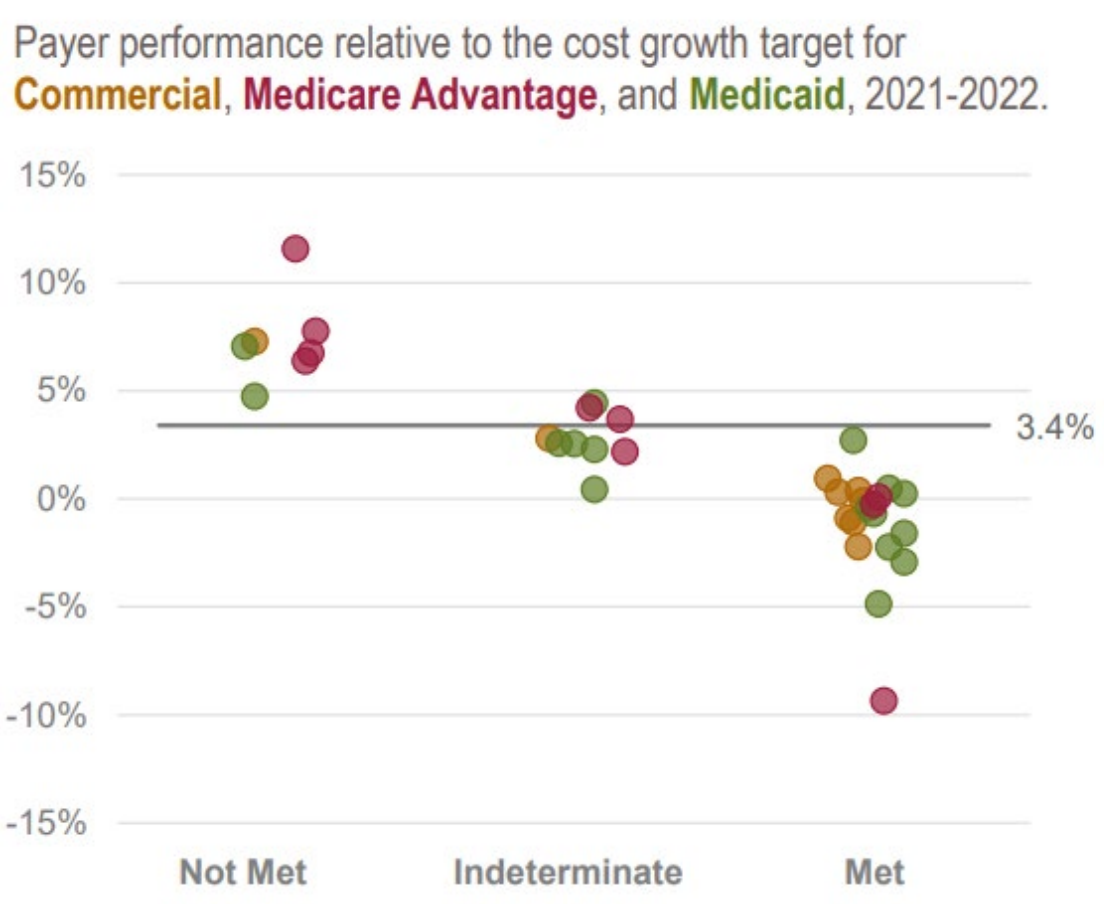

Percent change in THCE by market, 2021-2022

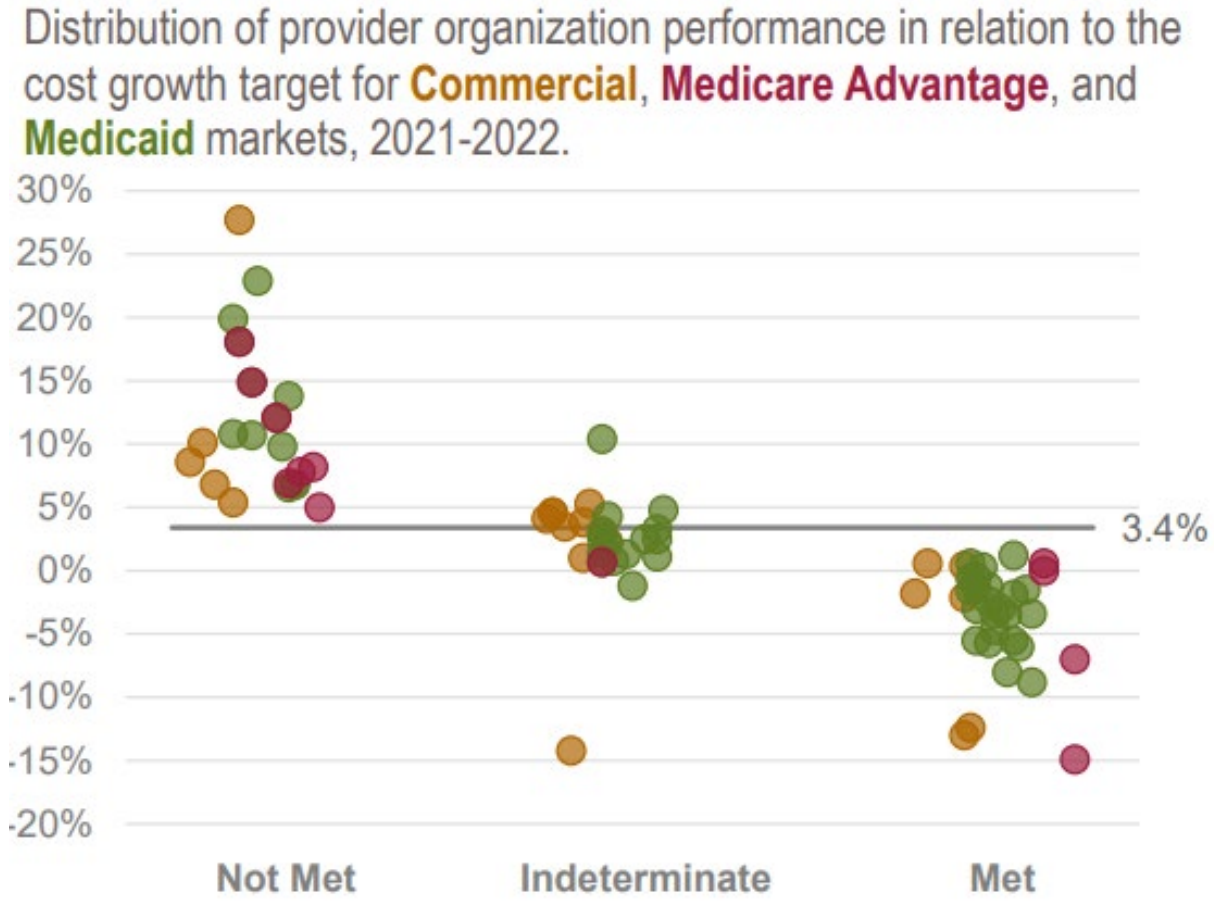



NCPI=Net Cost of Private Health Insurance

https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2024-Oregon-Cost-Growth-Target-Annual-Report.pdf

# Payer and Provider Org Cost Growth Varied (a lot)

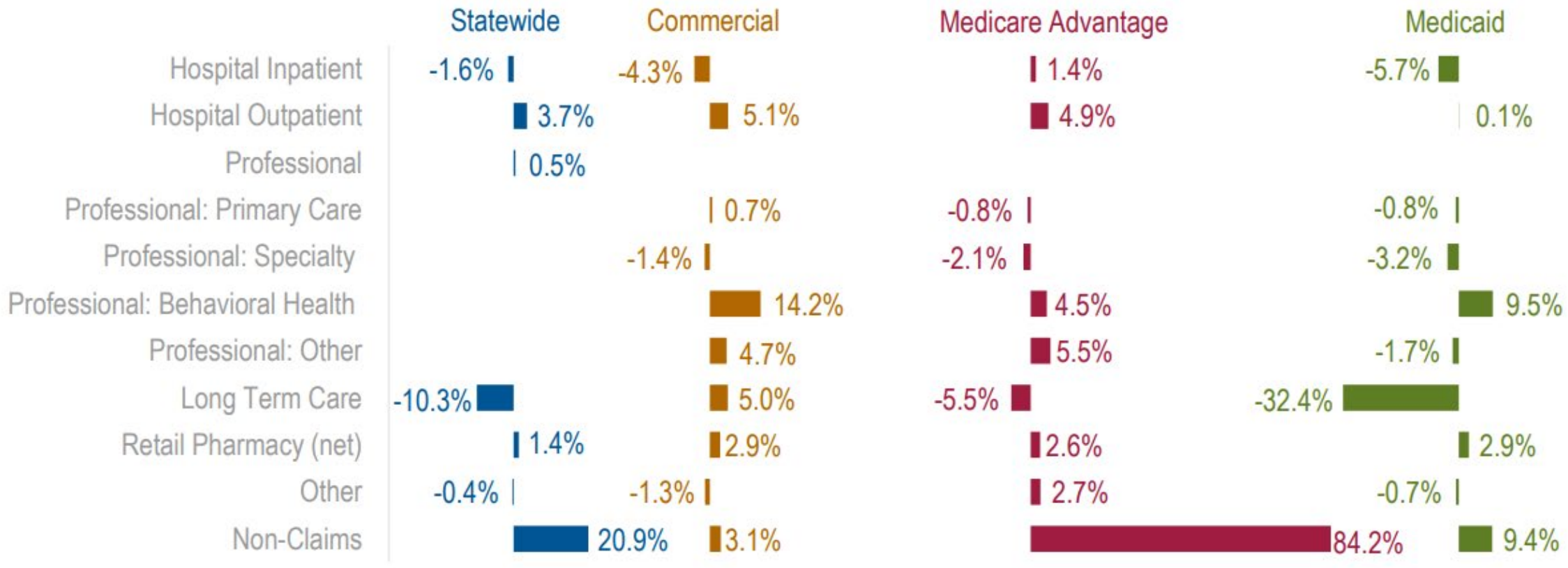



https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2024-Oregon-Cost-Growth-Target-Annual-Report.pdf

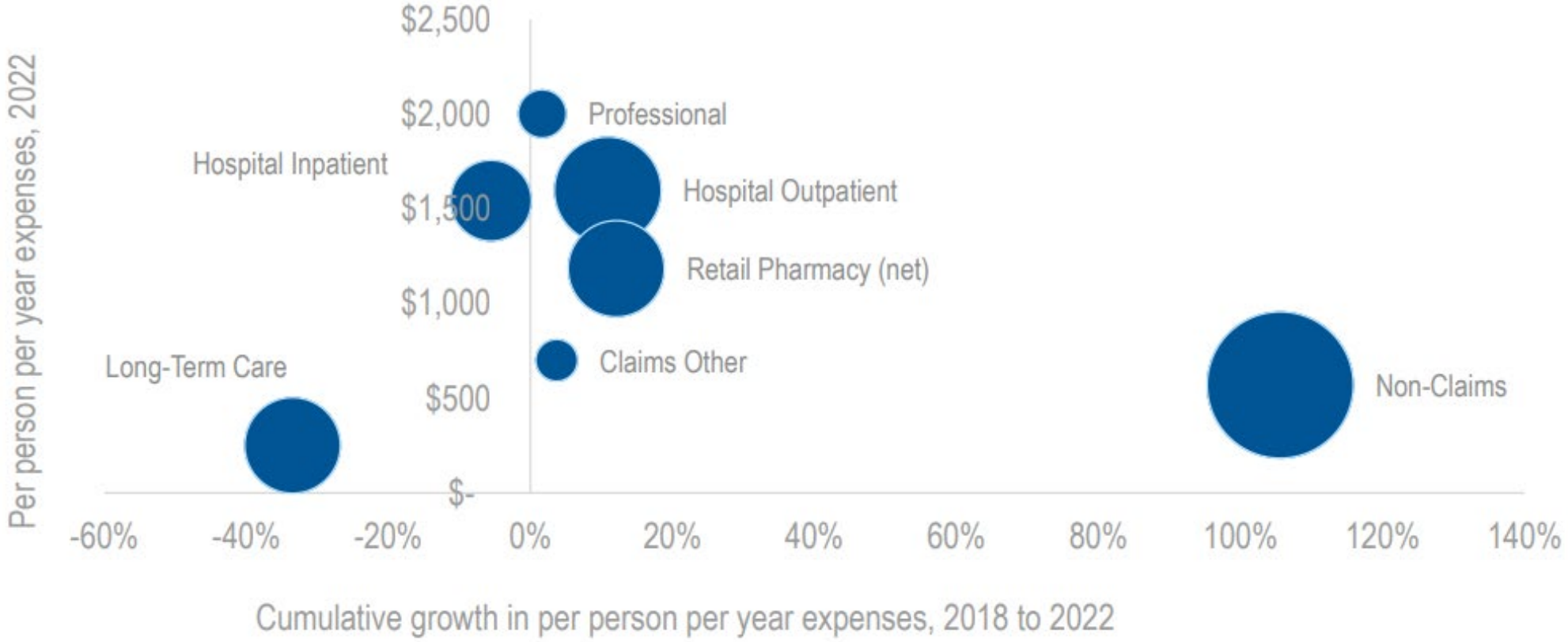
# Cost drivers in 2022 include hospital outpatient, behavioral health, and non-claims spending

Total Medical Expenses – growth in per person per year spending between 2021-2022, by market and service category .



# Since 2018, statewide cost growth has been driven by hospital outpatient and retail pharmacy spending.

Total Medical Expenses – Cumulative growth in spending per person per year from 2018-2022 and spending in 2022 with absolute dollar change (bubble size) from 2018-2022, by service category, Statewide*



# First Time Applying Accountability Measures

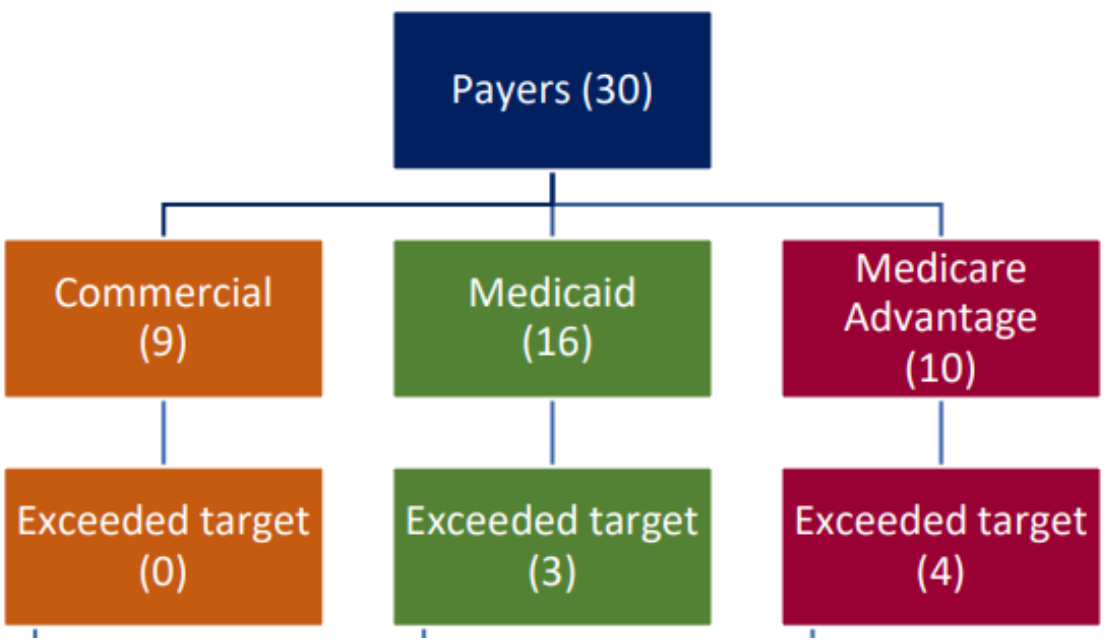
# Determining Reasonableness, 2021-2022

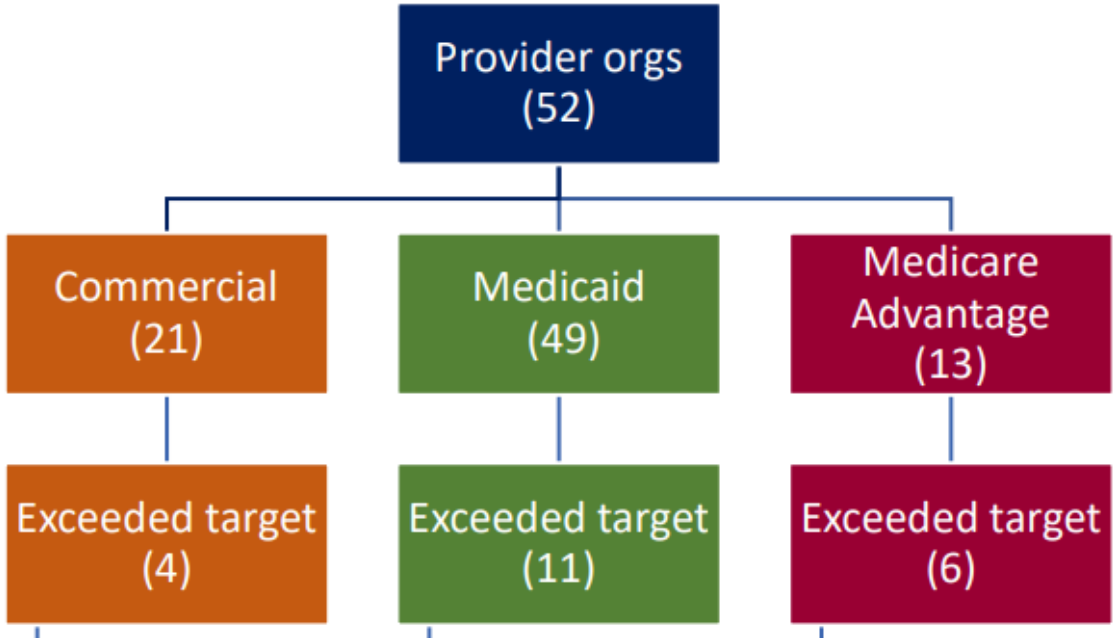
OHA previously reported on cost growth for the 2021-2022 measurement period in the May 2024 CGT Annual Report.

In January 2025, OHA released an addendum, identifying whether payers and provider organizations that exceeded the cost growth target with statistical confidence had an acceptable reason. OHA also published individual determination letters.

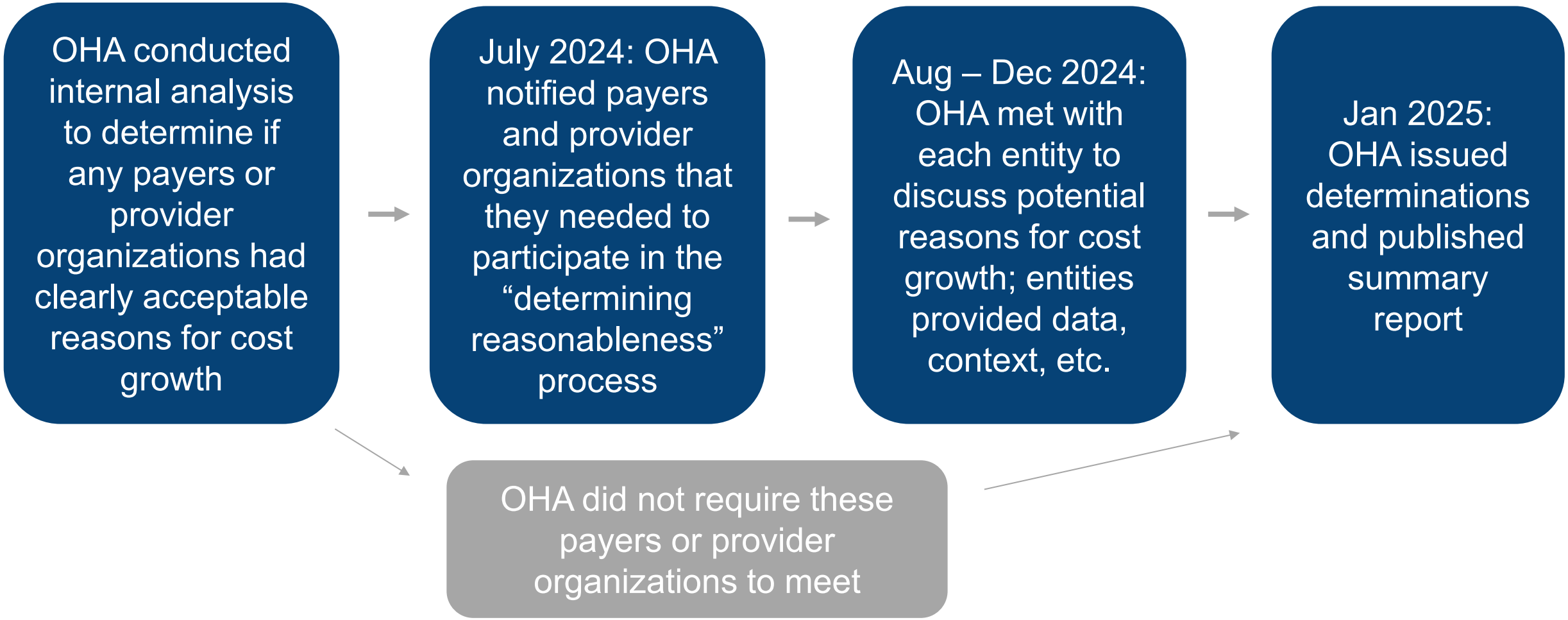

https://www.oregon.gov/oha/HPA/HP/Pages/cgt-accountability.aspx

# 28 payers and provider organizations were identified as exceeding the target in a specific market

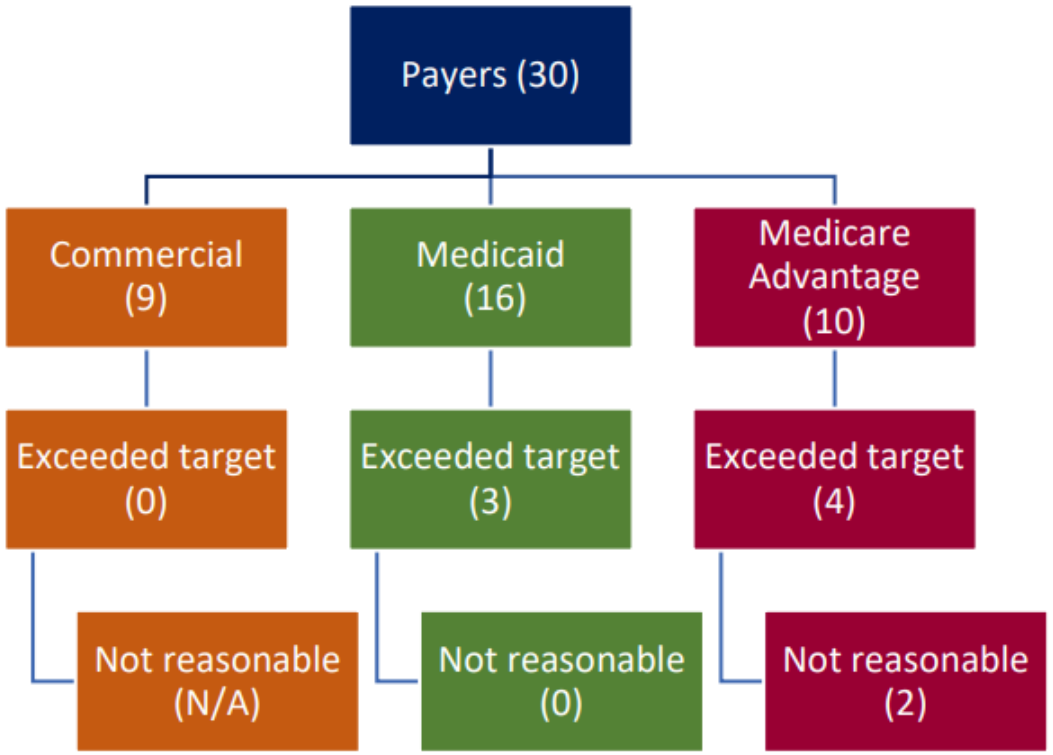


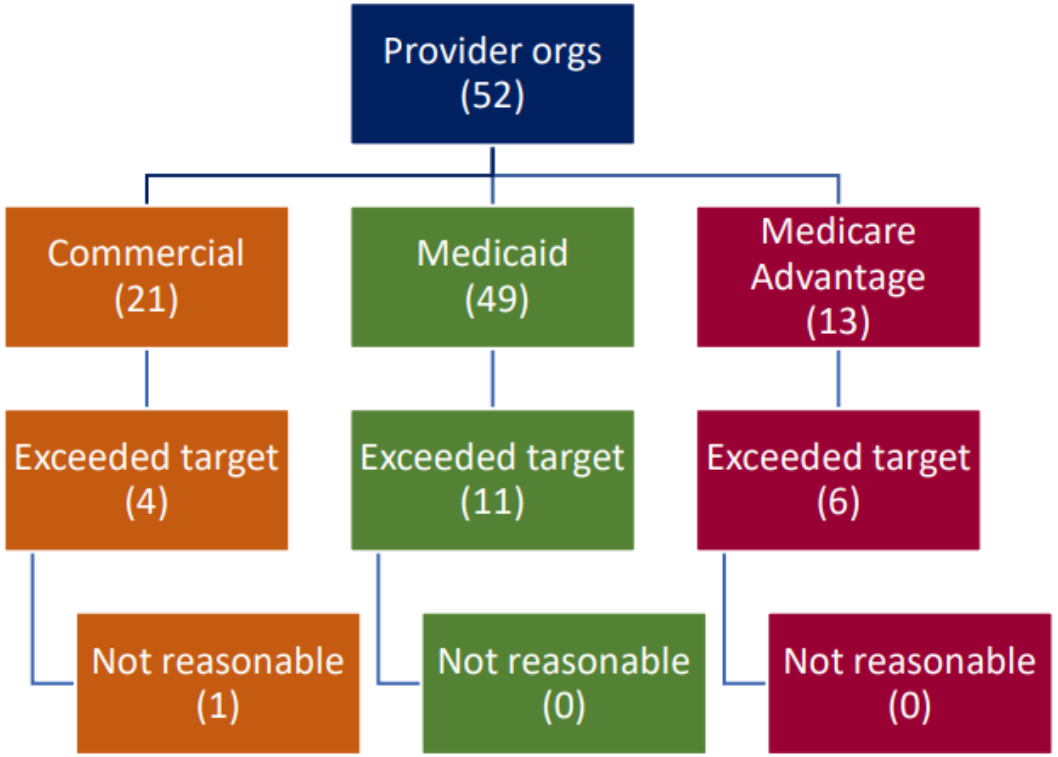
# Reasonableness Process, 2021-2022



# OHA determined that 25 entities exceeded the cost growth target for acceptable reasons; 3 did not




Moda
UHC Company




Oregon Medical Group

# Acceptable Reasons for Cost Growth, 2021-2022

- Increased behavioral health spending after state raised Medicaid rates
- Longer inpatient stays because hospitals were unable to discharge patients to other facilities
- Patients with more than $1 million in annual costs, especially for pediatric practices
- Increased Medicaid non-claims spending, likely quality payments and COVID-related payments
- Increased frontline workforce costs
- Service expansions to meet community needs

# Responses

## Media

Three health care companies increased costs excessively, Oregon warns

Notices to Oregon Medical Group, Moda Health and UnitedHealthcare amount to "first strike," one official said. The new program is preparing to leverage its authority in an effort to rein in inflation affecting patients and consumers and other members of the

OHA flags Eugene-based medical group, 2 insurers for excessive spending

HEALTH

Health officials say Eugene medical chain, two Oregon insurers unreasonably raised costs

## Entities

Kraig Anderson, senior vice president and chief actuary for Moda Health, acknowledged that the company's Medicare Advantage plans did not meet the state's cost growth threshold but said its commercial and Medicaid plans did.

"Medicare Advantage plans throughout the industry experienced unexpectedly high utilization coming out of COVID," Anderson said. "This, more than any other single factor, contributed to premium increases that were unsustainable. As a result, we exited the Medicare Advantage market in 2025."

Optum and UnitedHealthcare did not immediately respond to emailed requests for comment.

# Reflections

1. Oregon’s process for determining reasonableness is individualized and time-intensive.
2. Payer – provider organization coordination and data sharing is challenging.
3. Entity interpretations of acceptable reasons may vary from OHA’s.
4. Oregon's list of acceptable reasons is *very* broad.
5. Determinations are legal orders, with appeal rights.

# Currently: Determining Reasonableness for 2022-2023

| | | | First Year of Accountability | We Are Here | | |
|---|---|---|---|---|---|---|
| **CGT Year** | **0** | **1** | **2** | **3** | **4** | **5** |
| **Cost growth between** | 2018 – 20 | 2020 – 21 | 2021 – 22 | 2022 – 23 | 2023 –24 | 2024 – 25 |
| **Data submitted in** | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| **Report published in** | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
| **Are payers/providers publicly identified?** | No | Yes | Yes | Yes | Yes | Yes |
| **Do PIPs apply?** | No | No | No | Yes | Yes | Yes |
| **Applies to a potential $ penalty in 2028?** | No | No | Yes | Yes | Yes | Yes |

# For More Information

**2024 Cost Growth Target Annual Report**
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2024-Oregon-Cost-Growth-Target-Annual-Report.pdf

**Accountability Addendum and Determination Letters, 2021-2022**
https://www.oregon.gov/oha/HPA/HP/Pages/cgt-accountability.aspx

**Guidance on Reasonableness**
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/CGT-7-Subregulatory-Guidance-Reasonableness-PIPs-Penalties.pdf

**Contact us**
HealthCare.CostTarget@oha.Oregon.gov

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

# Public Comment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

# Proposed Emergency Regulation on Hospital Sector Definition including Summary of Public Comment Feedback

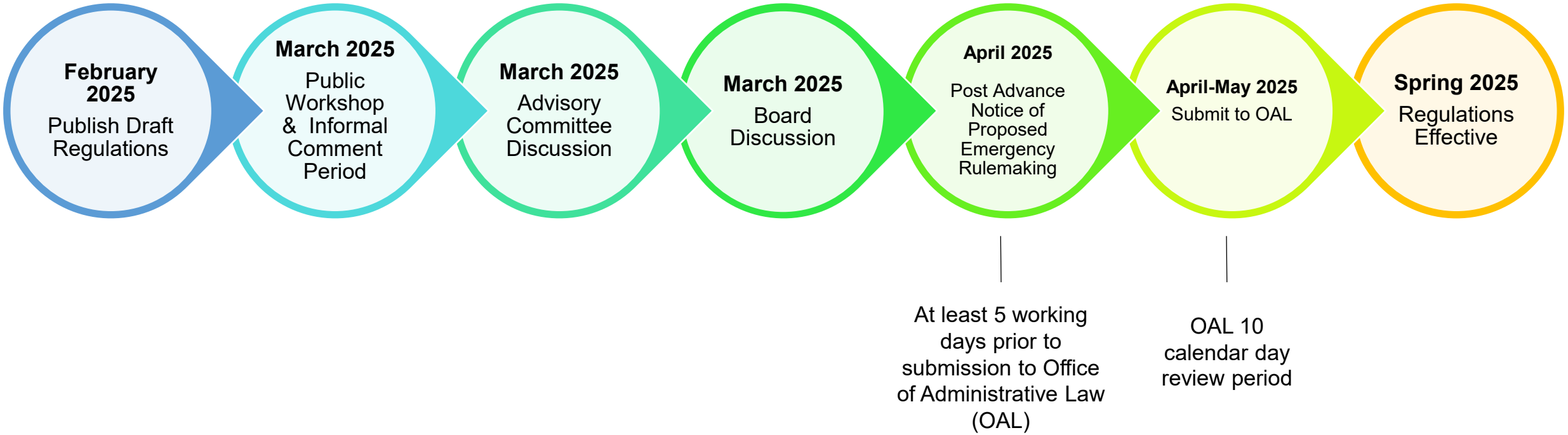
Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

HCAI

Department of Health Care Access and Information

# Hospital Sector Rulemaking Timeline for OHCA's Recommendation






OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

# Text of Proposed Regulations

**California Code of Regulations**
**Title 22. Social Security**
**Division 7. Health Planning and Facility Construction**
**Chapter 11.5. Promotion of Competitive Health Care Markets; Health Care Affordability**
**Article 2. Health Care Spending Targets.**

**§ 97446. Health Care Sectors**

Health care sectors, pursuant to Health and Safety Code section 127502, subdivisions (b)(1) and (l)(2)(A), are as follows:

(a) Hospital Sector. The hospital sector includes the following:
(1) General acute care hospitals, as used in Health and Safety Code section 1250, subdivision (a),
(2) Acute psychiatric hospitals, as used in Health and Safety Code section 1250, subdivision (b),
(3) Special hospitals, as used in Health and Safety Code section 1250, subdivision (f),
(4) Chemical dependency recovery hospitals, as used in Health and Safety Code section 1250.3, subdivision (a)(1), and
(5) Psychiatric health facilities, as used in Health and Safety Code section 1250.2, subdivision (a)(1).

*Note:* Authority: Sections 127501, 127501.2, 127501.11, and 127502, Health and Safety Code.
Reference: Sections 127501, 127501.11, and 127502, Health and Safety Code.

# Public Comments Received

| Theme | Key Points |
| --- | --- |
| **May be premature to set hospital sector targets at this stage.** | • Proposed Hospital sector comes years ahead of statutory deadlines<br>• Concern that patient access to care and the health of California hospitals are at stake.<br>• Singling out a single sector will destabilize equitable access to high-quality hospital care and undermine collaboration toward a shared vision of improved health care affordability for all Californians.<br>• OHCA has not yet done the following:<br>  ○ Cross-sector analysis or evaluated the impacts of either the statewide or a reduced target on equitable access to high-quality care<br>  ○ Analyzed full year of comprehensive spending data.<br>  ○ Looked at available data for any other potential sector<br>  ○ Determined how hospital spending growth will be measured.<br>  ○ Assessed the reasonableness of the statewide spending target |

# Public Comments Received

| Theme | Key Points |
| --- | --- |
| **Support for the proposed Hospital Sector Definition Regulations** | • Regulation consistent with the statute. Appreciate including all hospitals and those that are operated by Kaiser, consistent with SB 383.<br>• Definition takes a comprehensive approach to include all hospitals licensed as health care facilities in California, with the flexibility to adjust for select facilities in the future.<br>• Flexibility - including all hospitals in the proposed definition does not necessarily mean that all hospitals will be subject to a spending target. separate from the statewide target that is already in effect<br>• Any justifiable reasons for not meeting the target can be teased out in further discussions with stakeholders around enforcement. |

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

# Public Comment

HCAi

Department of Health Care Access and Information

OHCA
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Department of Health Care Access and Information

# Healthcare Payments Database Program Update

Michael Valle, Deputy Director and Chief Information Officer
Dionne Evans-Dean, Chief Data Officer
Chris Krawczyk, Chief Analytics Officer
Margareta Brandt, Assistant Deputy Director

HCAI
Department of Health Care Access and Information

# HPD Overview & Background

Michael Valle, HCAI Deputy Director, Information Services

# HPD Program Overview

- The Healthcare Payments Database (HPD) is a large research database of healthcare administrative data
- The HPD collects four core file types:
    1. Medical claims and encounters
    2. Pharmacy claims
    3. Member eligibility
    4. Provider
- The HPD collects data from:
    1. Commercial and Medicare Advantage health plans and insurers
    2. Department of Health Care Services (Medi-Cal)
    3. Centers for Medicare and Medicaid Services (Medicare Fee-For Service)
- HPD uses the National Association of Health Data Organizations APCD Common Data Layout data file format

**The HPD Program will continue to:**

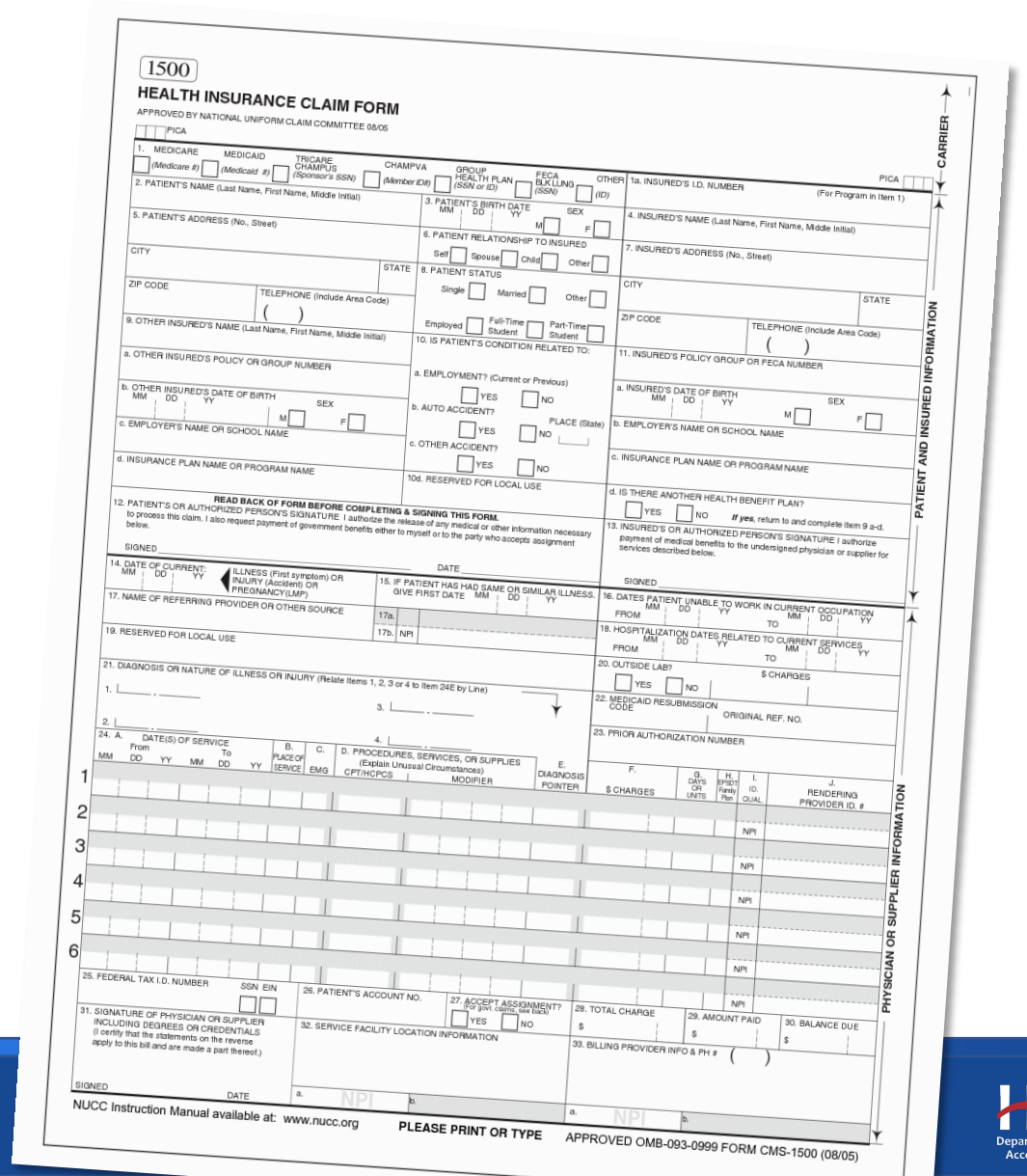
- Work with data submitters to improve data quality over time
- Produce public reports from HPD data
- Allow for controlled access to non-public HPD data, by request
- Develop approaches to incorporate other data and link to other datasets



For more information, visit hcai.ca.gov/hpd

# What Information Is On a Claim?

- Patient information
- Provider information
- Service date and location
- Diagnosis and procedure information
- Pharmacy information
- Payment information:
  - Base charge
  - Plan allowed amount
  - Amount plan paid to provider
  - Cost sharing paid by consumers


1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE

a. NPI b.

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-093-0999 FORM CMS-1500 (08/05)

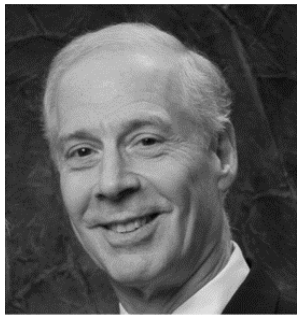
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

For illustrative purposes, a paper claims is shown. Most providers transmit claims electronically.

# HPD Stakeholder Governance



Ken Stuart, Chair
California Health Care Coalition

**HCAI**
Office of Information Services

Nuriel Moghavem, MD, Chair
Los Angeles General Medical Center

## Advisory Committee

- Advises in formulating program policies regarding data collection, management, use, and access
- Provides input on priorities for public reporting
- Provides a forum for stakeholder and public engagement

## Data Release Committee

- Advises on specific criteria, policies, and procedures for access to non-public data
- Reviews requests to access non-public data
- Considers whether use of the data is consistent with the goals of the program
- Advises the program on privacy and security matters



Committee roles described in California Health & Safety Code Sections 127671-127674

# 2025 Program Priorities

## Data Collection

- Continue to expand the database
- Continue to improve data quality and completeness

## Public Reporting

- Continue executing public reporting priorities: Publish new reports, refresh existing reports with new data
- Expand use of public reports

## Data Release

- Monitor demand; adjust staffing, program policies, and pricing as needed
- Strategically partner with other state agencies

# HPD Data Collection

Dionne Evans-Dean, HCAI Chief Data Programs Officer

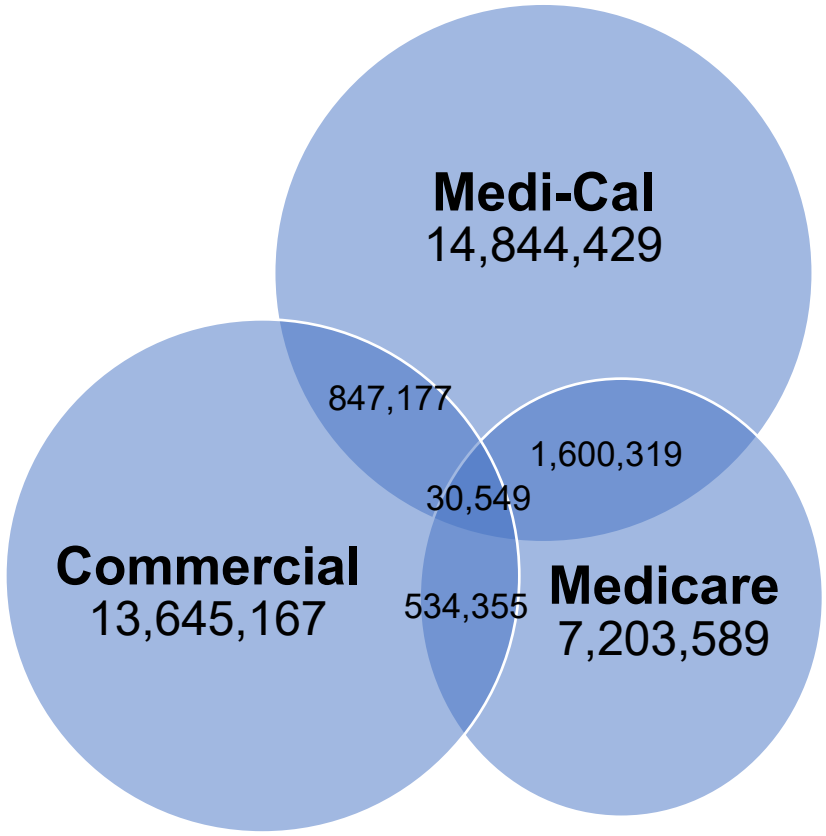
# What is in the HPD?

- Medi-Cal data provided by the California Department of Health Care Services (DHCS)
  - Including Medi-Cal Fee-for-Service, Medi-Cal Managed Care, and health insurance programs for specific populations administered by DHCS
- Medicare Fee-for-Service data acquired from the Center for Medicare and Medicaid Services
  - Including Medicare Part D coverage
- Fully Insured Commercial Health Plans and Insurers and Medicare Advantage Plans, public self-insured plans, and qualified health plans (>97% of covered lives in regulated plans)
  - Including HMO, PPO, POS, and EPO plans

# Distribution of Individuals by Type of Coverage

**December 2021**

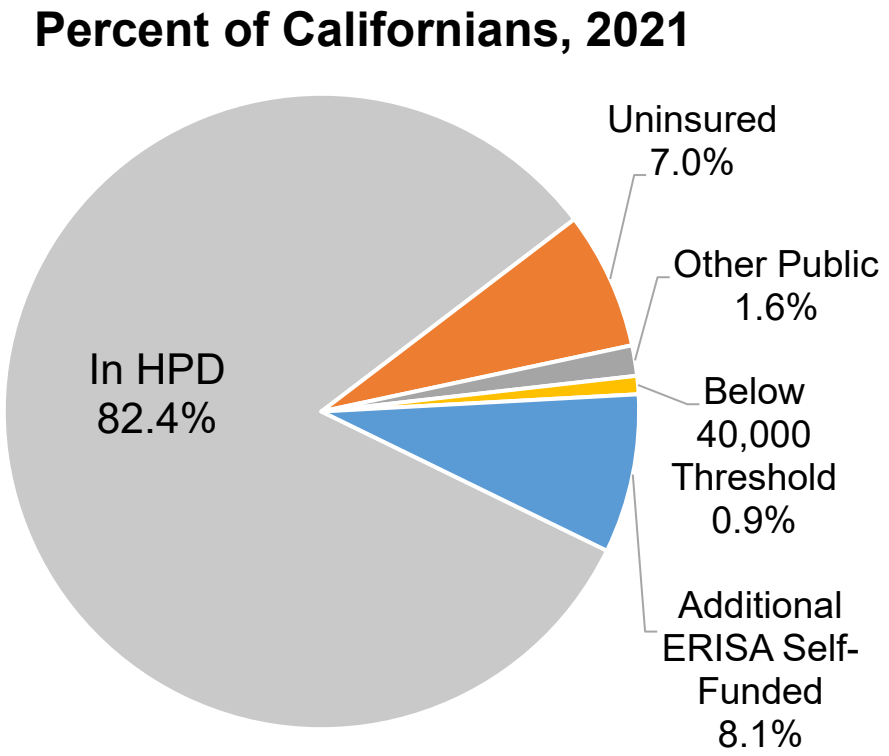
| COVERAGE TYPE | INDIVIDUALS | PERCENT |
|---|---|---|
| Medi-Cal Only | 12,366,384 | 37.9% |
| Medicare Only | 5,038,366 | 15.4% |
| Commercial Only | 12,233,086 | 37.5% |
| Medi-Cal & Commercial | 847,177 | 2.6% |
| Medi-Cal & Medicare | 1,600,319 | 4.9% |
| Medi-Cal & Commercial & Medicare | 30,549 | 0.1% |
| Commercial & Medicare | 534,355 | 1.6% |
| Total | 32,650,236 | 100.0% |




Notes: Data in each of the circles of the Venn diagram represent total enrollment in those programs, including the overlap figures. For example, there were 7,203,589 Medicare members in December 2021, including 1,600,319 that were also in Medi-Cal and 30,549 that were covered by all three product types.

# The HPD System Includes 82% of Californians

| POPULATION GROUP | NUMBER | % |
|---|---|---|
| **Included in the HPD** | 32,376,087 | 82.4% |
| **Not Included in the HPD (Estimated)** | | |
| Uninsured | 2,749,344 | 7.0% |
| Other Public (e.g., Military, Federal Employees, Indian Health Service) | 609,000 | 1.6% |
| Below 40,000 Threshold | 365,428 | 0.9% |
| Additional ERISA Self-Funded | 3,176,484 | 8.1% |
| **Total Californians** | 39,276,343 | 100% |



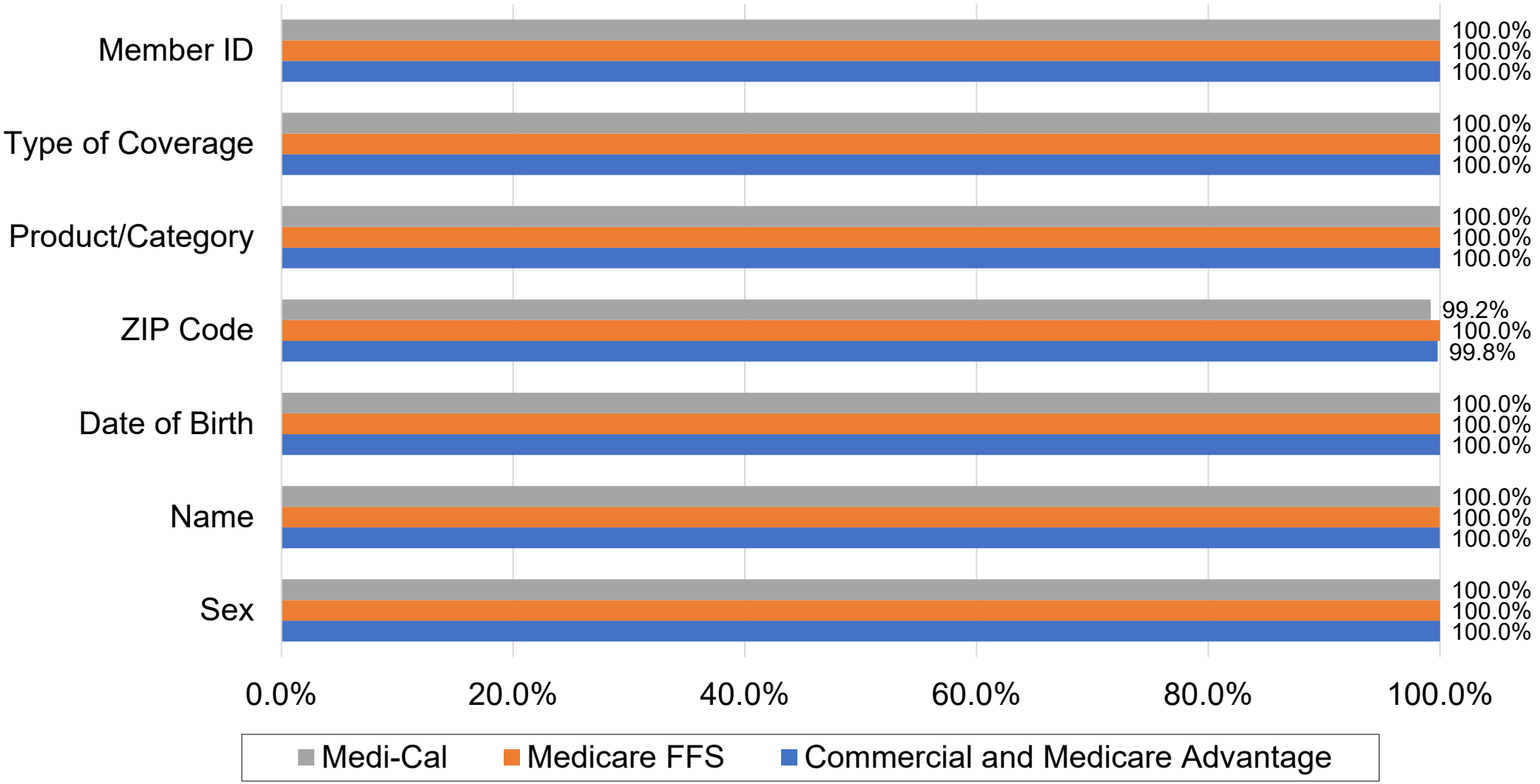

Notes:

- Number of Uninsured and Total Californians from US Census Bureau.
- Number in Other Public Programs from California Health Benefits Review Program, Estimates of Sources of Health Insurance in California, 2021.
- Number below threshold based on HCAI analysis of covered lives reported in the California Health Care Foundation, California Health Insurers, Enrollment, 2023 Edition and HPD Program mandatory reporting thresholds. Includes regulated health plans and insurers only.
- Number in ERISA Self-Funded estimated from HCAI analysis and represents *additional* ERISA covered lives not already included in the HPD System. Derived by subtracting other categories from Total Californians. Note this may also include a small number of covered lives in public self-funded plans.

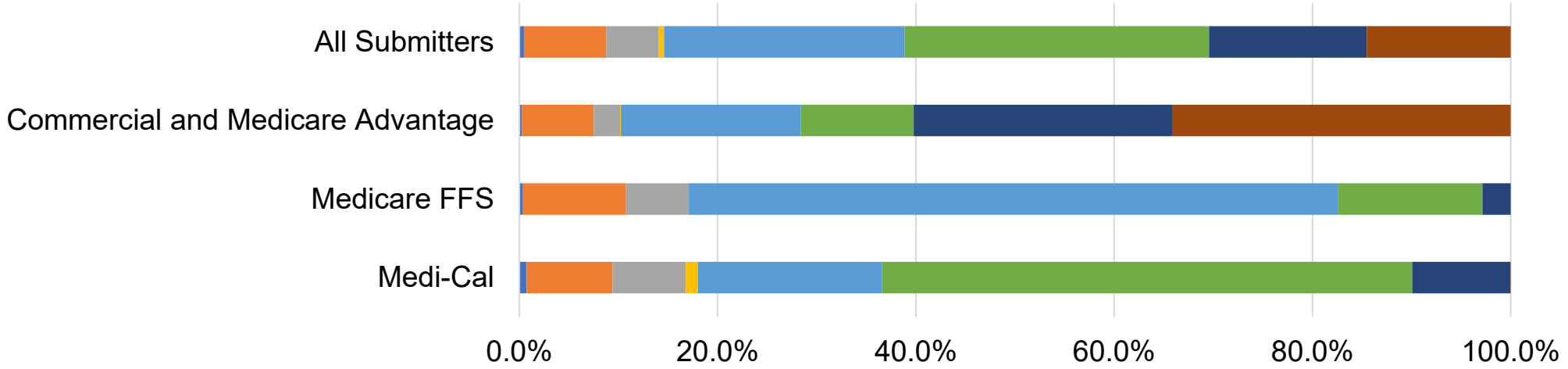
# Data Quality (Data Element Completeness)

- Data quality in the HPD System is reflective of and consistent with administrative data used in healthcare operations
  - Intake processes help ensure the best available data makes it into the HPD System
  - Administrative data was not originally intended for research databases, but there's tremendous value in the detailed records of services and members
  - Quality is high for the key commonly used elements
    - Information about the patient needed for health care coverage operations
    - Types and location of services
    - Information about the specific services and illnesses, including diagnosis code, procedure code, and national drug code
  - Quality is lower and more variable for elements less frequently used for health care coverage operations
    - For example, race and ethnicity

# Percent Complete for Selected Eligibility Elements, 2021



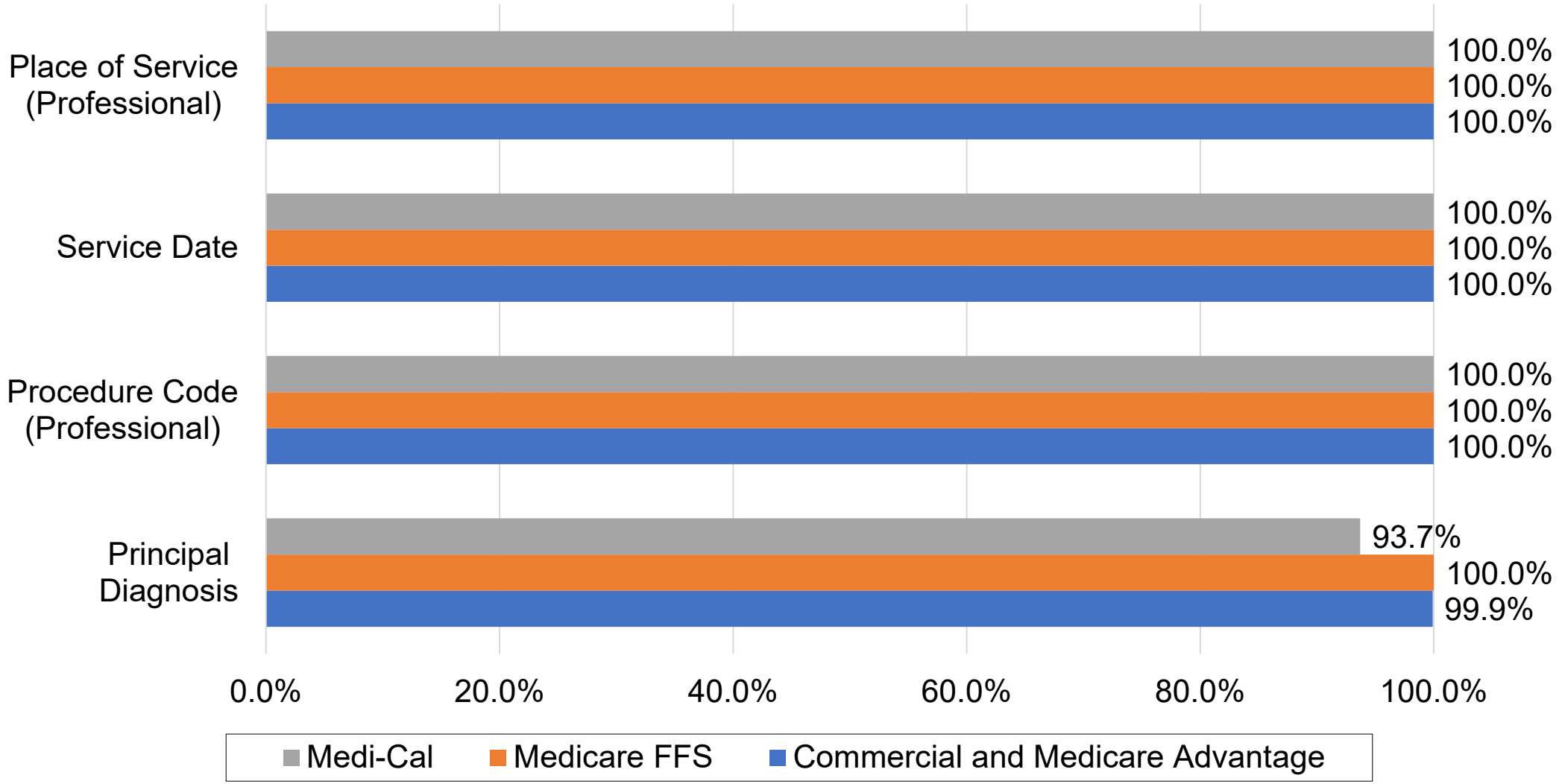
# Distribution of Race Values by Submitter Type, 2021



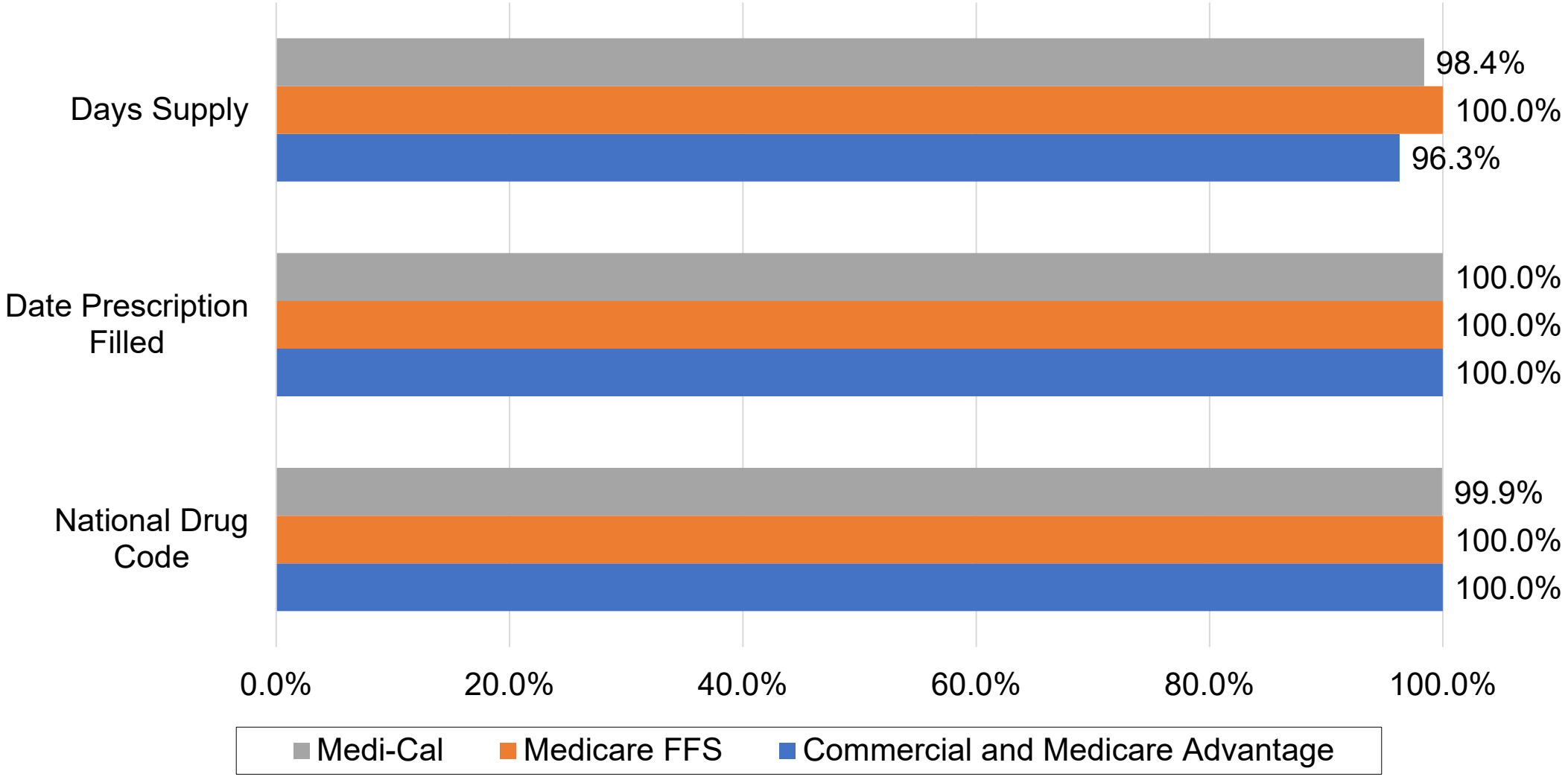

| | Medi-Cal | Medicare FFS | Commercial and Medicare Advantage | All Submitters |
|---|---|---|---|---|
| American Indian/Alaska Native | 0.7% | 0.3% | 0.2% | 0.5% |
| Asian | 8.7% | 10.4% | 7.3% | 8.3% |
| Black/African American | 7.4% | 6.4% | 2.7% | 5.3% |
| Native Hawaiian/Other Pacific Islander | 1.2% | 0.0% | 0.1% | 0.6% |
| White | 18.5% | 65.5% | 18.2% | 24.3% |
| Other | 53.5% | 14.6% | 11.4% | 30.7% |
| Unknown/Not Specified | 9.9% | 2.8% | 26.1% | 15.9% |
| Missing | 0.0% | 0.0% | 34.2% | 14.5% |

Note: Percentages based on percentage of eligibility records. Since one individual may have multiple eligibility records for different types of coverage, the percentages may not reflect the percent of the covered population. DHCS race & ethnicity field is combined. When mapping to APCD-CDL, categories of “Hispanic/Latino” are mapped to “Other” category.

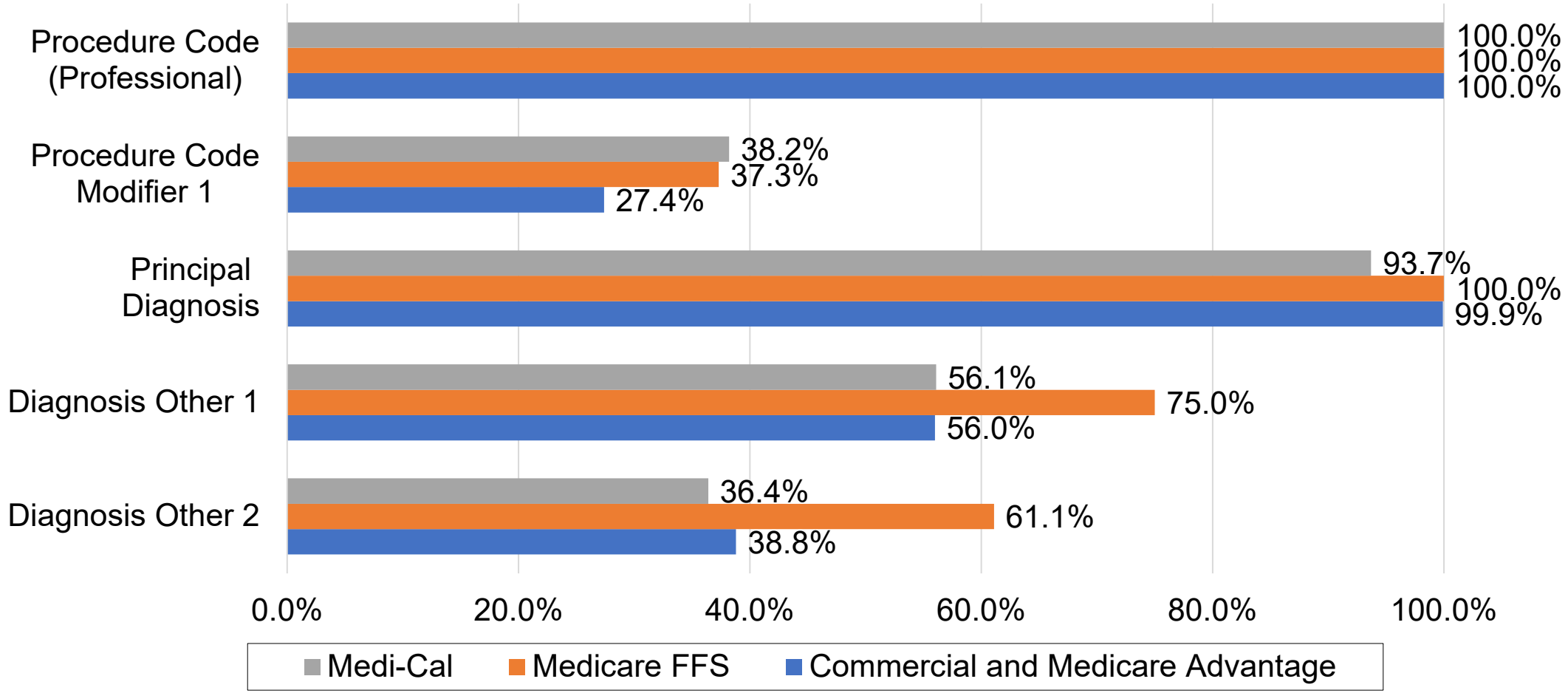
# Percent Complete for Selected Medical Elements, 2021



# Percent Complete for Selected Pharmacy Elements, 2021



# Percent Complete for Selected Medical Elements: Procedure Code Modifier and Additional Diagnosis Codes, 2021




Note: Procedure Code Modifier and Other Diagnosis elements are considered situational and are not expected to be present on all services.

# HPD Provider Data – Completeness Rates

| | | | Submitted HPD Data (Provider Table) | Linked to National Plan and Provider Enumeration System (NPPES) | | |
|---|---|---|---|---|---|---|
| ***Provider Data Element*** | ***Data Element Description*** | ***Requirements*** | ***All Records*** ***(Persons + Organizations)*** | ***All Records*** ***(Persons + Organizations)*** | ***Persons*** | ***Organizations*** |
| CDLPV004 | **Payer Assigned Provider ID** | Required | **100.0%** | **100.0%** | **100.0%** | **100.0%** |
| CDLPV006 | **Entity Type Qualifier** | Required | **13.1%** | **97.7%** | **100.0%** | **100.0%** |
| CDLPV007 | **Provider NPI** | Required | **97.2%** | **97.5%** | **99.8%** | **99.7%** |
| CDLPV009 | **Provider State License Number** | Required if available | **39.9%** | **75.6%** | **95.9%** | **35.9%** |
| CDLPV010 | **Provider First Name** | Situational | **59.7%** | **70.8%** | **99.8%** | **7.8%** |
| CDLPV012 | **Organization Name** | Required | **2.3%** | **29.6%** | **0.2%** | **98.4%** |
| CDLPV012 | **Provider Last Name or Organization Name** | Required | **88.7%** | **96.4%** | **100.0%** | **88.3%** |
| CDLPV014 | **Provider Office Street Address** | Required | **79.2%** | **79.2%** | **78.3%** | **83.5%** |
| CDLPV015 | **Provider City** | Required | **80.6%** | **98.8%** | **99.9%** | **100.0%** |
| CDLPV016 | **Provider Office State** | Required | **83.7%** | **98.8%** | **99.9%** | **100.0%** |
| CDLPV017 | **Provider Office ZIP Code** | Required | **83.6%** | **98.8%** | **99.9%** | **100.0%** |
| CDLPV021 | **Provider Specialty** | Required | **64.3%** | **97.6%** | **99.9%** | **99.8%** |

High Data Quality
Medium Data Quality
Low Data Quality

*Typos or changes to any of these data elements have an impact on data quality.*

# Individual Provider – NPI to NPPES Example

## From Commercial Provider File

| Submitter | NPI | Entity Type | First Name | Last Name/Org | Address Line 1 | City | Zip |
|---|---|---|---|---|---|---|---|
| Payor A | 1235467890 | 1 | Mickey | Mouse | 814 High Lane | Mahwah | 07430 |
| Payor A | 1235467890 | 1 | | Blizzard Beach | 86 Vale Avenue | Westfield | 01085 |
| Payor A | 1235467890 | 1 | Snow | White | 20 Camp Dr | San Angelo | 76901 |
| Payor A | 1235467890 | 1 | Peter | Pan | 7027 Newbridge | Logansport | 46947 |
| Payor A | 1235467890 | 1 | Peter | Pan | 7027 Newbridge Court | Logansport | 46947 |

x

✓

Most prevalent examples continue for thousands of rows.

## From CMS NPPES

| | NPI | Entity Type | First Name | Last Name/Org | Address Line 1 | City | Zip |
|---|---|---|---|---|---|---|---|
| | 1235467890 | 1 | Peter | Pan | 7027 Newbridge Court | Logansport | 46947 |

*Fictitious data emulating real identified scenarios

# Organization Provider – NPI to NPPES Example

## From Commercial Provider File

| Submitter | NPI | Entity Type | First Name | Last Name/Org | Address Line 1 | City | Zip |
|---|---|---|---|---|---|---|---|
| Payor A | 1235467890 | 2 | null | Magic Kingdom | 1180 Seven Seas Drive | Lake Buena Vista | 32830 |
| Payor A | 1235467890 | 2 | null | Disneyland Park | 1313 Disneyland Drive | Anaheim | 92802 |
| Payor A | 1235467890 | 2 | Myron | Blizzard | 351 S. Studio Drive | Lake Buena Vista | 32830 |
| Payor A | 1235467890 | 2 | null | Blizzard Beach | 1534 Blizzard | Orlando | 32836 |
| Payor A | 1235467890 | 2 | null | Blizzard Beach | 1534 Blizzard Beach Dr | Orlando | 32836 |

x

✓

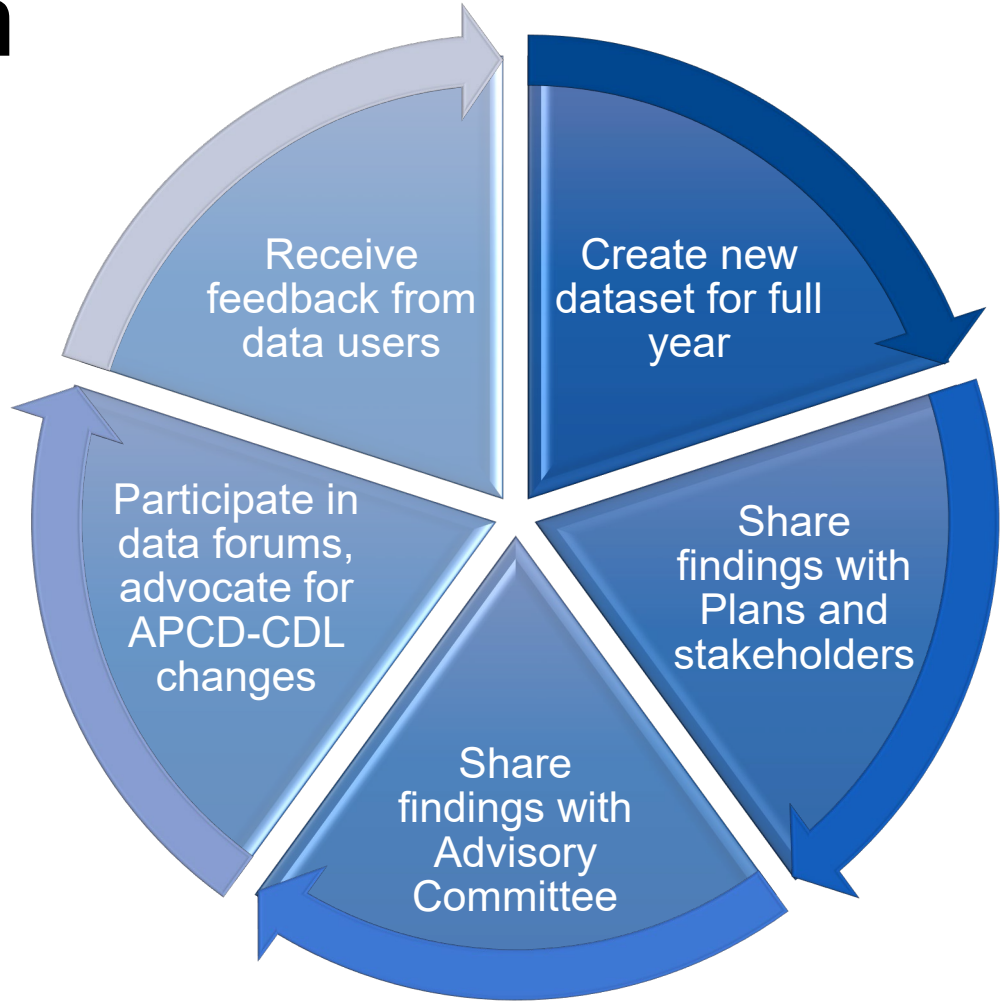
Most prevalent examples continue for thousands of rows.

## From CMS NPPES

| | NPI | Entity Type | First Name | Last Name/Org | Address Line 1 | City | Zip |
|---|---|---|---|---|---|---|---|
| | 1235467890 | 2 | null | Blizzard Beach | 1534 Blizzard Beach Dr | Orlando | 32836 |

*Fictitious data emulating real identified scenarios

# Approach for Ongoing Data Quality Collaboration



# Ongoing data collection activities

| Type | Status |
|---|---|
| Dental | Historical data through December 2021, catch up data through October 2024, and ongoing monthly data collection in process. |
| Non-Claims Payment (NCP) | Regulations under review to be effective in 2025. |
| Voluntary Data Submission | Engagement with private self-insured ERISA Plans to share voluntary data received to data and encourage ways to increase voluntary participation with private self-insured employers. |

# HPD Data Reporting & Use

Christopher Krawczyk, PhD., HCAI Chief Analytics Officer

# Generational Model of Data (GMoD) Analysis

## HCAI'S GOALS

- To generationally enhance the usefulness of information being made available in response to our stakeholders and customer's requests

## ENGAGING STAKEHOLDERS AND CUSTOMERS

- To generate business intelligence on the release of products
- To identify topics for future analytics

## INITIAL ANALYTICS AND PRODUCT RELEASE

- Generationally improve the presentations of the information
- Continue to explore the topic by adding in more data, measures, and visualizations

# HPD Public Reporting Priorities

## Specific Topics

1. Health Equity
2. Enhancement of Prescription Drug Costs report
3. Reporting on Hospital Costs

## Broader Categories

A. Focused Utilization and Payment Analysis
B. Specific Populations, Geographies
C. Coverage/Enrollment

### Other Activities Underway

Updates to existing HPD public reports with new years of data

Special analyses for DHCS on churn, primary care providers and services, and dual eligibles

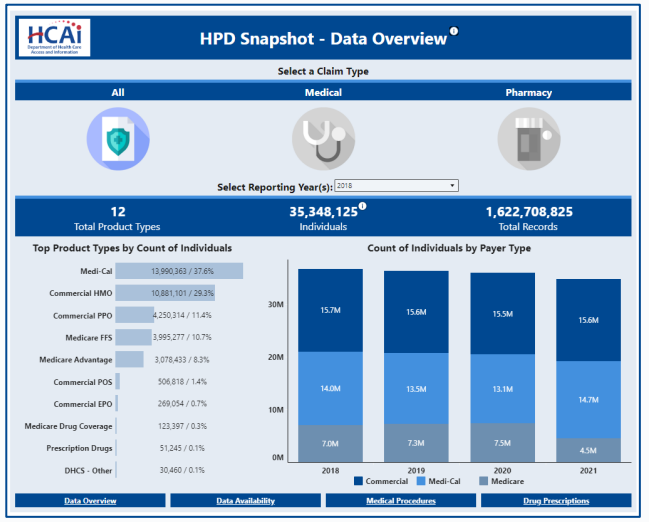
# Public Reporting Pipeline

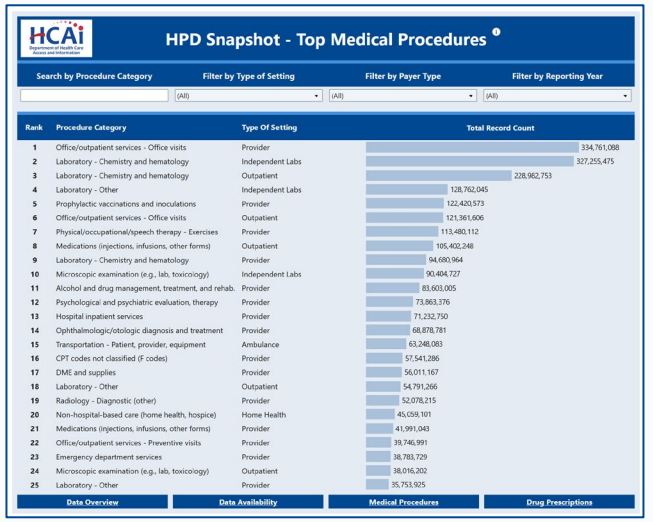
| Reports Released | Late-Stage Development | Early/Mid-Stage Development | Analyses for DHCS |
|---|---|---|---|
| • HPD Snapshot - Update<br>• Measures with LA SPAs<br>• Prescription Drug Costs<br>• Services<br>• Out-of-Pocket Costs | • Prescription Drug Costs - Update<br>• Healthcare Visits<br>• Updates to HPD Snapshot and Measures | • Health Equity<br>• Hospital Costs | • End of Continuous Coverage/ “Unwinding”<br>• Primary Care<br>• Dual Eligibles |

# HPD Program Releases

# HPD Snapshot

1. **Data Overview**
   - Counts of product types, individuals, and total records by payer type, claim type, and reporting year
   - Top product types by count of individuals
2. **Data Availability**
   - Count of enrollment and service records, member months, and unique individuals by product type
   - Filters for claim type, payer type, and reporting year
3. **Medical Procedures**
   - Top 25 medical procedures by record count, procedure category, and type of setting
   - Filters for type of setting, payer type, and reporting year
4. **Drug Prescriptions**
   - Top 25 prescriptions filled by record count, drug name, and drug class
   - Filters for drug class, drug type, payer type, and reporting year



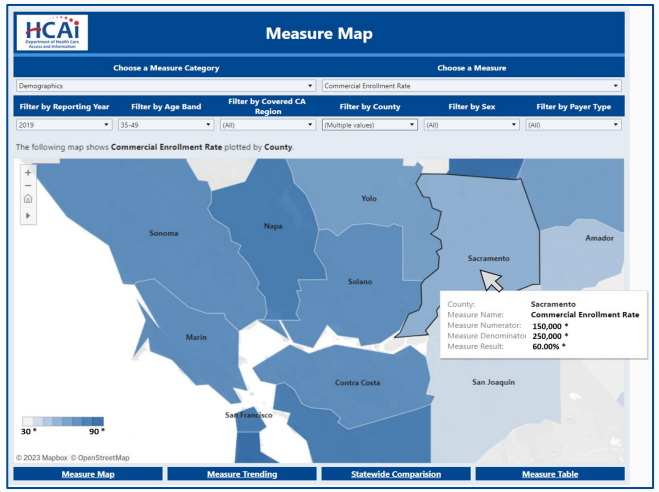



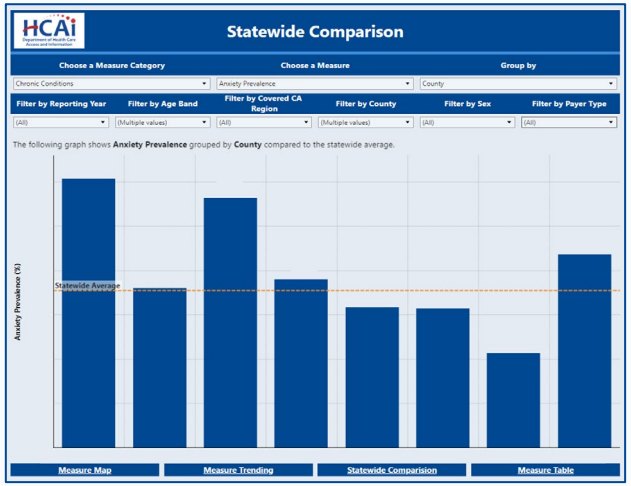



Updated September 2024, explore at: HPD Snapshot

# HPD Measures

- Standardized health conditions, demographics, and utilization measure categories
- Filters for up to 23 measure categories
- And additional filters for up to two simultaneous grouping dimensions, including age band, county, sex, payer type, and reporting year
- Feature to compare to statewide averages
- With four distinct views:
    1. Measure Map
    2. Measure Trending
    3. Statewide Comparison
    4. Measure Table






Updated October 2024, explore at: HPD Measures: Health Conditions, Utilization, and Demographics

# HPD Fee-For-Service Drug Costs in the Commercial Market

The Fee-for-Service Drug Costs in the Commercial Market report allows users to explore various aspects of the cost of pharmaceuticals by commercial plans in California.

The visualizations covers three topics:

1. The Top 25 costliest drug products (total annual statewide spending)
2. The Top 25 most frequently prescribed drugs covered by commercial plans
3. The Top 25 drugs with the largest monthly median out-of-pocket cost for members of commercial plans

Top 25 Commercial Fee-For-Service Prescription Drugs, 2021

Costliest | Most Frequently Prescribed | Out-of-Pocket Costs

Brand or Generic

Statewide Commercial Totals

| Number of Prescriptions | Number of Individuals | Total Cost | Cost per Prescription | Out-of-Pocket Median |
|---|---|---|---|---|
| 101.39M | 9.78M | $13,197M | $130.16 | $12.41 |

Top 25 Costliest Drugs Commercial Totals

| Number of Prescriptions | Number of Individuals | Total Cost | Cost per Prescription | Out-of-Pocket Median |
|---|---|---|---|---|
| 3.27M | 1,351,661 | $3,942M | $1,206.84 | $48.50 |

Sort by: Rank

| Drug Name | Therapeutic Class | Rank | Number of Prescriptions | Number of Individuals | Total Cost | Cost per Prescription | Monthly Median for Out-of-Pocket Costs |
|---|---|---|---|---|---|---|---|
| Humira Pen | Analgesics - Anti-Inflammatory | 1 | 69,844 | 9,429 | $447M | $6,400.15 | $150.00 |
| Biktarvy | Anti-Infective Agents - Antivirals | 2 | 93,525 | 14,113 | $431M | $4,608.49 | $25.00 |
| Stelara | Dermatologicals | 3 | 18,094 | 3,400 | $373M | $20,625.57 | $75.00 |
| Humira Pen | Analgesics - Anti-Inflammatory | 4 | 49,407 | 6,666 | $271M | $5,495.13 | $40.97 |
| Enbrel SureClick | Analgesics - Anti-Inflammatory | 5 | 45,644 | 6,416 | $247M | $5,407.79 | $124.50 |
| Cosentyx Sensoready (300 MG) | Dermatologicals | 6 | 44,191 | 6,181 | $217M | $4,906.91 | $75.00 |



Released July 2024, explore at: HPD: Fee-For-Service Drug Costs in the Commercial Market

# HPD Services

Two dashboards allow users to explore the types of healthcare services provided to Californians each year

- "Services" refers to individual procedures ranging from consultations with specialists, to a routine mammogram, to anesthesia administration during surgery
- Explores the "who, what and where" of the most common healthcare services provided to Californians each year

Services were grouped using the Restructured Berenson-Eggers Type of Service (BETOS) Classification System (RBCS), available from the US Centers for Medicare & Medicaid Services (CMS)

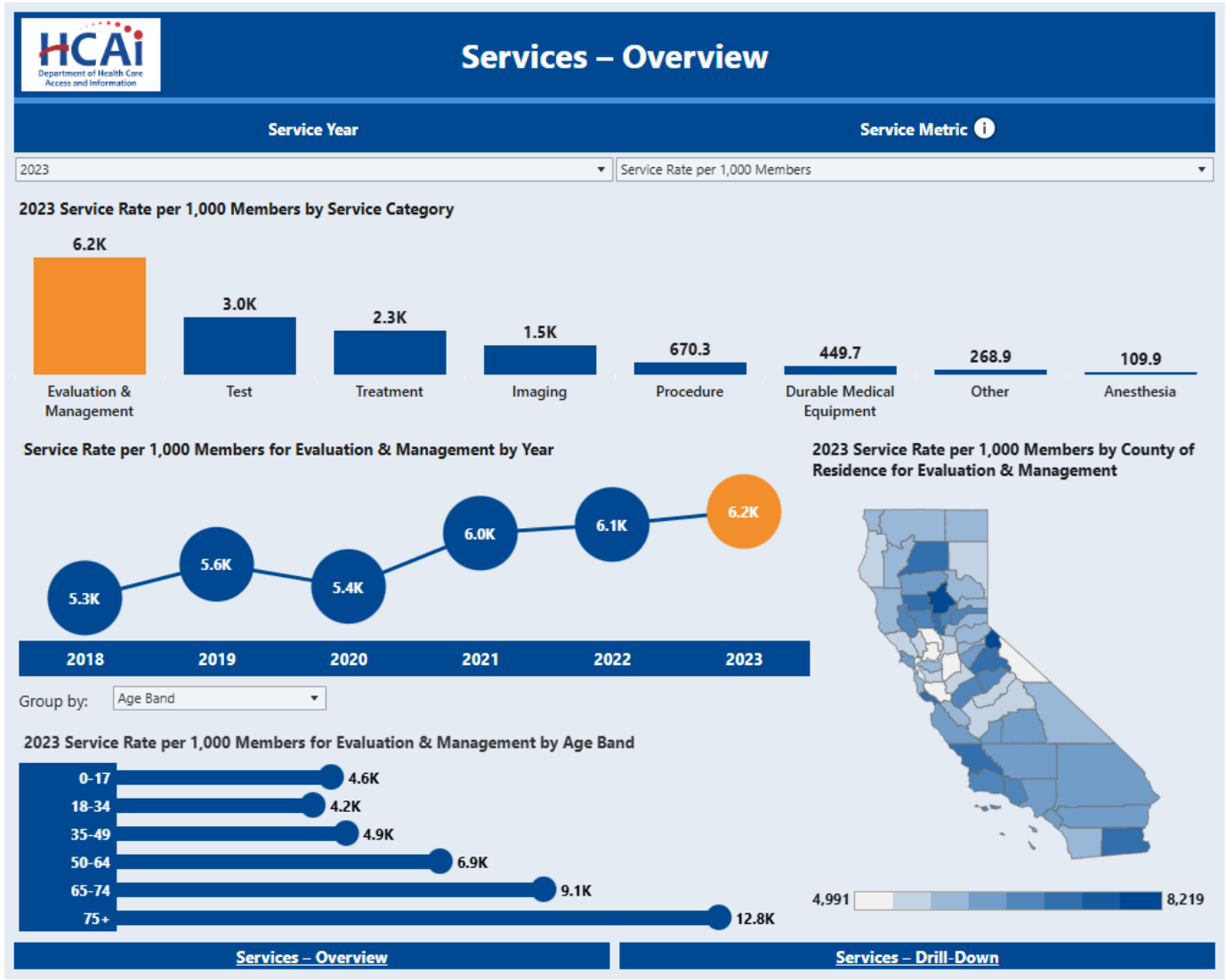
- Consists of eight large main service categories, each divided into multiple more granular service subcategories



Released February 2025, explore at: HPD Services Report

# HPD Services (Cont.)

- Focuses on 3 metrics:
  - Total number of occurrences
  - Number of people who received the service at least once
  - Utilization rate per 1,000 members
- Data can be filtered by year, age range, sex, Covered CA region and payer type
- Users can opt to view Los Angeles County divided into its eight Service Planning Areas (SPAs)






Released February 2025, explore at: HPD Services Report

# HPD Services (Cont.)

## Services – Drill-Down

| Metric | Group Rows by | Group Columns by | Service Category | County Granularity |
|---|---|---|---|---|
| Service Rate per 1,000 Members | Service Category | Reporting Year | (All) | County |

| Age Band | County of Residence | Covered CA Region | Sex | Payer Type |
|---|---|---|---|---|
| (All) | (All) | (All) | (All) | (All) |

The following table shows **Service Rate per 1,000 Members** by **Service Category** and **Reporting Year**

| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|
| E&M - Office/Outpatient Services | 3.4K | 3.6K | 3.4K | 3.8K | 3.8K | 3.8K |
| Test - General Laboratory | 1.8K | 1.9K | 1.5K | 1.7K | 1.7K | 1.7K |
| Treatment - Injections and Infusions (nononcologic) | 869.1 | 928.1 | 833.8 | 1.4K | 1.0K | 888.8 |
| E&M - Behavioral Health Services | 460.5 | 512.5 | 561.9 | 650.2 | 682.2 | 791.4 |
| Treatment - Physical, Occupational, and Speech Therapy | 700.8 | 746.0 | 558.8 | 698.2 | 749.5 | 791.3 |
| Imaging - Standard X-ray | 725.8 | 775.7 | 627.1 | 710.5 | 721.6 | 756.7 |
| Test - Molecular Testing | 195.3 | 209.7 | 561.5 | 967.4 | 1.1K | 533.6 |
| E&M - Hospital Inpatient Services | 348.5 | 363.7 | 345.0 | 360.3 | 356.6 | 383.6 |
| Imaging - Ultrasound | 338.7 | 358.7 | 313.0 | 353.0 | 354.7 | 363.4 |
| E&M - Emergency Department Services | 359.5 | 371.7 | 288.6 | 311.1 | 334.1 | 335.2 |
| Test - Cardiography | 298.8 | 321.2 | 267.4 | 296.7 | 310.0 | 325.5 |
| E&M - E&M - Miscellaneous | 128.5 | 150.9 | 170.2 | 206.8 | 228.2 | 227.8 |

Services – Overview | Services – Drill-Down

Selected Measure Name: **Service Rate per 1,000 Members**
Measure Definition: **The rate of service utilization calculated as the number of occurrences per 1,000 member per year**
Numerator Definition: **Count of services**
Denominator Definition: **Sum of member months divided by 12000 (rate per 1,000 members divided by 12 months)**

**County Granularity**

County

County
County + LA Service Planning Area

- [x] LA - Antelope Valley
- [x] LA - East
- [x] LA - Metro
- [x] LA - San Fernando Valley
- [x] LA - San Gabriel Valley
- [x] LA - South
- [x] LA - South Bay
- [x] LA - West

**Service Category**

- [x] (All)
- [x] Anesthesia
- [x] Anesthesia - Anesthesia
- [x] DME - Drugs Administered Through D...
- [x] DME - Hospital Beds
- [x] DME - Medical/Surgical Supplies
- [x] DME - Orthotic Devices
- [x] DME - Other DME
- [x] DME - Oxygen and Supplies
- [x] DME - Wheelchairs
- [x] Durable Medical Equipment
- [x] E&M - Behavioral Health Services
- [x] E&M - Care Management/Coordination
- [x] E&M - Critical Care Services
- [x] E&M - E&M - Miscellaneous
- [x] E&M - Emergency Department Services
- [x] E&M - Home Services
- [x] E&M - Hospice
- [x] E&M - Hospital Inpatient Services
- [x] E&M - Nursing Facility Services
- [x] E&M - Observation Care Services
- [x] E&M - Office/Outpatient Services
- [x] E&M - Ophthalmological Services
- [x] Evaluation & Management
- [x] Imaging
- [x] Imaging - CT Scan
- [x] Imaging - Imaging - Miscellaneous
- [x] Imaging - Magnetic Resonance
- [x] Imaging - Nuclear
- [x] Imaging - Standard X-ray

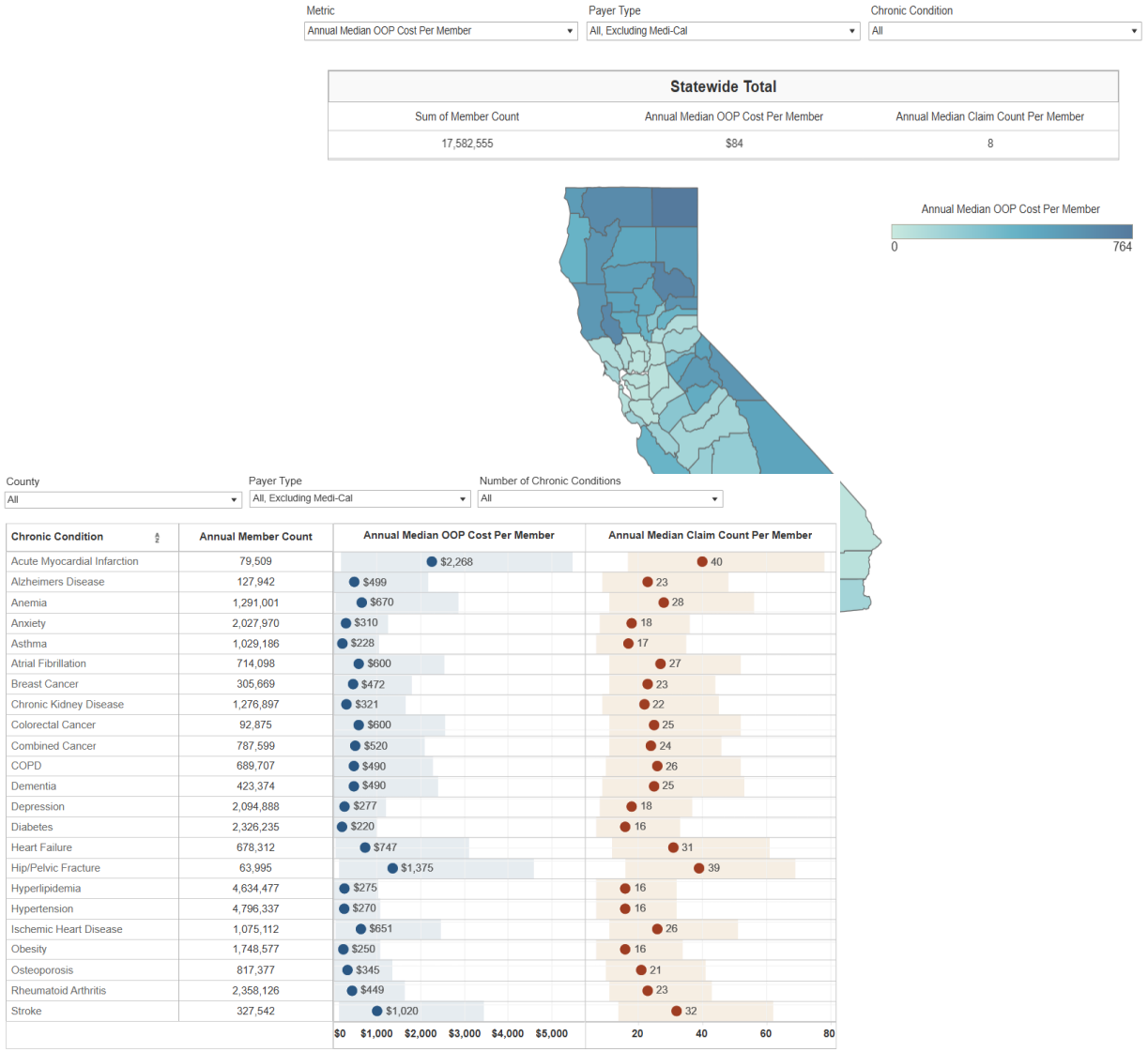
Cancel | Apply



Released February 2025, explore at: HPD Services Report

# Out-of-Pocket-Costs

- Purpose: understanding chronic condition prevalence and medical out-of-pocket cost
- Focuses on 3 metrics: member count, annual median out-of-pocket cost, annual median claim count per member
- Can display the data for the entire state, by county or for specific chronic conditions
- Data can be filtered by county, payer type, and the number of chronic conditions.



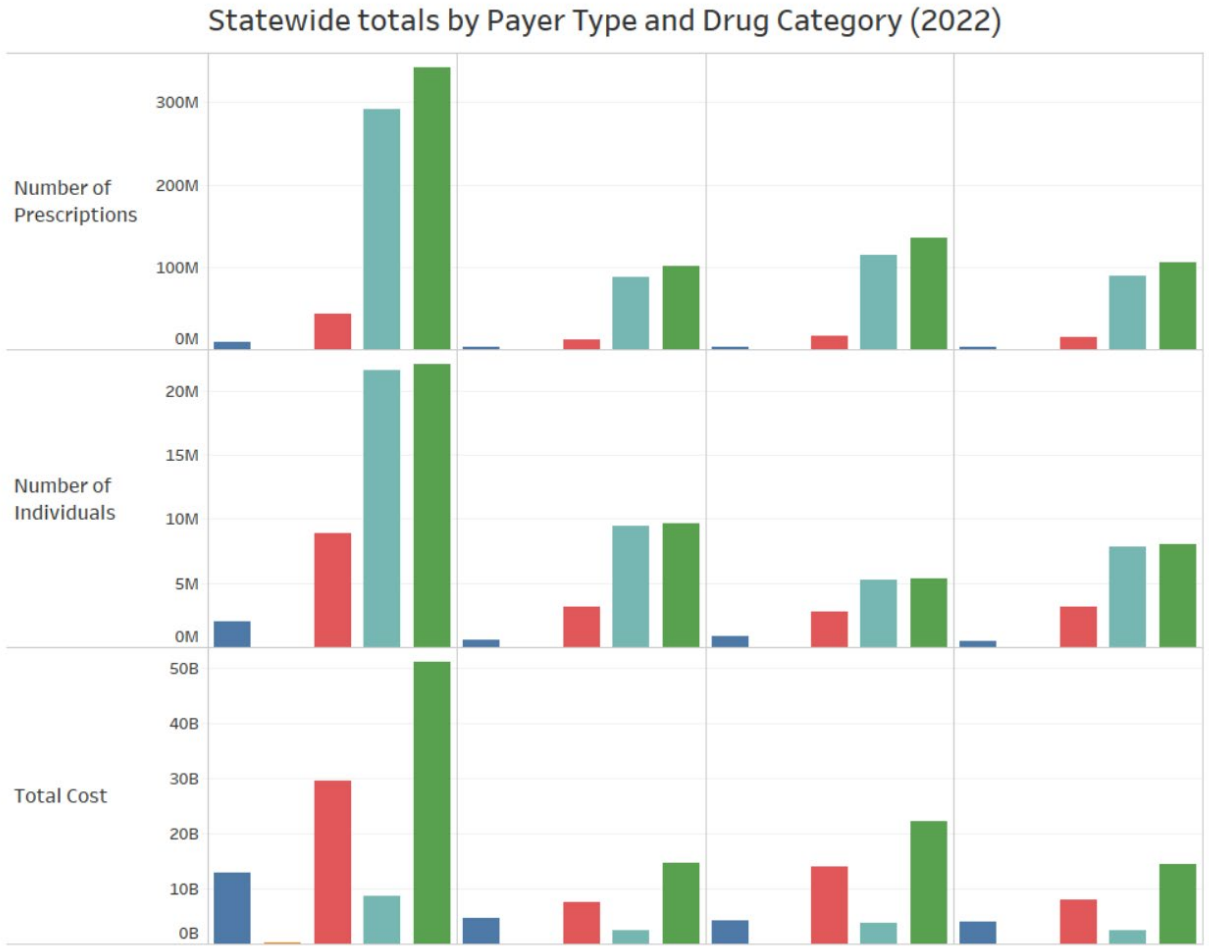



Released March 2025, explore at: HPD: Medical Out-of-Pocket Costs and Chronic Conditions

# HPD Program Upcoming Releases: Late-Stage Development

# **Late-Stage Development:** Prescription Drug Cost Report Update

- An update is underway, aiming for release in Q2 2025
- Major changes for the new report:
  - Adds Medi-Cal and Medicare data
    - Enables comparison across payer types commercial, Medi-Cal, Medicare
  - Adds data for 2022
    - Enables comparison between 2021 and 2022
  - Adds new prescription drug categories for biologic and biosimilar
    - Enables comparisons across four categories: generic, brand, biosimilar, biologic




PRELIMINARY ANALYSIS – PREPUBLICATION DRAFT

# **Late-Stage Development:** HPD Visits

- The dashboard groups medical services into visit types in four categories:
  - Inpatient: Visits are defined using MS-DRGs and include all medical claims incurred during the hospitalization.
  - Outpatient: For outpatient services, all CPT codes for the service are required to have been reported on the same day of service
    - Outpatient Diagnostic: All medical claims reported with the specific CPT procedure code identifying the service are included (includes facility and professional components of the cost)
    - Outpatient Surgical/Non-Diagnostic: All medical claims on the date of the procedure are included.
  - Professional: The medical claims records with the specific place of service code, CPT procedure code, and CPT modifier code identifying the service are included.
- Focuses on 3 metrics: Total visits, visit rate per 1,000 members, average out-of-pocket cost per visit

# Analysis for DHCS: Coverage/Churn, Primary Care, Dual Eligibles

# Analysis for DHCS

As part of CMS certification of the HPD (and as a condition of funding), three analyses were requested by DHCS and conducted using HPD data.

1. Assessment of "unwinding" of the Medi-Cal continuous coverage requirement temporarily in place during the pandemic
2. Assessment of primary care providers, primary care services, and number of patients across payer types
3. Assessment of utilization of inpatient services by members eligible for both Medi-Cal and Medicare ("dual eligibles")

# **Coverage/Churn:** Assessment of the “Unwinding” of the Medi-Cal Continuous Coverage Requirement

| Medi-Cal Continuous Coverage "Unwinding": Enrollment Status by Age Group and Month | | | | | |
|---|---|---|---|---|---|
| Initial Cohort of Medi-Cal Beneficiaries Enrolled April to June 2023 | Age Group, as of June 2023 | Medi-Cal Continuous Coverage "Unwinding," July to September 2023 | | | |
| | | Coverage | July | August | September |
| 5,265,384 | 0-20 | Medi-Cal | 5,248,369 | 5,216,156 | 5,133,075 |
| | 0-20 | Commercial - Covered CA | 1,130 | 2,595 | 4,582 |
| | 0-20 | Commercial - Other | 9,683 | 19,020 | 29,814 |
| | 0-20 | Lost to follow-up* | 6,202 | 27,613 | 97,913 |
| 7,305,216 | 21-64 | Medi-Cal | 7,262,924 | 7,174,040 | 6,960,656 |
| | 21-64 | Commercial - Covered CA | 4,847 | 10,571 | 17,357 |
| | 21-64 | Commercial - Other | 20,579 | 40,543 | 64,882 |
| | 21-64 | Lost to follow-up* | 16,866 | 80,062 | 262,321 |

*Includes those enrolled in Medicare (data are unavailable after March 2023), those that fall within the 90-day grace period for Medi-Cal dis-enrollment but may be reinstated at the end of the grace period, and those truly lost due death, out-of-state moves, unmeasured coverage sources like the VA.

# **Primary Care:** Count of PC Providers, Services, and Patients

| Count of Primary Care Providers, Primary Care Claims, an Patients, by Year, 2018 -2022 | | | | |
|---|---|---|---|---|
| **Year** | **Type** | **ount of Primary re Providers rendering ovider)** | **Total Nuber of Primaryare Visit Cs** | **Total Number of atients** |
| 2018 | All | 44,011 | 50,313,338 | 17,137,859 |
| | Medi-Cal | | 15,813,686 | 6,224,257 |
| | Commercial & Medicare | | 34,529,936 | 13,786,156 |
| 2019 | All | 44,966 | 51,085,670 | 17,263,158 |
| | Medi-Cal | | 16,122,864 | 6,289,552 |
| | Commercial & Medicare | | 34,994,641 | 14,078,578 |
| 2020 | All | 45,537 | 45,878,452 | 15,819,893 |
| | Medi-Cal | | 14,280,700 | 5,681,165 |
| | Commercial & Medicare | | 31,630,352 | 13,001,550 |
| 2021 | All | 46,422 | 50,310,276 | 16,914,542 |
| | Medi-Cal | | 16,176,477 | 6,374,355 |
| | Commercial & Medicare | | 34,171,908 | 14,111,855 |
| 2022 | All | 47,380 | 52,111,229 | 17,321,765 |
| | Medi-Cal | | 17,425,067 | 6,869,397 |
| | Commercial & Medicare | | 34,724,551 | 14,369,606 |

# Dual Eligibles:

## Dual Eligible Medi-Cal/Medicare Members with an Acute Inpatient Stay, 2022

| Measure | Result |
|---|---|
| Number of Dual Eligible Persons | 1,800,387 |
| Average Age | 68 |
| Percent Male/Female | 43.2% / 56.8% |
| Number of Dual Eligible Persons with an Acute Inpatient Stay | 263,832 |
| Number of Inpatient Stays | 497,825 |
| Average Age | 69 |
| Percent Male/Female | 45.1% / 54.9% |
| Average Length of Stay (ALOS) | 7 |
| In-Hospital Mortality Rate per 100 Inpatient Stays | 4.45 |
| Top Reasons for Acute Inpatient Stay | |
| Diseases and Disorders of the Circulatory System | 17.1% |
| Infectious and Parasitic Diseases, Systemic or Unspecified Sites | 16.0% |
| Diseases and Disorders of the Respiratory System | 12.6% |
| Diseases and Disorders of the Digestive System | 8.4% |

# HPD Data Release Program

# Data Release Program

- HPD data release regulations were approved on November 25, 2024.
- HPD data release program publicly launched on December 17, 2024.
- Information regarding the available data, data documentation, data request application, data request process, price schedule, and how to create an account to submit data requests is available on the HCAI website.
- HCAI hosted a data access and release webinar on January 15, 2025.
- 8 requests received to date.
- HCAI anticipates the first Data Release Committee public meeting to review data requests on May 21, 2025.
- Released Data Completeness Fact Sheet covering 30 key fields.

# HPD Program Product Demonstrations

Link 1: https://hcai.ca.gov/visualizations/healthcare-payments-data-hpd-fee-for-service-drug-costs-in-the-commercial-market/

Link2: https://hcai.ca.gov/visualizations/healthcare-payments-data-hpd-medical-out-of-pocket-costs-and-chronic-conditions-2022/

# 2025 Program Priorities

## Data Collection

- Continue to expand the database
- Continue to improve data quality and completeness

## Public Reporting

- Continue executing public reporting priorities: Publish new reports, refresh existing reports with new data
- Expand use of public reports

## Data Release

- Monitor demand; adjust staffing, program policies, and pricing as needed
- Strategically partner with other state agencies

# OHCA Use Case: Measuring Behavioral Health Spending

# HPD Analysis of Behavioral Health Spending

- The Health Care Payments Database (HPD) team analyzed claims data (2018-2023) to determine behavioral health spending based on a standardized methodology developed by the Milbank Memorial Fund.
  - This analysis provides OHCA with an initial understanding of behavioral health spending, including mental health (MH) and substance use disorder (SUD) spending.
- OHCA plans to expand upon this analysis to inform its behavioral health spending measurement and investment benchmark efforts.
  - OHCA analyses of HPD data may be used to inform decisions about the behavioral health investment benchmark structure and level.

Milbank Memorial Fund, August 2024. *Technical Specifications for a Standardized State Methodology to Measure Behavioral Health Clinical Spending.* https://www.milbank.org/wp-content/uploads/2024/08/BH-Measurement-Technical-Specifications.pdf

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

# Public Comment

HCAi
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Department of Health Care Access and Information

# General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

# Next Board Meeting:
# April 22, 2025
## 9:00 a.m.

## Location:
## May Lee State Office Complex
## 651 Bannon St.
## Auditorium, Room 300
## Sacramento, CA  95811

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

# Adjournment

HCAI

Department of Health Care Access and Information