Department of Health Care Access and Information

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

Report on Promoting High Value Health Care in California, 2023-2024

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2020 WEST EL CAMINO AVENUE, SUITE 1222 • SACRAMENTO, CA 95833
PHONE: (916) 326-3600 • EMAIL: HCAIDO@HCAI.CA.GOV

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Section 1. Executive Summary

As health care entities work to slow spending growth, the Office of Health Care Affordability (OHCA) simultaneously promotes efforts to improve California's health system in the areas of primary care and behavioral health investment, alternative payment model (APM) adoption, quality and equity performance, and workforce stability. In June 2024, the California Health Care Affordability Board approved statewide goals for APM adoption, and in October 2024, the Board approved primary care investment benchmarks. Fall 2025 marked the first collection of APM adoption and primary care spending data from payers. Each year, data will be collected and publicly reported to monitor trends and provide a more comprehensive view of health system performance over time. These annual reports will support understanding of payment and investment patterns and help identify opportunities to improve access, affordability, quality, and equity in the California health system.

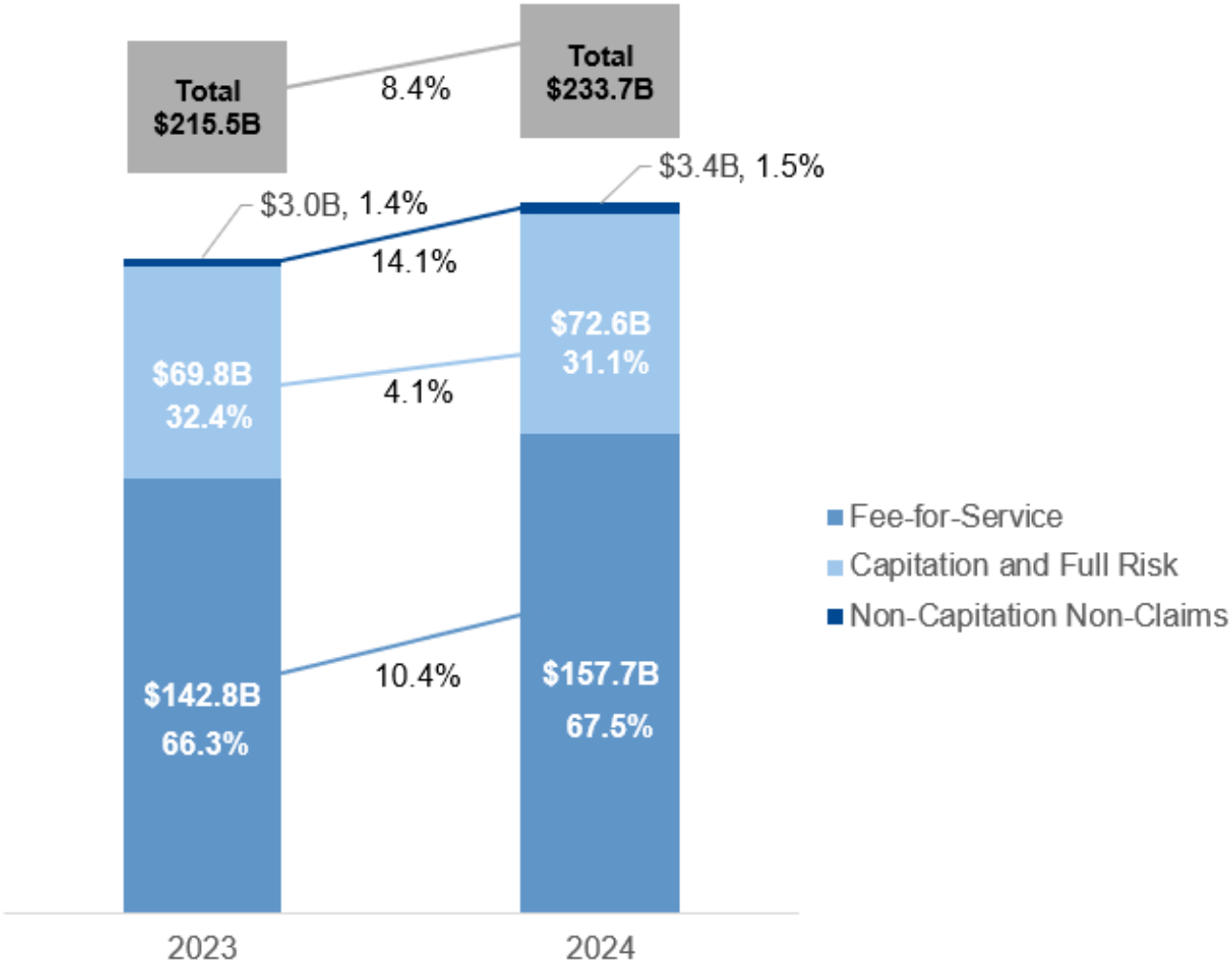
This initial report provides data for calendar years 2023 and 2024 for measures of primary care spending and APM adoption statewide, establishing a baseline for health system performance in California by market and by payer, where applicable. The report also highlights OHCA's other work to improve health system performance, such as measuring behavioral health spending, measuring quality and equity performance, monitoring health care workforce stability, and highlighting effective cost-reducing strategies. Future reports will include data on these other areas of health system performance. This report complements the *Interim Report: Health Care Spending Trends in California, 2023-2024*, which reports on the rate of growth of total health care spending from 2023 to 2024.

Key Findings

Between 2023 and 2024, statewide total medical expense (TME) increased from $215.5 billion to $233.7 billion, an increase of $18.2 billion or 8.4%, as shown in **Figure 1**.[1] Fee-for-service payments, or claims payments, accounted for 66.3% of TME in 2023 and 67.5% in 2024, while capitation and full risk non-claims payments accounted for 32.4% and 31.1%, respectively. Non-capitation non-claims payments, which include pay-for-performance and other non-claims payment types, accounted for 1.4% of TME in 2023 and 1.5% in 2024. Claims payments are payment requests that providers send to a payer for reimbursement. Non-claims payments are payments from payers to providers outside of claims payments for specific health care services, such as performance payments and capitation and full risk payments.

[1] Due to differences in details of measurement (*e.g.*, Medi-Cal Managed Care spending measured via payer submissions to OHCA in this report and by MLR reports submitted to DHCS in the Interim Report) and data exclusions (certain plans listed in Appendix A.1 excluded in this report; Medicare FFS not included in this report), TME as reported in this report will not match TME as reported in the *Interim Report: Health Care Spending Trends in California, 2023-2024.*

Figure 1. Statewide Total Medical Expense Within Each Payment Category in Billions, Including the Percent of Total Medical Expense and Percent Change by Payment Category, 2023-2024

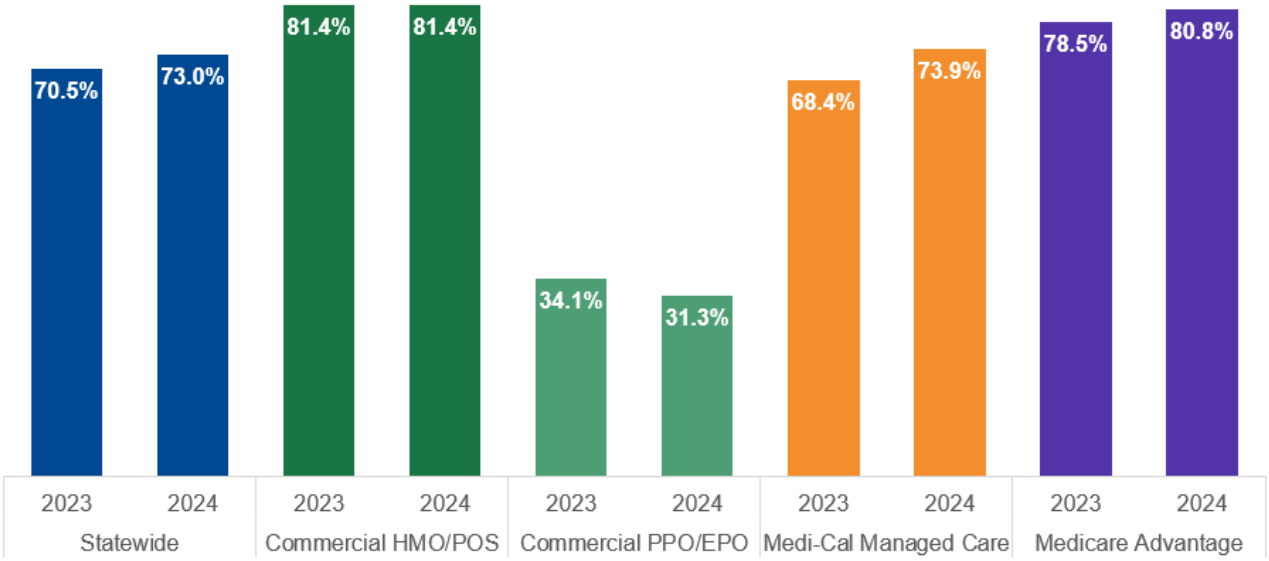


Changes in TME by Payment Category:

- **Statewide TME** grew 8.4%.
- **Fee-for-Service** payments grew 10.4%.
- **Capitation and Full Risk** payments grew 4.1%.
- **Non-Capitation Non-Claims** payments grew 14.1%.

Statewide APM adoption, as measured by the percent of members attributed to capitation and full risk or shared savings and shared risk payment categories eligible for quality-linked payments, increased from 70.5% in 2023 to 73.0% in 2024, as shown in **Figure 2**. Payers submit data on non-claims payments, like capitation, to OHCA using the APM Measurement Methodology described in Appendix A.4 APM and Primary Care Methodologies and Key Measures.

Figure 2. Percent of Members Attributed to APMs with Quality-Linked Payments Statewide and by Market and Plan Type, 2023-2024



Note: *APMs are defined as capitation/full risk or shared savings/risk payment models linked to quality performance.*

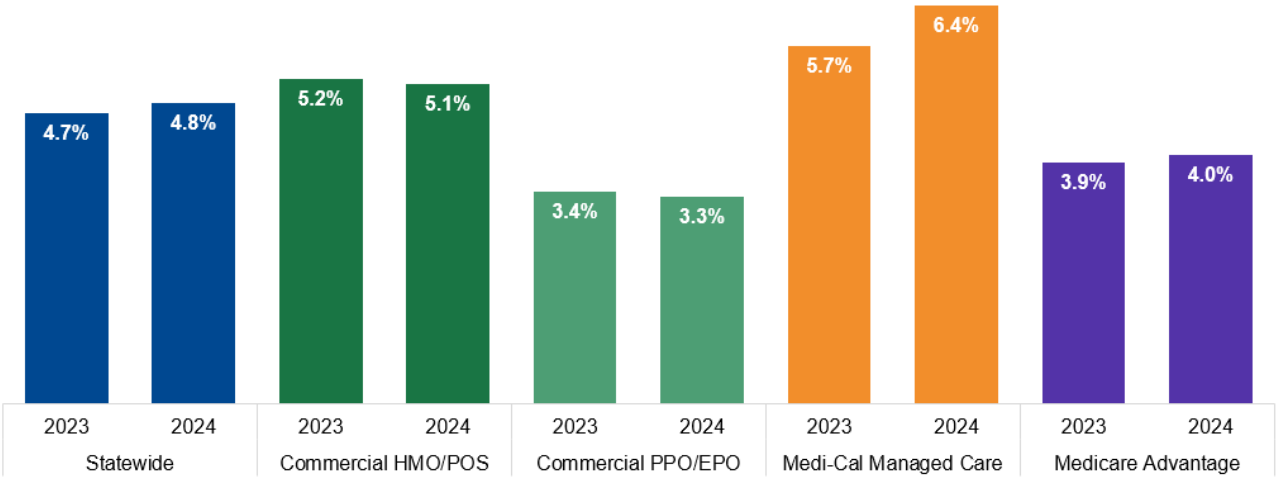
Changes in APM adoption by Market and Plan Type:

- **Statewide** APM adoption increased from 70.5% in 2023 to 73.0% in 2024.
- **Commercial Health Maintenance Organization/Point of Service (HMO/POS)** APM adoption remained the same at 81.4% in 2023 and 2024.
- **Commercial Preferred Provider Organization/Exclusive Provider Organization (PPO/EPO)** APM adoption declined from 34.1% in 2023 to 31.3% in 2024.
- **Medi-Cal Managed Care** APM adoption increased from 68.4% in 2023 to 73.9% in 2024.
- **Medicare Advantage** APM adoption increased from 78.5% in 2023 to 80.8% in 2024.

Primary care spending, measured by spending on primary care services through claims and non-claims payments, increased statewide from 4.7% in 2023 to 4.8% in 2024 as a percent of TME, as shown in **Figure 3**. Payers submit primary care spending data to OHCA using the Primary Care Measurement Methodology described in Appendix A.4 APM and Primary Care Methodologies and Key Measures.

In 2023 and 2024, primary care spending and APM adoption varied across markets and payers.

Figure 3. Primary Care Spending as Percent of Total Medical Expense, Statewide and by Market and Plan Type, 2023-2024



Note: *Medi-Cal Managed Care covered benefits do not align with those in other markets, making cross-market comparisons of primary care spending as a percent of TME unreliable. Specifically, Medi-Cal Managed Care TME does not include retail pharmacy spending. OHCA's measurement applied a set of specific inclusion and exclusion criteria, described in Appendix A.5 Context for Medi-Cal Data, for payments reported by Medi-Cal Managed Care Plans.*

Changes in Primary Care Spending by Market and Plan Type:

- **Statewide** primary care spending increased from 4.7% of TME in 2023 to 4.8% in 2024.
- **Commercial HMO/POS** primary care spending declined from 5.2% of TME in 2023 to 5.1% in 2024.
- **Commercial PPO/EPO** primary care spending declined from 3.4% of TME in 2023 to 3.3% in 2024.
- **Medi-Cal Managed Care** primary care spending increased from 5.7% of TME in 2023 to 6.4% in 2024.
- **Medicare Advantage** primary care spending increased from 3.9% of TME in 2023 to 4.0% in 2024.

Section 2. About HCAI and OHCA

The Department of Health Care Access and Information (HCAI) expands access to quality, equitable, affordable health care for all Californians by supporting high value delivery systems, resilient health facilities and workforces, and actionable health information and strategies. A range of boards and commissions advise on these program areas, with some certain boards empowered to decide on specific responsibilities. HCAI carries out its mission across five major program areas.

Affordability

HCAI promotes affordability of health care costs through multiple strategies, including spending targets, distribution of affordable generic drugs, and pharmaceutical policy and programs that aim to improve equitable access and affordability of medications in California by developing strategic partnerships and innovative policy solutions in the pharmaceutical sector. CalRx has launched initiatives around insulin production and leveraging the state's purchasing strategies for medications such as naloxone and albuterol.

The Hospital Bill Complaint Program enforces the Hospital Fair Pricing Act. Under this law, hospitals are required to have both discount payment and charity care policies to provide financial assistance to qualified patients. HCAI's Hospital Bill Complaint Program helps patients who have been wrongly denied financial assistance.

Workforce

To promote a diverse and culturally competent workforce, HCAI analyzes California's healthcare infrastructure and workforce needs. HCAI provides direct grant funding to medical schools, nursing programs, and other healthcare training institutions. HCAI also offers scholarships and loan repayments to students and health professionals who agree to provide patient care in medically underserved areas. Scholarships and loan repayments are offered for nursing, behavioral health, primary care, dental, and other medical professions. To diversify those entering health care professions, HCAI funds pipeline and pathway programs.

Data

HCAI collects, analyzes, and disseminates information about hospitals, skilled nursing facilities, clinics, health plans, and home health agencies licensed within California. Examples of facility information include financial reports and claims data, service utilization data, patient data, and quality of care information.

Built on the principle that every Californian should have access to their health information, HCAI's Data Exchange Framework (DxF) is a statewide initiative aimed at improving the secure, real time data sharing among health and social services entities throughout

California. DxF gives providers a timely, full picture of a patient's health history and the information for effective whole person care while maintaining data privacy and security.

The Office of Patient Advocate rates health care organizations using performance measures based on the quality of medical care and patient experience, and it publishes data on health consumer complaints.

Facilities

HCAI serves as the building department for hospitals and skilled nursing facilities in California, monitoring the construction, renovation, and seismic safety of these vital health care facilities. Its primary goal is to promote patient safety by ensuring that each facility remains functional following a natural disaster.

Financing

HCAI administers a suite of programs to stabilize financially distressed hospitals, strengthen rural healthcare access, and support long term health facility infrastructure across California. This includes no interest loans and grants to nonprofit and public hospitals experiencing significant financial distress and seismic safety grants and technical assistance to small, rural, and Critical Access Hospitals so they can remain open and safely deliver acute care services following an earthquake. HCAI also ensures long term capital financing for eligible health facilities, guaranteeing loans with the full faith and credit of the State of California.

Rural Health Transformation

HCAI leads the California Rural Health Transformation program, which is a statewide strategy to strengthen access, quality, and sustainability across rural and frontier communities to improve health outcomes. The program envisions a connected, resilient rural health system that delivers responsive person-centered care.

Office of Health Care Affordability Background

In enacting the California Health Care Quality and Affordability Act (Health and Safety Code, section 127500, et seq. (Act)), the Legislature recognized the health care affordability crisis for Californians struggling with continued and rapid growth in health care costs. The Act established OHCA as a core program within HCAI. OHCA has three primary responsibilities:

(1) slow health care spending growth,
(2) promote high value health system performance, and
(3) assess market consolidation that may impact market competition and consumer affordability.

OHCA advances these goals by collecting, analyzing, and publicly reporting data on total health care spending. OHCA also enforces spending targets that are established by the Health Care Affordability Board. While seeking to slow spending growth, OHCA promotes high value health system performance by measuring quality, equity, adoption of alternative payment models, workforce stability, and by promoting investment in primary care and behavioral health. Lastly, OHCA reviews and assesses market consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations.

Importance of Monitoring Health System Performance and Promoting High Value Health Systems

Globally, the United States spends more on health care than other high-income countries but experiences lower life expectancy and worse health outcomes.[2] In California, health care spending reached $345.3 billion in 2024, an increase of $28.0 billion or 8.8%, from 2023.[3] Despite rising spending that places a growing financial burden on Californians, access to care and health outcomes are uneven. For example, in 2023 California ranked 49th among states on receipt of preventive care and care quality.[4]

Strategies to improve health system performance include, but are not limited to: improving health care quality and reducing health disparities; increasing investment in primary care and behavioral health; advancing APMs that align financial incentives with quality, health outcomes, and accountability for total cost of care; and promoting health care workforce stability. For example, research shows that increased supply of primary care physicians is associated with improved mortality and increased primary care capacity can reduce overall health care costs.[5,6,7] Additionally, there is evidence to show participation in APMs is associated with increased preventive screenings, reduced emergency department

[2] The Commonwealth Fund, January 2023, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes, https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022

[3] Forthcoming *Interim Report: Health Care Spending Trends in California, 2023-2024,* https://hcai.ca.gov/affordability/ohca/office-of-health-care-affordability-data-and-reports/

[4] Commonwealth Fund, 2025. 2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities. https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance

[5] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med.* 2019;179(4):506–514. doi:10.1001/jamainternmed.2018.7624

[6] Gao J, Moran E, Grimm R, Toporek A, Ruser C. The Effect of Primary Care Visits on Total Patient Care Cost: Evidence From the Veterans Health Administration. J Prim Care Community Health. 2022 Jan-Dec;13:21501319221141792. doi: 10.1177/21501319221141792. PMID: 36564889; PMCID: PMC9793026.

[7] Milbank Memorial Fund, 2026. Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease. https://www.milbank.org/publications/investing-in-primary-care-the-missing-strategy-in-americas-fight-against-chronic-disease/

visits and inpatient hospitalizations, and modest reductions in total cost of care.[8,9,10] Similarly, expanded access to behavioral health services has been associated with overall lower medical spending and positive return on investment, while a stable workforce supports access to care and continuity of services.[11,12] Each of these efforts can support a shift toward more affordable, high value health care across the state.

Despite evidence that primary care is foundational to an effective health system, U.S. and California investments in primary care have fallen short.[13,14] Primary care spending in the U.S., typically 4% to 7% of total health care spending, lags far behind other high-income countries with higher performing health systems, where primary care spending typically ranges from 12% to 15%.[15] In California, prior studies using different methodologies from OHCA have found that primary care spending varied based on health plan type and population, ranging from 5% to 11% for commercial plans and 5% to 19% for Medi-Cal plans.[16,17]

Similarly, while adoption of APMs can re-orient the health system toward higher value by offering flexible payment structures that support improved quality and better care delivery, the shift of payments from fee-for-service to APMs or value-based payments has been

[8] APJM Focus, 2023. Association Between Capitation Payments and Preventive Care Among U.S. Adults. https://www.sciencedirect.com/science/article/pii/S2773065423000536

[9] JAMA, 2023. The Comprehensive Primary Care Plus Model and Health Care Spending, Service Use, and Quality. https://jamanetwork.com/journals/jama/fullarticle/2813197

[10] Health Affairs, 2022. Value-Based Payment as a Tool to Address Excess U.S. Health Spending. https://www.healthaffairs.org/content/briefs/value-based-payment-tool-address-excess-us-health-spending

[11] Association of Outpatient Behavioral Health Treatment with Medical and Pharmacy Costs in the First 27 Months Following a New Behavioral Health Diagnosis in the U.S. JAMA Network Open. December 6, 2022. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799220
JAMA Network Open, Return on Investment of Enhanced Behavioral Health Benefits. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2829859/

[12] U.S. Department of Health and Human Services, Health Care Workforce: Key Issue, Challenges, and the Path Forward. https://aspe.hhs.gov/sites/default/files/documents/82c3ee75ef9c2a49fa6304b3812a4855/aspe-workforce.pdf

[13] Committee on Implementing High-Quality Primary Care, Board on Health Care Services, Health and Medicine Division, & National Academies of Sciences, Engineering, and Medicine (NASEM). (2021). Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (L. McCauley, R. L. Phillips, M. Meisnere, & S. K. Robinson, Eds.; p. 25983). National Academies Press. https://doi.org/10.17226/25983

[14] Jill Yegian, 2022. CHCF Explainer: The Case for Investing in Primary Care in California. https://www.chcf.org/wp-content/uploads/2022/04/CaseInvestingPrimaryCare.pdf

[15] Yalda Jabbarpour, et al., "Investing in Primary Care: A State-Level Analysis," Patient-Centered Primary Care Collaborative, 2019. https://thepcc.org/reports/investing-in-primary-care-a-state-level-analysis/

[16] Yanagihara, D., & Hwang, A. (2022). Investing in Primary Care: Why It Matters for Californians with Commercial Coverage. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf

[17] Edrington, K., Costa, J., Williams, C., & Sadow, J. (2022). Investing in Primary Care: Why It Matters for Californians with Medi-Cal Coverage. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2022/07/InvestingPrimaryCareMMC.pdf

slow in the U.S.[18] In California, the percentage of individuals in capitated payment arrangements, an important type of APM, is higher than in most other states. Data from the Integrated Healthcare Association's California Regional Health Care Cost and Quality Atlas showed that average clinical quality scores rose 7% to 9% for physician organizations in capitated arrangements compared to those that were not in capitated arrangements.[19]

Opportunities remain for greater adoption of APMs that support increased investment in primary care and incentivize other high value services.

OHCA's Role in Promoting an Affordable, High Value Health System

OHCA is responsible for implementing several statutory requirements that aim to reorient the health system toward greater value.[20] OHCA defines, measures, and reports on the following key areas of the health system:

- **Primary Care Investment:** Define, measure, and report on primary care spending and establish a benchmark for primary care investment.
- **Behavioral Health Investment:** Define, measure, and report on behavioral health spending and establish a benchmark for behavioral health investment.
- **Alternative Payment Model (APM) Adoption:** Define, measure, and report on adoption of APMs, establish standards for use in contracting, and establish APM adoption goals.
- **Quality and Equity Performance:** Develop, adopt, and report performance on a set of measures for evaluating health care quality and equity across various health care entities.
- **Workforce Stability:** Establish and implement standards to promote a stable healthcare workforce, while monitoring and reporting on measures of workforce stability.
- **Cost-Reducing Strategies:** Identify best practices for improving affordability while maintaining or improving access, quality, and equity of care.

For each of these areas, OHCA receives regular input from sibling state departments, consumer advocates, payers, providers, labor representatives, and other stakeholders. To inform the areas of APM adoption and primary care and behavioral health investments,

[18] The Commonwealth Fund. Medicare Alternative Payment Models that Support Improved Primary Care, 2026. https://www.commonwealthfund.org/publications/issue-briefs/2026/feb/medicare-alternative-payment-models-support-improved-primary-care; California Quality Collaborative Payment Model Demonstration Project https://www.calquality.org/initiative/payment-model-demonstration-project/

[19] Shortell, S., Scheffler, R., Anand, S., & Arnold, D. (2019). Sustaining Universal Coverage: Lessons From California's Integrated Delivery System. Health Affairs. https://www.healthaffairs.org/content/forefront/sustaining-universal-coverage-lessons-california-s-integrated-delivery-system

[20] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/

OHCA launched the Investment and Payment Workgroup in June 2023, bringing together stakeholders representing providers, patients, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, hospitals and health systems, and payers.[21] OHCA presents proposals and recommendations for each area to the Health Care Affordability Advisory Committee and Health Care Affordability Board, and all proposals are shared for public comment.

OHCA establishes benchmarks and standards, collects data, increases transparency through public reporting, and tracks progress across these key areas of health system performance. This work supports a shift toward a more value-driven health system that prioritizes access to care, improved quality and equity, and affordability.

[21] OHCA Investment and Payment Workgroup: https://hcai.ca.gov/affordability/ohca/ohca-investment-and-payment-workgroup/

Section 3. About this Report

This report presents baseline information on APM adoption and primary care spending in California for calendar years 2023 and 2024. The report shows overall APM adoption and primary care spending across those two years, as well as change between those years. Results are presented at the statewide level and, where applicable, by market and payer.

This first report serves as a baseline assessment of APM adoption and primary care spending prior to implementation of APM adoption goals and primary care investment benchmarks. The 2023–2024 data are not used to assess performance against goals or benchmarks. Instead, they establish a foundation for tracking changes over time and identifying variation across markets and payers.

APM adoption and primary care spending are calculated using standardized data submissions and definitions to support consistency and comparability. As this represents the first year of reporting, OHCA recognizes there may have been varying levels of understanding of the methodologies and technical specifications among payers. Data completeness and data collection methods will continue to be refined in future reporting cycles.

This report also presents information on additional work by OHCA to promote a high value health system, including efforts related to quality and equity, behavioral health, workforce stability, and cost-reducing strategies.

Note, due to rounding, numbers presented throughout this report may not add precisely to the totals provided.

Data Sources

In 2025, OHCA implemented standardized data submissions to collect and analyze data on APM adoption and primary care spending, as required by statute. Data were collected directly from payers with at least 40,000 members across the Commercial, Medicare Advantage, and Medi-Cal Managed Care markets.

This report includes data submitted by 33 payers across the Commercial, Medicare Advantage, and Medi-Cal Managed Care markets. Submitted data contains member months of coverage, member attribution to payment arrangements, claims and non-claims payments, payments for primary care services, and TME.

Spending in the Commercial - Other market category was excluded from this report, as enrollment and spending in this category represented less than 1% of the Commercial

market.[22] Medi-Cal Fee-for-Service and Medi-Cal Rx spending is also excluded from this report.

Due to data validation concerns, primary care spending and APM adoption data for Alignment Health, and APM adoption data for Aetna, Blue Shield of California, and Kern Family Health Care were excluded from reporting.[23] OHCA is continuing to work with these payers to resolve these issues.

Submitted data were subject to automated and manual validations according to pre-specified criteria. Payers were offered technical assistance prior to the submission deadline, additional technical assistance when submitted data failed to meet validation criteria, and opportunities to re-submit data. All data presented in this report were reviewed for accuracy by the submitting payer.

See Appendix A.1 Exclusions and Appendix A.2 Data Validation for additional details.

Definitions

This report uses standardized methods for quantifying APM adoption and primary care spending.

OHCA groups payments between payers and providers or provider organizations into three major reporting categories used throughout this report:

(1) fee-for-service (FFS) payments,

(2) capitation and full risk payments, and

(3) non-capitation non-claims payments.

Non-capitation non-claims payments include population health and practice infrastructure payments, performance payments, shared savings and shared risk payments, and other non-claims payments. **Table 1** provides the descriptions of these payment types and indicates how the payment types are grouped throughout this report.

[22] Payers in the Commercial - Other market category do not fit descriptions of health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO), or exclusive provider organization (EPO). The Commercial - Other market category represented 0.6% of members in the Commercial market in 2023 and 2024, and 0.3% of all members statewide. The Commercial - Other market category represented 0.2% of TME in the Commercial market in 2023, and 0.1% in 2024. The Commercial - Other market contributed 0.1% to TME statewide for both years.

[23] The combined total members excluded for Aetna, Alignment Health, Blue Shield of California, and Kern Family Health Care for reporting years 2023 and 2024 are 4 million members and 4.1 million members, respectively. This represents 11.8% and 12.3% of all members statewide for 2023 and 2024. Please refer to Appendix A.1 Exclusions for details on the members excluded by market and plan type for each payer.

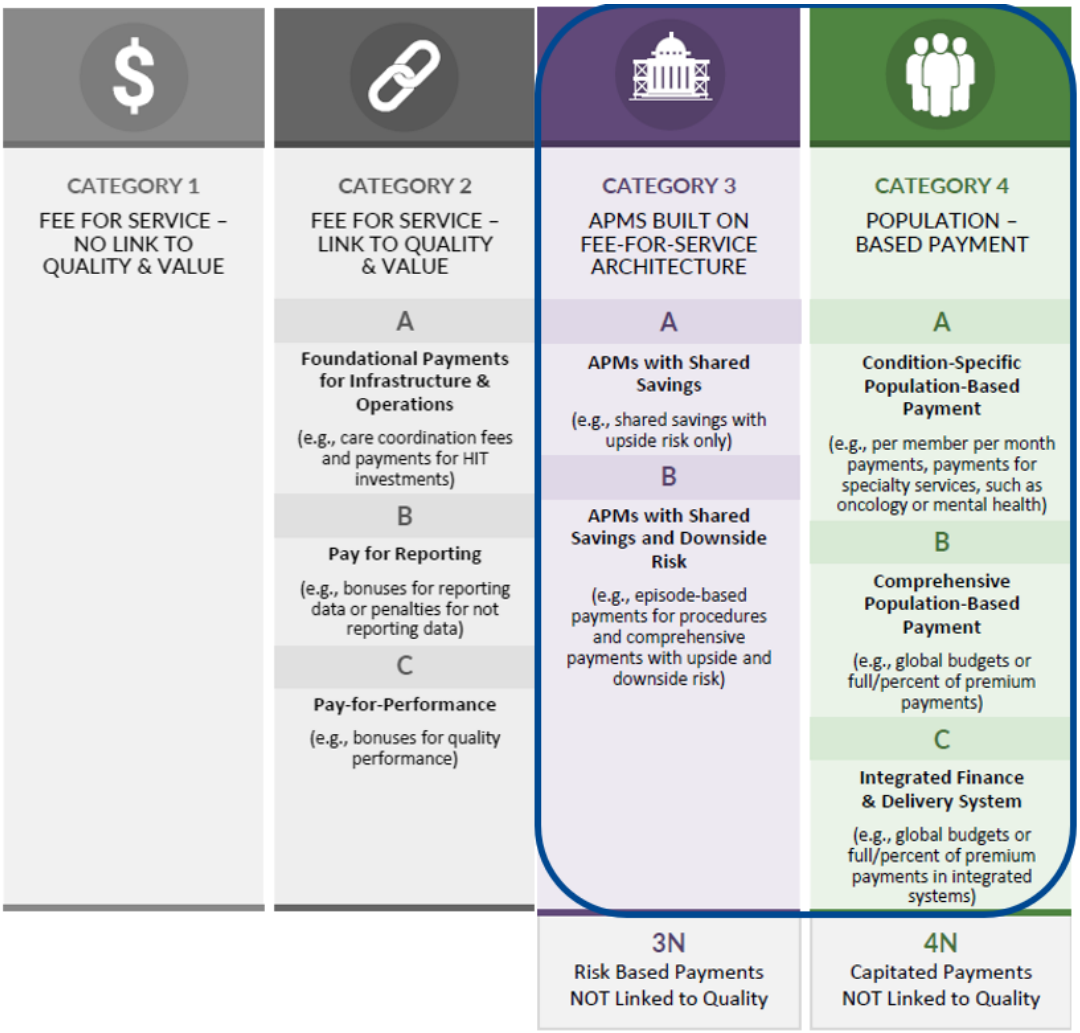
Table 1. Claims and Non-claims Payment Categories

Category	Description
Claims Payments	
Fee-for-service (FFS)	Claims payments in which health care providers or organizations are paid for each service performed. Examples of services include tests and office visits.
Non-claims Payments	
Capitation and Full Risk Payments	
Capitation and Full Risk Payments	Per capita, non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time.
Non-capitation Non-claims Payments	
Population Health and Infrastructure Payments	Prospective, non-claims payments paid to health care providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses.
Performance Payments	Non-claims bonus payments paid to health care providers and organizations for reporting data or achieving specific predefined goals for quality, cost reduction, equity, or another performance achievement domain.
Shared Savings and Shared Risk Payments[24]	Non-claims payments made to health care providers and organizations (or recouped from health care providers and organizations) based on performance relative to a defined spending target. Shared savings and shared risk payments can be associated with different types of budgets, including, but not limited to, episodes of care and total cost of care.
Other Non-Claims Payments	Any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit.

[24] Shared risk payments are referred to as “recoupments” in the Expanded Non-Claims Payments Framework.

Payers submitted data on non-claims payments described in **Table 1** using HCAI's Expanded Non-Claims Payments Framework (Expanded Framework).[25] The Expanded Framework was developed to capture both the type of payment arrangement and intent of the payment and is tailored to the types of payments in the California market, such as different types of capitation. The payment categories in the Expanded Framework correspond to payment categories in the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework, as shown in **Figure 4**, an industry standard for designing APMs and setting APM adoption goals. [26]

Figure 4. HCP-LAN Framework with Highlighted Categories that Count toward OHCA APM Adoption Goals



[25] California Department of Health Care Access and Information. Expanded Non-Claims Payments Framework. https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

[26] Health Care Payment Learning and Action Network (HCP-LAN). Alternative Payment Model (APM) Framework White Paper. Available at: https://hcp-lan.org/wp-content/uploads/2025/08/APM-Framework-White-Paper.pdf

OHCA's APM adoption goals are based on the percentage of members attributed to payment models that include shared savings, shared risk, capitation, or full risk arrangements tied to quality performance. These models fall under HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C, highlighted in the blue box in **Figure 4**, and include financial accountability for cost and quality outcomes. Payers attribute members to the highest applicable payment category on a continuum of clinical and financial risk, with capitation and full risk payment arrangements being the highest risk and FFS the lowest. A member attributed to capitation and full risk arrangements may still receive some care paid through FFS claims.

For a member to count toward the OHCA APM adoption goals, at least some payments made to any provider on a member's behalf – whether through performance payments, shared savings or shared risk, capitation, or full risk arrangements – must be eligible to be adjusted based on the provider's performance on predetermined quality benchmarks. This link to quality depends on whether the payment model allows for adjustments based on quality benchmarks, not whether a quality incentive was paid.

For example, if a member is attributed to a provider eligible for a performance payment and is also attributed to any provider with a capitation arrangement that is not adjusted based on quality performance, then that member is considered linked to quality. Additionally, if a payer delegates risk for its members to another payer through a capitation or full risk arrangement, this arrangement also counts toward the OHCA APM adoption goals if it includes a link to quality. Payers report the member's attribution to the applicable payment arrangement and whether the member is attributed to a payment linked to quality.

Primary care spending is measured as spending on primary care services as a percent of TME and includes both claims and non-claims payments. FFS primary care spending is defined as services delivered by a primary care provider, in a primary care setting, and identified as primary care services. All three criteria must be met for spending to be included. Non-claims primary care spending includes portions of capitation and full risk payments, population health and practice infrastructure payments, performance payments, and shared savings and shared risk payments allocated to primary care by payers based on standardized methodologies.

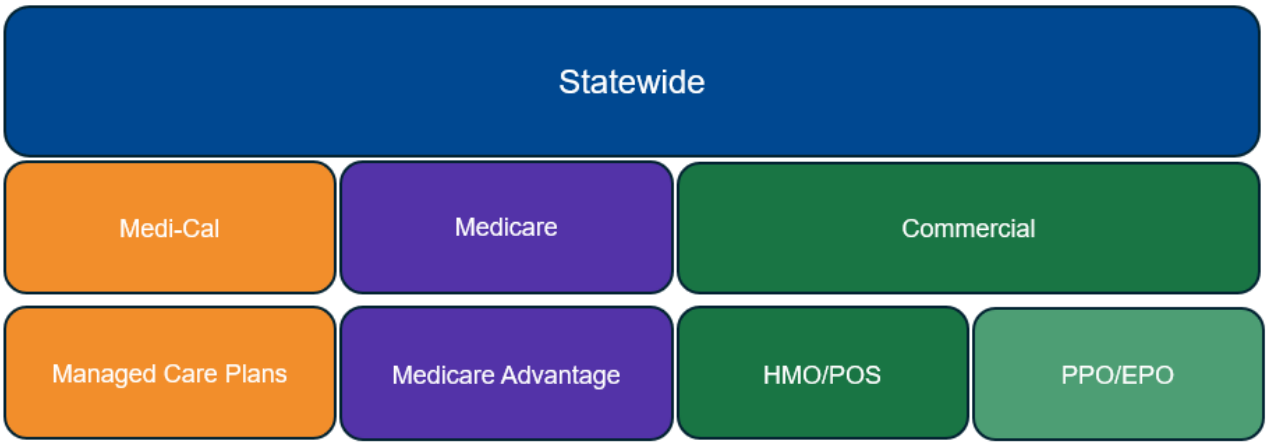
See Appendix A.3 Data Sources and Appendix A.4 APM and Primary Care Methodologies and Key Measures for additional details, including limitations of APM and primary care spending measurement.

Market Categories and Enrollment by Market

Figure 5 shows the levels of reporting, including overall statewide reporting and reporting by market and plan type.

The Commercial market includes members covered by employer-sponsored group coverage and plans purchased by individuals including through Covered California, the state's health insurance marketplace. Most commercially insured Californians are younger than 65 years old. Commercial payers offer multiple types of plans, primarily **(1)** health maintenance organization (HMO) or point of service (POS) plans which require a primary care provider to manage the member's care, and **(2)** preferred provider organization (PPO) or exclusive provider organization (EPO) plans which allow members to schedule visits without a referral.

Figure 5. Levels of Reporting for Primary Care Spending and APM Adoption: Statewide, Market, and Plan Type



As shown in **Figure 6**, about 16.1 million Californians had commercial coverage in 2024, of which 11.0 million were in HMO/POS plans and 5.1 million in PPO/EPO plans. Kaiser Permanente (63.2%) and UnitedHealthcare (11.4%) collectively accounted for around 75% of the Commercial HMO/POS market, while Anthem (33.2%), Blue Shield of California (24.8%), Cigna (19.1%), and Aetna (18.6%) collectively accounted for over 95% of the Commercial PPO/EPO market.

Figure 6. Commercial Payers by Market Share, 2024

Commercial HMO/POS	Market Share
Kaiser Permanente	63.2%
UnitedHealthcare	11.4%
Anthem	6.6%
Blue Shield of California	4.8%
Centene	3.8%
Aetna	2.5%
L.A. Care Health Plan	2.1%
Sharp Health Plan	1.2%
Western Health Advantage	1.1%
Sutter Health Plan	1.1%
Cigna	0.9%
Molina Healthcare	0.5%
Valley Health Plan	0.5%
Inland Empire Health Plan	0.2%
San Francisco Health Plan	0.1%
Contra Costa Health Plan	0.1%
Health Plan of San Mateo	< 0.1%
Total Members	**10,992,519**

Commercial PPO/EPO	Market Share
Anthem	33.2%
Blue Shield of California	24.8%
Cigna	19.1%
Aetna	18.6%
UnitedHealthcare	2.6%
Centene	1.7%
Kaiser Permanente	<0.1%
Sharp Health Plan	<0.1%
Total Members	**5,127,254**

Note: *Enrollment used for market share calculations is determined by taking member months reported in the OHCA APM file divided by 12. See Appendix A.4 APM and Primary Care Methodologies and Key Measures for additional details.*

Medicare is a health coverage program that serves seniors and individuals with disabilities. This report includes spending for members enrolled in Medicare Advantage plans, as reported by payers through data submitted to OHCA. Dual eligible members (those eligible for both Medicare and Medicaid) and Dual Eligible Special Needs Plans (D-SNPs) are captured in the Medicare Advantage totals.[27] Spending for members enrolled in Medicare FFS is not included in OHCA APM adoption and primary care spending reporting.

As shown in **Figure 7**, Medicare Advantage plans covered about 3.4 million Californians in 2024. Kaiser Permanente accounted for 41.9% of the Medicare Advantage market, UnitedHealthcare for 16.3%, and Anthem for 8.7%, collectively comprising approximately 66.9% of the Medicare Advantage market.

[27] Dual eligible members when the payer is only administering Medi-Cal benefits are captured in the Medi-Cal totals.

Figure 7. Medicare Advantage Payers by Market Share, 2024

Medicare Advantage	Market Share
Kaiser Permanente	41.9%
UnitedHealthcare	16.3%
Anthem	8.7%
SCAN Health	8.1%
Blue Shield of California	5.0%
Alignment Health	4.7%
Centene	4.4%
Aetna	4.0%
Bright Health	1.7%
Central Health Plan of California	1.2%
Inland Empire Health Plan	1.0%
L.A. Care Health Plan	0.6%
Molina Healthcare	0.5%
CalOptima	0.5%
Sharp Health Plan	0.4%
Santa Clara Family Health Plan	0.3%
Health Plan of San Mateo	0.2%
Community Health Group	0.2%
Western Health Advantage	0.1%
Total Members	**3,364,121**

Note: *Enrollment used for market share calculations is determined by taking member months reported in the OHCA APM file divided by 12. See Appendix A.4 APM and Primary Care Methodologies and Key Measures for additional details.*

Medi-Cal is California's Medicaid program that provides health care services for low-income individuals. Medi-Cal delivers services through both FFS and Medi-Cal Managed Care Plans (MCPs). The majority of Medi-Cal members are enrolled in MCPs that provide most members' health care services through established networks of organized systems of care. A small portion of Medi-Cal members are not enrolled in MCPs and receive services through Medi-Cal FFS.

Certain behavioral health services are "carved out" of Medi-Cal managed care. These carved out services are covered under three different programs: Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Drug Medi-Cal (DMC). SMHS and DMC-ODS are managed by counties, with oversight from DHCS and CMS, through "behavioral health plans." Pharmacy benefits are also carved out of Medi-Cal managed care as part of Medi-Cal Rx.

As shown in **Figure 8**, approximately 13.7 million Medi-Cal members received their health care through managed care in 2024. This report includes Medi-Cal MCP data only. Services and spending that are not covered by MCPs, including Medi-Cal FFS, county-administered behavioral health services, and Medi-Cal Rx, are excluded.

Twenty-three payers served Medi-Cal Managed Care enrollees in 2024. L.A. Care Health Plan holds the largest share of Medi-Cal Managed Care enrollment at 17.1%, followed by Centene at 11.4%, Inland Empire Health Plan at 10.7%, and Kaiser Permanente at 7.5%. Collectively, these four plans account for 46.7% of total Medi-Cal Managed Care enrollment.

Figure 8. Medi-Cal Managed Care Payers by Market Share, 2024

Medi-Cal Managed Care	Market Share
L.A. Care Health Plan	17.1%
Centene	11.4%
Inland Empire Health Plan	10.7%
Kaiser Permanente	7.5%
Partnership HealthPlan of California	6.6%
CalOptima	6.3%
Anthem	5.9%
Molina Healthcare	4.2%
Central California Alliance for Health	3.3%
CalViva Health	3.2%
Health Plan of San Joaquin	3.1%
Kern Family Health Care	3.0%
Alameda Alliance for Health	2.9%
Community Health Group	2.9%
Santa Clara Family Health Plan	2.1%
Contra Costa Health Plan	1.9%
Gold Coast Health Plan	1.8%
CenCal Health	1.8%
San Francisco Health Plan	1.3%
Blue Shield of California	1.3%
Health Plan of San Mateo	1.0%
Community Health Plan of Imperial Valley	0.7%
Total Members	**13,667,037**

Note: *Enrollment used for market share calculations is determined by taking member months reported in the OHCA APM file divided by 12. See Appendix A.4 APM and Primary Care Methodologies and Key Measures for additional details.*

Section 4. Alternative Payment Model (APM) Adoption 2023-2024

In June 2024, the Health Care Affordability Board approved statewide APM adoption goals and APM standards for payer–provider contracting. The APM standards provide a set of ten best practices that are grounded in evidence to guide contracting decisions between payers and providers across APMs.[28] The purpose of the APM adoption goals is to promote a shift from FFS payments to APMs and better align financial incentives for equitable, high quality, and cost-efficient care.

The APM adoption goals were established over a ten-year period, with targets increasing every two years from 2026 through 2034, as shown in **Table 2**. The goals are defined as the percentage of members that are attributed to shared savings, shared risk, and capitation and full risk payment arrangements linked to quality performance, which correspond to HCP-LAN Categories 3 and 4.

Distinct APM adoption goals apply to each market category and plan type (Commercial HMO, Commercial PPO, Medi-Cal, Medicare Advantage).

Table 2. California's Statewide APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer and Plan Type

Year	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	45%	65%	75%
2034	95%	60%	75%	95%

This section of the report presents a baseline view of APM adoption in calendar years 2023 and 2024. As previously mentioned, APM adoption data for Aetna, Alignment Health, Blue Shield of California, and Kern Family Health Care were excluded from reporting due to data validation concerns.

[28] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/

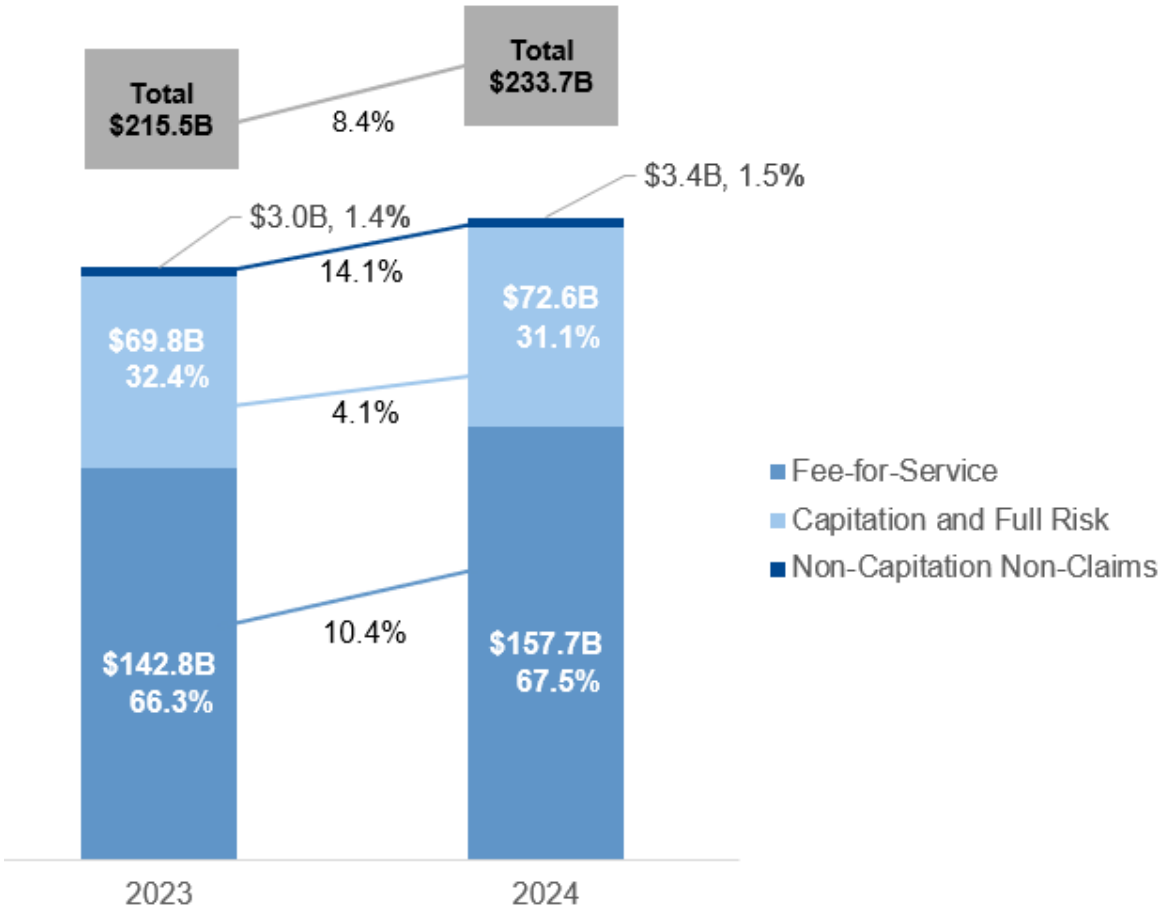
See Appendix A.4 APM and Primary Care Methodologies and Key Measures for additional details on the APM adoption measurement methodology.

TME and Members by Payment Category

The majority of payments statewide are FFS payments, twice as much as payments in capitation and full risk arrangements in 2024.

Figure 9 shows TME by payment category for 2023 and 2024. FFS payments were $142.8 billion or 66.3% of TME in 2023 and $157.7 billion or 67.5% of TME in 2024, an increase of 10.4% from one year to the next. Capitation and full risk payments were $69.8 billion or 32.4% of TME in 2023 and $72.6 billion or 31.1% of TME in 2024, an increase of 4.1%. Non-capitation non-claims payments were $3.0 billion in 2023 or 1.4% of TME in 2023 and $3.4 billion in 2024 or 1.5% of TME in 2024, an increase of 14.1%. TME increased 8.4% from $215.5 billion in 2023 to $233.7 billion in 2024.

Figure 9. Statewide Total Medical Expense Within Each Payment Category in Billions, Including the Percent of Total Medical Expense and Percent Change by Payment Category, 2023-2024



As shown in **Figure 10**, across all members statewide, 29.8 million members in 2023 and 29.1 million members in 2024 were attributed to a payment category, a decrease of 748,218 or 2.5%.

Figure 10 shows the count and percent of members attributed to each payment category for 2023 and 2024. Statewide, 25.6 million members or 85.7% in 2023 and 25.2 million members or 86.7% in 2024 were attributed to capitation and full risk arrangements, a decrease of 1.4% in attributed members. In 2023, 2.8 million members or 9.5% and 2.6 million members or 9.0% in 2024 were attributed to FFS payment arrangements, a decrease of 7.4% in attributed members, while 1.5 million members or 4.9% in 2023 and 1.3 million members or 4.3% in 2024 were attributed to non-capitation non-claims payment arrangements, a decrease of 13.2% in attributed members.

Despite the vast majority of members in California being attributed to some type of capitation or full risk arrangement, most spending continues to be through FFS payments, as shown in **Figure 9**.

Figure 10. Count and Percent of Statewide Members by Attributed Payment Category, 2023-2024

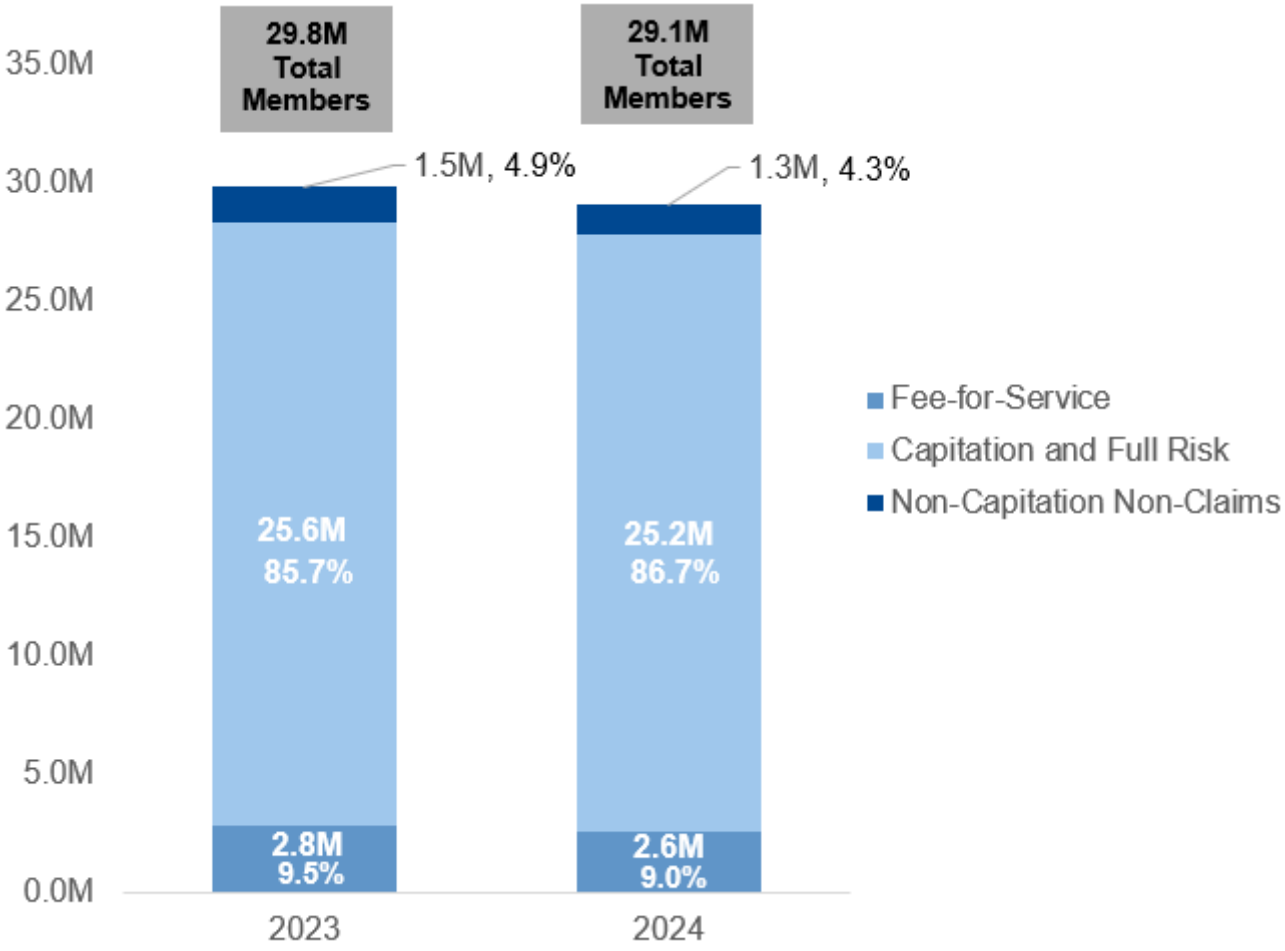


Figure 11 shows the percent of members attributed to each payment category by market and plan type. In Commercial HMO/POS, 90.3% of members in 2023 and 90.5% of members in 2024 were attributed to capitation and full risk arrangements, 8.7% of members in 2023 and 2024 were attributed to FFS arrangements, and 1.0% of members in 2023 and 0.9% of members in 2024 were attributed to non-capitation non-claims payment arrangements.

In Commercial PPO/EPO, 35.1% of members in 2023 and 37.7% of members in 2024 were attributed to capitation and full risk arrangements, 38.5% of members in 2023 and 42.4% of members in 2024 were attributed to FFS arrangements, and 26.4% of members in 2023 and 19.9% of members in 2024 were attributed to non-capitation non-claims payment arrangements.

In Medi-Cal Managed Care, 91.6% of members in 2023 and 93.7% of members in 2024 were attributed to capitation and full risk arrangements, 5.1% of members in 2023 and 2.5% of members in 2024 were attributed to FFS arrangements, and 3.3% of members in 2023 and 3.8% of members in 2024 were attributed to non-capitation non-claims payment arrangements.

In Medicare Advantage, 92.0% of members in 2023 and 90.8% of members in 2024 were attributed to capitation and full risk arrangements, 3.9% of members in 2023 and 6.2% of members in 2024 were attributed to FFS arrangements, and 4.1% of members in 2023 and 3.0% of members in 2024 were attributed to non-capitation non-claims payments.

The Commercial HMO/POS, Medi-Cal Managed Care, and Medicare Advantage markets each had more than 90% of members attributed to capitation and full risk arrangements in both 2023 and 2024, while the Commercial PPO/EPO market had the lowest share of members, under 40%, attributed to these arrangements.

Figure 11. Percent of Members Attributed to Each Payment Category, by Market and Plan Type, 2023-2024

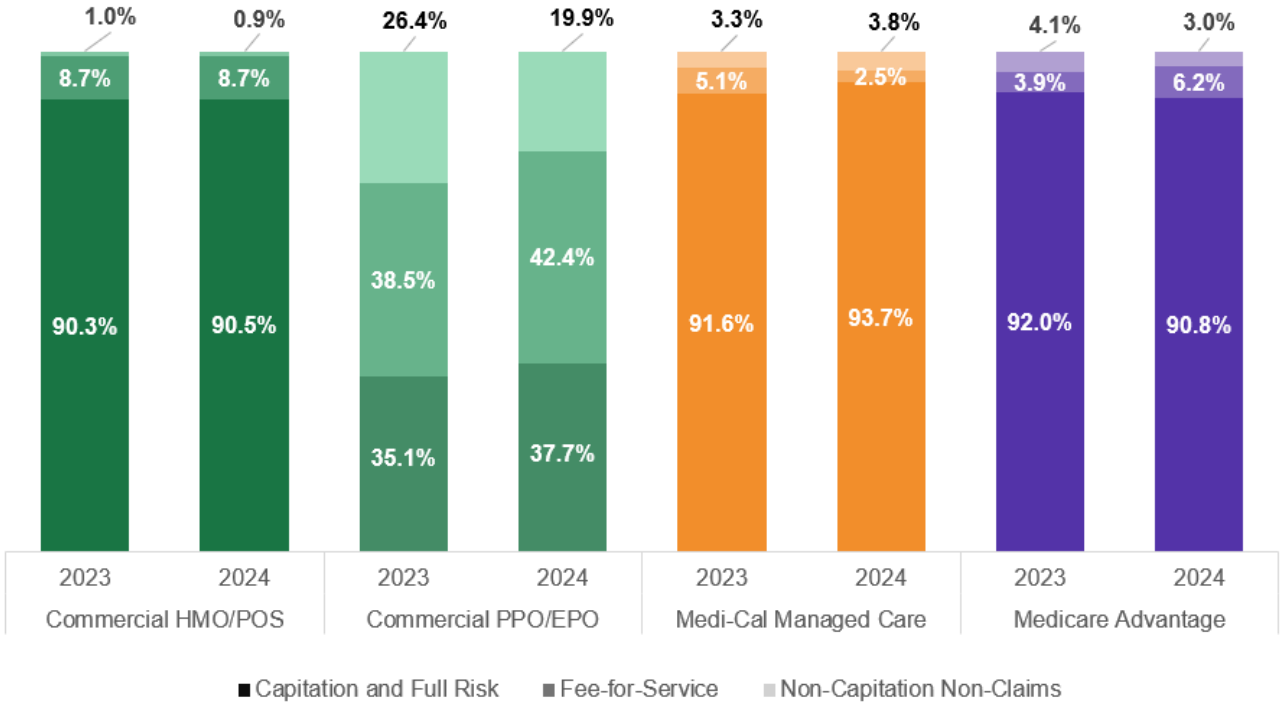


Figure 12 shows the percent of members statewide and by market and plan type that are attributed to providers eligible for quality-linked payments and in capitation and full risk or shared savings and shared risk arrangements that count toward the OHCA APM adoption goals. Compared with **Figure 11**, **Figure 12** shows the subset of members attributed to payment arrangements with quality-linked payments that count toward the OHCA APM adoption goals. Increasing the use of quality-linked payments in payer and provider contracting is needed to progress toward the OHCA APM adoption goals.

In the Commercial HMO/POS market, the percent of members in payment arrangements that count toward the OHCA APM adoption goals was 81.4% in 2023 and 2024.

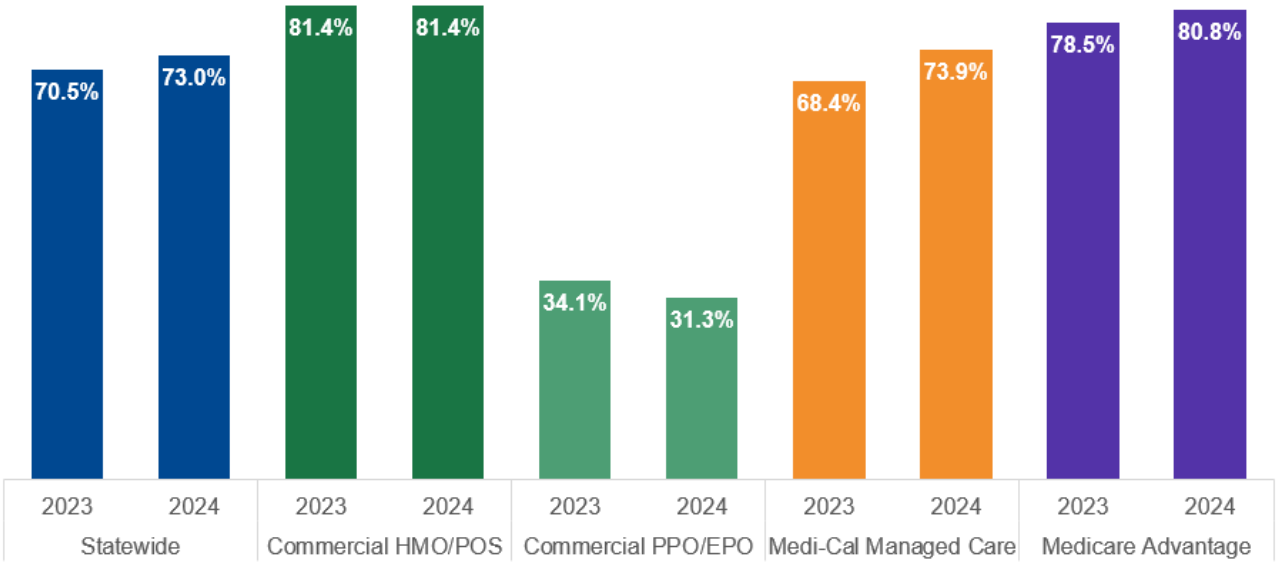
In the Commercial PPO/EPO market, the percent of members that count toward the OHCA APM adoption goals was 34.1% in 2023 and 31.3% in 2024, a decrease of 2.8 percentage points.

APM adoption in the Medi-Cal Managed Care market grew more than other markets from 2023 to 2024. In Medi-Cal Managed Care, the percent of members that count toward the OHCA APM adoption goals was 68.4% in 2023 and 73.9% in 2024, an increase of 5.5 percentage points.

In Medicare Advantage, the percent of members that count toward the OHCA APM adoption goals was 78.5% in 2023 and 80.8% in 2024, an increase of 2.3 percentage points.

Statewide, the percent of members that count toward OHCA APM adoption goals was 70.5% in 2023 and 73.0% in 2024, an increase of 2.5 percentage points.

Figure 12. Percent of Members Attributed to APMs with Quality-Linked Payments Statewide and by Market and Plan Type, 2023-2024



Note: *APMs are defined as capitation/full risk or shared savings/risk payment models linked to quality performance.*

APM Adoption by Payer

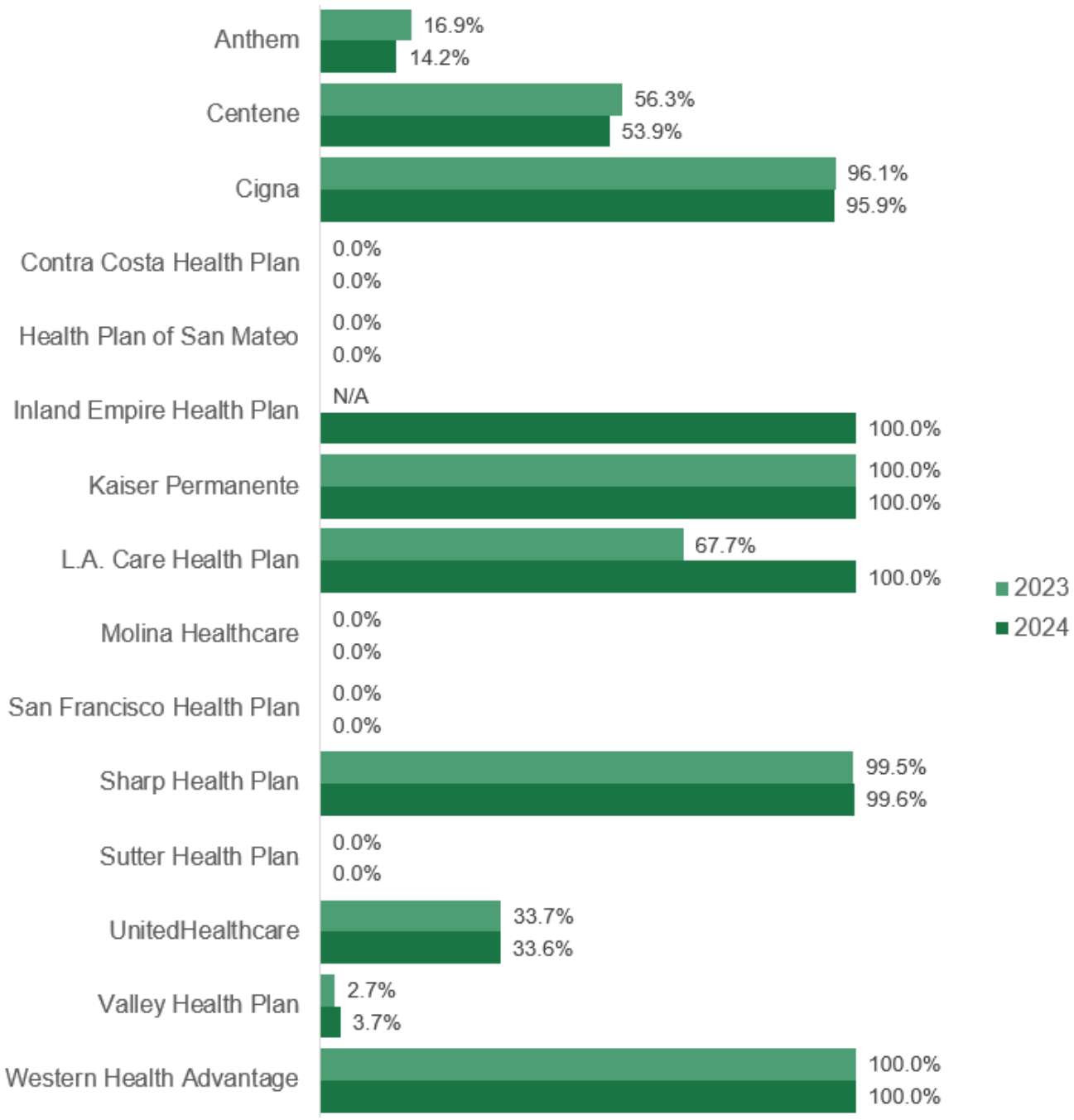
This section presents APM adoption in 2023 and 2024, and changes in adoption between those two years, by payer in the Commercial HMO/POS, Commercial PPO/EPO, Medi-Cal Managed Care, and Medicare Advantage markets.

Commercial HMO/POS

As shown in **Figure 13**, in 2024, the percent of a payer's members attributed to payment arrangements that count toward the OHCA APM adoption goals ranged from 0% to 100% in the Commercial HMO/POS market, with five payers reporting 0% APM adoption. L.A. Care Health Plan and Valley Health Plan showed an increase of members in quality-linked payment arrangements from 2023 to 2024, while Anthem and Centene showed a decrease, meaning the percent of members attributed to quality-linked payment arrangements increased or decreased by at least one percentage point from 2023 to 2024. Ten

payers remained stable from 2023 to 2024, meaning a change of less than one percentage point from 2023 to 2024.

Figure 13. Commercial HMO/POS Members Attributed to APMs with Quality-Linked Payments, 2023-2024

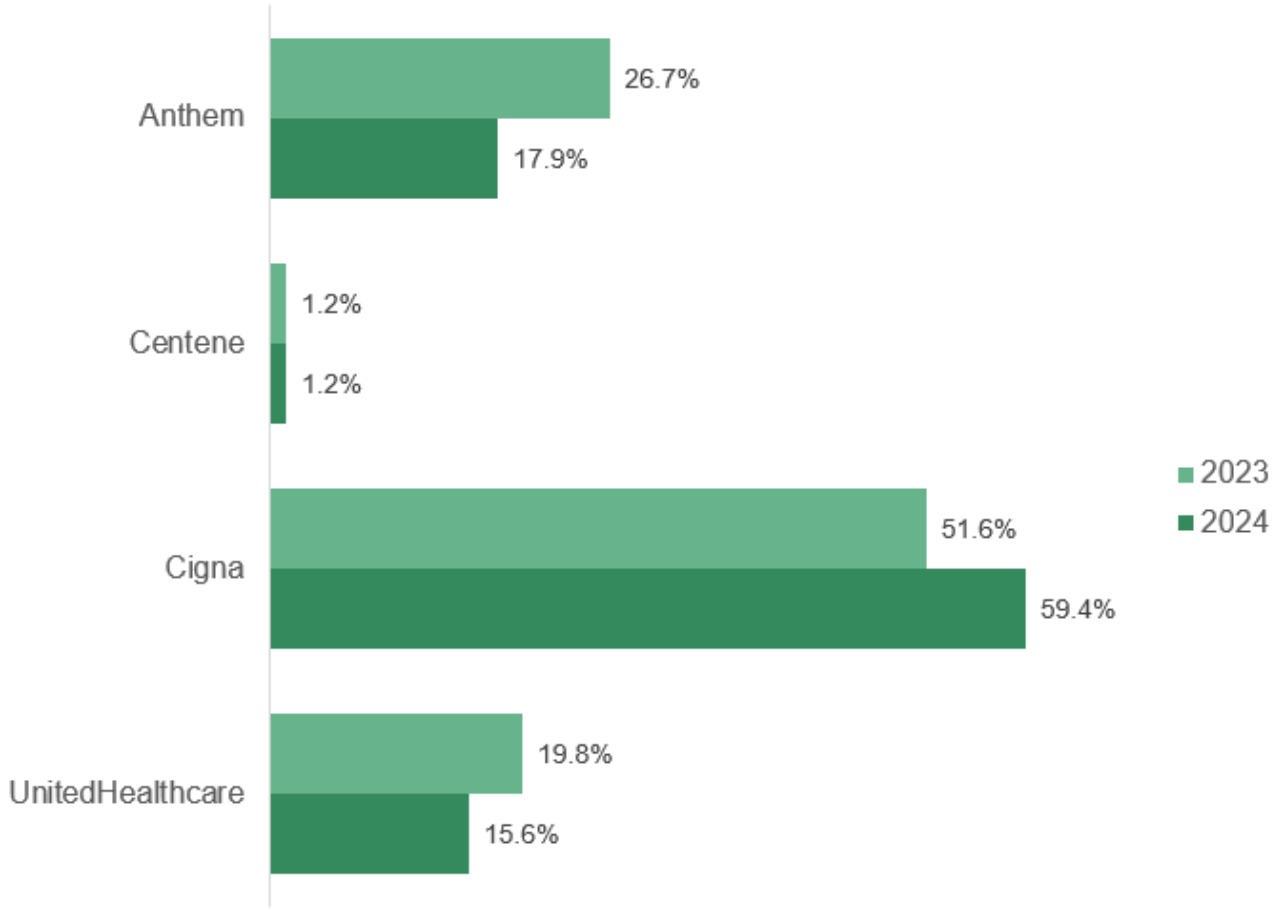


***Note:** APMs are defined as capitation/full risk or shared savings/risk payment models linked to quality performance.*

Commercial PPO/EPO

As shown in **Figure 14**, in 2024, the percent of a payer's members attributed to payment arrangements that count toward the OHCA APM adoption goals ranged from 1.2% to 59.4% in the Commercial PPO/EPO market. Cigna showed an increase of members in quality-linked payment arrangements from 2023 to 2024, while Anthem and United Healthcare showed decreases, and Centene remained stable.

Figure 14. Commercial PPO/EPO Members Attributed to APMs with Quality-Linked Payments, 2023-2024

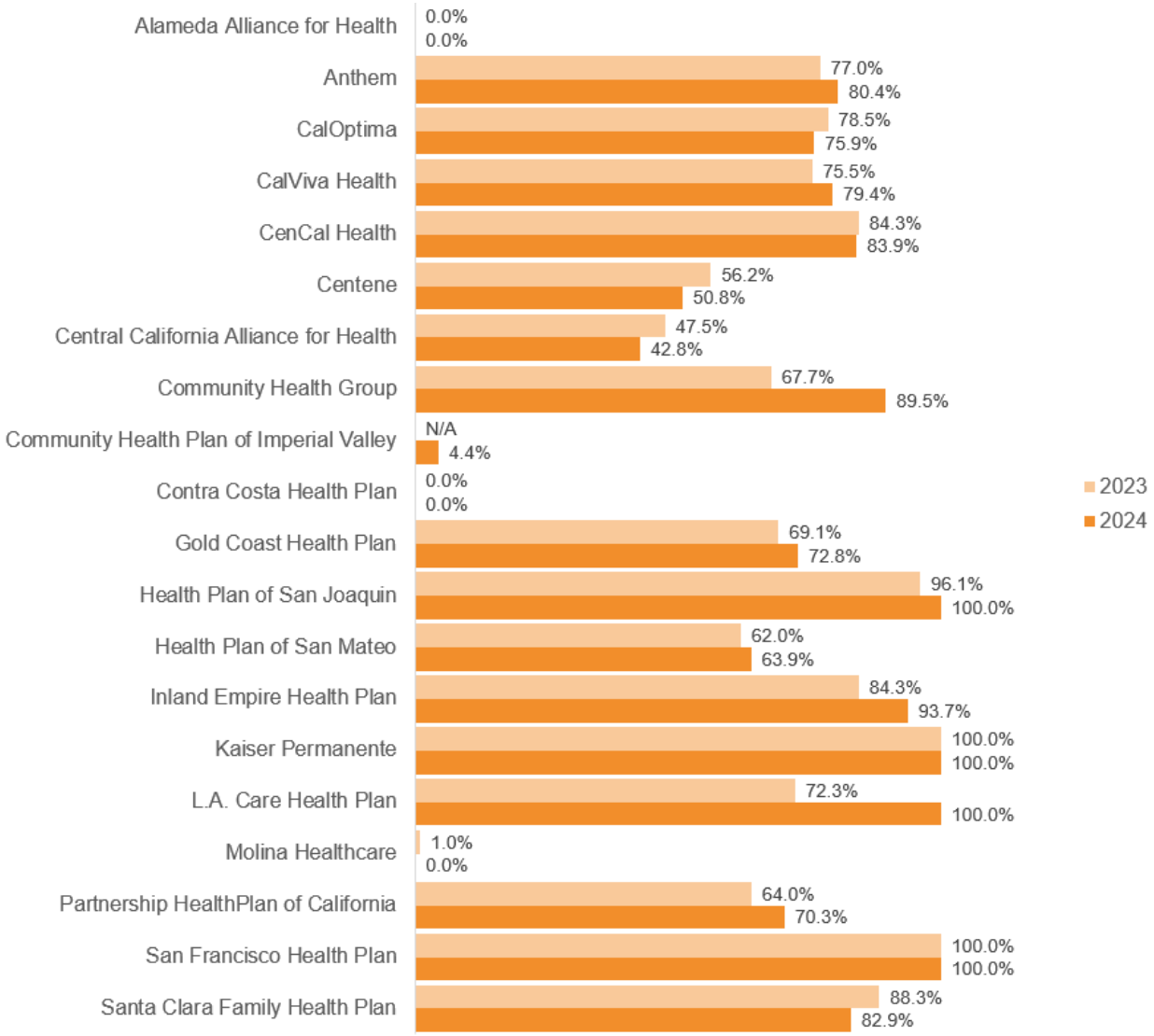


Note: *APMs are defined as capitation/full risk or shared savings/risk payment models linked to quality performance. Sharp Health Plan and Kaiser Permanente Commercial PPO/EPO plans are not included due to low volume of members. See Appendix A.1 Exclusions for numbers of members excluded.*

Medi-Cal Managed Care

As shown in **Figure 15**, in 2024, the percent of a payer's members attributed to payment arrangements that count toward the OHCA APM adoption goals ranged from 0% to 100% in the Medi-Cal Managed Care market, with three payers reporting 0% APM adoption. Nine payers showed an increase of members in quality-linked arrangements from 2023 to 2024, while five payers, CalOptima, Centene, Central California Alliance for Health, Molina Healthcare, and Santa Clara Family Health Plan, showed decreases. Five payers, Alameda Alliance for Health, CenCal Health, Contra Costa Health Plan, Kaiser Permanente, and San Francisco Health Plan, remained stable from 2023 to 2024.

Figure 15. Medi-Cal Managed Care Members Attributed to APMs with Quality-Linked Payments, 2023-2024

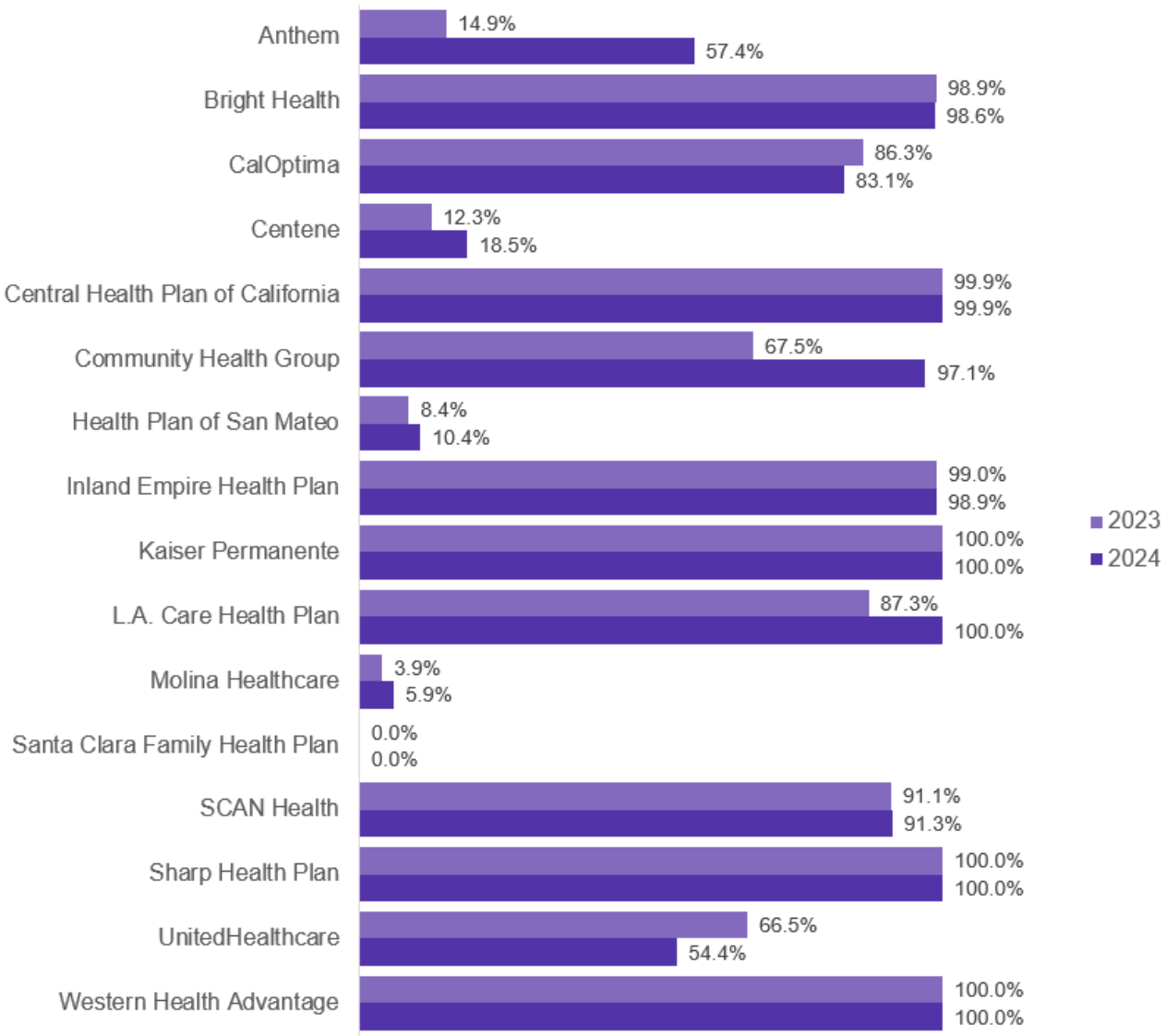


***Note:** APMs are defined as capitation/full risk or shared savings/risk payment models linked to quality performance.*

Medicare Advantage

As shown in **Figure 16**, in 2024, the percent of a payer's members attributed to payment arrangements that count toward the OHCA APM adoption goals ranged from 0% to 100% in the Medicare Advantage market, with one payer reporting 0% adoption. Six payers, Anthem, Centene, Community Health Group, Health Plan of San Mateo, L.A. Care Health Plan, and Molina Healthcare, showed an increase of members in quality-linked payment arrangements from 2023 to 2024, while two payers, CalOptima and UnitedHealthcare, showed decreases. Eight payers remained stable from 2023 to 2024.

Figure 16. Medicare Advantage Members Attributed to APMs with Quality-Linked Payments, 2023-2024



***Note:** APMs are defined as capitation/full risk or shared savings/risk payment models linked to quality performance.*

Section 5. Primary Care Spending 2023-2024

In October 2024, the Health Care Affordability Board approved two related primary care investment benchmarks:

1. **Annual improvement benchmark**: 0.5 percentage points to 1 percentage point per year increase in primary care spending as a percent of total medical expense (TME) for each payer for performance years 2025 through 2033. This benchmark applies to each payer by market and plan type (*i.e.*, Commercial HMO/POS, Commercial PPO/EPO, Medicare Advantage, and Medi-Cal); and
2. **Statewide investment benchmark**: 15 percent of TME allocated to primary care for all payers by performance year 2034. The statewide investment benchmark applies across all payers, markets, and plan types.

These complementary primary care investment benchmarks promote sustained systemwide investment in primary care while addressing historic underinvestment in primary care.[29]

Primary care spending, the numerator for the benchmark, is measured as spending on primary care services as a percent of TME, the denominator of the benchmark. Primary care spending includes both claims and non-claims payments.

For the Commercial and Medicare Advantage markets, TME includes retail pharmacy spending (gross of rebates). For the Medi-Cal Managed Care market, TME does not include retail pharmacy spending which is paid directly by the Department of Health Care Services through Medi-Cal Rx. As such, caution should be taken when comparing trends across the three markets.

This section of the report presents a baseline view of primary care spending in calendar years 2023 and 2024. As previously mentioned, primary care spending data for Alignment Health was excluded from reporting due to data validation concerns.

See Appendix A.3 Data Sources and Appendix A.4 APM and Primary Care Methodologies and Key Measures for additional details on the primary care spending measurement methodology.

[29] OHCA Primary Care Investment Benchmark, December 2024: https://hcai.ca.gov/wp-content/uploads/2024/12/Board-Approved-Primary-Care-Investment-Benchmark-Memo.pdf.

Statewide Primary Care Spending by Market and Plan Type

As shown in **Figure 17**, statewide primary care spending was $10.1 billion in 2023 and $11.3 billion in 2024, an increase of $1.2 billion or 12.0%.

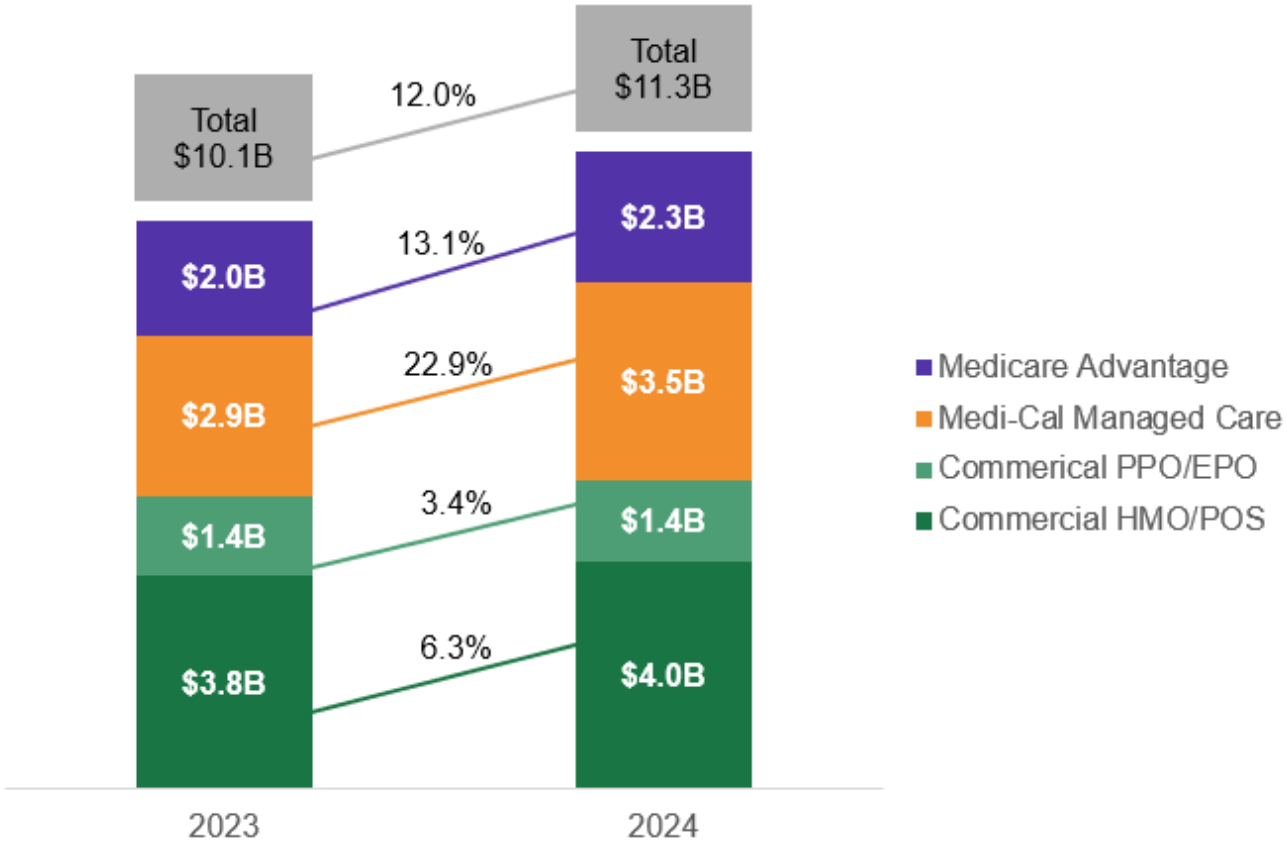
Commercial HMO/POS primary care spending was $3.8 billion in 2023 and $4.0 billion in 2024, an increase of $0.2 billion or 6.3%. Commercial HMO/POS primary care spending decreased from 37.7% of statewide primary care spending in 2023 to 35.7% in 2024, which were the largest shares across all markets in both years.

Commercial PPO/EPO primary care spending was approximately $1.4 billion in both 2023 and 2024, an increase of $46.7 million or 3.4%. Commercial PPO/EPO primary care spending decreased from 13.8% of statewide primary care spending in 2023 to 12.7% in 2024.

Medi-Cal Managed Care primary care spending grew more than other markets from 2023 to 2024. Medi-Cal Managed Care primary care spending was $2.9 billion in 2023 and $3.5 billion in 2024, an increase of $0.7 billion or 22.9%. Medi-Cal Managed Care primary care spending increased from 28.5% of statewide primary care spending in 2023 to 31.2% in 2024.

Medicare Advantage primary care spending was $2.0 billion in 2023 and $2.3 billion in 2024, an increase of $0.3 billion or 13.1%. Medicare Advantage primary care spending increased from 20.1% of statewide primary care spending in 2023 to 20.3% in 2024.

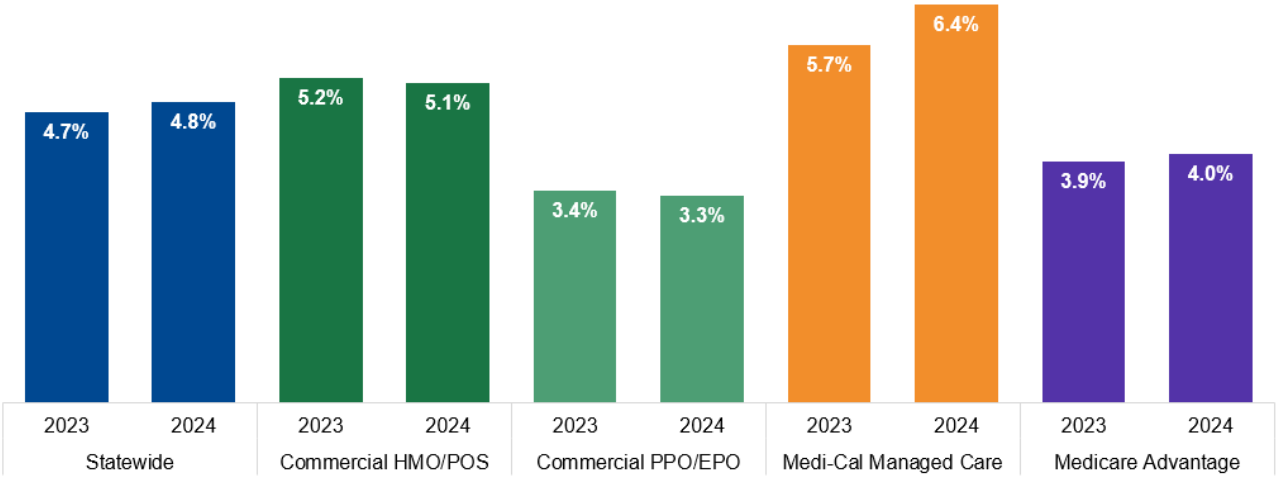
Figure 17. Statewide Total Primary Care Spending in Billions and Primary Care Spending Growth by Market and Plan Type, 2023-2024



As shown in **Figure 18**, statewide primary care spending as a percent of TME was 4.7% in 2023 and 4.8% in 2024.

Commercial HMO/POS primary care spending as a percent of TME was 5.2% in 2023 and 5.1% in 2024. Commercial PPO/EPO primary care spending as a percent of TME was 3.4% in 2023 and 3.3% in 2024. Medi-Cal Managed Care primary care spending as a percent of TME was 5.7% in 2023 and 6.4% in 2024. Medicare Advantage primary care spending as a percent of TME in 2023 was 3.9% and 4.0% in 2024.

Figure 18. Primary Care Spending as Percent of Total Medical Expense, Statewide and by Market and Plan Type, 2023-2024



Note: *Medi-Cal Managed Care covered benefits do not align with those in other markets, making cross-market comparisons of primary care spending as a percent of TME unreliable. Specifically, Medi-Cal Managed Care TME does not include retail pharmacy spending. OHCA's measurement applied a set of specific inclusion and exclusion criteria, described in Appendix A.5 Context for Medi-Cal Data, for payments reported by Medi-Cal Managed Care Plans.*

In contrast to the variable year-over-year trends when primary care spending was measured as a percent of TME, when measured as an absolute amount spent per member per year (PMPY), primary care spending increased between 2023 and 2024 in every market. **Figure 19** shows that statewide primary care spending on a PMPY basis was $298 in 2023 and $341 in 2024, an increase of $43 or 14.4%.

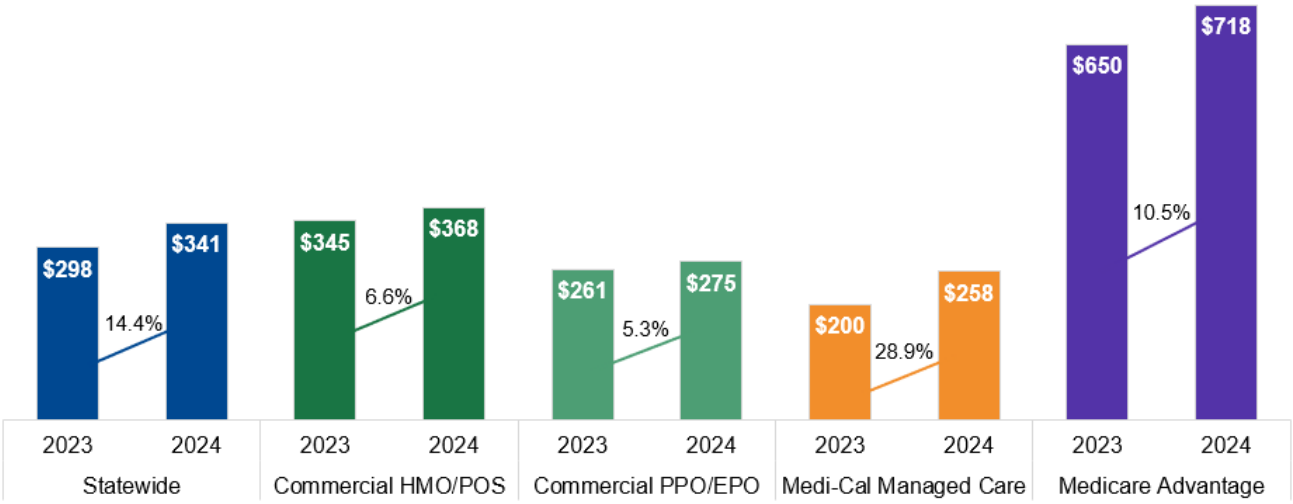
Commercial HMO/POS primary care spending on a PMPY basis was $345 in 2023 and $368 in 2024, an increase of $23 or 6.6%. Commercial PPO/EPO primary care spending on a PMPY basis was $261 in 2023 and $275 in 2024, an increase of $14 or 5.4%.

Medi-Cal Managed Care primary care spending on a PMPY basis was $200 in 2023 and $258 in 2024, an increase of $58 or 28.9%. Statewide policy changes, including

implementation of Medi-Cal Targeted Provider Rate Increases, likely contributed to the observed growth in Medi-Cal Managed Care primary care spending.[30]

Medicare Advantage primary care spending on a PMPY basis was $650 in 2023 and $718 in 2024, an increase of $68 or 10.5%.

Figure 19. Primary Care Spending Per Member, Per Year, Statewide and by Market and Plan Type, 2023-2024



Primary Care Spending by Payment Category

This section shows primary care spending by claims and non-claims payment categories. In this section, primary care spending paid through a specific payment category, such as FFS, is the numerator and all primary care spending serves as the denominator. This differs from calculations of primary care spending as a percent of TME. In those calculations, the numerator includes all primary care spending and the denominator includes all medical spending.

As shown in **Figure 20**, statewide primary care spending via capitation and full risk payments was $7.2 billion in 2023 and $8.0 billion in 2024, an increase of $0.8 billion or 11.6%. Statewide primary care spending via FFS was $2.6 billion in 2023 and $3.0 billion in 2024, an increase of $0.3 billion or 12.5%. Statewide primary care spending via non-capitation non-claims payments including population health and practice infrastructure payments, performance payments, and shared savings and shared risk payments was $0.2 billion in 2023 and $0.3 billion in 2024, an increase of $46.2 million or 20.4%.

[30] Medi-Cal Targeted Provider Rate Increases: https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx

Figure 20. Statewide Primary Care Spending by Payment Category, 2023-2024

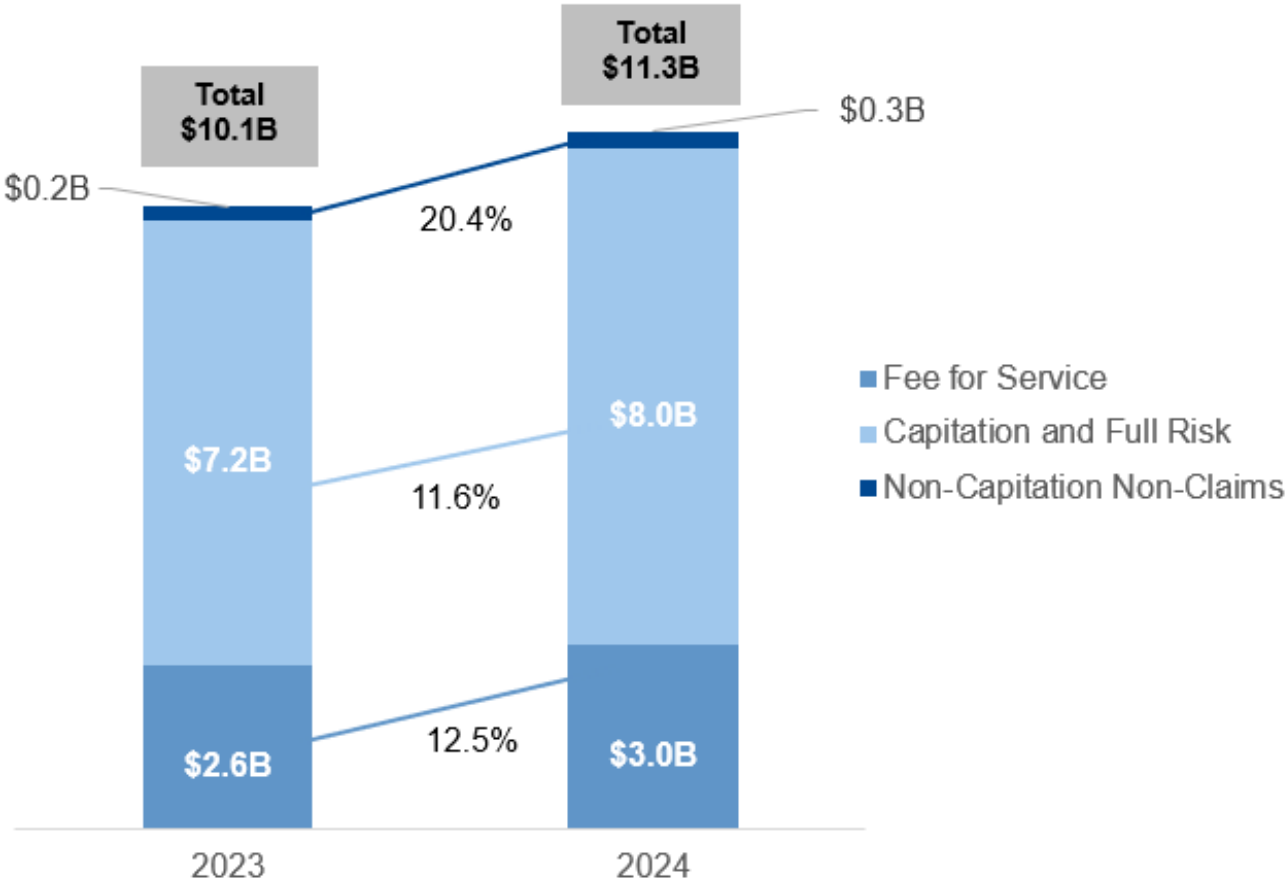


Figure 21 shows the percent of total primary care spending within each payment category statewide and in each market. Statewide primary care spending via capitation and full risk payments was 71.4% of total primary care spending in 2023 and 71.2% in 2024. Primary care spending via FFS was 26.3% of total primary care spending in 2023 and 26.4% in 2024. Primary care spending via non-capitation non-claims payments was 2.3% of total primary care spending in 2023 and 2.4% in 2024.

In the Commercial HMO/POS market, primary care spending via capitation and full risk payments was 84.4% of total primary care spending in 2023 and 83.4% in 2024. Primary care spending via FFS was 15.0% of total primary care spending in 2023 and 15.7% in 2024. Primary care spending via non-capitation non-claims payments was 0.6% of total primary care spending in 2023 and 0.9% in 2024.

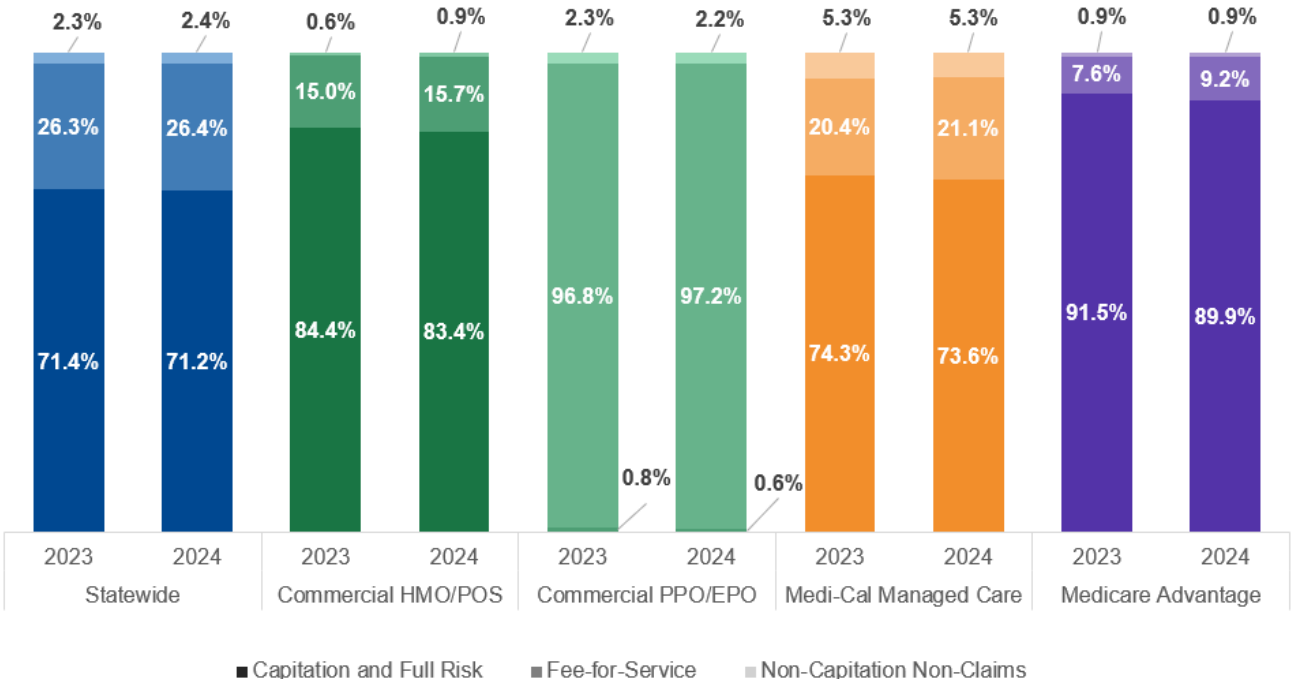
Primary care spending in the Commercial PPO/EPO market differed substantially from the Commercial HMO/POS market. In the Commercial PPO/EPO market, primary care spending via capitation and full risk payments was 0.8% of total primary care spending in

2023 and 0.6% in 2024. Primary care spending via FFS was 96.8% of total primary care spending in 2023 and 97.2% in 2024. Primary care spending via non-capitation non-claims was 2.3% of total primary care spending in 2023 and 2.2% in 2024.

In the Medi-Cal Managed Care market, primary care spending via capitation and full risk payments was 74.3% of total primary care spending in 2023 and 73.6% in 2024. Primary care spending via FFS was 20.4% of total primary care spending in 2023 and 21.1% in 2024. Primary care spending via non-capitation non-claims was 5.3% of total primary care spending in both 2023 and 2024.

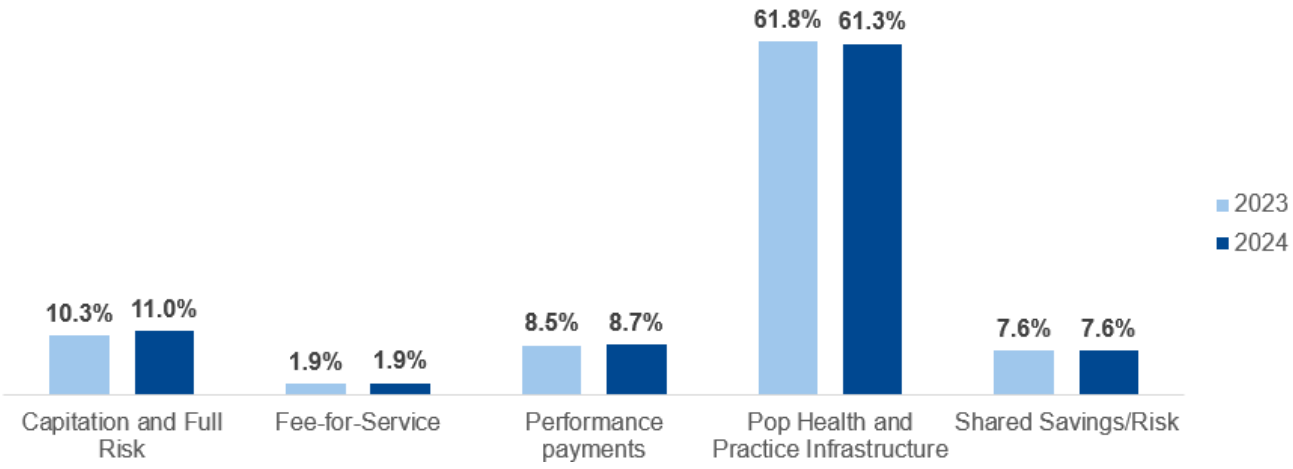
In the Medicare Advantage market, primary care spending via capitation and full risk payments was 91.5% of total primary care spending in 2023 and 89.9% in 2024. Primary care spending via FFS was 7.6% of total primary care spending in 2023 and 9.2% in 2024. Primary care spending via non-capitation non-claims payments was 0.9% of total primary care spending in both 2023 and 2024.

Figure 21. Primary Care Spending by Payment Category, Statewide and by Market and Plan Type, 2023-2024



Across the state, some payment categories, such as population health and infrastructure payments, are more likely to be focused on primary care than others. **Figure 22** shows that the portion of each payment category allocated to primary care differed substantially. The share of capitation and full risk payments allocated to primary care was 10.3% of total capitation and full risk payments in 2023 and 11.0% in 2024. The share of FFS payments allocated to primary care was 1.9% of total FFS payments in both 2023 and 2024. The share of performance payments allocated to primary care was 8.5% of total performance payments in 2023 and 8.7% in 2024. The share of population health and practice infrastructure payments allocated to primary care was 61.8% of total population health and practice infrastructure payments in 2023 and 61.3% in 2024. The share of shared savings and shared risk payments allocated to primary care was 7.6% of total shared savings and shared risk payments in both 2023 and 2024.

Figure 22. Percent of Payment Category Allocated to Primary Care Statewide, 2023-2024



Primary Care Spending by Payer

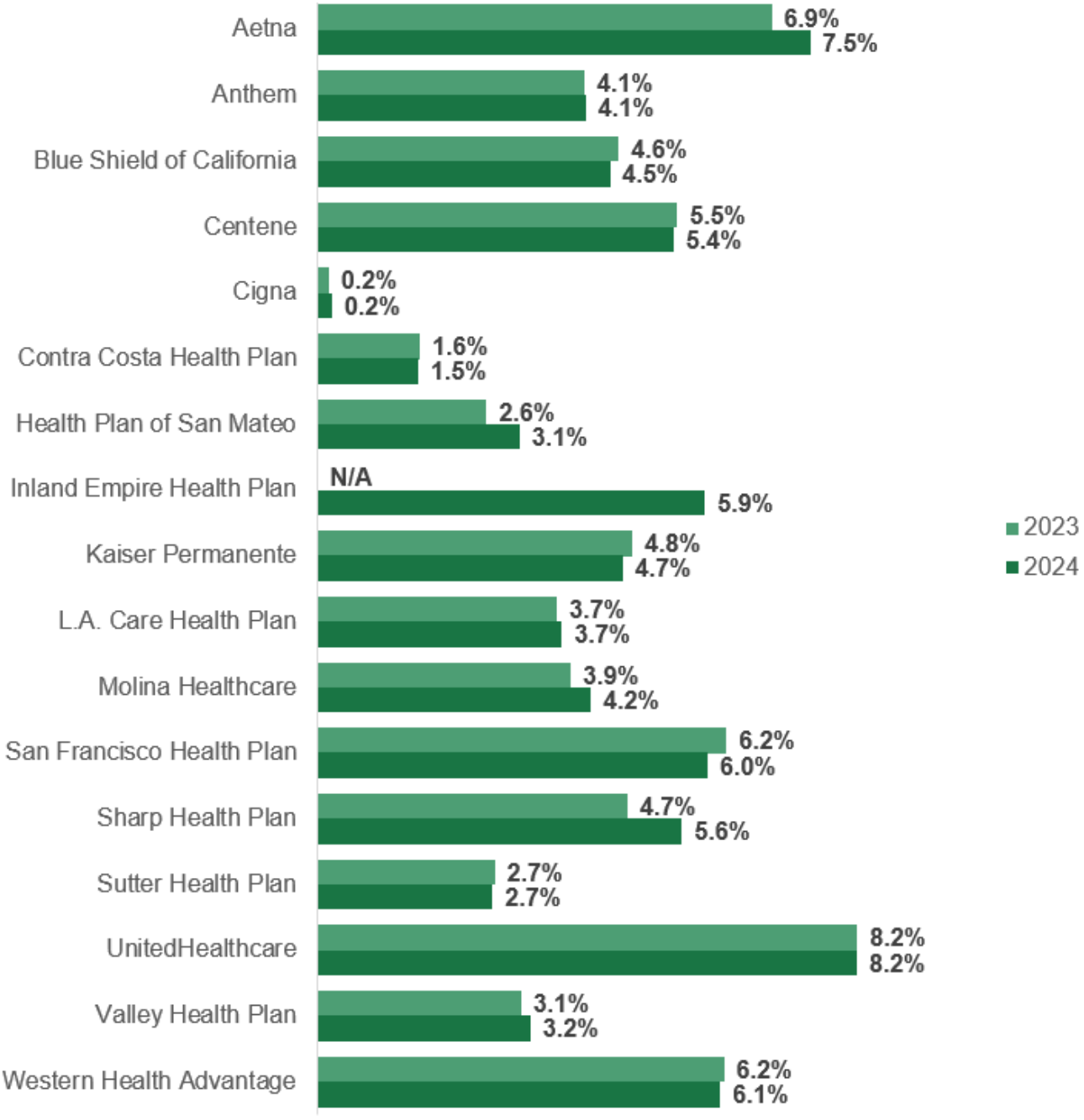
This section presents primary care spending in 2023 and 2024, and changes in spending between those two years, by payer in the Commercial HMO/POS, Commercial PPO/EPO, Medi-Cal Managed Care, and Medicare Advantage markets.

Commercial HMO/POS

As shown in **Figure 23**, primary care spending as a percent of TME by payer in the Commercial HMO/POS market ranged from 0.2% to 8.2% in 2024. Six payers, Aetna, Health Plan of San Mateo, L.A. Care Health Plan, Molina Healthcare, Sharp Health Plan, and Valley Health Plan, increased their primary care spending as a percent of TME between 2023 and 2024, while five payers, Blue Shield of California, Centene, Kaiser Permanente, San Francisco Health Plan, and Western Health Advantage, decreased primary care

spending as a percent of TME. Six payers, Anthem, Cigna, Contra Costa Health Plan, Sutter Health Plan, and UnitedHealthcare, changed by less than 0.1 percentage points in primary care spending as a percent of TME.

Figure 23. Commercial HMO/POS Primary Care Spending as a Percent of TME, 2023-2024



Note: *N/A indicates that a payer did not have a plan for this market category in a given reporting year.*

Table 3 shows the change in primary care spending as a percent of TME and as PMPY from 2023 to 2024 for the Commercial HMO/POS market. Change in primary care spending as a percent of TME varied by payer from a decrease of 0.3 percentage points to an increase of 0.8 percentage points. Across the Commercial HMO/POS market, primary care spending as a percent of TME decreased by 0.1 percentage points from 2023 to 2024.

Fifteen of seventeen Commercial HMO/POS payers increased primary care spending on a PMPY basis between 2023 and 2024, whereas only six payers increased primary care spending as a percent of TME. This indicates that while primary care spending on a PMPY basis increased for more payers, the growth in TME outpaced the growth in primary care spending for many payers, resulting in fewer payers with growth in primary care spending as a percent of TME.

Table 3. Commercial HMO/POS Primary Care Spending as Percent of TME and as PMPY, 2023-2024 shown

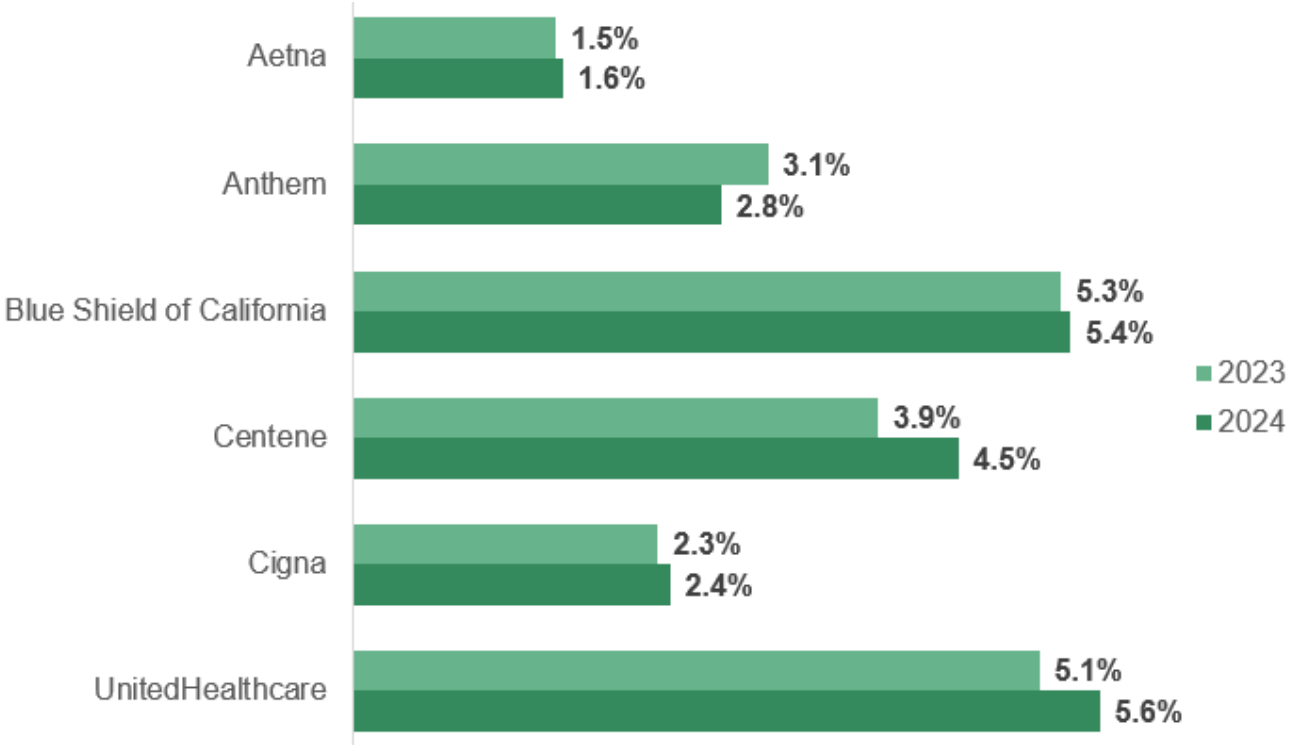
Payers	Percent of Total Medical Expense			PMPY		
	2023	2024	Percentage Point Change 2023-2024	2023	2024	PMPY Change 2023-2024
Statewide Commercial HMO/POS	5.2%	5.1%	-0.1%	$345	$368	$23
Aetna	6.9%	7.5%	0.6%	$448	$499	$51
Anthem	4.1%	4.1%	0.0%	$236	$249	$13
Blue Shield of California	4.6%	4.5%	-0.1%	$348	$370	$23
Centene	5.5%	5.4%	-0.1%	$407	$413	$6
Cigna	0.2%	0.2%	0.0%	$12	$16	$4
Contra Costa Health Plan	1.6%	1.5%	0.0%	$159	$173	$14
Health Plan of San Mateo	2.6%	3.1%	0.5%	$150	$203	$53
Inland Empire Health Plan	N/A	5.9%	N/A	N/A	$252	N/A
Kaiser Permanente	4.8%	4.7%	-0.1%	$308	$326	$18
L.A. Care Health Plan	3.7%	3.7%	0.1%	$131	$138	$6
Molina Healthcare	3.9%	4.2%	0.3%	$190	$225	$35
San Francisco Health Plan	6.2%	6.0%	-0.3%	$425	$419	-$6
Sharp Health Plan	4.7%	5.6%	0.8%	$293	$361	$69
Sutter Health Plan	2.7%	2.7%	0.0%	$196	$210	$14
UnitedHealthcare	8.2%	8.2%	0.0%	$656	$718	$62
Valley Health Plan	3.1%	3.2%	0.1%	$249	$295	$47
Western Health Advantage	6.2%	6.1%	-0.1%	$435	$466	$31

Note: *N/A indicates that a payer did not have a plan for this market category in a given reporting year.*

Commercial PPO/EPO

As shown in **Figure 24**, primary care spending as a percent of TME by payer in the Commercial PPO/EPO market ranged from 1.6% to 5.6% in 2024. Five payers, Aetna, Blue Shield of California, Centene, Cigna, and UnitedHealthcare, increased their primary care spending as a percent of TME between 2023 and 2024, while Anthem decreased their primary care spending as a percent of TME.

Figure 24. Commercial PPO/EPO Primary Care Spending as a Percent of TME, 2023-2024



Note: *Sharp Health Plan and Kaiser Permanente Commercial PPO/EPO plans are not included due to low volume of members. See Appendix A.1 Exclusions for numbers of members excluded.*

Table 4 shows the change in primary care spending as a percent of TME and as PMPY from 2023 to 2024 for the Commercial PPO/EPO market. Change in primary care spending as a percent of TME varied by payer from a decrease of 0.3 percentage points to an increase of 0.6 percentage points. Across the Commercial PPO/EPO market, primary care spending as a percent of TME decreased by 0.1 percentage points from 2023 to 2024.

Five out of six Commercial PPO/EPO payers increased their primary care spending on a PMPY basis between 2023 and 2024, whereas the same five payers also increased their

primary care spending as a percent of TME. This indicates that in these five payers, the increase in primary care spending on a PMPY basis outpaced the growth in TME, resulting in higher primary care spending as a percent of TME.

Table 4. Commercial PPO/EPO Primary Care Spending as Percent of TME and as PMPY, 2023-2024

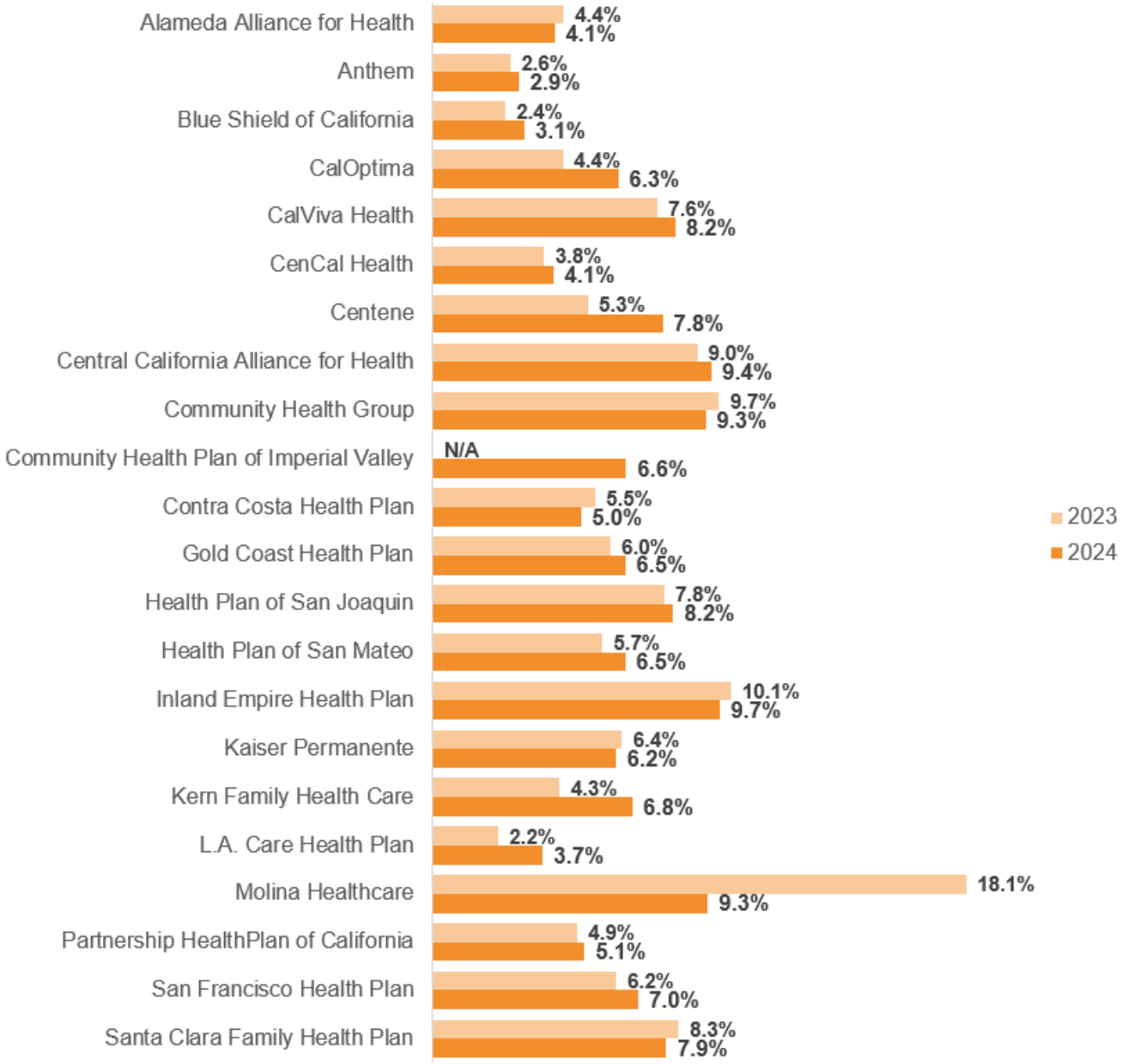
Payers	Percent of Total Medical Expense			PMPY		
	2023	2024	Percentage Point Change 2023-2024	2023	2024	PMPY Change 2023-2024
Statewide Commercial PPO/EPO	3.4%	3.3%	-0.1%	$261	$275	$14
Aetna	1.5%	1.6%	0.1%	$127	$144	$17
Anthem	3.1%	2.8%	-0.3%	$229	$221	-$8
Blue Shield of California	5.3%	5.4%	0.1%	$498	$544	$46
Centene	3.9%	4.5%	0.6%	$341	$397	$56
Cigna	2.3%	2.4%	0.1%	$113	$126	$12
UnitedHealthcare	5.1%	5.6%	0.4%	$370	$434	$65

Medi-Cal Managed Care

As shown in **Figure 25**, primary care spending as a percent of TME by payer in the Medi-Cal Managed Care market ranged from 2.9% to 9.7% in 2024. Fourteen payers increased their primary care spending as a percent of TME between 2023 and 2024, while seven payers decreased their primary care spending as a percent of TME.

Note that TME submitted to OHCA by Medi-Cal Managed Care Plans does not include pharmacy spending. Therefore, the denominator used when calculating percent of primary care spending does not include pharmacy spending. This smaller denominator will result in the same primary care spending on a PMPY basis appearing as higher primary care spending as a percent of TME. See Appendix A.5 Context for Medi-Cal Data for more information on Medi-Cal Managed Care Plan spending measurement.

Figure 25. Medi-Cal Managed Care Primary Care Spending as a Percent of TME, 2023-2024



Note: *Molina Healthcare reported an increase and change in membership population served, along with provider network composition changes which impacted the primary care spending as a percent of TME in the Medi-Cal Managed Care market between 2023 and 2024.*

Table 5 shows the change in primary care spending as a percent of TME and as PMPY from 2023 to 2024 for the Medi-Cal Managed Care market. Change in primary care spending as a percent of TME varied by payer from a decrease of 8.8 percentage points to an increase of 2.5 percentage points. Across the Medi-Cal Managed Care market, primary care spending as a percent of TME increased by 0.8 percentage points from 2023 to 2024.

Twenty out of twenty-two Medi-Cal Managed Care payers increased primary care spending on a PMPY basis between 2023 and 2024, whereas only fourteen payers increased primary care spending as a percent of TME. This indicates that while primary care spending on a PMPY basis increased for more payers, the growth in TME outpaced the growth in primary care spending for several payers, resulting in fewer payers with growth in primary care spending as a percent of TME.

Table 5. Medi-Cal Managed Care Primary Care Spending as Percent of TME and as PMPY, 2023-2024

Payers	Percent of Total Medical Expense			PMPY		
	2023	2024	Percentage Point Change 2023-2024	2023	2024	PMPY Change 2023-2024
Statewide Medi-Cal Managed Care	5.7%	6.4%	0.7%	$200	$258	$58
Alameda Alliance for Health	4.4%	4.1%	-0.3%	$172	$194	$23
Anthem	2.6%	2.9%	0.3%	$93	$111	$18
Blue Shield of California	2.4%	3.1%	0.6%	$144	$195	$51
CalOptima	4.4%	6.3%	1.9%	$163	$262	$99
CalViva Health	7.6%	8.2%	0.6%	$220	$264	$44
CenCal Health	3.8%	4.1%	0.3%	$124	$155	$31
Centene	5.3%	7.8%	2.5%	$208	$336	$128
Central California Alliance for Health	9.0%	9.4%	0.5%	$290	$354	$64
Community Health Group	9.7%	9.3%	-0.5%	$281	$318	$37
Community Health Plan of Imperial Valley	N/A	6.6%	N/A	N/A	$176	N/A
Contra Costa Health Plan	5.5%	5.0%	-0.5%	$198	$211	$14
Gold Coast Health Plan	6.0%	6.5%	0.5%	$186	$220	$33
Health Plan of San Joaquin	7.8%	8.2%	0.3%	$156	$224	$67
Health Plan of San Mateo	5.7%	6.5%	0.8%	$211	$251	$39
Inland Empire Health Plan	10.1%	9.7%	-0.4%	$338	$417	$79
Kaiser Permanente	6.4%	6.2%	-0.2%	$291	$328	$38
Kern Family Health Care	4.3%	6.8%	2.5%	$114	$231	$118
L.A. Care Health Plan	2.2%	3.7%	1.5%	$71	$139	$68
Molina Healthcare	18.1%	9.3%	-8.8%	$428	$261	-$167
Partnership HealthPlan of California	4.9%	5.1%	0.3%	$186	$211	$25
San Francisco Health Plan	6.2%	7.0%	0.7%	$333	$427	$94
Santa Clara Family Health Plan	8.3%	7.9%	-0.4%	$296	$326	$29.74

Medicare Advantage

As shown in **Figure 26**, primary care spending as a percent of TME by payer in the Medicare Advantage market ranged from 0.6% to 12.2%. Eleven payers increased their primary care spending as a percent of TME between 2023 and 2024, while six payers, Aetna, Bright Health, Community Health Group, Inland Empire Health Plan, L.A. Care Health Plan, and Santa Clara Family Health Plan, decreased their primary care spending as a percent of TME, and Anthem changed by less than 0.1 percentage points in primary care spending as a percent of TME.

Figure 26. Medicare Advantage Primary Care Spending as a Percent of TME, 2023-2024

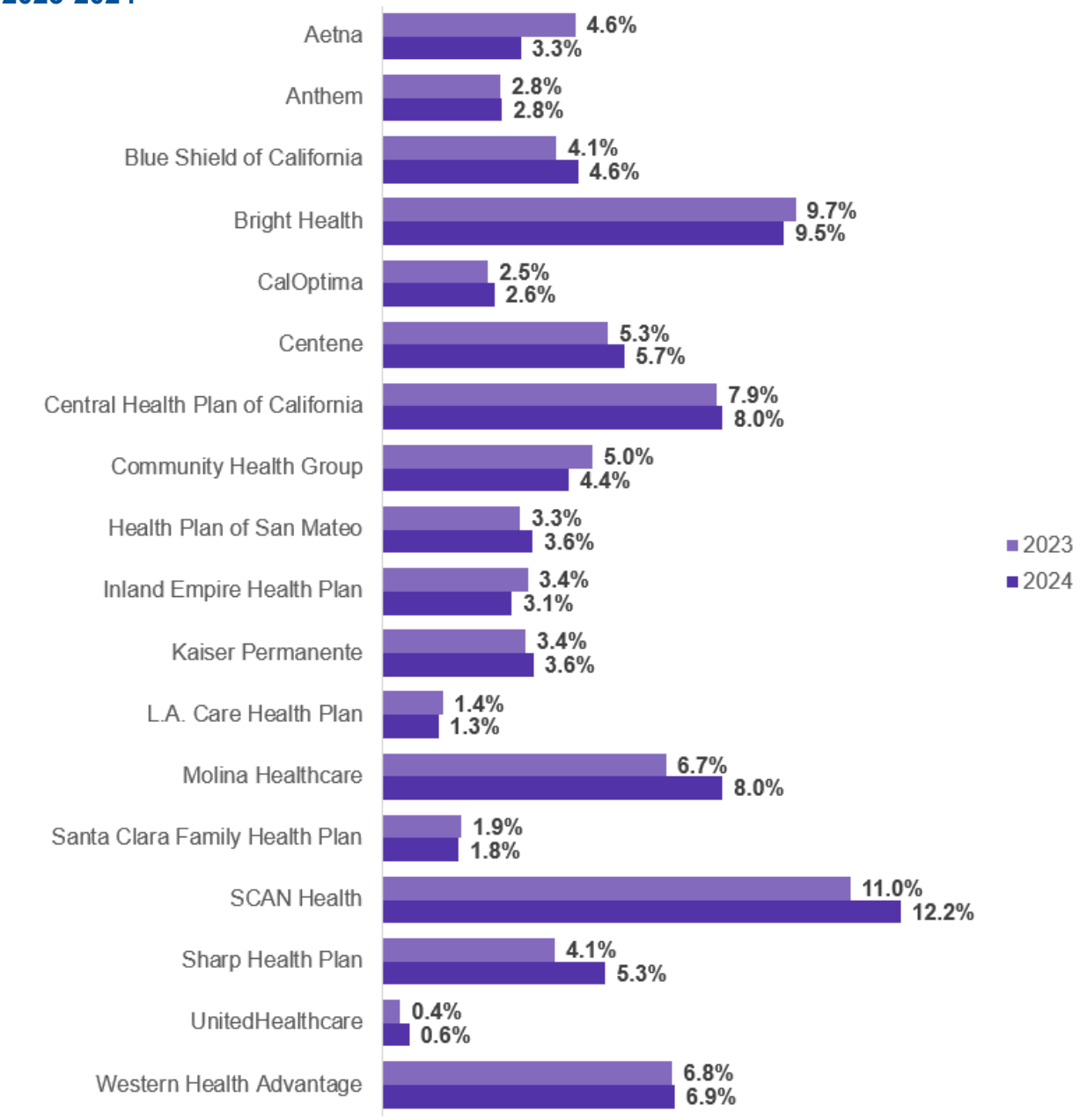


Table 6 shows the change in primary care spending as a percent of TME and as PMPY from 2023 to 2024 for the Medicare Advantage market. Change in primary care spending as a percent of TME varied by payer from a decrease of 1.3 percentage points to an increase of 1.3 percentage points. Across the Medicare Advantage market, primary care spending as a percent of TME increased by 0.1 percentage points from 2023 to 2024.

Thirteen out of eighteen Medicare Advantage payers increased their primary care spending on a PMPY basis between 2023 and 2024, whereas only eleven payers increased their primary care spending as a percent of TME. This indicates that while primary care spending on a PMPY basis increased for more payers, the growth in TME outpaced the growth in primary care spending for several payers, resulting in fewer payers with growth in primary care spending as a percent of TME.

Table 6. Medicare Advantage Primary Care Spending as Percent of TME and as PMPY, 2023-2024

Payers	Percent of Total Medical Expense			PMPY		
	2023	2024	Percentage Point Change 2023-2024	2023	2024	PMPY Change 2023-2024
Statewide Medicare Advantage	3.9%	4.0%	0.1%	$650	$718	$68
Aetna	4.6%	3.3%	-1.3%	$925	$728	-$197
Anthem	2.8%	2.8%	0.0%	$513	$549	$36
Blue Shield of California	4.1%	4.6%	0.5%	$667	$776	$109
Bright Health	9.7%	9.5%	-0.3%	$2,131	$2,058	-$73
CalOptima	2.5%	2.6%	0.1%	$520	$585	$66
Centene	5.3%	5.7%	0.4%	$894	$946	$52
Central Health Plan of California	7.9%	8.0%	0.1%	$1,246	$1,230	-$16
Community Health Group	5.0%	4.4%	-0.6%	$1,336	$1,320	-$16
Health Plan of San Mateo	3.3%	3.6%	0.3%	$1,081	$1,253	$172
Inland Empire Health Plan	3.4%	3.1%	-0.4%	$956	$929	-$27
Kaiser Permanente	3.4%	3.6%	0.2%	$506	$586	$80
L.A. Care Health Plan	1.4%	1.3%	-0.1%	$307	$315	$7
Molina Healthcare	6.7%	8.0%	1.3%	$1,159	$1,656	$497
Santa Clara Family Health Plan	1.9%	1.8%	-0.1%	$403	$421	$18
SCAN Health	11.0%	12.2%	1.2%	$1,834	$2,198	$364
Sharp Health Plan	4.1%	5.3%	1.2%	$508	$686	$178
UnitedHealthcare	0.4%	0.6%	0.2%	$80	$122	$42
Western Health Advantage	6.8%	6.9%	0.1%	$663	$734	$71

Section 6. Additional Work to Promote High Value System Performance

In addition to monitoring progress toward APM adoption goals and primary care investment benchmarks, OHCA's work to promote high value health system performance includes monitoring health care quality and equity, behavioral health investment, and workforce stability. Beginning in 2027, OHCA will report performance of health care entities in these areas. Additionally, as part of its work to identify best practices for slowing health care spending growth while improving access, quality, and equity of care, OHCA works with health care entities to highlight examples of cost-reducing strategies. This section describes OHCA's work to date and upcoming reporting in these areas.

Quality and Equity Performance

OHCA will use its Quality and Equity Measure Set, adopted in April 2025, to report performance and evaluate health care quality and equity across various health care entities. OHCA adopted all measures, or a subset of measures, from three publicly available measure sets and their stratification requirements that were developed through intensive multi-stakeholder processes.[31] Each measure set is tailored to a specific health care entity type: payer, physician organization, or hospital. Fully integrated delivery systems will be measured across all three measure sets. Combined, these measure sets make up the OHCA Quality and Equity Measure Set.[32] Adopting the OHCA Quality and Equity Measure Set is a starting point. OHCA is required by statute to regularly review and update its measure set. OHCA will continue to work with sibling state departments, stakeholders, and other partners to evolve the measure set, collaboratively address limitations, and strengthen quality and equity analyses.

In 2027, OHCA will publish the first report with health care entities' performance on the OHCA Quality and Equity Measure Set. OHCA will continue to publish annual quality and equity performance reports thereafter. OHCA will also explore including additional equity analyses in future reports such as analyses on population health measures by other state departments, data from California-specific reports, data from social drivers of health indices, and data from national reports to provide additional context for interpreting and understanding performance on the OHCA Quality and Equity Measure Set.

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[31] For payers, OHCA adopted the full Department of Managed Health Care's Health Equity and Quality Measure Set and stratification requirements. For physician organizations, OHCA adopted a subset of the Office of the Patient Advocate's Health Care Quality Report Card measures. For hospitals, OHCA adopted the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements.

[32] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/quality-and-equity-performance/

Behavioral Health

Informed by extensive stakeholder engagement in 2024 and 2025, OHCA established a methodology for measuring behavioral health spending as a percent of total medical expense in spring 2026. OHCA will begin collecting behavioral health spending data from Commercial, Medicare Advantage, and Medi-Cal Managed Care payers in the fall of 2026 for calendar years 2024 and 2025. In 2025, OHCA and the Health Care Affordability Board decided to delay setting a behavioral health investment benchmark until further analysis of existing behavioral health data could provide a clearer picture of current levels and categories of spending.

The behavioral health spending definition and measurement methodology outlines how to identify, allocate, and categorize behavioral health spending for claims and non-claims payments.[33] Behavioral health spending data is expected to be reported in 2027. OHCA will also continue working with the Investment and Payment Workgroup, Health Care Affordability Advisory Committee, and the Health Care Affordability Board to explore options for a behavioral health investment benchmark in 2026. Additionally, OHCA will continue ongoing work with the Department of Health Care Services to develop a measurement methodology for Medi-Cal behavioral health spending occurring outside of Managed Care Plans (*e.g.*, through Medi-Cal FFS and county-administered behavioral health services) and to identify Medi-Cal-specific considerations related to setting a behavioral health investment benchmark.

Workforce Stability

OHCA is charged with monitoring the effects of spending targets on healthcare workforce stability, high quality jobs, and training needs of healthcare workers, with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care. In June 2024, with input from the Health Care Affordability Board, OHCA adopted its Workforce Stability Standards.[34] These standards define a set of six best practices that health care entities should adopt to ensure health care workforce stability in the context of spending targets.

OHCA will monitor the effects of spending targets on the healthcare workforce using its Workforce Stability Metrics and will analyze additional state and national data sources to complement these metrics.[35] Data sources OHCA is considering for 2027 reporting include the Employment Development Department Worker Adjustment and Retraining Notification (EDD WARN) notices, California Division of Occupational Safety and Health (Cal/OSHA) violation data, HCAI's Hospital Annual Financial Disclosure Reports (HAFDR), and the U.S. Census American Community Survey (ACS). These data sources

[33] See Data Submission Guide version 3.0 section 4.10: https://hcai.ca.gov/wp-content/uploads/2026/04/THCE-Data-Submission-Guide-v3.0.pdf

[34] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/workforce-stability/

[35] https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/workforce-stability/

track economic factors such as wages and contract labor use, workforce disruptions, and workplace conditions that impact workforce stability in California's health care sector. OHCA will engage stakeholders in 2026 for feedback on chosen data sources, metrics, and preliminary findings. In 2027, OHCA will begin reporting summarized findings from its workforce monitoring and will continue reporting annually thereafter.

Cost-Reducing Strategies

OHCA works with payers, hospitals, physician organizations, and other health care entities to identify cost-reducing strategies that lower spending while maintaining or improving quality of care.[36] OHCA solicits scalable strategies with measurable outcomes for presentation to the Health Care Affordability Board and the Health Care Affordability Advisory Committee. Strategies presented to the Board and Advisory Committee to date include: the use of appropriate sites of care; care management for complex patients; expanded use of virtual home care; implementation of shared administrative services across health systems; use of advanced primary care models; improving hiring, training, and organizational culture to reduce healthcare worker turnover; and population health management programs supported by capitation payments.

By compiling and disseminating successes, OHCA aims to provide resources that enable health care entities across the state to learn from peers. Presentations from the health care entities highlight how targeted interventions can improve access, quality, equity of care, and support progress toward statewide spending targets.

[36] https://hcai.ca.gov/affordability/ohca/cost-reducing-strategies/

Section 7. Conclusion

Rising health care costs are a substantial access barrier and place significant financial strain on consumers, employers, and the state and federal government, but increased spending is not consistently associated with improved health outcomes. OHCA's efforts to increase primary care investment, expand the use of APMs, invest in high value behavioral health care, and track quality, equity, and workforce stability work together with spending targets to create a more affordable, accessible, high quality, and equitable health system.

Statewide APM adoption increased from 70.5% in 2023 to 73.0% in 2024. Across markets and plan types, APM adoption ranged from 34.1% to 81.4% in 2023 and from 31.3% to 81.4% in 2024. Statewide primary care spending as a percent of total medical expense also increased from 4.7% in 2023 to 4.8% in 2024. Primary care spending ranged from 3.4% to 5.7% in 2023 and from 3.3% to 6.4% in 2024 across markets and plan types. In both 2023 and 2024, primary care spending and APM adoption also varied across payers within each market. Despite the majority of members in California being attributed to some type of capitation or full risk arrangement, most medical expense across the state is paid through fee-for-service.

This report establishes a baseline for primary care spending and APM adoption in California for calendar years 2023 and 2024. In future reports, OHCA will report on performance against APM adoption goals and primary care investment benchmarks and provide additional context on how these trends relate to overall health care spending.

Consistent measurement of progress toward statewide benchmarks for primary care investment and goals for APM adoption are critical to transforming California's health care landscape. These efforts have the potential to drive down health care spending and enable a sustainable future where every Californian receives affordable, high quality, and equitable care.

Appendix A. Methods and Data Sources

A.1 Exclusions

OHCA's measurement of APM adoption and primary care spending exclude the following:

- Spending in the Commercial - Other market category, as enrollment and spending in this category represented less than 1% of the Commercial market.[37]
- Expenditures from non-accountable payers. These are payers with fewer than 40,000 covered lives in any market (*i.e.*, Commercial, Medicare Advantage, or Medi-Cal Managed Care).
- Medicare Fee-for-Service (FFS) (Traditional Medicare) payments.
- Consumer payments for non-covered health care services (*e.g.*, self-pay for California residents without health coverage and self-pay for services and providers not covered by a health plan or insurer).
- Risk transfer payments among small and individual group plans within the fully insured commercial market.
- Reinsurance recoveries.
- Medicare Advantage Risk Adjustment Data Validation payments.
- Medicare supplemental insurance.
- Medi-Cal spending other than spending by Managed Care Plans (*e.g.*, Medi-Cal FFS, Medi-Cal Rx).
- Certain DHCS Medi-Cal specific payments for Medi-Cal Managed Care Plans. Refer to Appendix A.5 Context for Medi-Cal Data for details on Medi-Cal inclusions and exclusions.
- A portion of commercial self-insured spending and enrollment, due to incomplete reporting.
- Other spending through state and federal programs such as California Correctional Health Care Services (CCHCS), Indian Health Service (IHS), and Veterans Health Administration (VHA).

[37] Payers in the Commercial - Other market category do not fit descriptions of health maintenance organization (HMO), point of service (POS), preferred provider organization (PPO), or exclusive provider organization (EPO). The Commercial - Other market category represented 0.6% of members in the Commercial market in 2023 and 2024, and 0.3% of all members statewide. The Commercial - Other market category represented 0.2% of TME in the Commercial market in 2023, and 0.1% in 2024. The Commercial - Other market contributed 0.1% to TME statewide for both years.

Payer-specific data exclusions:

- Aetna, Blue Shield of California, and Kern Family Health Care's APM adoption data have been excluded from this report due to ongoing data validation concerns which OHCA is working with these payers to resolve. All markets and plan types for these payers have been excluded. The number of excluded members and percent of respective markets are as follows:
    - Aetna (statewide 1.3 million members in 2023, 1.4 million members in 2024):
        - Commercial HMO/POS market: 253,000 members (2.3% of the market) in 2023 and 273,000 members (2.5% of the market) in 2024.
        - Commercial PPO/EPO market: 950,000 members (18.2% of the market) in 2023 and 953,000 members (18.6% of the market) in 2024.
        - Medicare Advantage market: 91,000 members (2.8% of the market) in 2023 and 135,000 members (4.0% of the market) in 2024.
    - Blue Shield of California (statewide 2.2 million members in 2023, 2.1 million members in 2024):
        - Commercial HMO/POS market: 536,000 members (4.9% of the market) in 2023 and 531,000 members (4.8% of the market) in 2024.
        - Commercial PPO/EPO market: 1.4 million members (26% of the market) in 2023 and 1.3 million members (25% of the market) in 2024.
        - Medi-Cal Managed Care market: 128,000 members (0.9% of the market) in 2023 and 172,000 members (1.3% of the market).
        - Medicare Advantage market: 190,000 members (5.9% of the market) in 2023 and 168,000 members (5.0% of the market).
    - Kern Family Health Care (Medi-Cal Managed Care market only): 350,000 members (2.5% of the market) in 2023 and 405,000 members (3.0% of the market) in 2024.
- Alignment Health's APM adoption and primary care spending data have been excluded from this report due to ongoing data validation concerns which OHCA is working with Alignment Health to resolve. Alignment Health operates in the Medicare Advantage market only. The number of excluded members and percent of the market were: 105,000 members (3.2% of the market) in 2023 and 158,000 members (4.7% of the market) in 2024.
- Kaiser Permanente and Sharp Health Plan have been excluded from Commercial PPO/EPO payer-level reporting, due to low enrollment in PPO plans for those payers, but their spending is included in Commercial PPO/EPO market-level reporting.

- Kaiser Permanente: 1,600 members (less than 0.1% of the market) in 2023 and 1,400 members (less than 0.1% of the market) in 2024.
- Sharp Health Plan: 20 members (less than 0.1% of the market) in 2024.

A.2 Data Validation

To help payers prepare data for the first year of reporting APM adoption and primary care spending, OHCA held five data submitter workgroup meetings and conducted twenty voluntary technical assistance sessions prior to the September 1, 2025 data submission deadline. Payers submitted APM adoption data in an APM file and primary care spending data in a primary care file. OHCA developed a data validation process with automated within-file and manual cross-file validation checks that rejected files with invalid data or triggered a discussion with the payer if data failed programmed checks. After files passed all validations, OHCA conducted manual reasonableness checks of submitted data, based on alignment with industry norms for contracting and spending. OHCA communicated with payers through email exchanges and additional voluntary technical assistance sessions if payers' files were rejected, failed reasonableness checks, or if OHCA had questions or concerns about the validity of the data. Payers also communicated with OHCA if they had questions about the APM and primary care measurement methodologies. OHCA allowed payers to resubmit their data when necessary.

Once payers' files were fully validated, OHCA reviewed each payer's summary data during a preview meeting, allowing payers to confirm accuracy of the data to be reported and raise any additional questions or concerns. If payers noted discrepancies between OHCA's reported values and their own calculations, OHCA allowed opportunities for resubmission when agreed upon. OHCA's extensive data validation process is designed to ensure data accuracy and completeness to the extent possible.

OHCA recognizes that with this inaugural cycle of data collection and reporting for APM adoption and primary care spending, there may have been varying levels of understanding of the methodologies and technical specifications among payers. For example, OHCA's APM adoption methodology requires payers to designate payments as "linked to quality" or "not linked to quality." Several payers indicated to OHCA that the instructions for determining a link to quality were unclear, which may be reflected in the 2023-2024 APM adoption results included in this report. Instructions for determining which payments are "linked to quality" have been updated for clarity in the Data Submission Guide (DSG) 3.0.[38]

[38] Data Submission Guide (Version 3.0), dated April 2026.

A.3 Data Sources

Commercial, Medicare Advantage, and Medi-Cal Managed Care payers and fully integrated delivery systems (FIDS) directly submitted data on the total number of member months of coverage, member attribution to payment arrangements, claims and non-claims payments, payments for primary care services, and total medical expense (TME) to OHCA via OHCA's data submission process.

Payers submitted APM adoption data in an APM file and primary care spending data in a primary care file through the Total Health Care Expenditures (THCE) data portal. Mandatory submitters are those with at least 40,000 members in either the Commercial, Medicare Advantage, or Medi-Cal Managed Care markets. This report includes data submitted for 33 payers across the Commercial, Medicare Advantage, and Medi-Cal Managed Care markets.

A.4 APM and Primary Care Methodologies and Key Measures

APM Definition and Measurement Methodology

OHCA's APM adoption goals were developed with extensive stakeholder input in 2023 and 2024 to promote a shift from FFS payments to APMs and better align financial incentives for equitable, high quality, and cost-efficient care. The goals are based on the percentage of members attributed to payment models that include shared savings, shared risk, capitation, or full risk arrangements to promote accountability for all members, aligning with population health principles. APM adoption is measured as the percentage of members attributed to payment models that include shared savings, shared risk, capitation, or full risk arrangements tied to quality performance which are the payment models that count toward OHCA's APM adoption goals. These models fall under the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework Categories 3A, 3B, 4A, 4B, and 4C and include financial accountability for cost and quality outcomes.

Payers submit data on non-claims payments using HCAI's Expanded Non-Claims Payments Framework (Expanded Framework).[39] The payment categories in the Expanded Framework correspond to the HCP-LAN categories.

Payers attribute members to the highest applicable payment category on a continuum of clinical and financial risk, with capitation and full risk payment arrangements being the highest risk and FFS the lowest, as specified in Data Submission Guide (DSG) 2.0

[39] California Department of Health Care Access and Information. Expanded Non-Claims Payments Framework. https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

(Section 4.8 and Appendix B).[40] A member attributed to capitation and full risk arrangements may still receive some care paid through FFS claims.

For a member to count toward the OHCA APM adoption goals, at least some payments made to any provider on a member's behalf – whether through performance payments, shared savings or shared risk, capitation or full risk arrangements – must be eligible to be adjusted based on the provider's performance on predetermined quality benchmarks. This link to quality depends on whether the payment model allows for adjustments based on quality benchmarks, not whether a quality incentive was paid. For example, if a member is attributed to a provider eligible for a performance payment and is attributed to a provider with a capitation arrangement that is not adjusted based on quality performance, then that member is considered linked to quality. Payers report the member's total medical expense in the applicable payment category and whether the member is attributed to a payment arrangement linked to quality.

Limitations of APM Measurement

The following limitations should be considered when interpreting the APM data in this report:

Member attribution to payment arrangements is limited to one category. The APM file attributes each member to only one payment arrangement, to facilitate assessment against the APM adoption goals. For this reason, OHCA's data collection does not provide insight into how many payment arrangements a member is included in or the proportion of their total spend in each of those arrangements.

Differences in understanding of link to quality. As mentioned in the data validation section, OHCA received feedback that guidance on determining a member's link to quality was unclear in DSG 2.0. OHCA understands this led some payers to interpret that a link to quality should be reported only when a performance payment was made, and not merely when a provider was eligible for a performance payment for predefined quality benchmarks. DSG 3.0 instructions have been updated for the next data collection cycle to better clarify when to report a quality link. Although OHCA provided technical assistance during the data collection cycle to avoid incorrect data submission, this report may understate the number of members attributed to capitation and full risk or shared savings and shared risk categories that have quality-linked payments.

Primary Care Definition and Measurement Methodology

OHCA's primary care definition and measurement methodology were developed, with extensive stakeholder input in 2023 and 2024, to align measurement with a vision of primary care as person- and family-centered, relationship-based, accessible, comprehensive,

[40] Data Submission Guide (Version 2.0), dated April 2025.

team-based, integrated, coordinated and equitable.[41] Primary care spending is measured as spending on primary care services as a percent of TME and includes both claims and non-claims payments. In all markets other than Medi-Cal Managed Care, the TME denominator includes total pharmacy spending (gross of rebates). Because Medi-Cal pharmacy benefits are paid directly by the Department of Health Care Services, Medi-Cal Managed Care Plan data submissions do not include pharmacy spending.

FFS primary care spending is defined as services delivered by a primary care provider, in a primary care setting, and identified as primary care services, as specified in DSG 2.0 (Section 4.9 and Appendix E).[42] All three criteria must be met for spending to be included. Non-claims primary care spending includes portions of capitation and full risk payments, population health and practice infrastructure payments, performance payments, and shared savings and shared risk payments allocated to primary care by payers based on standardized methodologies outlined in DSG 2.0. These methodologies specify how to allocate some, all, or none of a given non-claims payment to primary care, using the Expanded Framework.[43]

Limitations of Primary Care Measurement

While OHCA's primary care spending measurement methodology represents a rigorous and comprehensive approach, several limitations should be considered when interpreting the data:

Non-claims primary care spending is estimated. This is particularly relevant for capitation and full risk payments, where encounter data are used as a proxy to determine the share of capitation attributable to primary care. While the allocation framework is structured and consistent, these estimates may not fully capture actual resource allocation to primary care.

Measurement of FFS spending on primary care relies on a structured definition of primary care. OHCA's definition of primary care spending specifies the primary care providers, primary care places of service, and primary care services to be included in measurement. As with any structured definition of primary care, universal agreement on all providers, services and places of service to be included is elusive.[44] OHCA has been responsive to stakeholder requests to add providers, places of service, and service codes to the definition that align with its vision for primary care. For example, OHCA added

[41] https://hcai.ca.gov/wp-content/uploads/2024/12/Board-Approved-Primary-Care-Investment-Benchmark-Memo.pdf
[42] Data Submission Guide (Version 2.0), dated April 2025.
[43] California Department of Health Care Access and Information. Expanded Non-Claims Payments Framework. https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/
[44] Agency for Healthcare Research and Quality, 2024. Technical Brief Number 44: Measuring Primary Healthcare Spending. https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/primary-healthcare-spending-tech-brief-edits.pdf

several codes for facilities where primary care services are delivered in DSG 3.0.[45] Additionally, since OHCA relies on a point-in-time network filing of credentialed primary care providers submitted to regulators, services delivered by primary care providers who left the network prior to the time of filing may be under-counted. OHCA discussed this approach extensively with stakeholders, who recognized this limitation but preferred this approach to ensure that services delivered by providers with primary care taxonomies but who do not actually practice primary care will not be counted.

Measurement of FFS spending on primary care relies on claims completeness. OHCA acknowledges that the completeness of fields on claims, for example completion of the rendering provider taxonomy field which is used to identify the provider as a primary care provider, will impact measurement.

Downstream distribution of payments is not visible. While the methodology captures what payers intend to be allocated to primary care, it cannot track how funds are distributed internally within physician organizations, limiting the ability to confirm if spending reaches frontline primary care providers.

A.5 Context for Medi-Cal Data

In collaboration with the California Department of Health Care Services (DHCS), and in response to questions from Medi-Cal Managed Care Plans about how to report certain Medi-Cal specific payments during the 2025 data submission cycle, OHCA sent a memo to Medi-Cal Managed Care Plans via email in June 2025 providing supplemental information for Medi-Cal Managed Care reporting, as shown in **Table 7**. The supplemental information aimed to encourage consistent and accurate reporting of specific Medi-Cal payments in the APM and primary care files and has been formalized in DSG 3.0 as the OHCA Medi-Cal Payments Addendum.[46] OHCA continues to work with DHCS and Medi-Cal Managed Care Plans to refine the inclusions and exclusions of specific Medi-Cal payments. These inclusions and exclusions, alongside differences in covered benefits (*e.g.*, long-term care, pharmacy spending), lead to primary care spending measurements that are not directly comparable between Medi-Cal Managed Care Plans and other markets.

Table 7 describes what categories of Medi-Cal specific payments Medi-Cal Managed Care Plans were encouraged to include or exclude in the primary care spending and the TME amount reported in both the APM and primary care files. Additionally, because Medi-Cal pharmacy benefits are paid directly by DHCS, Medi-Cal Managed Care Plan data submissions do not include pharmacy spending.

[45] Based on stakeholder feedback, UB-04 payments with facility type codes 71 (Clinic, Rural) and 77 (Freestanding Provider-Based FQHC) were added to DSG 3.0 in the primary care claims payments methodology. https://hcai.ca.gov/wp-content/uploads/2026/04/THCE-Data-Submission-Guide-v3.0.pdf

[46] OHCA Medi-Cal Payments Addendum, dated April 2026

Table 7. Supplemental Information for Medi-Cal Managed Care Plan Reporting to OHCA in 2023-2024 Primary Care and APM Data

Arrangement Type	Program Name	Include/ Exclude
Minimum Fee Schedule	Adverse Childhood Experiences (ACEs)	Include
Minimum Fee Schedule	Children and Youth Behavioral Health Initiative (CYBHI)	Include
Minimum Fee Schedule	Dental Managed Care Plans (DMC Plans) and Health Plan of San Mateo (HPSM) under the Dental Integration Pilot (DIP)	Include
Minimum-maximum Fee Schedule	Long-Term Care Fee-For-Service Equivalent Directed Payment	Include
Minimum-maximum Fee Schedule	Major Organ Transplant (MOT)	Include
Minimum Fee Schedule	Proposition 56 Abortion Services	Exclude
Minimum Fee Schedule	Targeted Rate Increases (excluding FQHC Parity)	Include
Other	California Children's Services (CCS)	Include
Other	Whole Child Model (WCM)	Include
Other	Community Supports (CS)	Exclude
Other	Community Reinvestment	Exclude
Other	Enhanced Care Management (ECM)	Exclude
Other	FQHC APM payments	Exclude
Other	FQHC Prospective Payment System (PPS) payments	Exclude
Other	Nonemergency medical transportation (NEMT)	Exclude
Other	Nonmedical transportation (NMT)	Exclude
Pass-Through Payment	Benioff Children's Hospital Oakland	Exclude
Pass-Through Payment	DMPH DP/NF	Exclude
Pass-Through Payment	DPH Distinct Part Nursing Facility (DP/NF)	Exclude
Pass-Through Payment	Hospital Quality Assurance Fee (HQAF)	Exclude

Arrangement Type	Program Name	Include/ Exclude
Pass-Through Payment	Martin Luther King Jr. (MLK) Community Hospital	Exclude
Uniform Dollar Increase	Children's Hospital Supplemental Payment (CHSP)	Exclude
Uniform Dollar or Percent Increase	Designated Public Hospital Enhanced Payment Program (EPP)	Exclude
Uniform Dollar Increase	Developmental Screening Services	Exclude
Uniform Dollar Increase	District and Municipal Public Hospital Directed Payment (DHDP)	Exclude
Uniform Dollar Increase	Equity and Practice Transformation (EPT)	Exclude
Uniform Dollar Increase	Non-Hospital 340B Community Clinic Directed Payment (CCDP)	Exclude
Uniform Dollar Increase	Private Hospital Directed Payment (PHDP)	Exclude
Uniform Dollar or Percent Increase	Proposition 56 Dental	Exclude
Uniform Dollar Increase	Proposition 56 Family Planning	Exclude
Uniform Dollar Increase	Proposition 56 Physician Services	Exclude
Uniform Dollar Increase	Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIP)	Exclude
Value-based Payment	Designated Public Hospital Quality Incentive Pool (DPH-QIP)	Exclude
Value-based Payment	District and Municipal Public Hospital Quality Incentive Pool (DMPH-QIP)	Exclude

Appendix B. Key Terms

Capitation: A way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of providing care for a specified set of services for a given patient over a defined period.

Capitation and Full Risk Payments: Per capita, non-claims payments paid to health care providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time.

Claim: A request for payment that a provider sends to a health plan or insurer.

Dual eligible special needs plans (D-SNPs): Medicare Advantage plans that provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid). D-SNPs must have a State Medicaid Agency Contract (SMAC) with DHCS and DHCS can choose whether to contract with D-SNPs.

Fee-for-service (FFS): A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Fully integrated delivery system (FIDS): 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.[47]

Health care entity: A payer, provider, or a fully integrated delivery system.[48]

Health equity: Is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (*e.g.*, sex, gender, ethnicity, disability, or sexual orientation).[49]

Health insurer: An entity licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.[50]

Health plan: A health care service plan or a specialized mental health care service plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). “Health plan”

[47] Health & Safety Code § 127500.2(h).
[48] Health & Safety Code § 127500.2(k).
[49] World Health Organization. (2026). *Health Equity*. Health Topics. https://www.who.int/health-topics/health-equity#tab=tab_1.
[50] 22 CCR 97445(g).

does not include a health care service plan that holds only a restricted or limited license under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations.[51]

Medi-Cal Managed Care Plan: Medi-Cal Managed Care Plans are HMOs which receive a set per member per month (capitation) payment to provide health services to Medi-Cal members through their network of providers.

Market: The highest levels of categorization of the health insurance market. For example, Medicare FFS and Medicare Advantage plans are collectively referred to as the "Medicare market." Medi-Cal Fee-for-Service and Medi-Cal Managed Care are collectively referred to as the "Medi-Cal market." Individual, self-insured, small and large group, and student health insurance plan types are collectively referred to as the "Commercial market."

Members: The number of people served by a given payer or market. Payers that submitted data through the Total Health Care Expenditures (THCE) data portal report member months, or the number of months each member is enrolled. Using this variable, the number of members is calculated as member months divided by 12.

Non-claims spending: Includes payments from payers to providers outside of claims for specific health care services. These include population health and practice infrastructure payments, performance payments, shared savings and shared risk payments, capitation and full risk payments, and other non-claims payments. For a list of all non-claims payment categories and subcategories, refer to the Expanded Non-Claims Payments Framework.[52]

Office or OHCA: The Office of Health Care Affordability (OHCA) established by Section 127501 of the Health and Safety Code.

Other Non-Claims Payments: Any other payments to a health care provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit.

Payer: A private or public health care payer, including the following:

(1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), or a Medi-Cal Managed Care Plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section

[51] 22 CCR 97445(h).

[52] California Department of Health Care Access and Information. Expanded Non-Claims Payments Framework. https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/

14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.[53]

Performance Payments: Non-claims bonus payments paid to health care providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.

Per capita: A measure of a given value for each person in a given population. This report looks at health care spending per California resident.

Per member per year (PMPY): Health care spending per insured person per year. Members are included in the denominator regardless of whether they utilized services. Expressing spending as PMPY makes it comparable across entities, regardless of the number of people served.

Pharmacy rebates: Payments, regardless of how they are categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.

Population Health and Infrastructure Payments: Prospective, non-claims payments paid to health care providers or organizations to support specific care delivery; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.

Physician organization: As referenced in the Health and Safety Code, any of the following:

(1) An organization described in paragraph (2) of subdivision (g) of Section 1375.4.

(2) A risk-bearing organization, as defined in Section 1375.4.

(3) A restricted health care service plan and limited health care service plan under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations. The inclusion of restricted health care service plans and limited health care service plans in the definition of “physician organization” does not narrow, abrogate, or otherwise alter the regulatory authority of the Department of Managed Health Care over these entities.

[53] Health & Safety Code § 127500.2(q).

(4) A medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206.

(5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of 25 or more physicians.

(6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that is a high-cost outlier whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671). The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization.[54]

Plan type: Commercial payers offer multiple types of plans, primarily (1) health maintenance organization (HMO) or point of service (POS) plans which require a primary care provider to manage the member's care, and (2) preferred provider organization (PPO) or exclusive provider organization (EPO) plans which allow members to schedule visits without a referral.

Quality-Linked Payments: Payment arrangements on behalf of a member are considered "linked to quality" if any payments in a performance arrangement, shared savings or shared risk arrangement, or capitation and full risk arrangement made on their behalf to any provider would be adjusted based on specific predefined goals for quality. The link to quality is established based on eligibility for payment in recognition of quality performance, not actual payment of any quality incentive. For example, if a member is attributed to a provider eligible for a pay-for-performance payment in recognition of quality performance and a professional capitation payment that is not adjusted based on specific predefined quality goals was made on behalf of the member to any provider, then in the APM file all of the member's TME and member months would be reported in the professional capitation payment arrangement and indicated as "linked to quality."

Reporting year: The service year for which data files are being reported.[55]

Shared Savings and Shared Risk Payments: Non-claims payments to health care providers or organizations (or recouped from health care providers or organizations) based

[54] Health & Safety Code § 127500.2(r).
[55] 22 CCR 97445(n).

on performance relative to a defined spending target. Shared savings and shared risk payments can be associated with different types of budgets, including but not limited to episode of care and total cost of care.

Social drivers of health (also known as social determinants of health): The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[56]

Total health care expenditures (THCE): The sum of total medical expense and total non-medical expense.

THCE Data Submission Guide (DSG) 2.0: The Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 2.0), dated April 2025. DSG 2.0 is available on, and may be downloaded from, HCAI's website.[57]

THCE Data Submission Guide (DSG) 3.0: The Office of Health Care Affordability: Total Health Care Expenditures Data Submission Guide (Version 3.0), dated April 2026. DSG 3.0 is available on, and may be downloaded from, HCAI's website.[58]

Total medical expense (TME): All payments from payers to providers for reimbursement of the cost of health care, including medical claims, pharmacy claims, and non-claims payments.

[56] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/objectives-and-data/social-determinants-health.
[57] Data Submission Guide (Version 2.0), dated April 2025.
[58] Data Submission Guide (Version 3.0), dated April 2026.