

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

# Health Care Affordability Board Meeting

March 25, 2025



Department of Health Care  
Access and Information



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

# Welcome, Call to Order, and Roll Call



# Agenda

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

*Secretary Kim Johnson, Chair*

Item #2 **Executive Updates**

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

Item #3 **Action Consent Item**

*Vishaal Pegany*

- a) Vote to Approve February 25, 2025 Meeting Minutes

Item #4 **Informational Items**

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

- a) Follow up - Sector Target Methodology and Values including Advisory Committee Feedback
- b) Massachusetts and Oregon Cost Target Program Update Presentations
- c) Proposed Emergency Regulation on Hospital Sector Definition including Summary of Public Comment Feedback
- d) Healthcare Payments Data Program Update

Item #5 **General Public Comment**

Item #6 **Adjournment**



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# Executive Updates

Elizabeth Landsberg, Director  
Vishaal Pegany, Deputy Director



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# With Appreciation



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

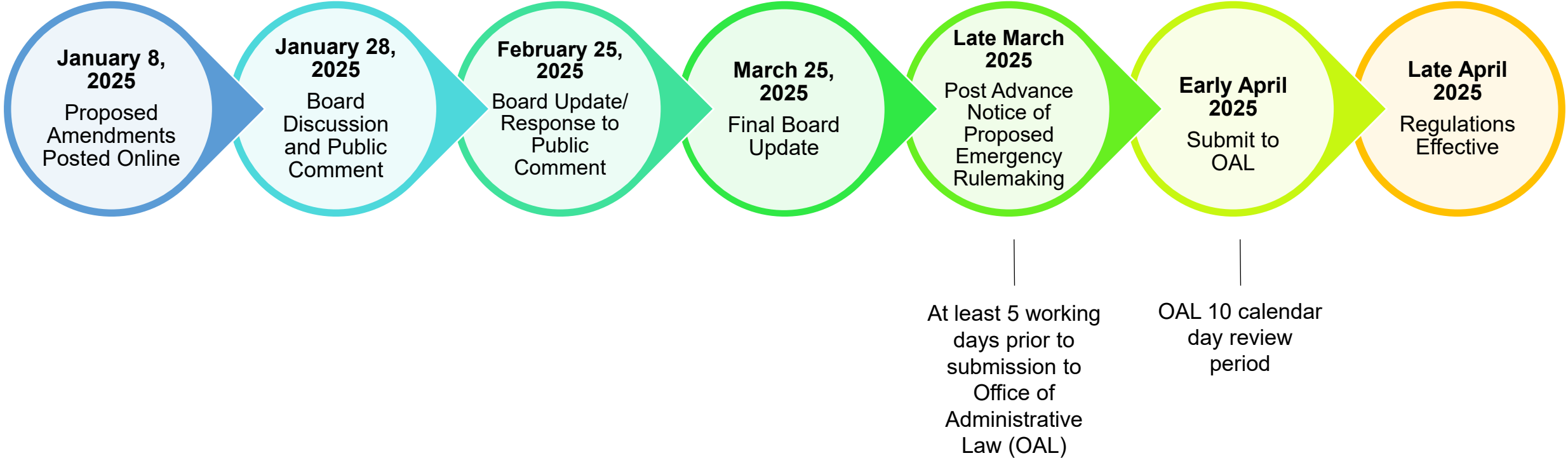
# Milbank Report on Primary Care Spending

- To address primary care workforce shortages and help keep care more affordable, a growing number of states are engaged in efforts to strategically invest in primary care.
- Milbank's March 2025 report looked at efforts to increase primary care spending across five states:
  - **California (15% by 2034)** – Established a benchmark of 15% investment in primary care by 2034 for all payers and a 0.5% to 1% annual improvement benchmark through 2033. This is paired with a statewide health care spending target of 3.5%. Primary care spending benchmarks are not enforceable, but there is flexibility to not apply enforcement measures on the statewide health care target if plans achieve primary care target.
  - **Connecticut (10% by 2025)** – Established a primary care spending target of 10% by 2025 for commercial health plans, Medicare, and Medicaid in 2020 via executive order and codified by General Assembly in 2022. The state has increased spending but missed targets thus far, including 4.9% in spending against a 5.3% target in 2022. 2023 data will be released in March 2025. There are currently no enforcement mechanisms.

# Milbank Report on Primary Care Spending

- **Oklahoma (11% by 2028)** – Transitioned about 50% of state’s Medicaid enrollees to a managed care model called SoonerSelect, which launched in April 2024. SoonerSelect has a primary care spending target of 11% within 4 years of launch. They are currently spending 5% of health care budget on primary care. The spending target does not apply to other health plans.
- **Rhode Island (10%)** – First state to set a primary care spending target in 2010 of 1% annual increases to achieve 10.7% by 2014. In 2023 Rhode Island recalibrated by publishing a report, redefining “Primary Care Expenditure” to include physicians practicing outside of Rhode Island, and set a new target of 10%. Most commercial health insurers meet the target and they have never taken enforcement action.
- **Virginia (target coming soon)** – Public-private partnership task force work began in 2020 and they have released an annual scorecard to track investment, regional clinician capacity, utilization, outcomes, access to primary care, and compares with national benchmarks. The 2024 scorecard reported that Virginia spent 2.3% to 4.1% of the state’s total health care dollars on primary care services. The task force plans to recommend a spending target and enforcement mechanism to the state’s General Assembly in 2025.

# THCE Rulemaking Timeline





# Slide Formatting



Indicates informational items for the Board and decision items for OHCA



Indicates current or future action items for the Board



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# Public Comment





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



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# Public Comment





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# Informational Items





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# Sector Target Methodology and Values including Advisory Committee Feedback

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

Andrew Feher, Research and Analysis Group Manager



# Board Follow-Up Items

# Board Follow-ups

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



# 1. Hospital Feedback

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

**Approach:**

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

**Discussion included:**

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

# 1. Hospital Feedback

## Identification of High-Cost Hospitals:

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

# 1. Hospital Feedback

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

# 1. Hospital Feedback

## Other feedback and comments:

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

# 1. Hospital Feedback

## Other feedback and comments:

Consideration is needed for:

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

# 1. Hospital Feedback

## Other feedback and comments:

Consideration is needed for:

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

# 2. Distribution of Relative Price Among Comparable Hospitals

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

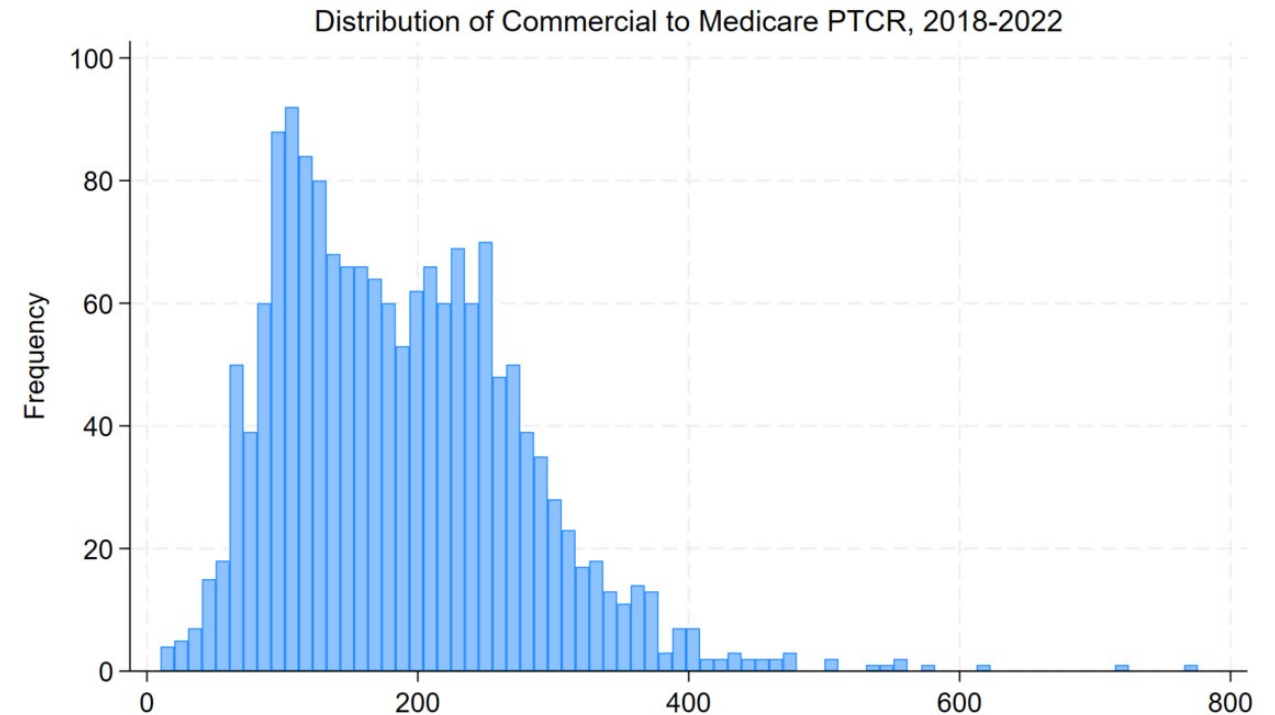
**Approach:** Based on 2018-2022 HCAI Hospital Annual Financial Disclosure data, OHCA

- Compared the share of public hospitals\* in each peak.
- Compared the share of hospitals in competitive markets\*\* (HHI <1500) in each peak.
- Compared the share of hospitals in Southern vs Northern regions\*\*\* in each peak.

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

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

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



## 2. Distribution of Relative Price Among Comparable Hospitals

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

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



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

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

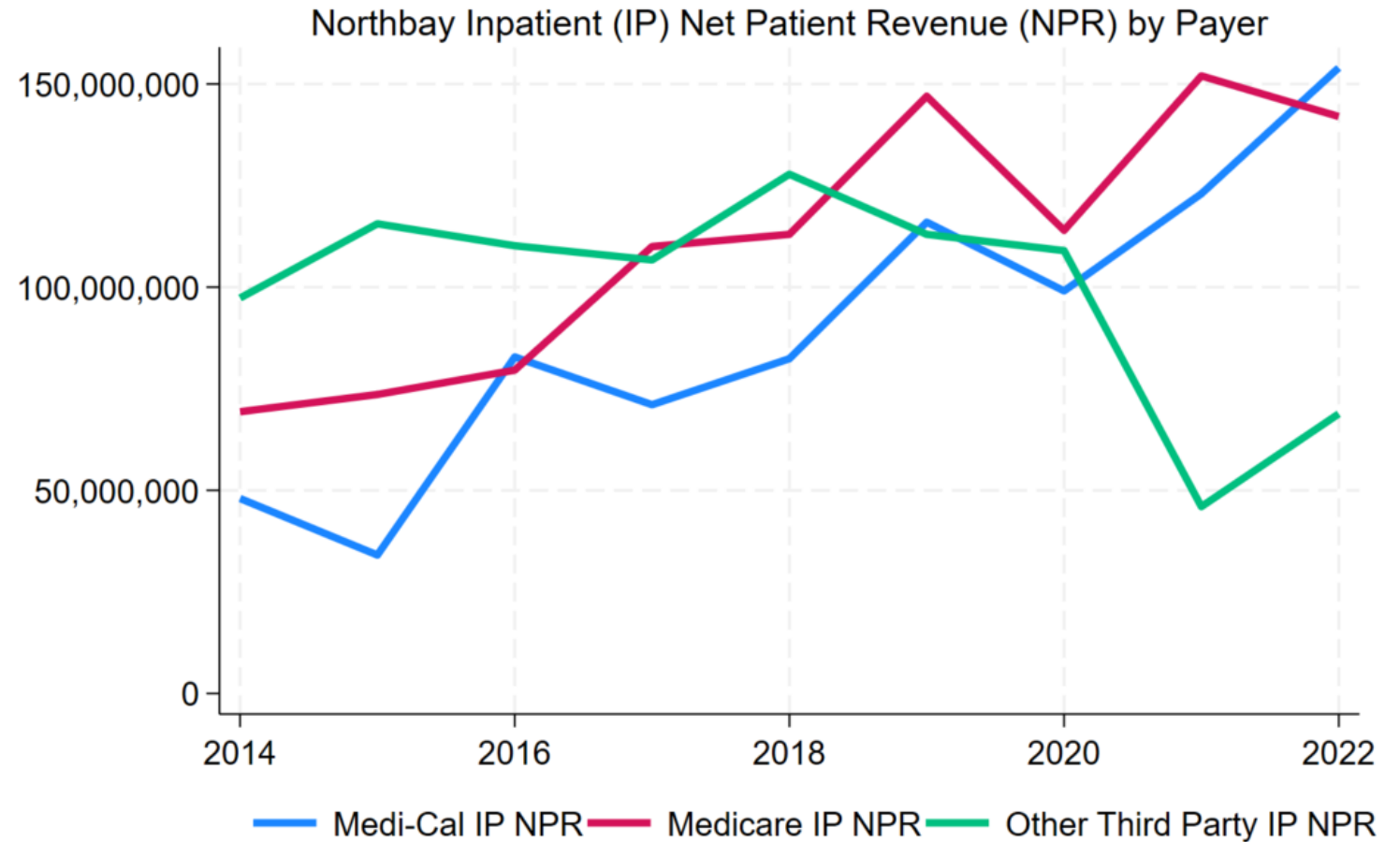
**Discussion:** OHCA verified its code accurately calculated the unit and relative price measures. OHCA can confirm that the data used in the calculations matches the data Northbay submitted to HCAI. OHCA also met with Northbay staff to understand what contributed to the steep decreases in unit and relative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

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

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

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

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



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

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

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

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

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

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

## **Summary:**

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

# 4. OHCA Statute: Fully Integrated Delivery Systems

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

## §127500.2(h) Fully Integrated Delivery System

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

# 4. HCAI Definition: Hospital Systems

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

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

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

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

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

## AHRQ Compendium Definition:

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

The definition requires that a system include:

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

# 4. Pending Legislation: Health System Definition

## AB 1415 Definition:

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

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

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

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

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



# 4. Health Systems Have Substantial Variation and Complexity

***RAND: “If you’ve seen one health system, you’ve seen one health system.”***

Systems span the continuum from a single legal entity to very complex multi-layered systems that operate or manage multiple hospitals and multiple physician organizations and also provide care through clinically integrated networks and other affiliation arrangements with private practice physicians.

## **Health Systems Vary Across Multiple Dimensions:**

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

# Advisory Committee Feedback

# Advisory Committee Feedback

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

# Advisory Committee Feedback

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



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# Public Comment





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# Massachusetts and Oregon Cost Target Program Updates

Vishaal Pegany, Deputy Director





# The Massachusetts Health Care Cost Growth Benchmark

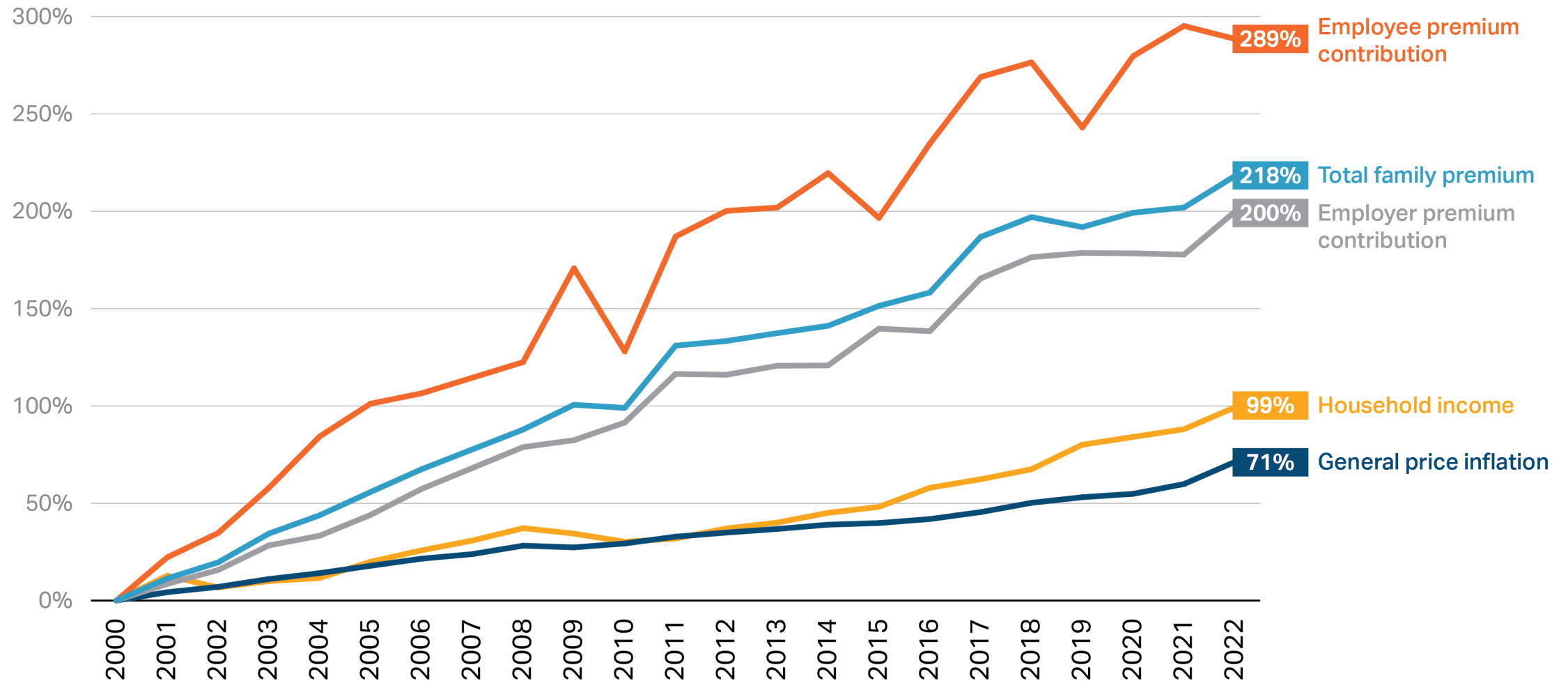
**Update on Spending Trends, Implications for  
Affordability, and New Tools for Accountability**

March 2025

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



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



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

## CHAPTER 224 OF THE ACTS OF 2012



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

## GOAL



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

## VISION



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

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

The health care cost growth benchmark:



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

## TOTAL HEALTH CARE EXPENDITURES

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

**Includes:**

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

## WHAT THE BENCHMARK IS

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

## WHAT THE BENCHMARK IS NOT

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

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



## Step 1: Benchmark

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



## Step 2: Data Collection

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



## Step 4: HPC Analysis

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



## Step 3: CHIA Referral

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



## Step 5: Decision to Require a PIP

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



## Step 6: PIP Implementation

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

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



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

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

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

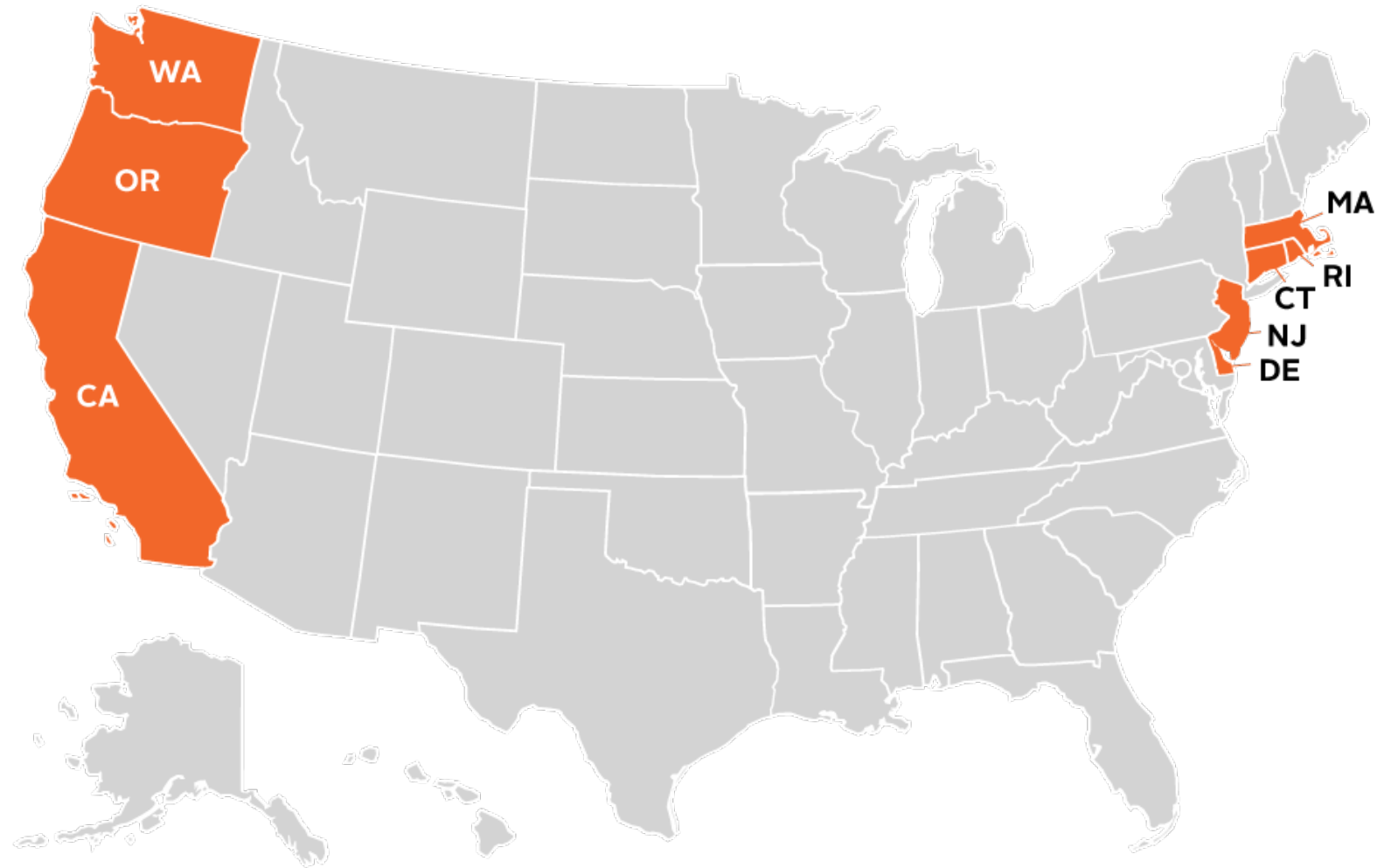


- In January 2022, the HPC Board voted unanimously to require Mass General Brigham (MGB) to develop a PIP to reduce cost growth, finding:
  - MGB regularly had spending growth above the benchmark and higher absolute spending levels for its patients than most other systems.
  - Price and mix were the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

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

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

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



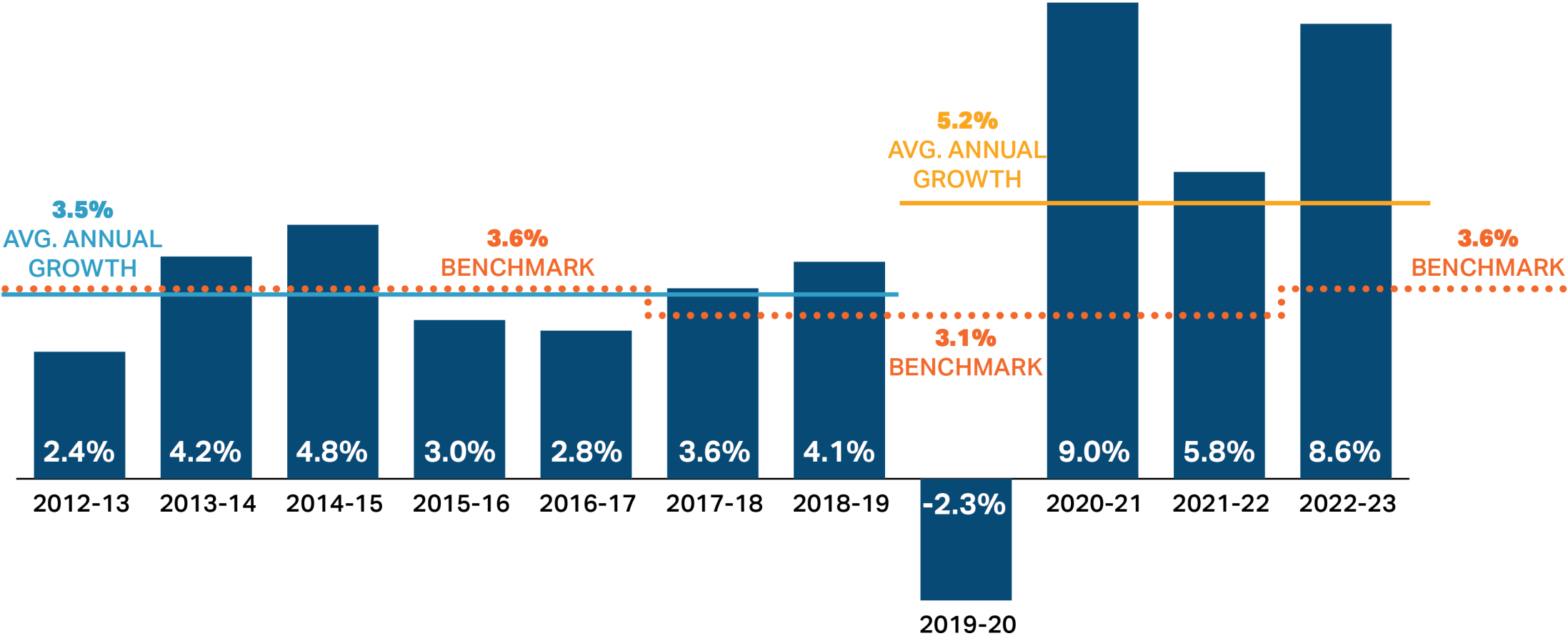


1. Overview of the Health Policy Commission and the Health Care Cost Growth Benchmark
2. **Recent Spending Trends**
3. Implications for Affordability of Health Care
4. Recently Passed Legislative Improvements

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



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

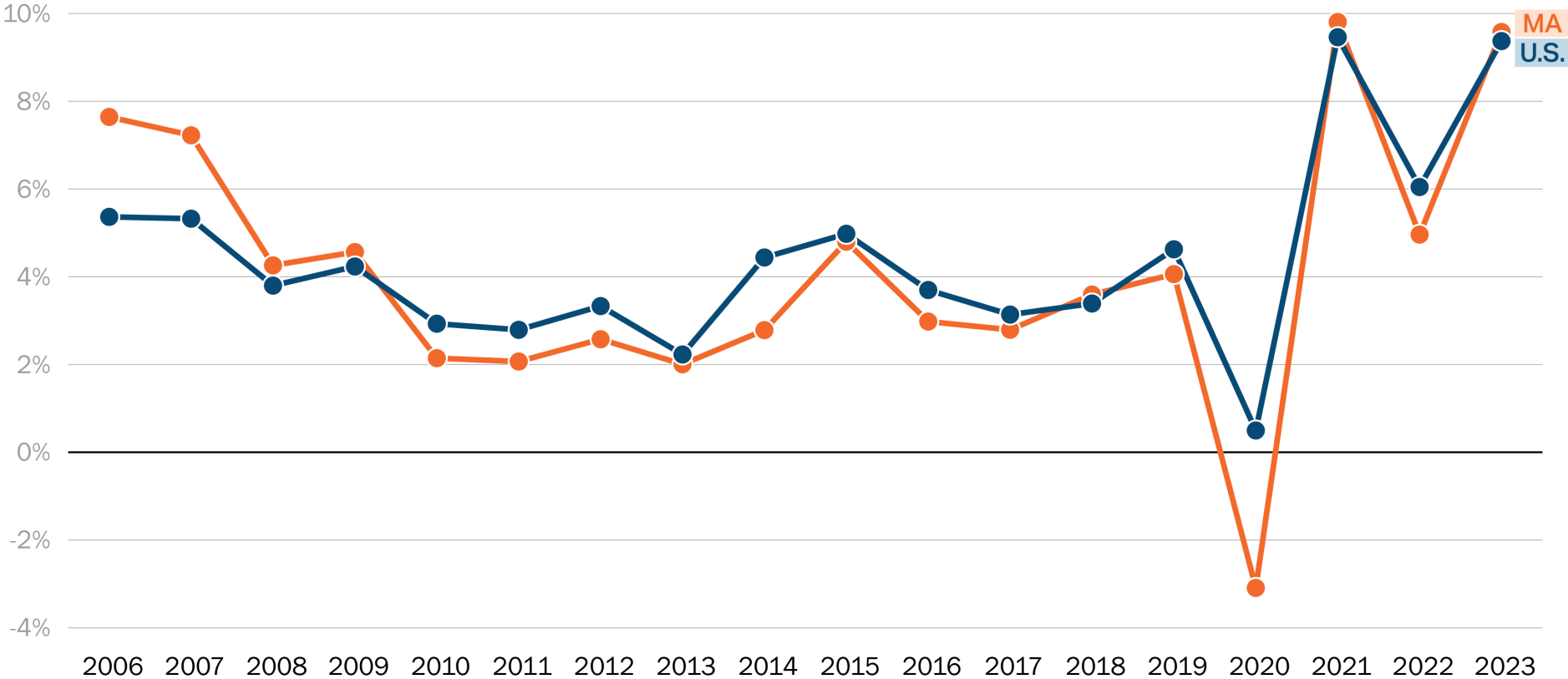


Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System 2013-2025.

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



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

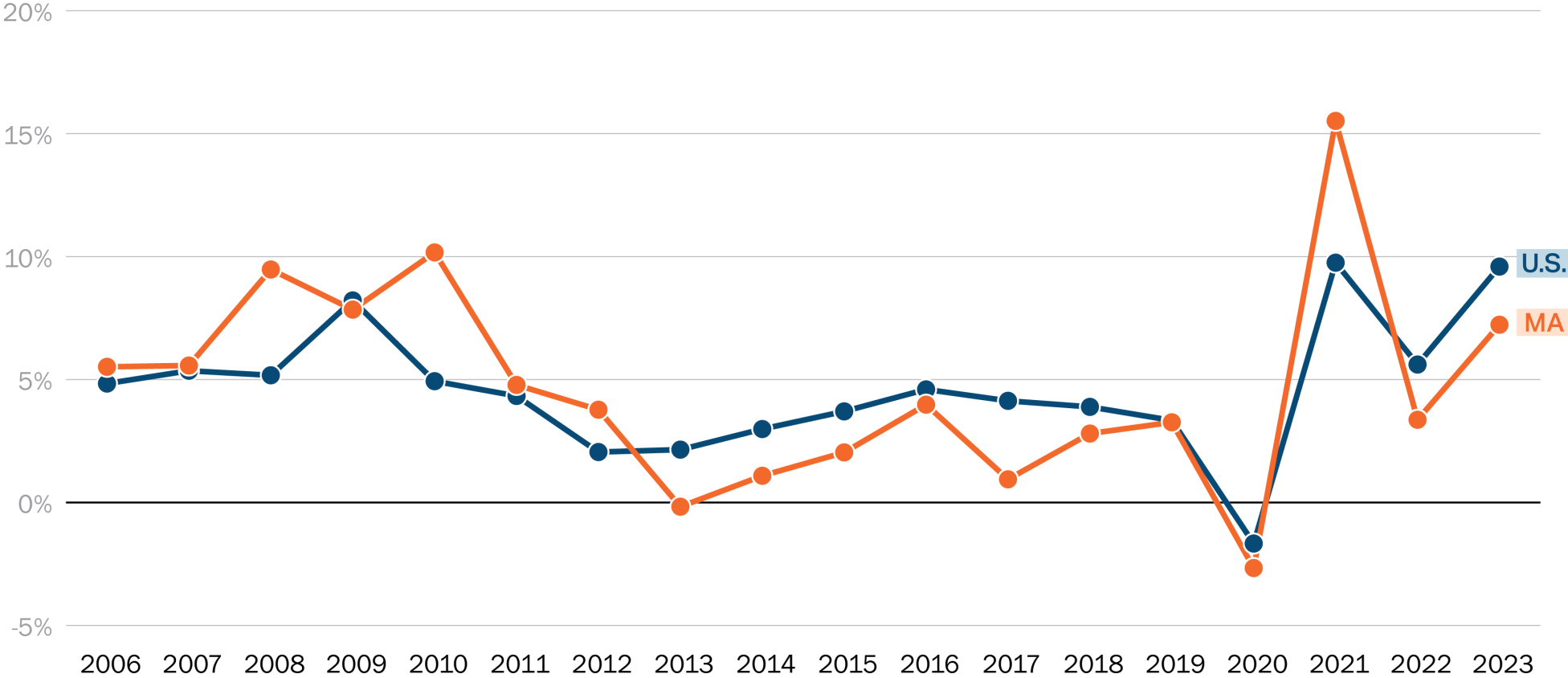


Notes: U.S. data includes Massachusetts. Massachusetts and U.S. data exclude federal and state supplemental COVID-19 relief funding.  
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2023 and State Healthcare Expenditure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

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



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

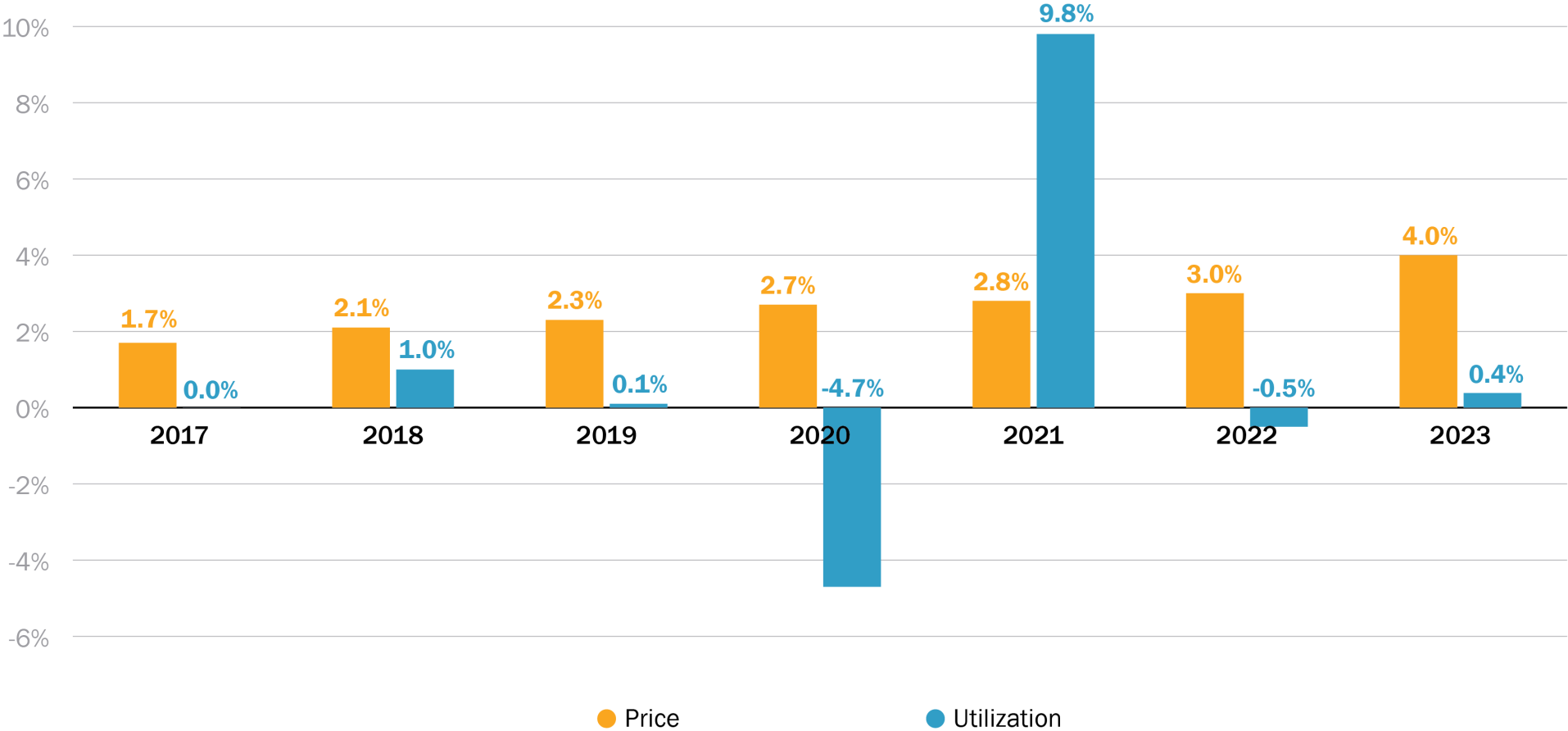


Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance. Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2023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

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



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

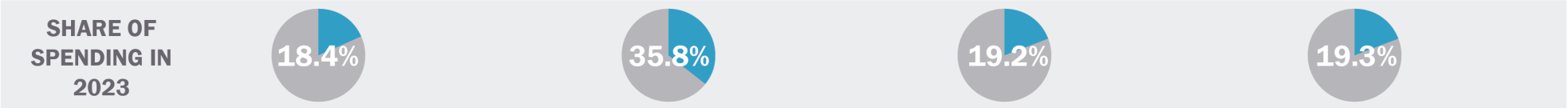
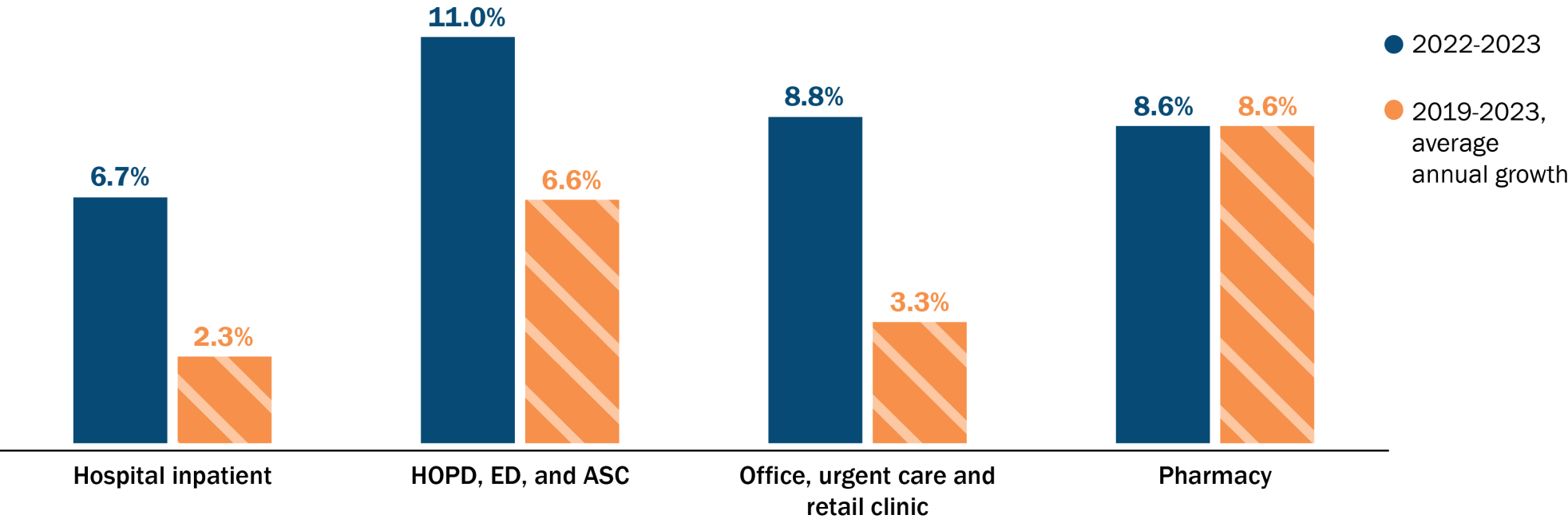


Sources: Pre-Filed testimony submitted to the HPC in advance of the 2021, 2022, 2023 and 2024 Annual Cost Trends Hearings.

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



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



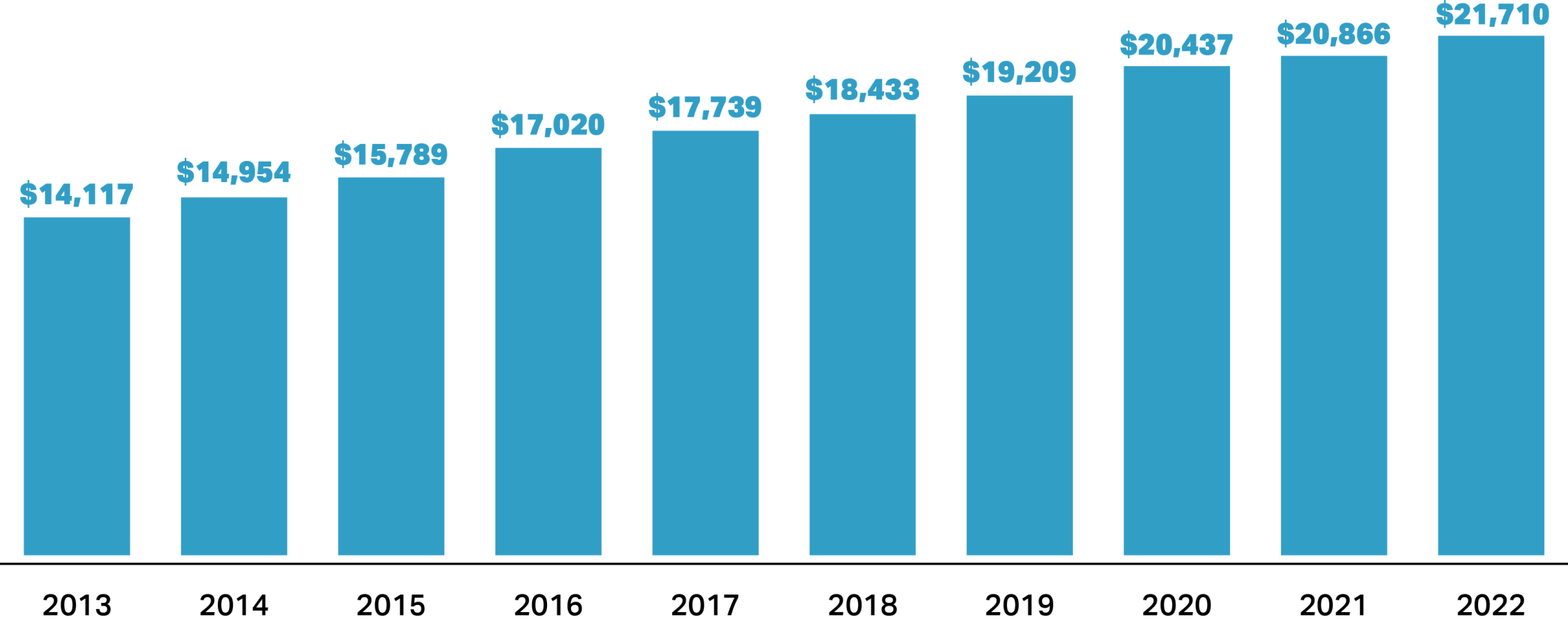
Notes: Pharmacy spending is net of rebates. Share of spending does not sum to 100% as sites of care with smaller spending amounts are not shown. Spending amounts in all hospital categories include both professional and facility spending.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA), Total Medical Expenditures, 2019-2023 (pharmacy spending, full claims only). HPC analysis of CHIA All-Payer Claims Database V2023, 2019-2023 (spending at other sites).

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



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

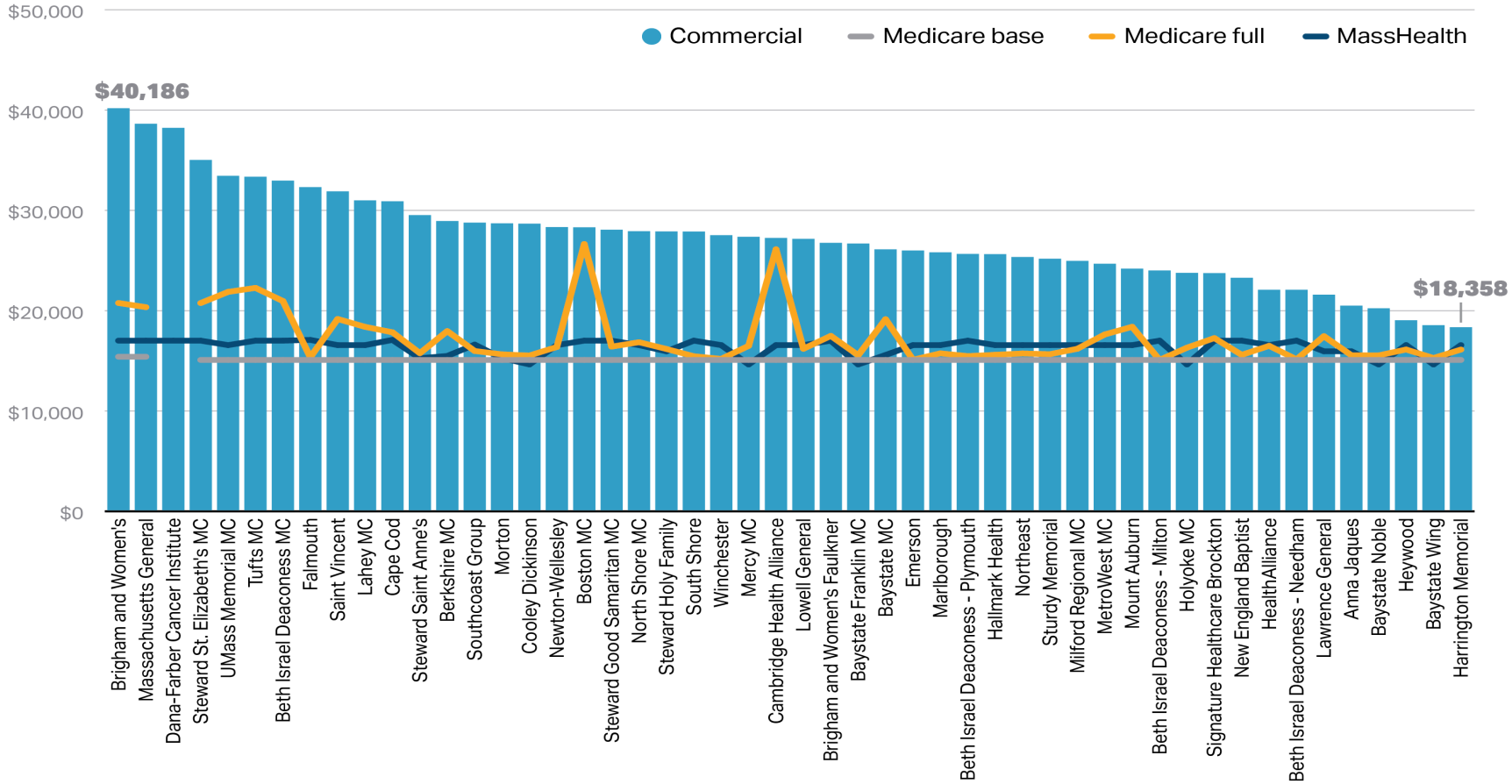


Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge database, 2013-2022 and Annual reports, 2015-2024; Bureau of Labor Statistics, CPI-U for the greater Boston metro area. Inflation averaged 2.5% annually from 2013 to 2022.

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



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



➤ “Full” Medicare prices are higher for teaching hospitals and those serving a high proportion of uninsured and MassHealth patients.

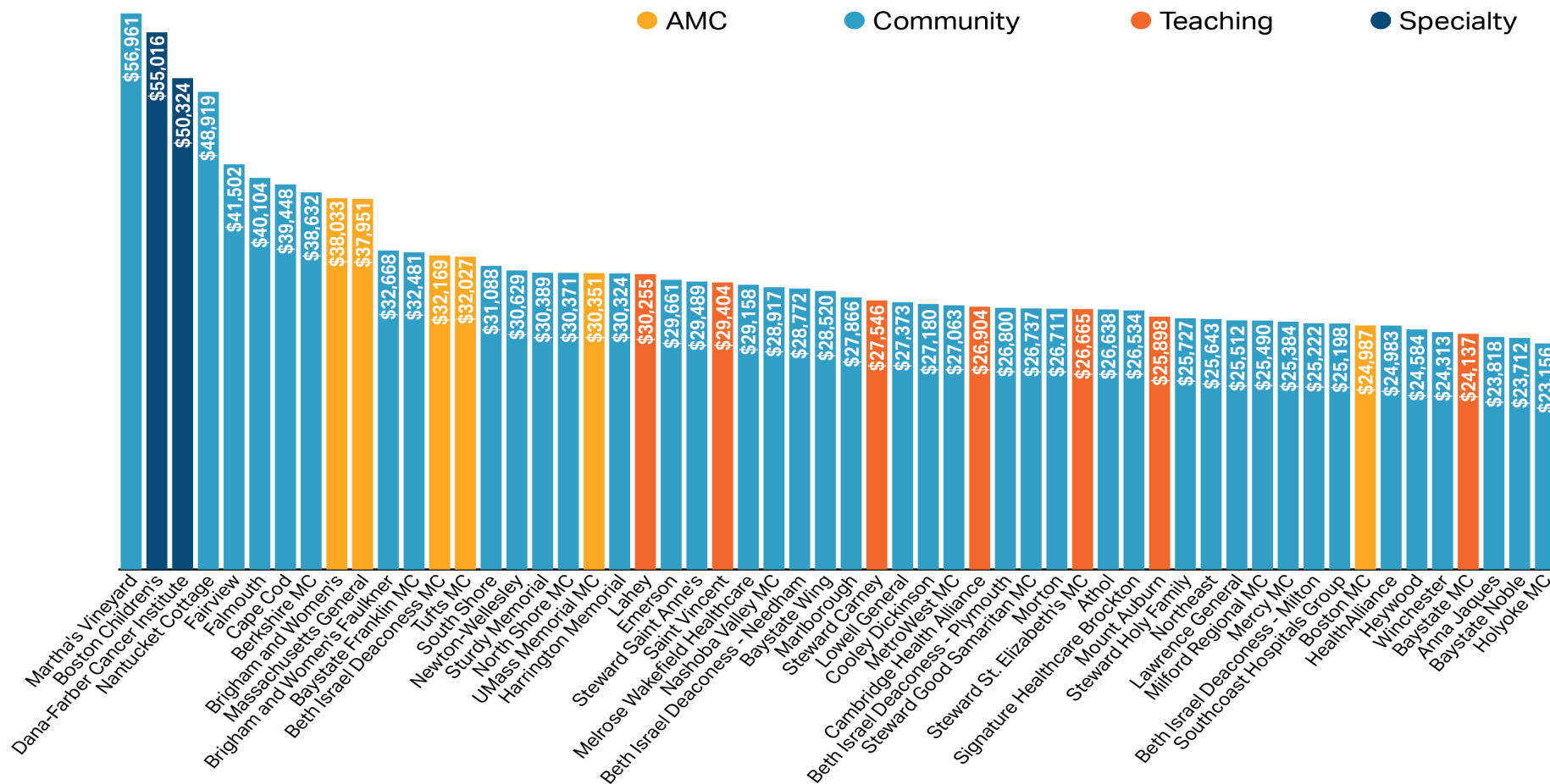
Notes: Exhibit includes the top 50 acute care hospitals by volume of adult non-maternity and non-psychiatric patients in 2022. Stays that are outliers in payment and length of stay within their APR-DRG as well as transfers are excluded to ensure comparable prices. Commercial prices are adjusted for the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



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



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



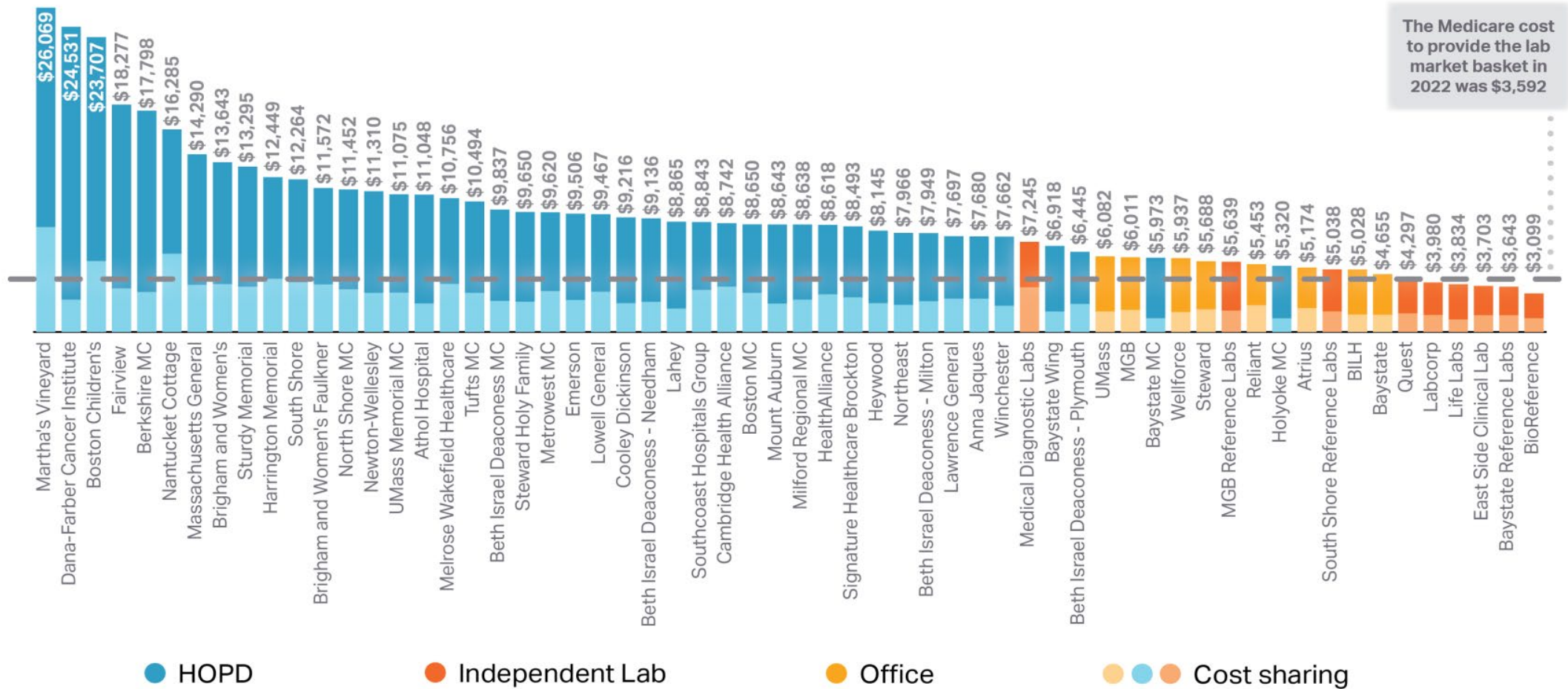
Notes: Academic medical center (AMC). For each hospital, the same 50 procedure codes are evaluated using a fixed statewide volume (computed using 2022 data) and hospital-specific average service prices in 2022 for each procedure code. Hospitals with fewer than 20 service encounters for any individual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

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

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



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



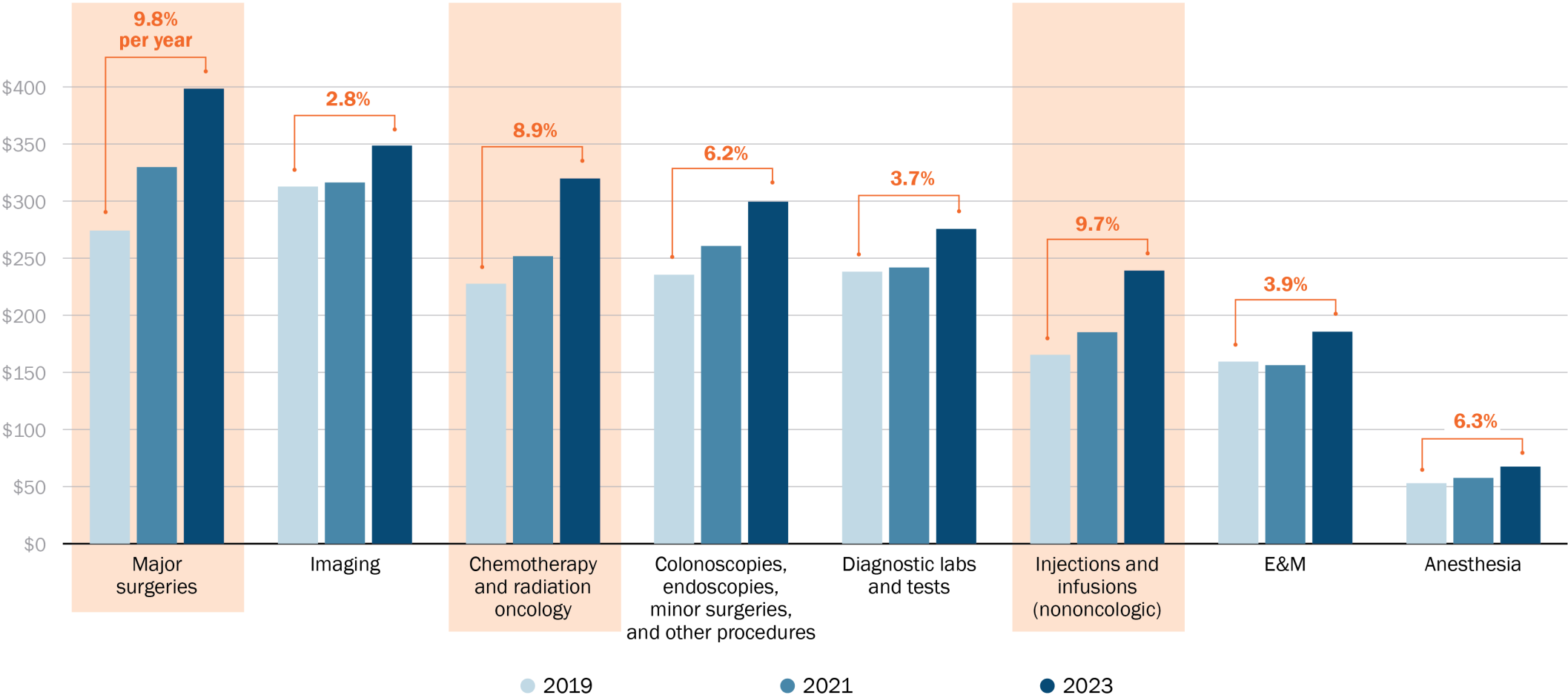
Notes: The lab market basket reflects the quantity and type of lab tests ordered per 100 members in 2022. For each provider, the same 50 highest-aggregate-spending procedure codes are evaluated using a fixed statewide volume (computed using 2022 data) and provider-specific mean service prices in 2022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

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

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



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

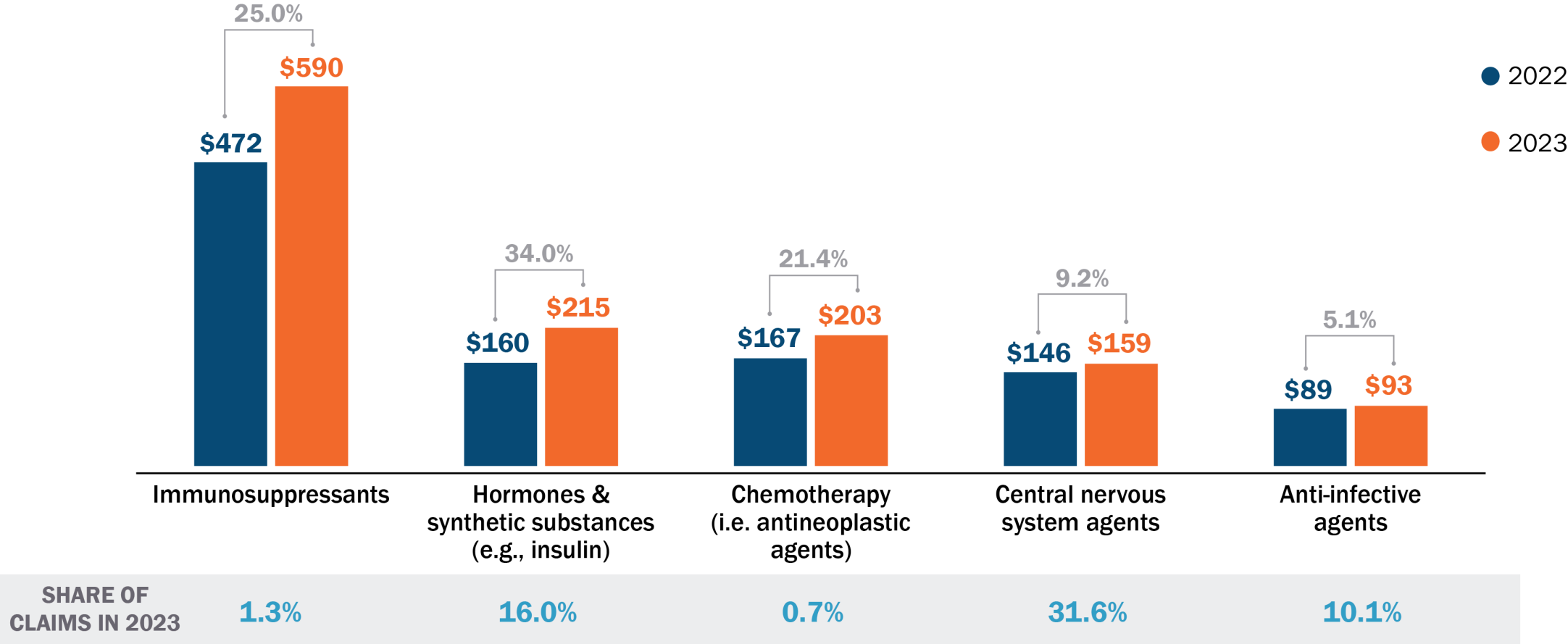


Notes: E&M = evaluation and management services. Includes spending from Massachusetts acute hospitals only. Service categories adapted from Restructured BETOS Classification System 2023 and Agency for Health Care Research and Quality Surgery Flags Software. Categories with small spending amounts are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

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



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

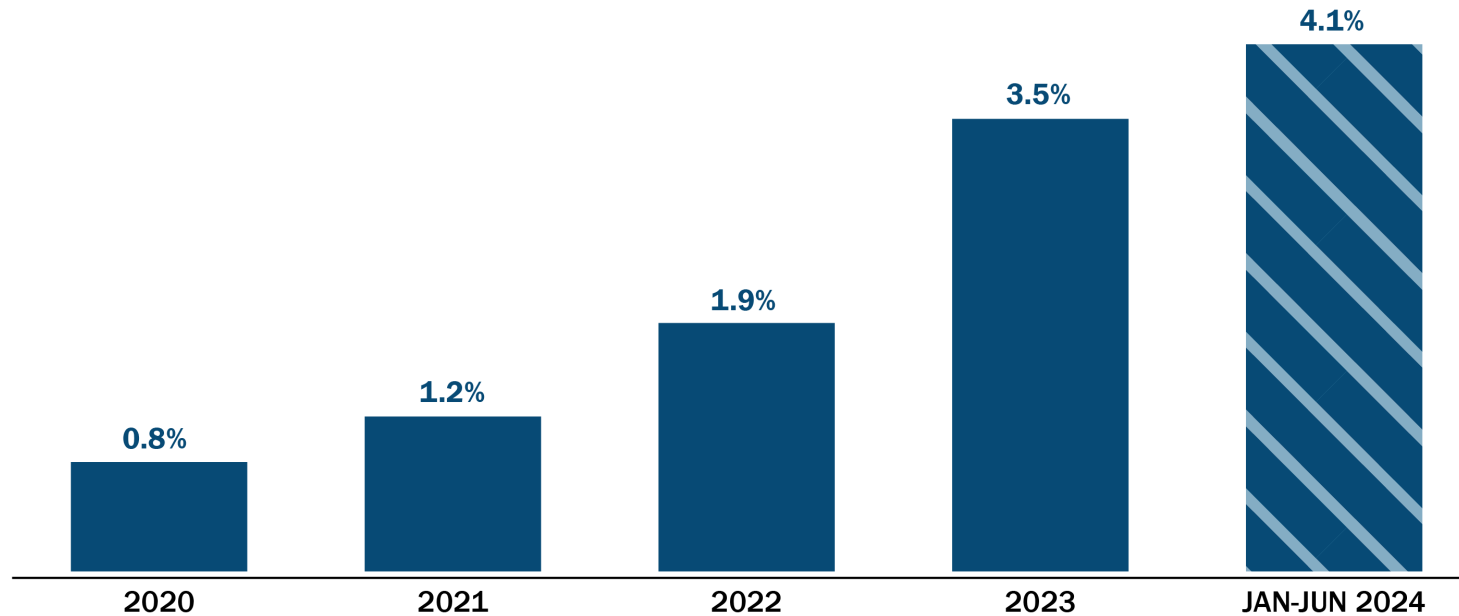


Notes: Therapeutic class based on Red Book. Spending is net of rebates. Rebates were sourced from The Medicare Payment Advisory Commission July 2024 Data Book, Section 10: Prescription drugs. Available at: <https://www.medpac.gov/document-topic/part-d/>

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

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

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



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

Notes: The following medications were included: Victoza, Saxenda, Trulicity, Ozempic, Rybelsus, Wegovy, and Mounjaro. Exhibit includes prescriptions among commercially-insured members between 18 and 64 years of age and with 12 months of medical and pharmacy coverage that year (6 months in 2024). Analysis for the sidebar texts includes commercially-insured members of all ages. Pharmacy spending is net of rebate.

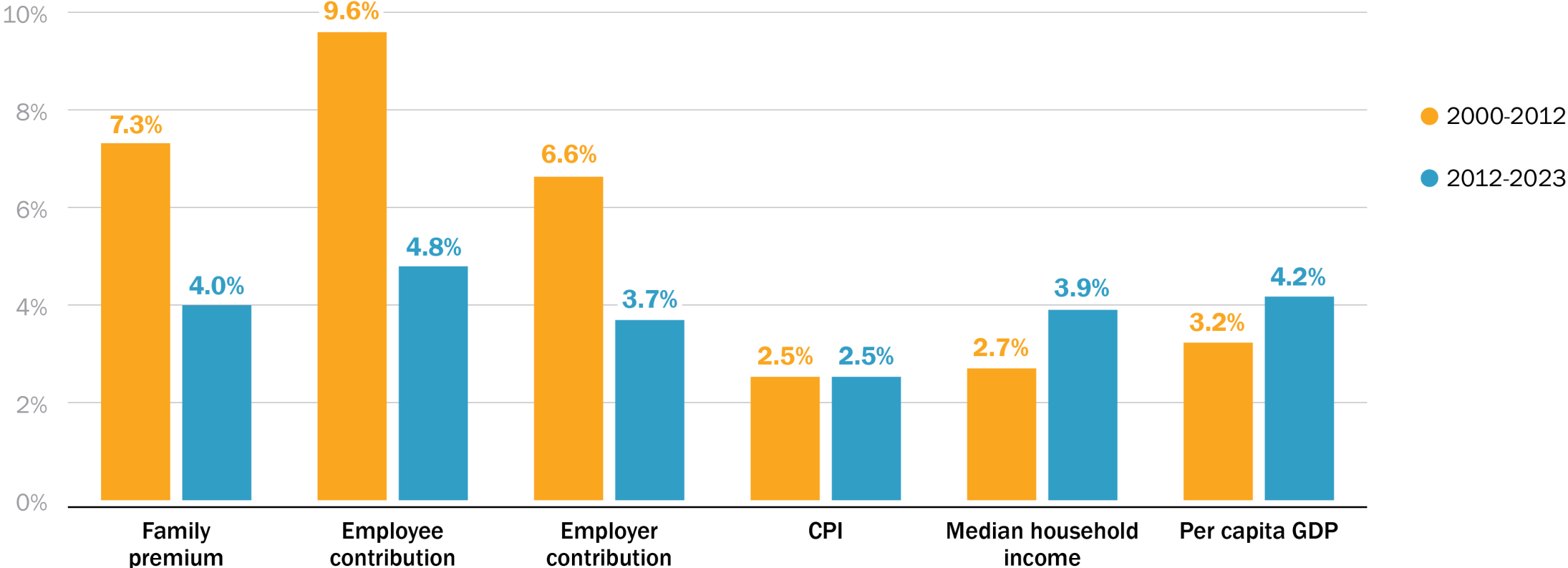
Sources: HPC analysis of Massachusetts Enhanced All-Payer Claims Database, 2020-2024 (for exhibit). HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims Database, V2023 2022-2023 (for sidebar statistic). CHIA Annual Report on the Performance of the Massachusetts Health Care System 2024 (for commercial spending and average commercial rebates). GLP-1 rebates were sourced from the following two publications: Hernandez I, Sullivan SD. Net prices of new antiobesity medications. Obesity. 2024 Mar;32(3):472-5. Ippolito BN, Levy JF. Estimating the cost of new treatments and diabetes and obesity. American Enterprise Institute. Sep 2023. Available at: <https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208>

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

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

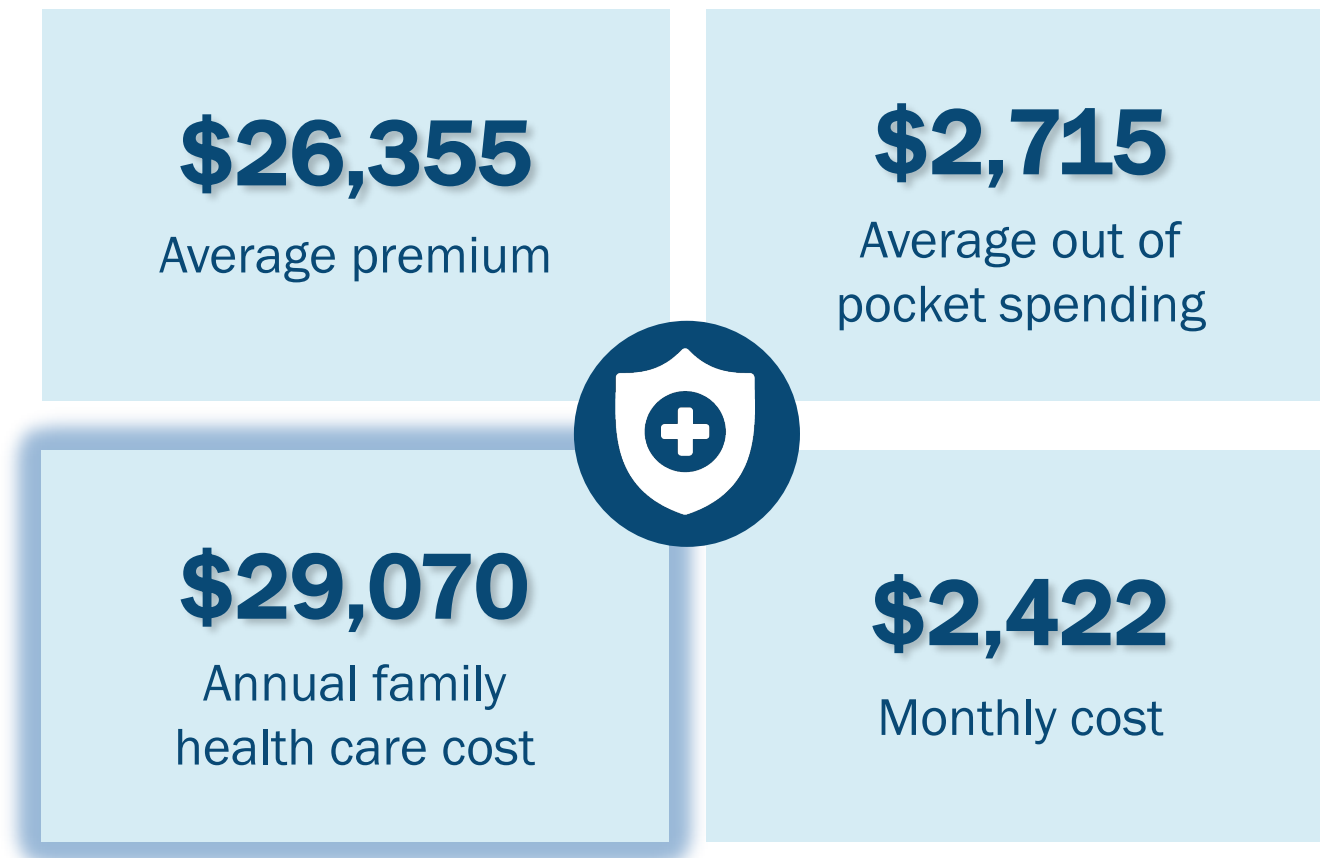


*Average annual growth of various quantities in Massachusetts from 2000-2012 and 2012-2023.*



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

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



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

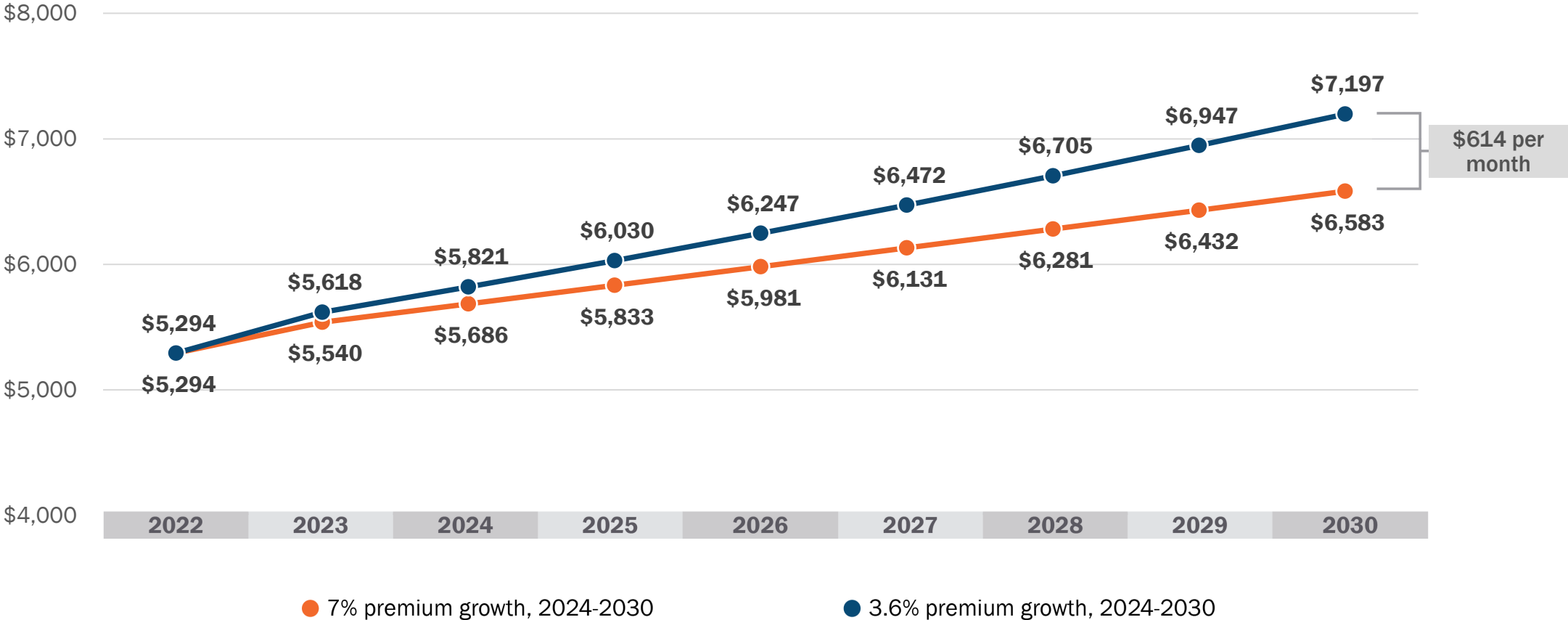
Notes: Cost sharing amount based on data on cost sharing relative to premium payments in from CHIA's Annual Report, 2024. Source: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey-Insurance Component and Center for Health Information and Analysis, Annual Report, 2024; Kaiser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



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



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



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

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

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

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

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

## An Act enhancing the market review process

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





## David Seltz

*Executive Director*

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OREGON  
**HEALTH**  
AUTHORITY

March 2025

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

Sarah Bartelmann | Cost Programs Manager  
[HealthCare.CostTarget@oha.oregon.gov](mailto:HealthCare.CostTarget@oha.oregon.gov)

# Oregon's Cost Growth Target Program Development

2017-18

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

2019

- SB 889 created program and Implementation Committee

2020

- Committee developed program and set target (3.4%)

2021

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

2022

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

2023

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

# Oregon's Cost Growth Target Applies Broadly

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

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

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

## **Payers**

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

## **Provider Organizations**

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



# Oregon's Cost Growth Accountability Measures

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## 1. Transparency

public reporting and public hearings

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

## 3. Financial Penalties

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

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

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

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

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

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

# Cost Growth Target Accountability Phases in Over Time

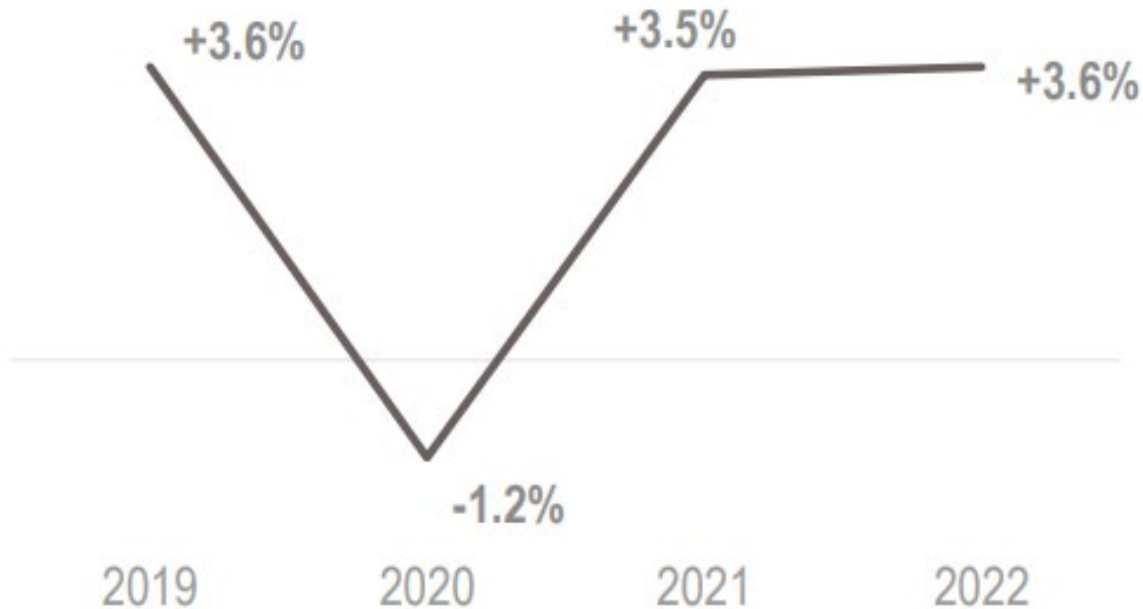
CGT Year	0	1	First Year of Accountability	3	4	5
Cost growth between	2018 – 20	2020 – 21	2021 – 22	2022 – 23	2023 –24	2024 – 25
Data submitted in	2021	2022	2023	2024	2025	2026
Report published in	2022	2023	2024	2025	2026	2027
Are payers/providers publicly identified?	No	Yes	Yes	Yes	Yes	Yes
Determination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



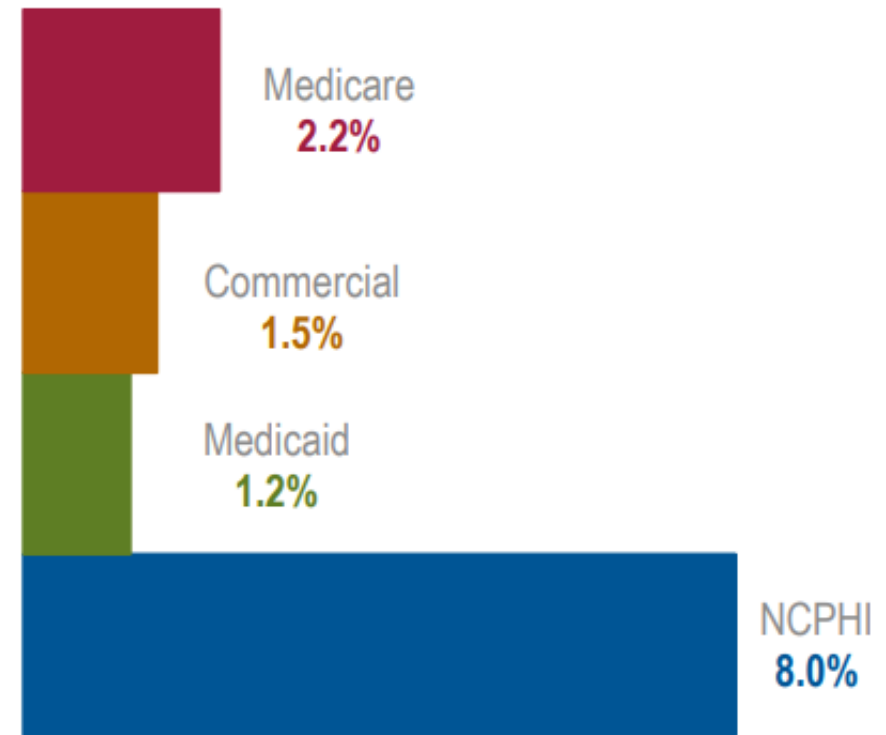
## **Oregon Cost Growth, 2021-2022**

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

Growth in Total Health Care Expenditures, 2018-2022  
Years are year 2 of a 2-year period, e.g. "2022" represents 2021-2022



Percent change in THCE by market, 2021-2022

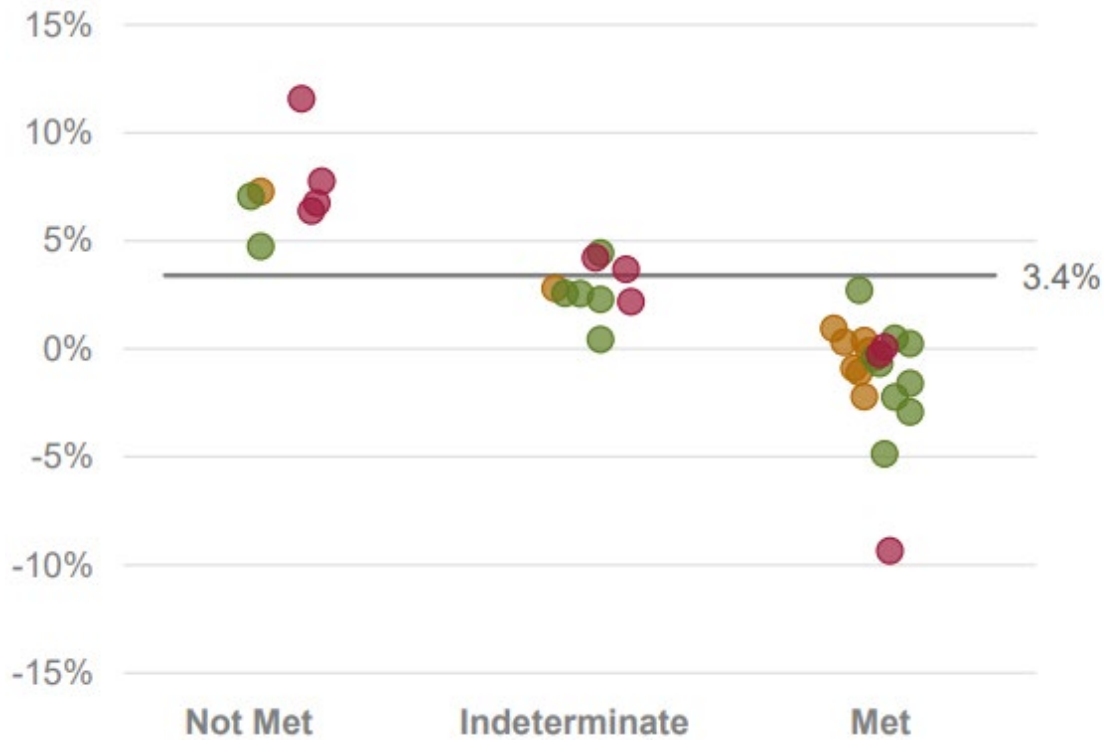


NCPHI=Net Cost of Private Health Insurance

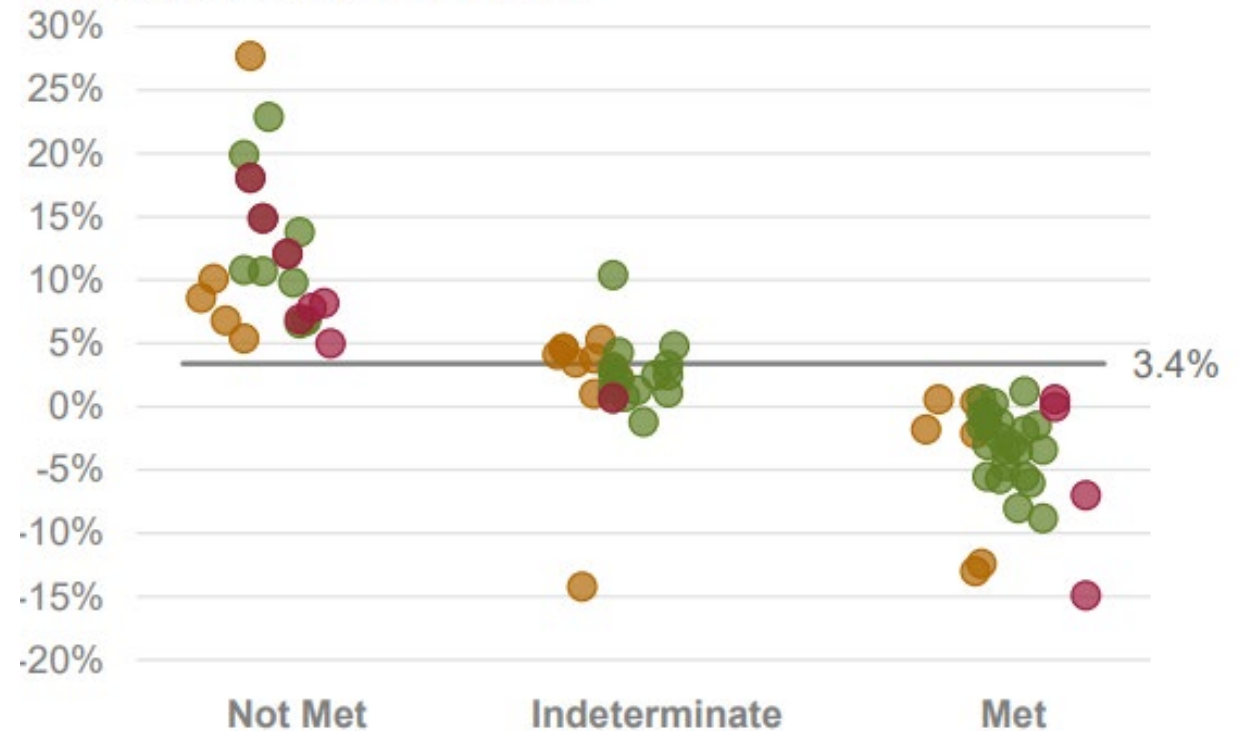
<https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2024-Oregon-Cost-Growth-Target-Annual-Report.pdf>

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

Payer performance relative to the cost growth target for **Commercial**, **Medicare Advantage**, and **Medicaid**, 2021-2022.



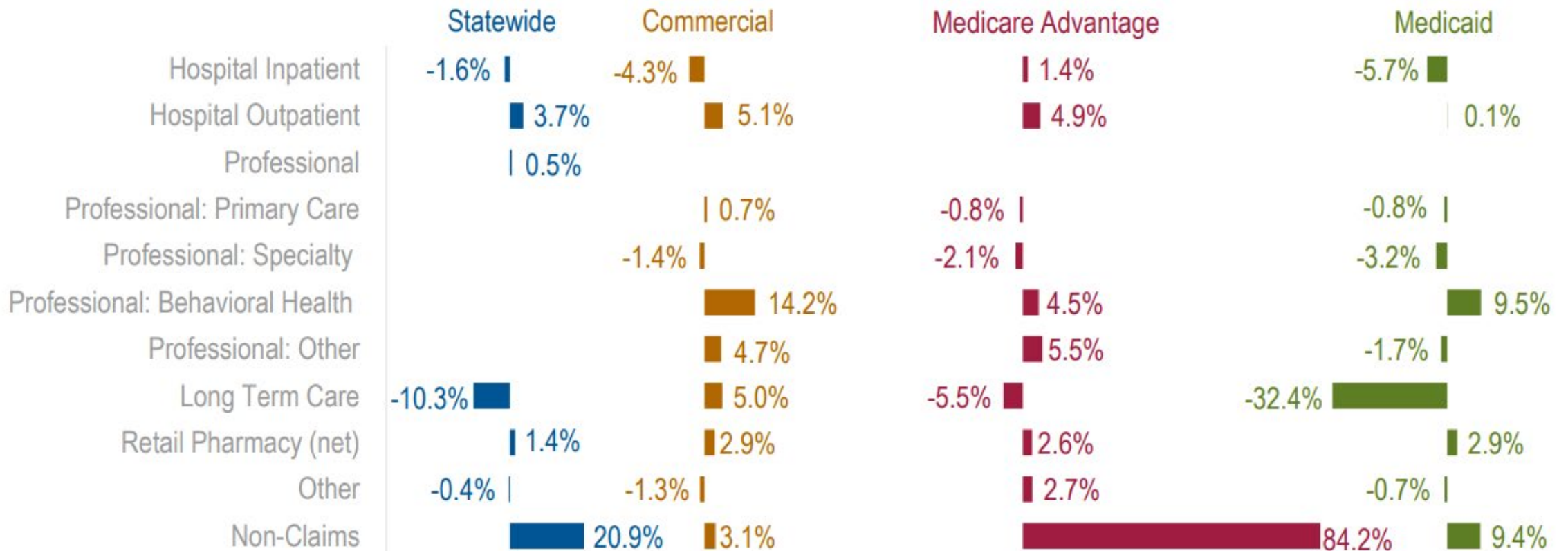
Distribution of provider organization performance in relation to the cost growth target for **Commercial**, **Medicare Advantage**, and **Medicaid** markets, 2021-2022.





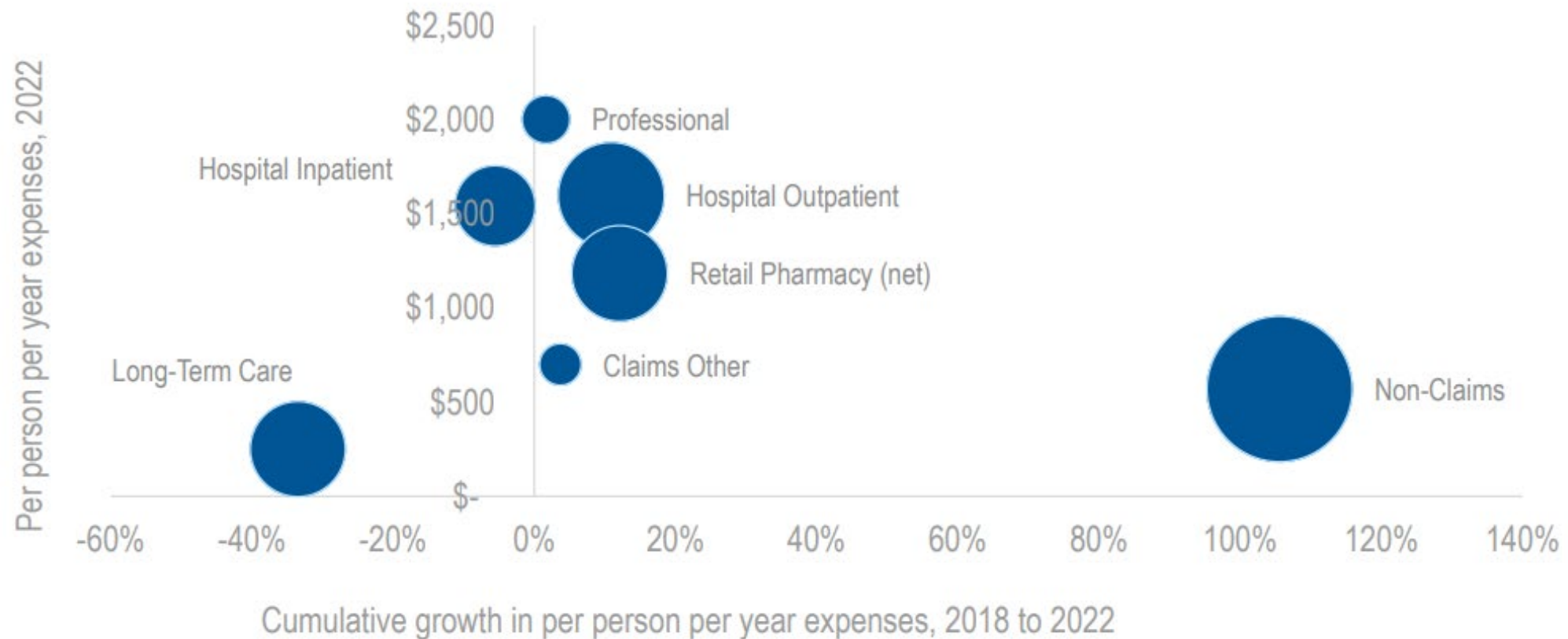
# Cost drivers in 2022 include hospital outpatient, behavioral health, and non-claims spending

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



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

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







# **First Time Applying Accountability Measures**

# Determining Reasonableness, 2021-2022

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

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

## Cost Growth Target Accountability, 2021-2022

Addendum to 2024 Annual Report  
Sustainable Health Care Cost Growth Target Program

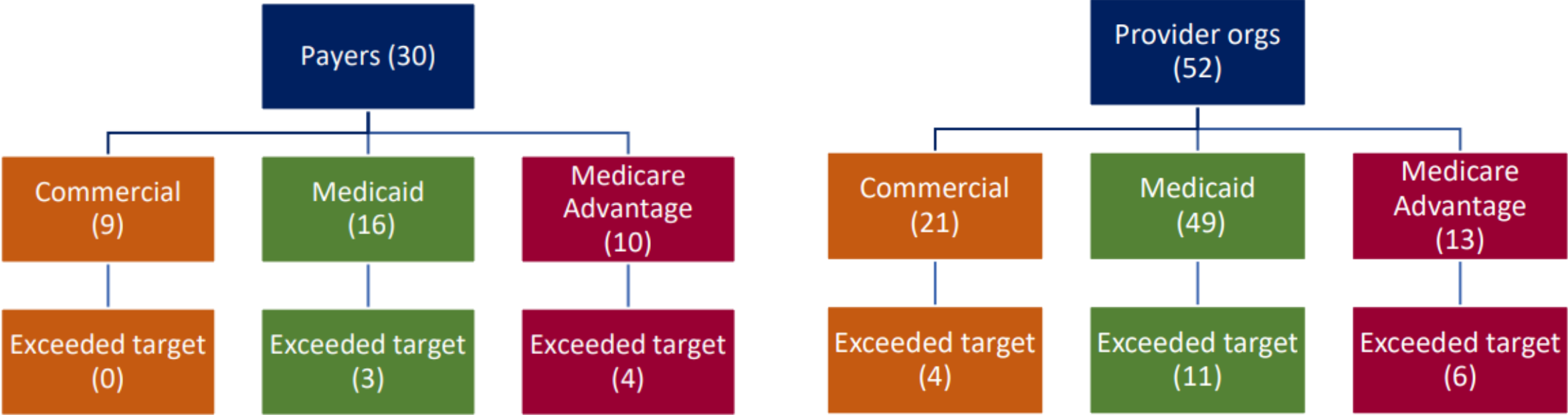
January 2025

HEALTH CARE  
COST GROWTH  
TARGET



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

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



# Reasonableness Process, 2021-2022

OHA conducted internal analysis to determine if any payers or provider organizations had clearly acceptable reasons for cost growth



July 2024: OHA notified payers and provider organizations that they needed to participate in the “determining reasonableness” process



Aug – Dec 2024: OHA met with each entity to discuss potential reasons for cost growth; entities provided data, context, etc.



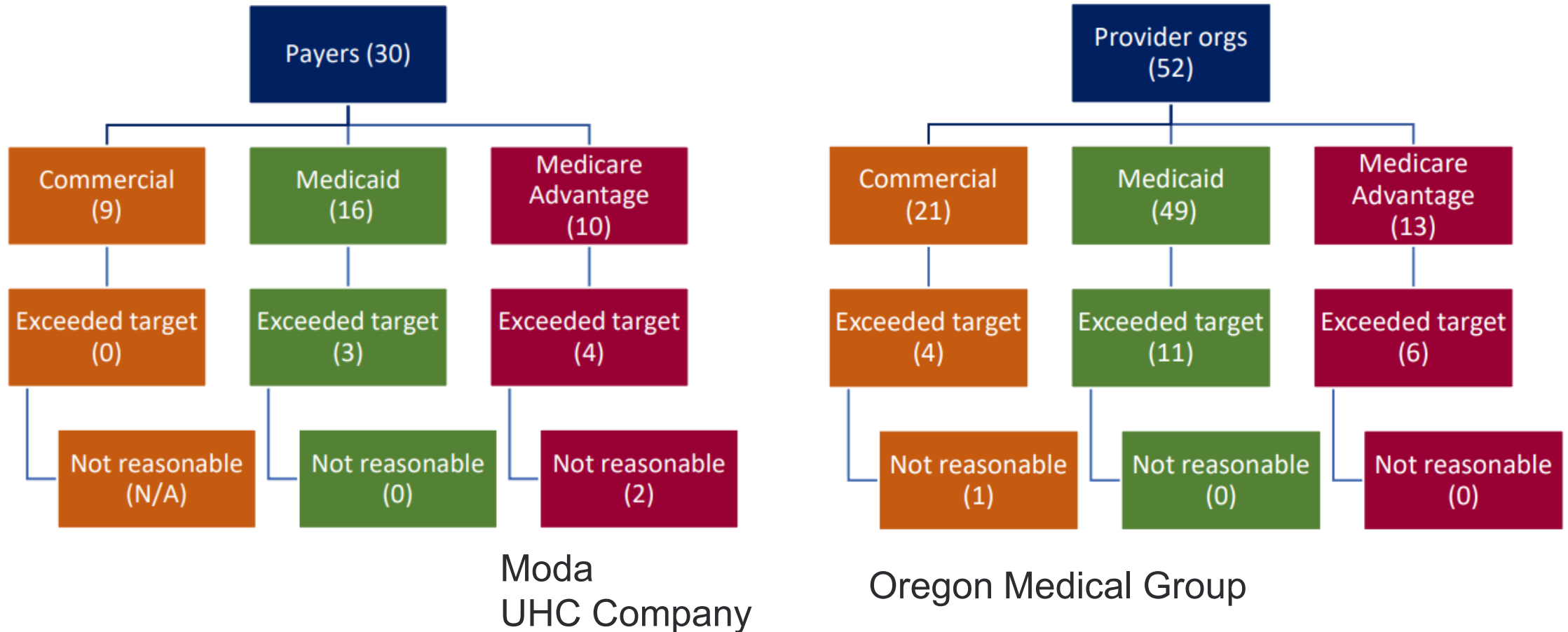
Jan 2025: OHA issued determinations and published summary report



OHA did not require these payers or provider organizations to meet



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



# Acceptable Reasons for Cost Growth, 2021-2022

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Increased behavioral health spending after state raised Medicaid rates

Longer inpatient stays because hospitals were unable to discharge patients to other facilities

Patients with more than \$1 million in annual costs, especially for pediatric practices

Increased Medicaid non-claims spending, likely quality payments and COVID-related payments

Increased frontline workforce costs

Service expansions to meet community needs

# Responses

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## Media

### Three health care companies increased costs excessively, Oregon warns

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

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

HEALTH

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

## Entities

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

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

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

# Reflections

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



# Currently: Determining Reasonableness for 2022-2023

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

# For More Information

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## **2024 Cost Growth Target Annual Report**

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

## **Accountability Addendum and Determination Letters, 2021-2022**

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

## **Guidance on Reasonableness**

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

## **Contact us**

[HealthCare.CostTarget@oha.Oregon.gov](mailto:HealthCare.CostTarget@oha.Oregon.gov)



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

# Public Comment





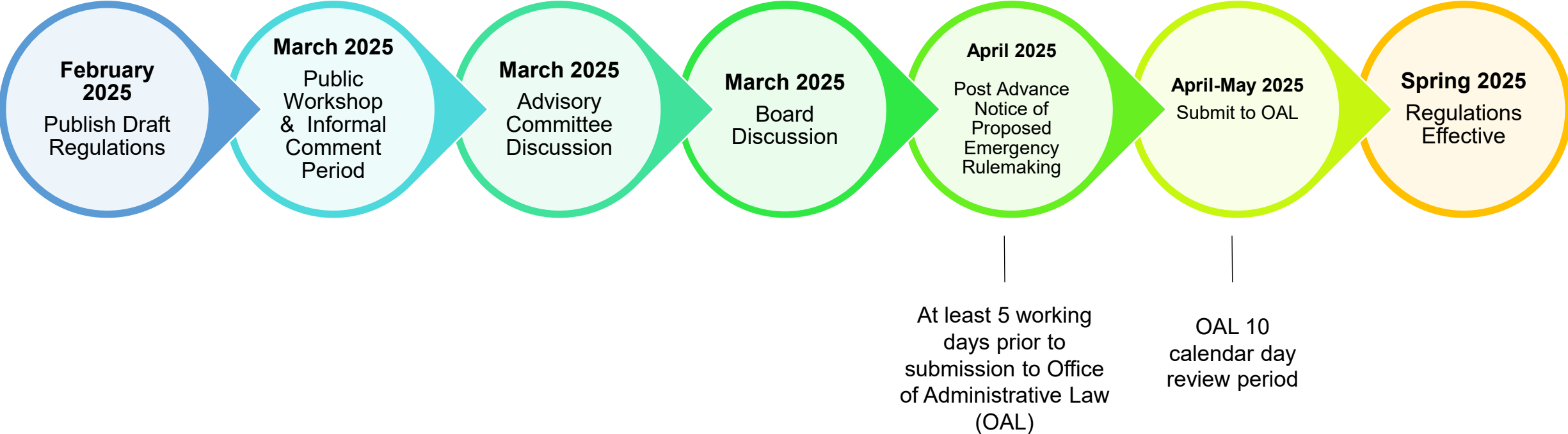
Office of Health Care Affordability  
Department of Health Care Access and Information

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

Vishaal Pegany, Deputy Director  
CJ Howard, Assistant Deputy Director



# Hospital Sector Rulemaking Timeline for OHCA's Recommendation



# Text of Proposed Regulations

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

## **§ 97446. Health Care Sectors**

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

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

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

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

# Public Comments Received

Theme	Key Points
<p><b>May be premature to set hospital sector targets at this stage.</b></p>	<ul style="list-style-type: none"><li>• Proposed Hospital sector comes years ahead of statutory deadlines</li><li>• Concern that patient access to care and the health of California hospitals are at stake.</li><li>• Singling out a single sector will destabilize equitable access to high-quality hospital care and undermine collaboration toward a shared vision of improved health care affordability for all Californians.</li><li>• OHCA has not yet done the following:<ul style="list-style-type: none"><li>○ Cross-sector analysis or evaluated the impacts of either the statewide or a reduced target on equitable access to high-quality care</li><li>○ Analyzed full year of comprehensive spending data.</li><li>○ Looked at available data for any other potential sector</li><li>○ Determined how hospital spending growth will be measured.</li><li>○ Assessed the reasonableness of the statewide spending target</li></ul></li></ul>

# Public Comments Received

Theme	Key Points
<b>Support for the proposed Hospital Sector Definition Regulations</b>	<ul style="list-style-type: none"><li>• Regulation consistent with the statute. Appreciate including all hospitals and those that are operated by Kaiser, consistent with SB 383.</li><li>• Definition takes a comprehensive approach to include all hospitals licensed as health care facilities in California, with the flexibility to adjust for select facilities in the future.</li><li>• Flexibility - including all hospitals in the proposed definition does not necessarily mean that all hospitals will be subject to a spending target. separate from the statewide target that is already in effect</li><li>• Any justifiable reasons for not meeting the target can be teased out in further discussions with stakeholders around enforcement.</li></ul>





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

# Public Comment





# Healthcare Payments Database Program Update

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



# HPD Overview & Background

Michael Valle, HCAI Deputy Director, Information Services

# HPD Program Overview

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

## The HPD Program will continue to:

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

# What Information Is On a Claim?

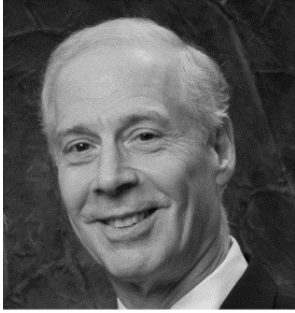
- Patient information
- Provider information
- Service date and location
- Diagnosis and procedure information
- Pharmacy information
- Payment information:
  - Base charge
  - Plan allowed amount
  - Amount plan paid to provider
  - Cost sharing paid by consumers

The image shows a CMS-1500 Health Insurance Claim Form, titled "HEALTH INSURANCE CLAIM FORM" and "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05". The form is divided into several sections:

- Section 1:** Insurance type selection (Medicare, Medicaid, Tricare, etc.).
- Section 2:** Patient's name and address.
- Section 3:** Patient's birth date, sex, and relationship to the insured.
- Section 4:** Insured's name and address.
- Section 5:** Patient's address, city, state, and ZIP code.
- Section 6:** Patient's status (Single, Married, etc.).
- Section 7:** Insured's address, city, state, and ZIP code.
- Section 8:** Other insured's name and address.
- Section 9:** Other insured's policy or group number.
- Section 10:** Patient's condition related to the claim (Employment, Auto accident, etc.).
- Section 11:** Insured's policy group or FECA number.
- Section 12:** Patient's or authorized person's signature and date.
- Section 13:** Insured's or authorized person's signature and date.
- Section 14:** Date of current illness or injury.
- Section 15:** Date of previous illness.
- Section 16:** Dates patient unable to work.
- Section 17:** Name of referring provider.
- Section 18:** Hospitalization dates.
- Section 19:** Reserved for local use.
- Section 20:** Outside lab charges.
- Section 21:** Diagnosis or nature of illness or injury.
- Section 22:** Medicaid resubmission code.
- Section 23:** Prior authorization number.
- Section 24:** Table for procedures, services, or supplies, including dates of service, place of service, diagnosis, and charges.
- Section 25:** Federal tax ID number.
- Section 26:** Patient's account number.
- Section 27:** Accept assignment?
- Section 28:** Total charge.
- Section 29:** Amount paid.
- Section 30:** Balance due.
- Section 31:** Signature of physician or supplier.
- Section 32:** Service facility location information.
- Section 33:** Billing provider info.

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

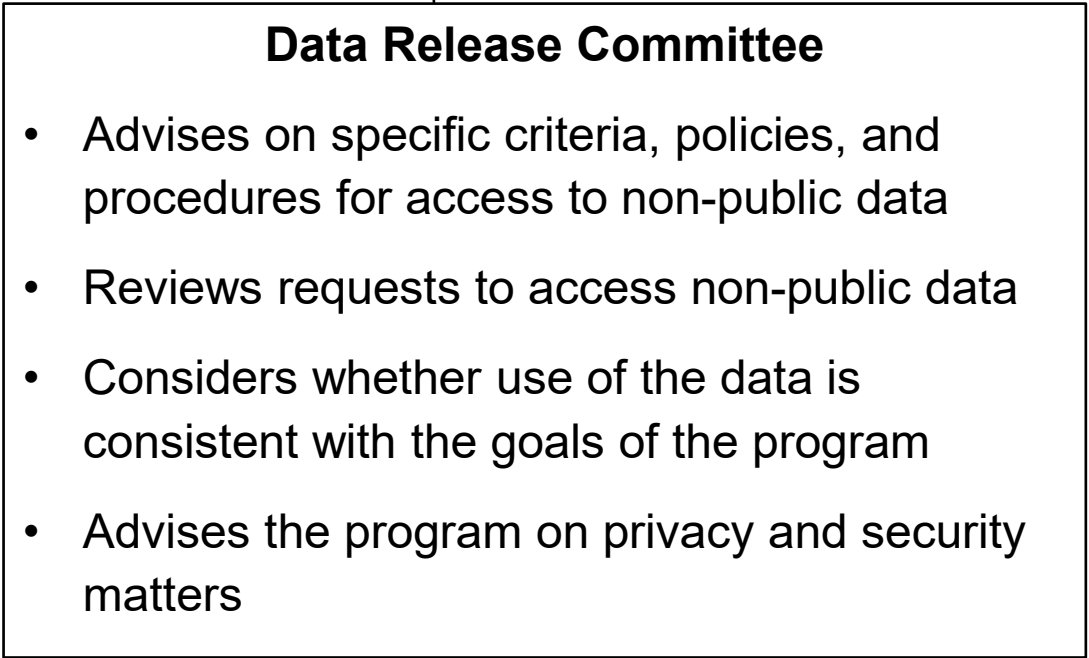
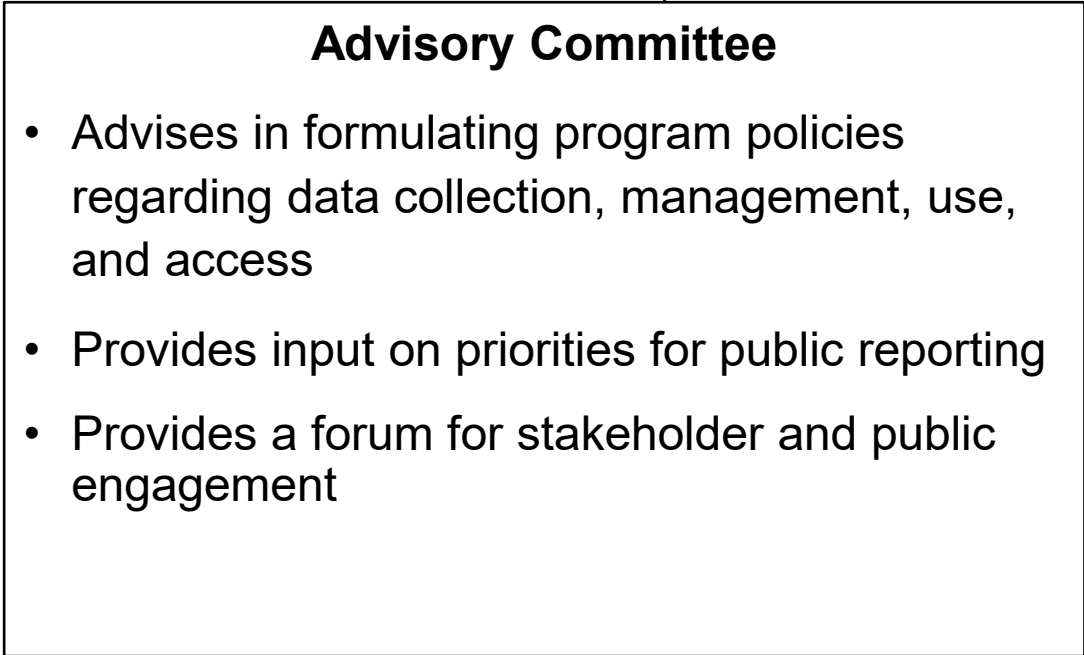
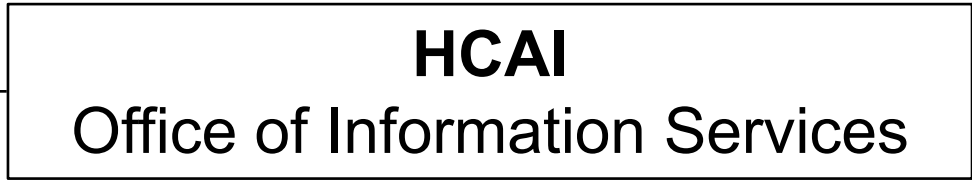
# HPD Stakeholder Governance



Ken Stuart, Chair  
California Health Care Coalition



Nuriel Moghavam, MD, Chair  
Los Angeles General Medical Center



# 2025 Program Priorities



## Data Collection

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



## Public Reporting

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



## Data Release

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

# HPD Data Collection

Dionne Evans-Dean, HCAI Chief Data Programs Officer



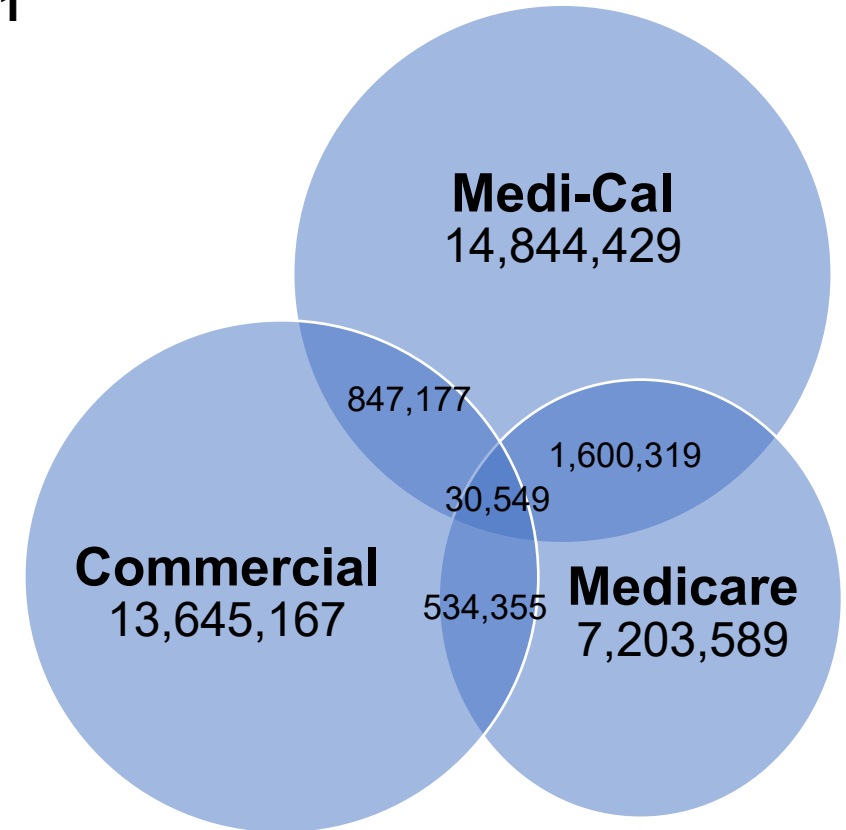
# What is in the HPD?

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

# Distribution of Individuals by Type of Coverage

December 2021

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

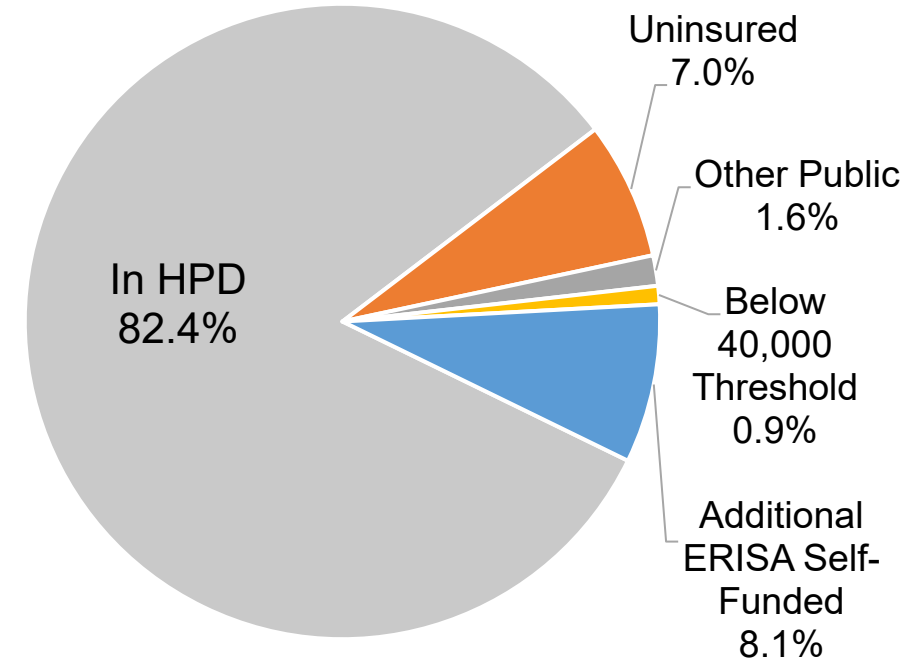


Notes: Data in each of the circles of the Venn diagram represent total enrollment in those programs, including the overlap figures. For example, there were 7,203,589 Medicare members in December 2021, including 1,600,319 that were also in Medi-Cal and 30,549 that were covered by all three product types.

# The HPD System Includes 82% of Californians

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

Percent of Californians, 2021



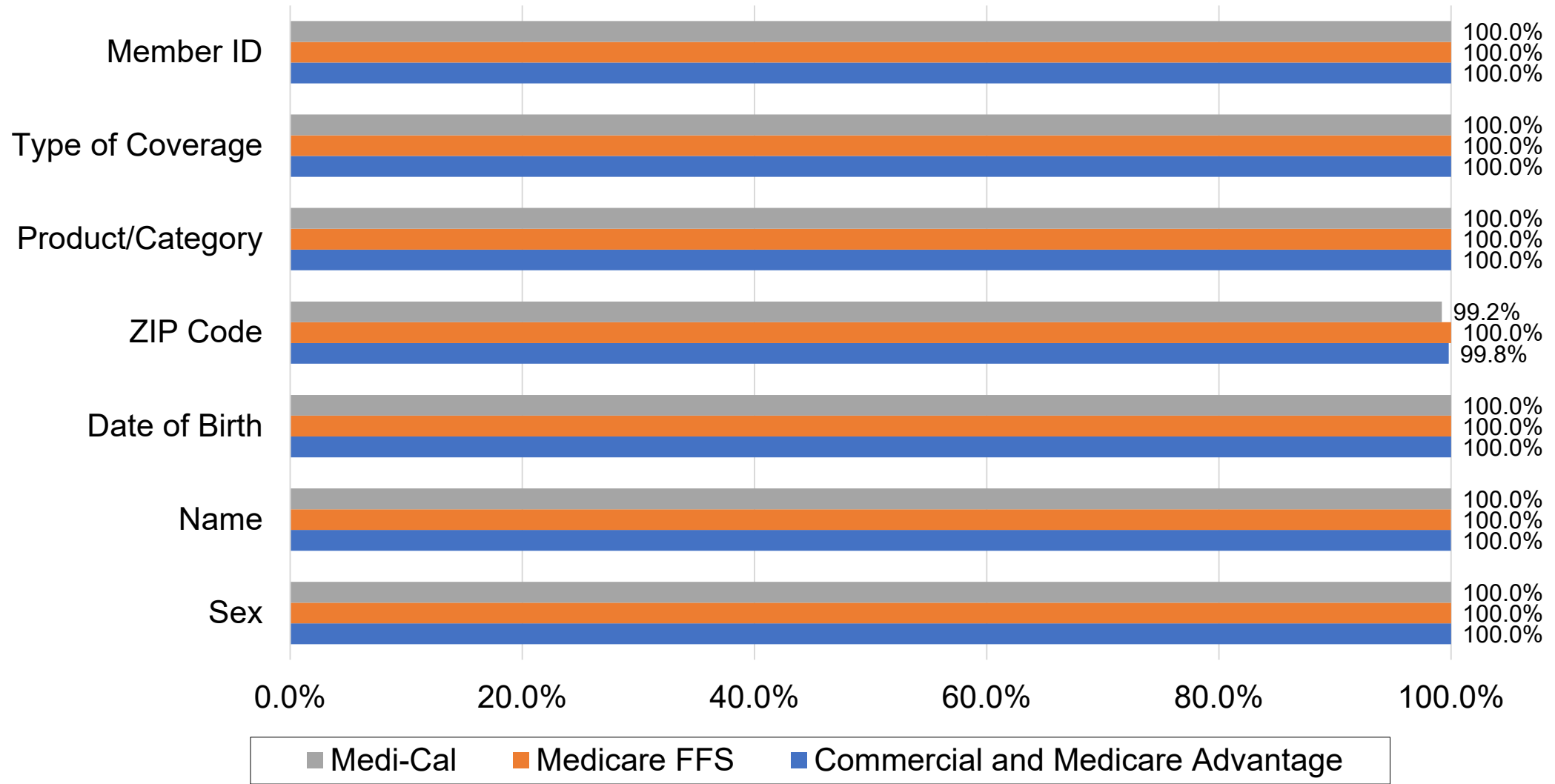
Notes:

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

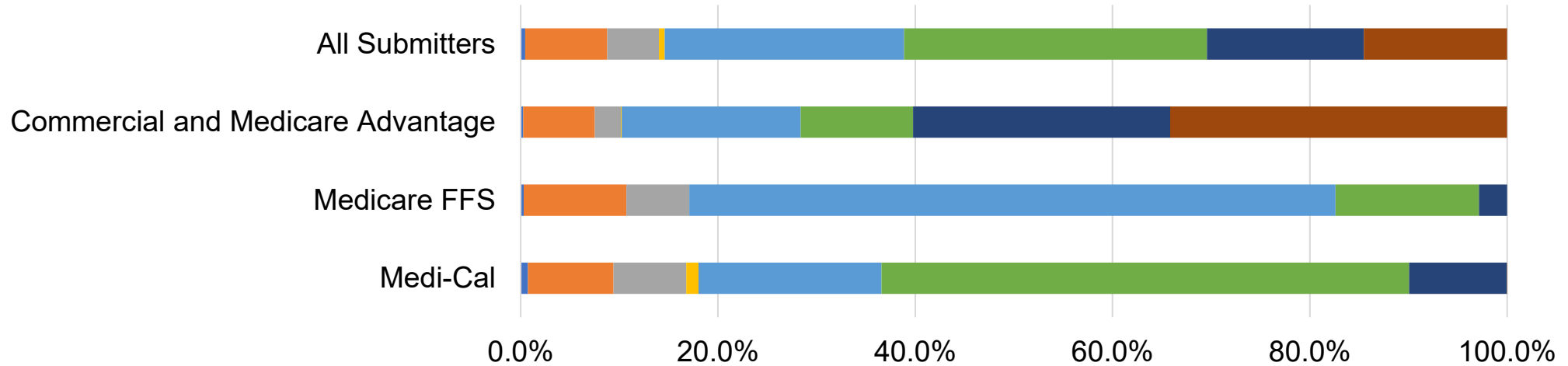
# Data Quality (Data Element Completeness)

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

## Percent Complete for Selected Eligibility Elements, 2021



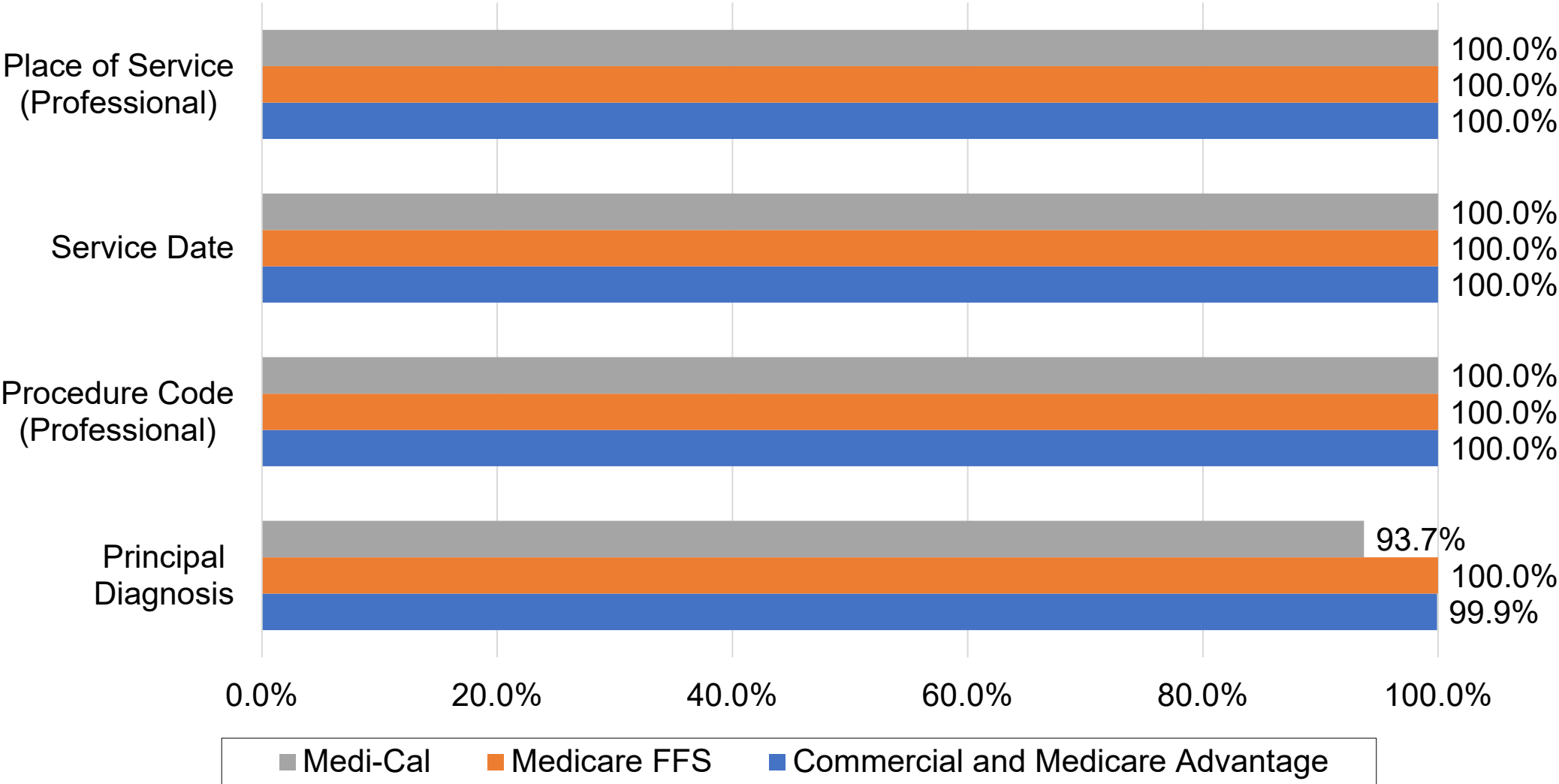
## Distribution of Race Values by Submitter Type, 2021



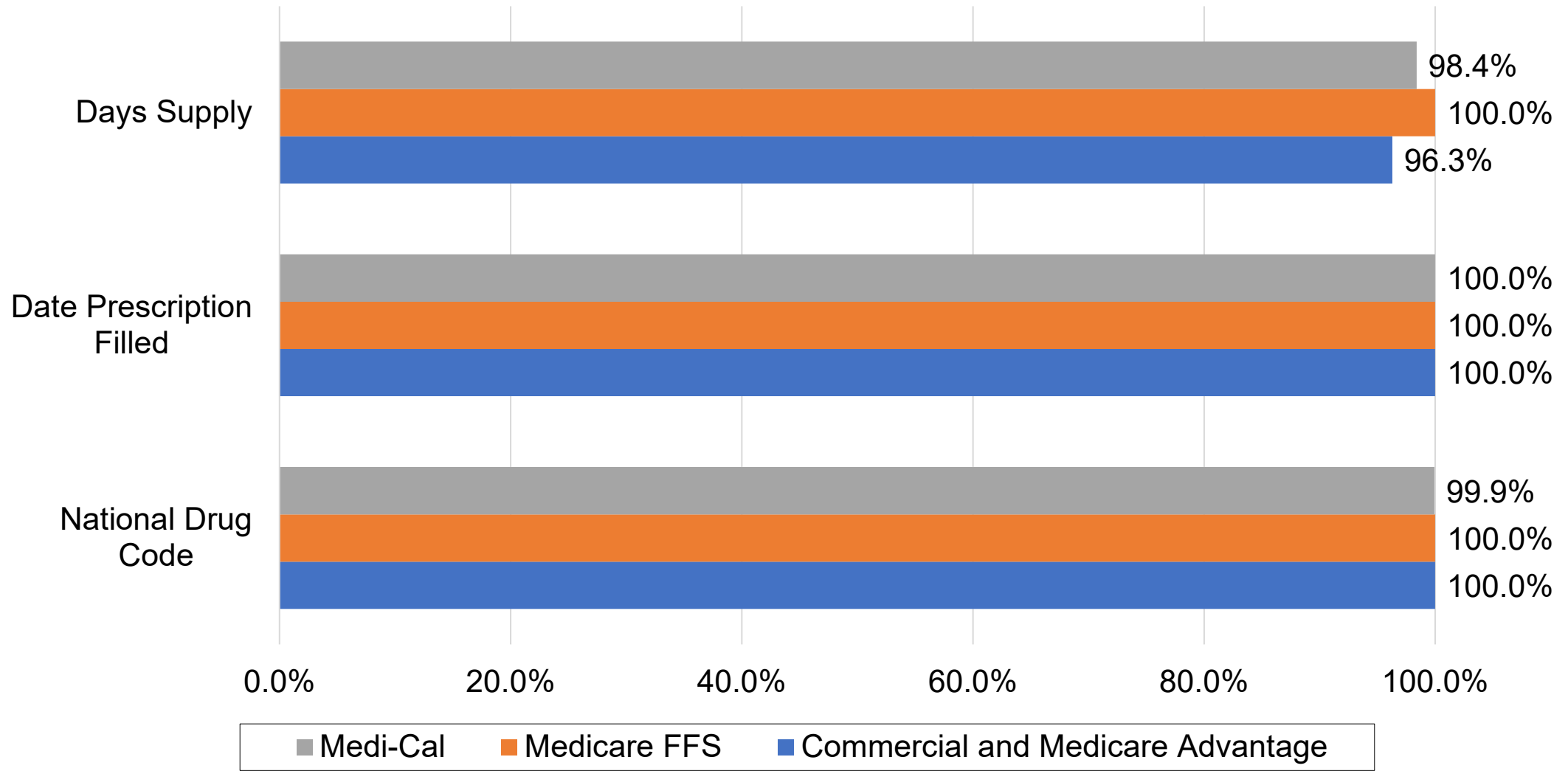
	Medi-Cal	Medicare FFS	Commercial and Medicare Advantage	All Submitters
■ American Indian/Alaska Native	0.7%	0.3%	0.2%	0.5%
■ Asian	8.7%	10.4%	7.3%	8.3%
■ Black/African American	7.4%	6.4%	2.7%	5.3%
■ Native Hawaiian/Other Pacific Islander	1.2%	0.0%	0.1%	0.6%
■ White	18.5%	65.5%	18.2%	24.3%
■ Other	53.5%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

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

# Percent Complete for Selected Medical Elements, 2021

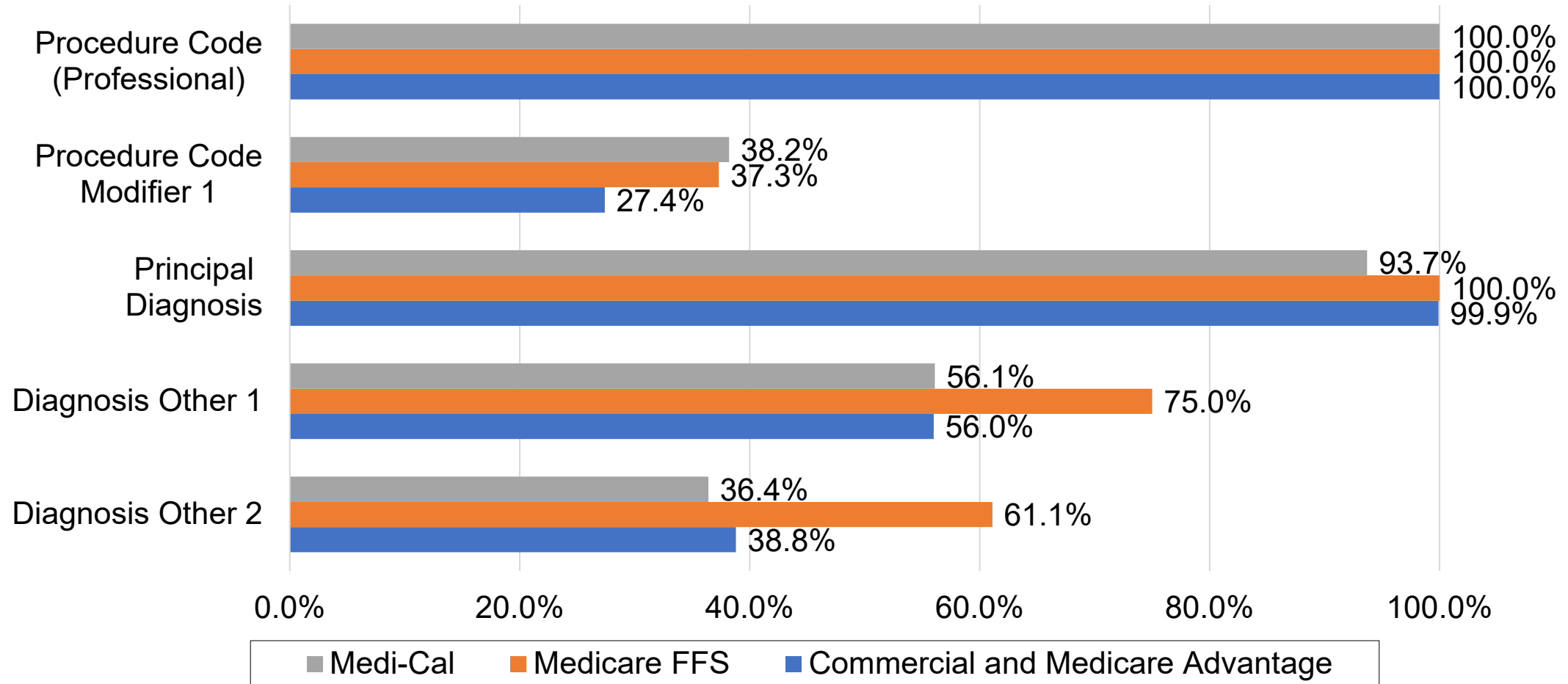


## Percent Complete for Selected Pharmacy Elements, 2021





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



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

# HPD Provider Data – Completeness Rates

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

■	High Data Quality
■	Medium Data Quality
■	Low Data Quality

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

# Individual Provider – NPI to NPPES Example

## From Commercial Provider File

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

Most prevalent examples continue for thousands of rows.

## From CMS NPPES

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

\*Fictitious data emulating real identified scenarios

# Organization Provider – NPI to NPPES Example

## From Commercial Provider File

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

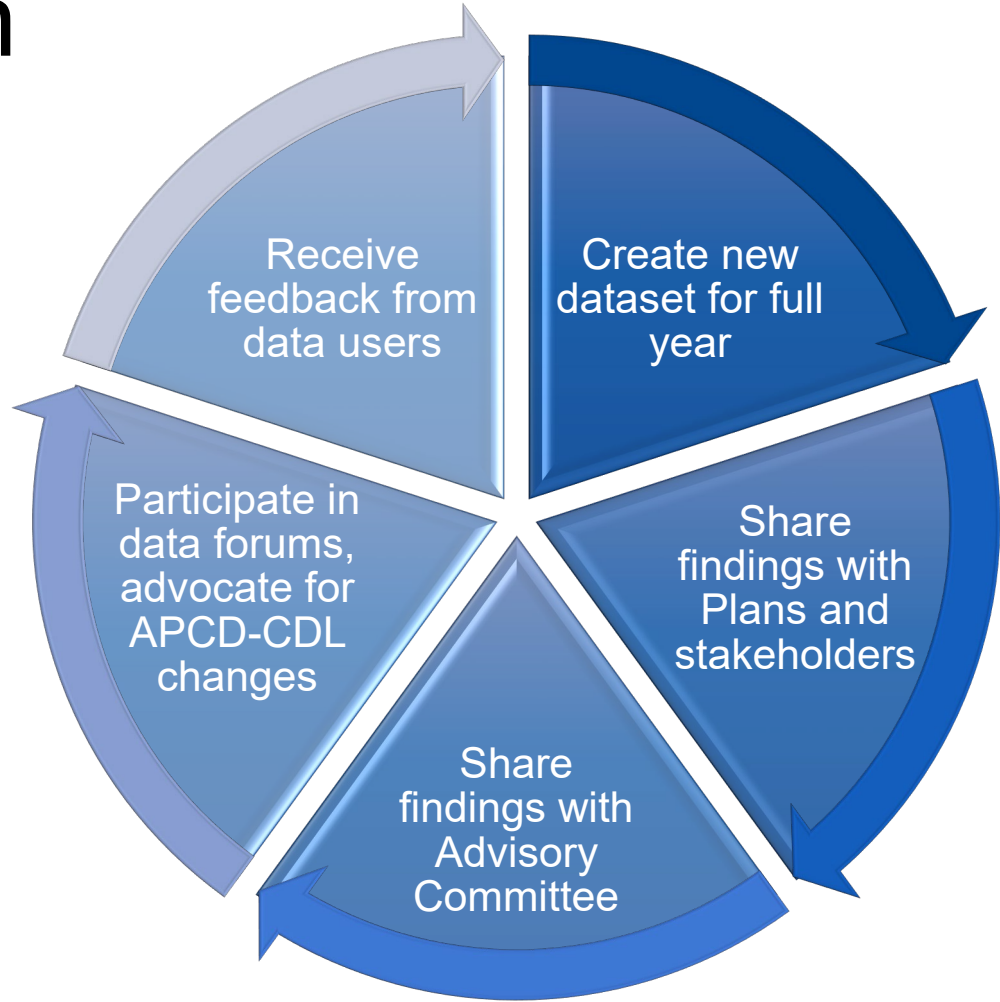
Most prevalent examples continue for thousands of rows.

## From CMS NPPES

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

\*Fictitious data emulating real identified scenarios

# Approach for Ongoing Data Quality Collaboration



# Ongoing data collection activities

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

# HPD Data Reporting & Use

Christopher Krawczyk, PhD., HCAI Chief Analytics Officer

# Generational Model of Data (GMod) Analysis

## HCAI'S GOALS

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

## ENGAGING STAKEHOLDERS AND CUSTOMERS

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

## INITIAL ANALYTICS AND PRODUCT RELEASE

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



# HPD Public Reporting Priorities

## Specific Topics

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

## Broader Categories

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

### Other Activities Underway

Updates to existing HPD public reports with new years of data

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

# Public Reporting Pipeline

## Reports Released

- HPD Snapshot - Update
- Measures with LA SPAs
- Prescription Drug Costs
- Services
- Out-of-Pocket Costs

## Late-Stage Development

- Prescription Drug Costs - Update
- Healthcare Visits
- Updates to HPD Snapshot and Measures

## Early/Mid-Stage Development

- Health Equity
- Hospital Costs

## Analyses for DHCS

- End of Continuous Coverage/ “Unwinding”
- Primary Care
- Dual Eligibles

# HPD Program Releases

# HPD Snapshot

## 1. Data Overview

- Counts of product types, individuals, and total records by payer type, claim type, and reporting year
- Top product types by count of individuals

## 2. Data Availability

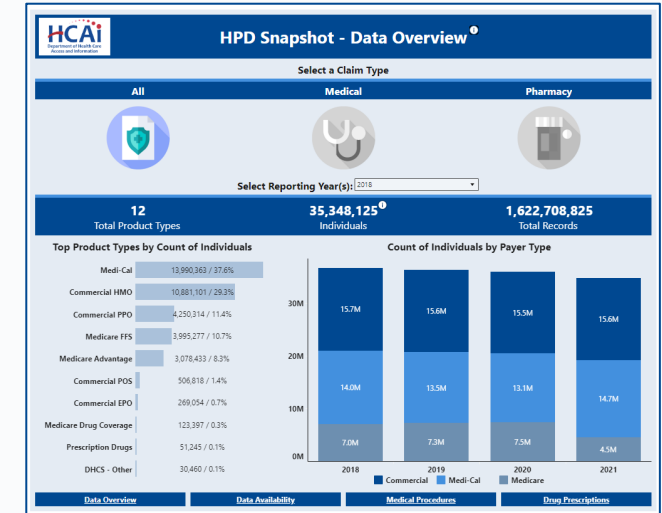
- Count of enrollment and service records, member months, and unique individuals by product type
- Filters for claim type, payer type, and reporting year

## 3. Medical Procedures

- Top 25 medical procedures by record count, procedure category, and type of setting
- Filters for type of setting, payer type, and reporting year

## 4. Drug Prescriptions

- Top 25 prescriptions filled by record count, drug name, and drug class
- Filters for drug class, drug type, payer type, and reporting year



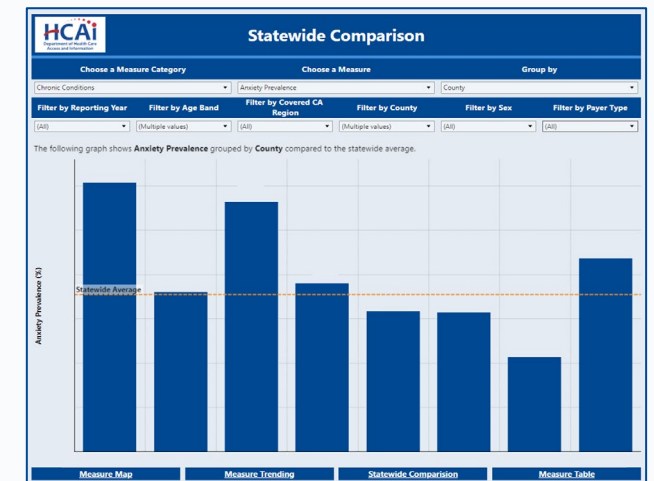
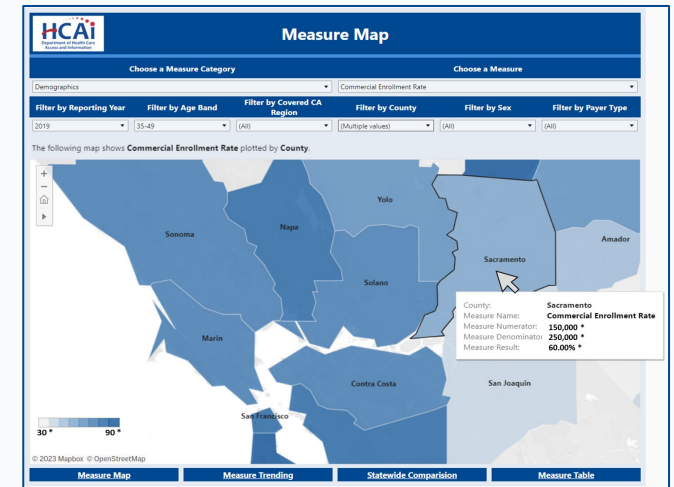
**HPD Snapshot - Top Medical Procedures**

Search by Procedure Category: (All) | Filter by Type of Setting: (All) | Filter by Payer Type: (All) | Filter by Reporting Year: (All)

Rank	Procedure Category	Type Of Setting	Total Record Count
1	Office/outpatient services - Office visits	Provider	334,761,008
2	Laboratory - Chemistry and hematology	Independent Labs	327,205,475
3	Laboratory - Chemistry and hematology	Outpatient	238,982,753
4	Laboratory - Other	Independent Labs	128,762,045
5	Prophylactic vaccinations and inoculations	Provider	122,420,573
6	Office/outpatient services - Office visits	Outpatient	121,361,606
7	Physical/occupational/speech therapy - Exercises	Provider	113,480,112
8	Medications (injections, infusions, other forms)	Outpatient	105,402,248
9	Laboratory - Chemistry and hematology	Provider	94,690,364
10	Microscopic examination (e.g. lab, toxicology)	Independent Labs	90,404,727
11	Alcohol and drug management, treatment, and rehab.	Provider	83,003,005
12	Psychological and psychiatric evaluation, therapy	Provider	73,863,376
13	Hospital inpatient services	Provider	71,232,750
14	Ophthalmology/otologic diagnosis and treatment	Provider	68,878,781
15	Transportation - Patient, provider, equipment	Ambulance	63,248,083
16	CPT codes not classified (F codes)	Provider	57,541,286
17	DME and supplies	Provider	56,011,167
18	Laboratory - Other	Outpatient	54,791,366
19	Radiology - Diagnostic (other)	Provider	52,078,215
20	Non-hospital-based care (home health, hospice)	Home Health	45,058,101
21	Medications (injections, infusions, other forms)	Provider	41,991,043
22	Office/outpatient services - Preventive visits	Provider	39,746,991
23	Emergency department services	Provider	38,783,729
24	Microscopic examination (e.g. lab, toxicology)	Outpatient	38,016,202
25	Laboratory - Other	Provider	35,753,905

# HPD Measures

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



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

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

The visualizations covers three topics:

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

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

Costliest
Most Frequently Prescribed
Out-of-Pocket Costs

Brand or Generic:

**Statewide Commercial Totals**

Number of Prescriptions	Number of Individuals	Total Cost	Cost per Prescription	Out-of-Pocket Median
101.39M	9.78M	\$13.197M	\$130.16	\$12.41

**Top 25 Costliest Drugs Commercial Totals**

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

Sort by:

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

# HPD Services

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

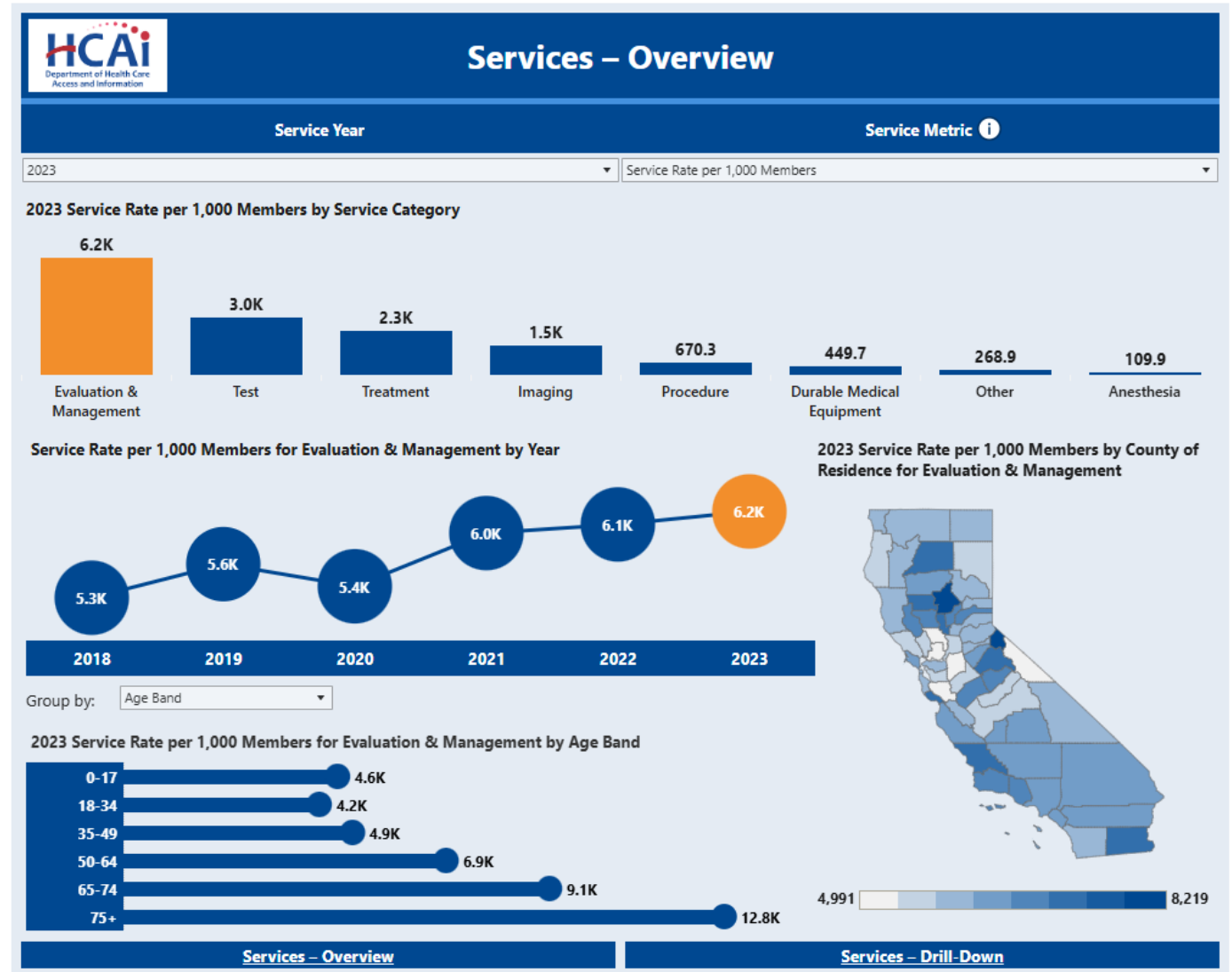
- "Services" refers to individual procedures ranging from consultations with specialists, to a routine mammogram, to anesthesia administration during surgery
- Explores the "who, what and where" of the most common healthcare services provided to Californians each year

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

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

# HPD Services (Cont.)

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





# HPD Services (Cont.)

Services – Drill-Down

Metric i
Group Rows by
Group Columns by
Service Category
County Granularity

Service Rate per 1,000 Members
Service Category
Reporting Year
(All)
County

Age Band
County of Residence
Covered CA Region
Sex
Payer Type

(All)
(All)
(All)
(All)
(All)

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

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

Services – Overview
Services – Drill-Down

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

County Granularity

County

County

County + LA Service Planning Area

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

Service Category

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

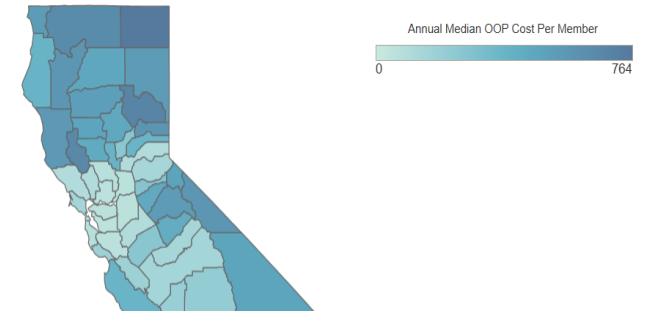
Cancel
Apply

# Out-of-Pocket-Costs

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

Metric: Annual Median OOP Cost Per Member | Payer Type: All, Excluding Medi-Cal | Chronic Condition: All

Statewide Total		
Sum of Member Count	Annual Median OOP Cost Per Member	Annual Median Claim Count Per Member
17,582,555	\$84	8



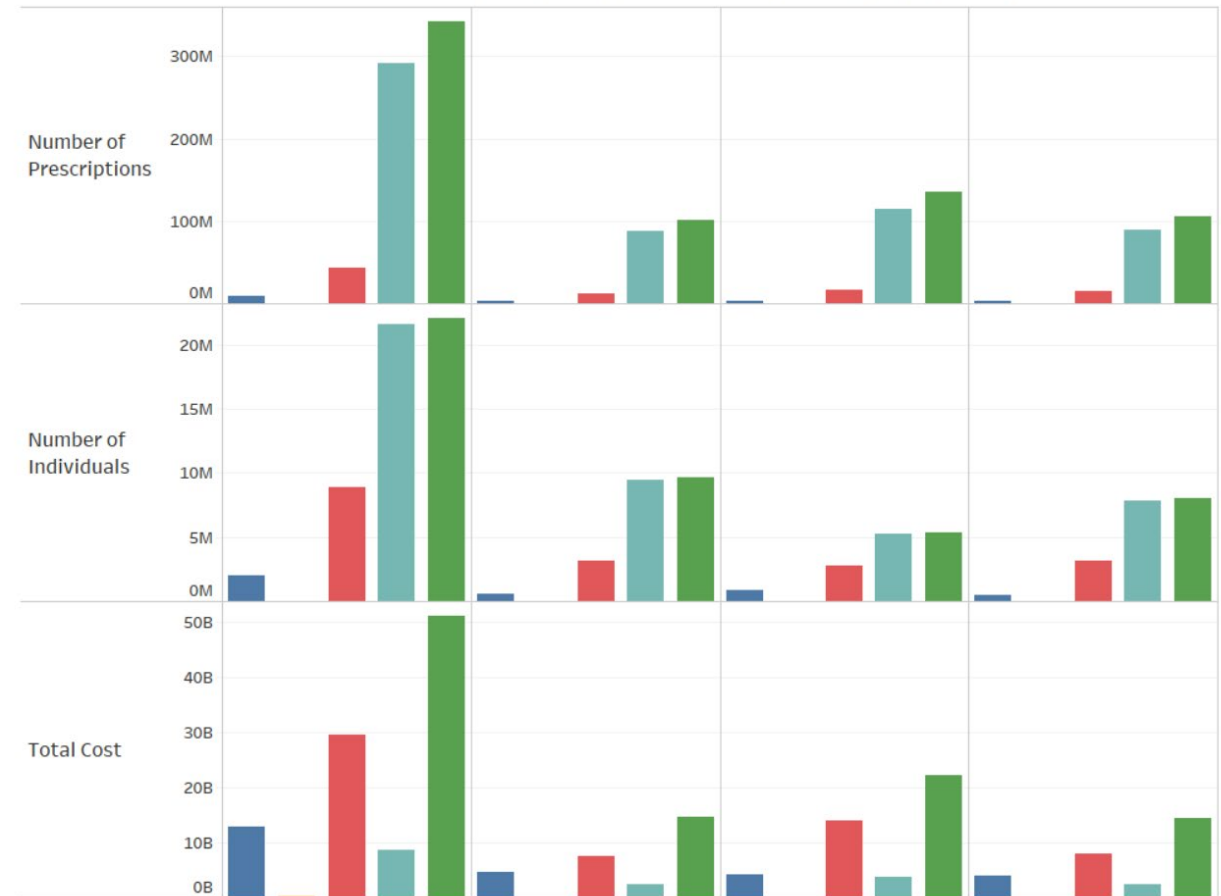
Chronic Condition	Annual Member Count	Annual Median OOP Cost Per Member	Annual Median Claim Count Per Member
Acute Myocardial Infarction	79,509	\$2,268	40
Alzheimers Disease	127,942	\$499	23
Anemia	1,291,001	\$670	28
Anxiety	2,027,970	\$310	18
Asthma	1,029,186	\$228	17
Atrial Fibrillation	714,098	\$600	27
Breast Cancer	305,669	\$472	23
Chronic Kidney Disease	1,276,897	\$321	22
Colorectal Cancer	92,875	\$600	25
Combined Cancer	787,599	\$520	24
COPD	889,707	\$490	26
Dementia	423,374	\$490	25
Depression	2,094,888	\$277	18
Diabetes	2,326,235	\$220	16
Heart Failure	678,312	\$747	31
Hip/Pelvic Fracture	63,995	\$1,375	39
Hyperlipidemia	4,634,477	\$275	16
Hypertension	4,796,337	\$270	16
Ischemic Heart Disease	1,075,112	\$651	26
Obesity	1,748,577	\$250	16
Osteoporosis	817,377	\$345	21
Rheumatoid Arthritis	2,358,126	\$449	23
Stroke	327,542	\$1,020	32

# HPD Program Upcoming Releases: Late-Stage Development

# Late-Stage Development: Prescription Drug Cost Report Update

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

Statewide totals by Payer Type and Drug Category (2022)



PRELIMINARY ANALYSIS – PREPUBLICATION DRAFT

# Late-Stage Development: HPD Visits

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

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

# Analysis for DHCS

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

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

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

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

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



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

Count of Primary Care Providers, Primary Care Claims, and Patients, by Year, 2018-2022

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

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

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

# HPD Data Release Program

# Data Release Program

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

# HPD Program Product Demonstrations

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

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

# 2025 Program Priorities



## Data Collection

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



## Public Reporting

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



## Data Release

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

# OHCA Use Case: Measuring Behavioral Health Spending

# HPD Analysis of Behavioral Health Spending

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





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

# Public Comment





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

# General Public Comment

Written public comment can be emailed to:

[ohca@hcai.ca.gov](mailto:ohca@hcai.ca.gov)

To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.



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

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



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

# Adjournment



Department of Health Care  
Access and Information