Advisory Committee on Data Issues

May 5, 2022

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Data Issues
Meeting Materials Book

May 5, 2022
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

Index

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Advisory Committee on Data Issues
AGENDA

May 5 , 2022
10:00 a.m. – 12:00 p.m.
Zoom Meeting

Committee Members:					
☐	Megan Atkinson	☐	Jason Brown	☐	David Mancuso
☐	Amanda Avalos	☐	Jerome Dugan	☐	Ana Morales
☐	Allison Bailey	☐	Leah Hole-Marshall	☐	Hunter Plumer
☐	Jonathan Bennett	☐	Scott Juergens	☐	Mark Pregler
☐	Purav Bhatt	☐	Lichiou Lee	☐	Julie Sylvester
☐	Bruce Brazier	☐	Josh Liao	☐	

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00 – 10:05 (5 min)	Welcome, call to order, and roll call		AnnaLisa Gellermann Health Care Authority
10:05 – 10:10 (5 min)	Approval of March meeting minutes	2	AnnaLisa Gellermann Health Care Authority
10:10 – 10:15 (5 min)	Topics for today	3	AnnaLisa Gellermann Health Care Authority
10:15 – 10:20 (5 min)	Recap of March discussion	4	AnnaLisa Gellermann Health Care Authority
10:20 – 10:35 (15 min)	Truncation Report and Recommendation	5	Ross McCool Health Care Authority
10:35 – 10:55 (20 min)	Benchmark Data Call Technical Manual	6	January Angeles Bailit Health
10:55 – 11:05 (10 min)	Public comment		AnnaLisa Gellermann Health Care Authority
11:05 – 11:35 (30 min)	The Colorado Story: Hospital Cost Analysis	7	John Bartholomew Tom Nash
11:35 – 11:55 (20 min)	Grant proposal in development: Policy Support Unit	8	AnnaLisa Gellermann Health Care Authority
11:55 – 12:00 (5 min)	Wrap-up and adjournment		AnnaLisa Gellermann Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Advisory Committee of Providers and Carriers will be conducted virtually.

Washington State Health Care Authority

March meeting minutes

TAB 2

Advisory Committee on Data Issues meeting minutes

March 1, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
10:00 a.m. – 12:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Health Care Cost Transparency Board webpage.

Members present

Allison Bailey
Ana Morales
David Mancuso
Hunter Plumer
Jason Brown
Jonathan Bennett
Julie Sylvester
Leah Hole-Marshall
Lichiou Lee
Mark Pregler
Purav Bhatt
Scott Juergens

Members absent

Jerome Dugan
Josh Liao

Agenda items

Welcome, Roll Call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m.

Approval of Minutes

AnnaLisa Gellermann provided a recap of the January Committee meeting, and the Committee approved them.

Topics for Today

Topics include a recap of the January meeting discussion, a presentation of price and utilization analysis developed by OnPoint at the request of the Office of the Insurance Commissioner, and a presentation by Bailit health on spending and spending growth in Washington state.

Recap of January Discussion

AnnaLisa Gellermann, HCA

Ms. Gellermann presented a recap of the January meeting which included the introduction of const analyses and cost growth drivers. The committee also heard the distinction between Phase 1 reports (standard analytic reports intended to be reproduced annually), and Phase 2 reports (in-depth analyses based on results of Phase 1). Initial Phase 1 reports will include price/utilization, health condition, and demographic. The committee also discussed truncation and recommended both a Washington specific analysis of truncation and an approach that would permit visibility of truncation totals.

Office of the Insurance Commissioner Cost Analysis

Jane Beyer, Sr. Health Policy Advisor, Office of the Insurance Commissioner
Amy Kinner, OnPoint

Ms. Beyer introduced an analysis requested by the Office of the Insurance Commissioner of claims data from the Washington All-Payer Claims Database (WA-APCD) focused on cost trends in the commercial market. Ms. Beyer shared that Commissioner Kreidler has a long-standing concern about the cost of care, including the results of consolidation, and wanted specific information on the Washington state commercial market.
Ms. Kinner presented the analysis. The goals of the project were to calculate the rate of cost growth in Washington for commercial insurance spending, identify drivers of cost, and determine how much of the change in cost is due to price versus utilization. Additional areas for deeper analysis included the type of inpatient service, mental health services, air ambulance services, and the Exchange and PEBB markets. All reflected increased cost in various markets.

Public Comment

There was no public comment.

Data on Spending and Spending Growth in Washington

Michael Bailit, Bailit Health
January Angeles, Bailit Health

Mr. Bailit presented existing data about health care spending in Washington to identify potential opportunities to slow cost growth. He asked the committee to focus on three questions: what do the data say about where costs are highest and rising fastest, are there concerns that should be considered when interpreting the data, and what further analyses should HCA consider to better understand what is driving spending and spending growth?
Mr. Bailit reviewed overall market trends from various sources, including the Washington Health Alliance, the Office of the Insurance Commissioner, and the Health Care Cost Institute. Each of these reflected upward cost trends in various markets and sectors.

Mr. Bailit posed the questions directly to the committee and asked for feedback. One committee member commented that clear conclusions were difficult to make based on the wide variety of reports presented, but that deeper review would allow meatier conclusions. One member raised the question of whether the APCD collected race and ethnicity data and wondered if it would be possible to analyze race and ethnicity composition in different markets (e.g., Medicaid and commercial) and the extent to which price differentials in those markets exist and contribute to disparities across communities, and further whether per capita growth targets might exacerbate those differentials. Mr. Bailit stated that differentials did exist, and that data collection was unfortunately not standardized, and that APCDs unfortunately did not tend to have adequate demographic data. As a result, other

data sources would be necessary and that other states have used data from the American Community Survey that allow a look at race and income.

Ms. Angeles continued the presentation and turned to service category level trends in spending, beginning with a chart comparing Washington vs. national growth in prescription drug spending based in a 2018 Health Care Cost Institute Report. This report indicated that Washington's increase in prescription drug spending over the period was significantly higher than the national average. He presented information from Washington Health Alliances Total Cost of Care tool, including a map of relative cost by county, commercial spending by service category, and Medicaid spending by service category, and commercial inpatient spending trends. Ms. Angeles highlighted a conclusion related to pharmacy cost, indicating the prescription drug spending is the highest cost and fastest growing service category. She also highlighted that spending for inpatient care declined by 1.5%, but that an increase in price (per unit price and service intensity) accounted for an overall increase in spending, which 21 of 287 patients accounting for half the inpatient spending in the state.

At the conclusion of her presentation, Ms. Angeles sought feedback from the committee, asking if it triggered further ideas from the group about opportunities for further analysis. Several committee members suggested that additional mandated services should be identified when considering cost trends, especially in Medicaid. One member suggested that new drug availability should also be considered as a driver of cost. One member suggested awareness of procedure shifts from in-patient to out-patient, for example knee replacement surgeries.

Benchmark Performance Assessment

January Angeles, Bailit Health

Ms. Angeles presented the committee with information related to risk adjustment of benchmark data. For future measurement of performance against the target, spending will be risk-adjusted using standard age/sex factors. To implement this, carriers will need to submit aggregate spending and member months data by age/sex cells. Ms. Angeles shared the staff proposal to use eight age bands for all markets: 0-1, 2-18, 19-39, 40-54, 55-64, 65-75, 77-84 and 85+. She shared that Rhode Island was the first state to use age/sex risk adjustment, and that this was the method they were using.

Ms. Angeles asked the committee if the proposed age bands seemed reasonable, and if there was a preference for which point in the year would be used to set the age. The committee asked if there were any results from Rhode Island, and Ms. Angeles shared there was preliminary data showing some, but not large, differences. One committee member suggested that in the commercial market 2-24 was a frequently used band and suggested talking to plan actuaries to determine if there was a need to use different bands for different lines of business. One committee member responded that December 31 was an easier point in time to use, and no other preference was suggested.

Ross McCool, HCA, provided an update on truncation analysis. HCA has contracted with OnPoint to perform an analysis of truncation level impacts in Washington. The analysis will be presented at a future meeting. Mr. McCool also provided a truncation dashboard created by committee member Hunter Plumer. Mr. Plumer shared his dashboard based on MEPS data.

Wrap Up and Adjournment

Meeting adjourned at 12:00 p.m.

Next meeting

Thursday, May 5, 2022
Meeting to be held on Zoom
10:00 a.m. – 12:00 p.m.

Washington State Health Care Authority

Topics for today

TAB 3

Topics for today

- Truncation report and recommendations
- Benchmark data call technical manual
- Colorado hospital cost study
- Grant proposal: review and feedback

Washington State Health Care Authority

Recap of March Discussion

TAB 4

Recap of March discussion

- OnPoint presentation of price/utilization in the commercial market, 2016-2019
- Review of data on spending and spending growth in Washington
  - Committee suggested that future analyses should identify impact of additional mandated services and new drug availability.
  - Analyses should also consider shifts of procedures from inpatient to out-patient (eg knee replacement).
- Benchmark performance assessment
  - Reviewed recommendation for age banding, and point in time for age progression
  - Truncation discussion, pending report

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Truncation report and recommendation

TAB 5

Reminder of Board Decision on Truncation

- Upon recommendation by the Data Committee, the Board decided to "truncate" high-cost outlier spending when assessing performance against the benchmark.
  - Truncated spending will only be used for payer and provider benchmark performance.
  - Untruncated spending will be used to calculate state and market-level performance.
- The Board instructed HCA to conduct further research into what the appropriate truncation thresholds might be for each market segment in Washington.

Truncation Analysis Using Washington Data

- Following the Board's direction, HCA commissioned OnPoint to conduct a truncation analysis using data from the Washington All-Payer Claims Database (APCD).
- Specifications for the truncation analysis included the following:
  - Claims incurred between Jan 1, 2017 and Dec 31, 2019.
  - Commercial, Medicaid managed care and Medicare Advantage products
  - All claim types (medical and pharmacy)
  - All ages
  - Washington residents only
  - Restricted to claims paid as primary and primary eligibility

Approach to Evaluating Truncation Points

- OnPoint used two approaches to evaluating truncation points:
  - Identify percentage of 2019 spending that that would be removed by using specific dollar thresholds
  - Identify the dollar thresholds that would need to be established to remove a certain percentage of 2019 spending
- For both approaches, OnPoint calculated:
  - Percentage of members with spending exceeding specific dollar cut-offs
  - Percentage of total spending above the threshold

Spending Removed with RI Truncation Levels

Market	Truncation Level	Percent of Health Expenditures Removed with Truncation	Percent of Members Exceeding Threshold
Commercial	$150,000	7.05%	0.22%
Medicaid (MC)	$200,000	3.14%	0.04%
Medicare (Adv)	$100,000	7.14%	1.03%

Chart based on findings for 2019
RI's Medicaid Truncation level was $250,000
Truncation analysis performed by OnPoint

Truncate ~5% of Spending

Market	Truncation Level	Percent of Health Expenditures Removed with Truncation	Percent of Members Exceeding Threshold
Commercial	$200,000	5.02%	0.12%
Medicaid (MC)	$125,000	5.47%	0.12%
Medicare (Adv)	$125,000	4.85%	0.64%

Chart based on findings for 2019
Truncation analysis performed by OnPoint

Truncate Above 99.5 Percentile of Highest Spend

Market	Truncation Level	Percent of Health Expenditures Removed with Truncation	Percent of Members Exceeding Threshold
Commercial	$100,352	10.86%	0.44%
Medicaid (MC)	$65,536	11.27%	0.43%
Medicare (Adv)	$144,384	3.68%	0.45%

Chart based on findings for 2019
Truncation analysis performed by OnPoint

Discussion

- How do the results of the truncation analysis line up with payer/provider experience with truncation points used in total cost of care contracts?
- To capture the vast majority of spending while truncating spending for the fewest number of members, HCA recommends adopting the following truncation points that would remove the top ~5% of spending.
  - Commercial: $200k
  - Medicaid: $125k
  - Medicare: $125k
- Does the Data Committee have any concerns with the above proposal?

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Benchmark data call technical manual

TAB 6

Data Collection Timeline and Process

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Data Specifications Manual

- Which insurers are required to submit data
- Large provider entities for which insurers will submit spending data
- Data specifications, including:
  - Population inclusion/exclusion criteria
  - Categories of claims and non-claims spending (including code level definition for primary care) to report
  - Adjustments needed (including high-cost outlier truncation and estimates for partial claims data)
  - Attribution methodology
- Data submission process
- Data submission template

How Washington's Data Specifications Compare to Other States

- Population/spending inclusion/exclusion criteria will be the same.
  - Spending for state residents, regardless of where care was received.
  - Inclusion only of policies that provide comprehensive medical benefits.
- Claims and non-claims service categories are the same.
  - Primary care definitions will differ since each state has their own definition of primary care.
- Attribution methodologies vary slightly, but states generally allow insurers to use their own attribution methodologies.
- Adjustments to data may vary.
  - Most require adjustments to partial claims data.
  - Some apply truncation.

Feedback on the Data Specifications Manual

- HCA plans to distribute an initial draft of the data specifications manual for insurers to review.
  - It is important that the specifications be reviewed by the data analysts who will be working on the data request.
- HCA will schedule 1-2 calls in the May/June timeframe to obtain feedback from insurers.
  - Feedback should focus on identifying areas that need further clarification for insurers to be able to submit data according to HCA specifications.
  - Feedback on policies (e.g., what type of spending to include, truncation thresholds to use, etc.) will not be considered at this time.

Draft List of Insurers Required to Submit Data

- Kaiser Foundation Group
- UnitedHealth Group
- Premera Blue Cross Group
- Molina Healthcare Inc Group
- Cambia Health Solutions
- Centene Corporation Group
- Community Health Network Group
- Anthem Inc. Group
- Humana Group
- CVS Group
- Health Alliance Northwest Health Plan
- Cigna Health and Life Insurance Company

Provider Entities for Which Insurers Must Submit Data (Tentative)

- 24 community health centers
- 4 medical groups and IPAs
- 22 health systems

HCA Support to Data Submitters

- Technical webinar on the data request
- Scheduled office hours for questions
- Additional one-on-one calls, as needed

Discussion

- Do members of the Data Committee have any feedback about the process or time needed to prepare submissions?
- Are there processes that members would recommend HCA implement to facilitate the data collection and validation process?

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Public comment

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The Colorado Story: Hospital Cost Analysis

TAB 7

Hospital Costs, Price, and Profit Analysis: The Colorado Story

John Bartholomew, Presenting
Bartholomew-Nash & Associates

Data Advisory Committee
May 5, 2022

Analysis by the Colorado Department of Health Care Policy and Financing – Kim Bimestefer
Executive Director, Tom Nash, and John Bartholomew

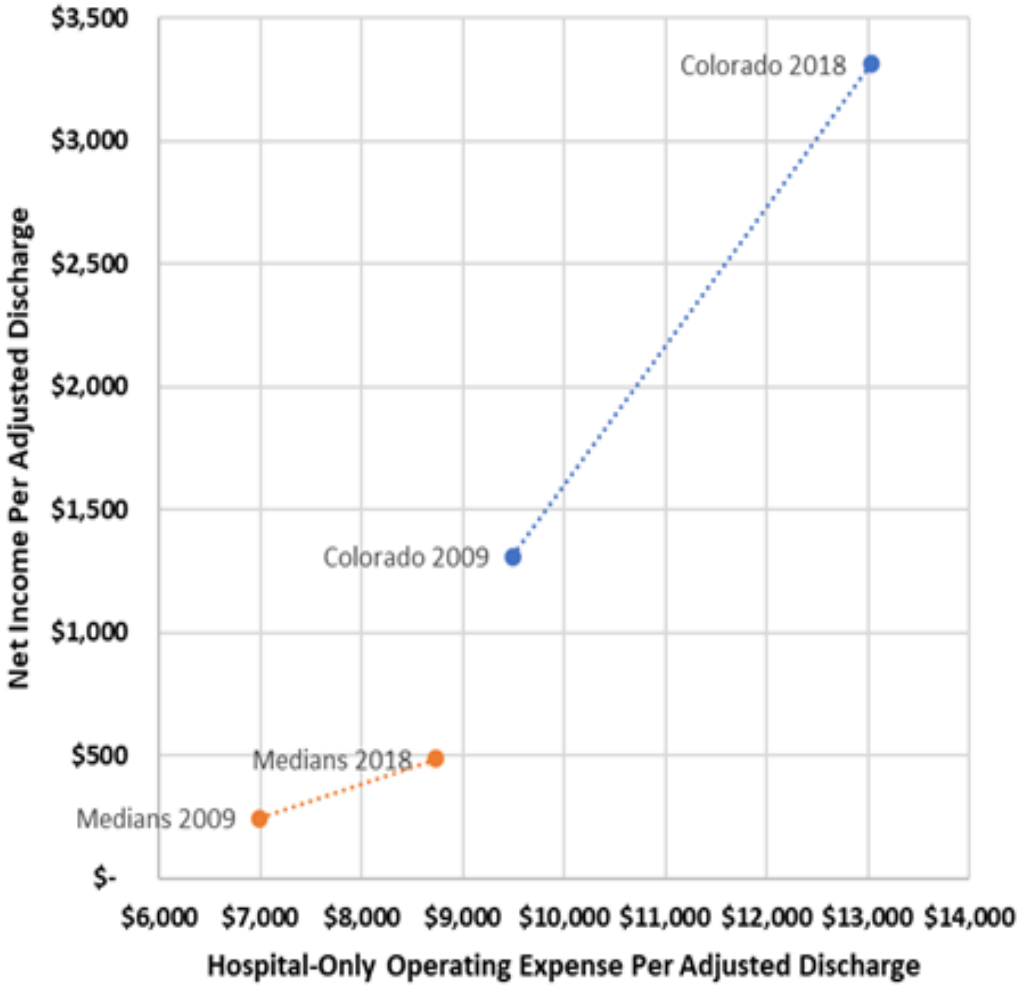
The Problem

State inititiatives to improve coverage and fund hospital care in Medicaid

- 2009: Hospital provider tax that increased hospital reimbursement for Medicaid services and created state funding source for the ACA Medicaid expansion
- 2014: ACA Medicaid expansion decreased uninsured rate and cut charity care/bad debt by 50%+

Results = Rising insurance costs and hospital costs

- 2009-2018 CO hospital costs grew 50%+ more than national average
- In 2009, CO hospital profits exceeded national median by 5 times; in 2018, profits exceeded national median by 7 times



The Approach to Identify Solutions

- In 2014, the State Legislature established the Colorado Commission on Affordable Health Care to understand why commercial health care costs were rising so fast
  - The main finding still used today: hospital financial analysis is needed at the state level.

- Using Medicare Cost Report data, create metrics on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by dividing data by adjusted discharges.
  - Net Patient Revenue divided by Adjusted Discharge = **Price per Patient**
  - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**
  - Net Income divided by Adjusted Discharges = **Profit per Patient**

- Observe trends across hospital types
  - Health systems, independents, for-profit, not-for-profit, rural, urban, by bed size

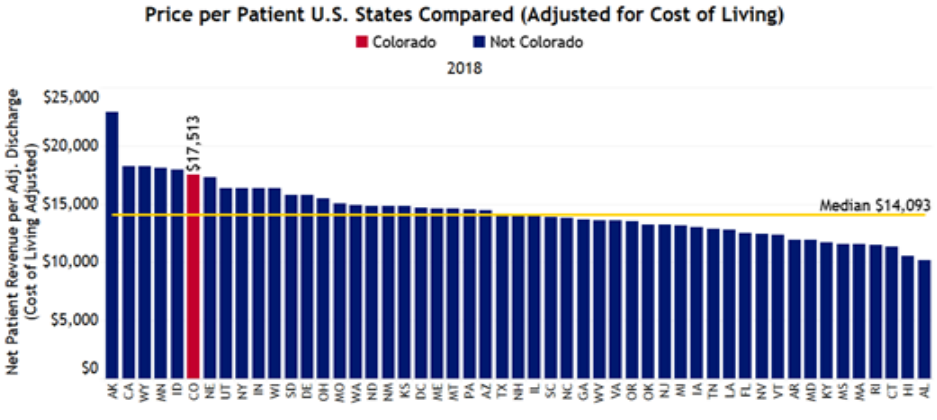
Summary of the Analysis Conducted by The Colorado Department of Health Care and Financing

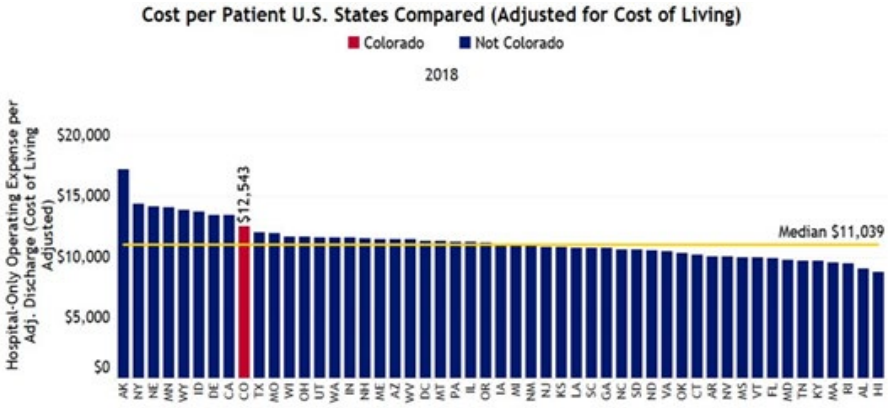
Report Published in August, 2021:
Hospital Cost, Price & Profit Review

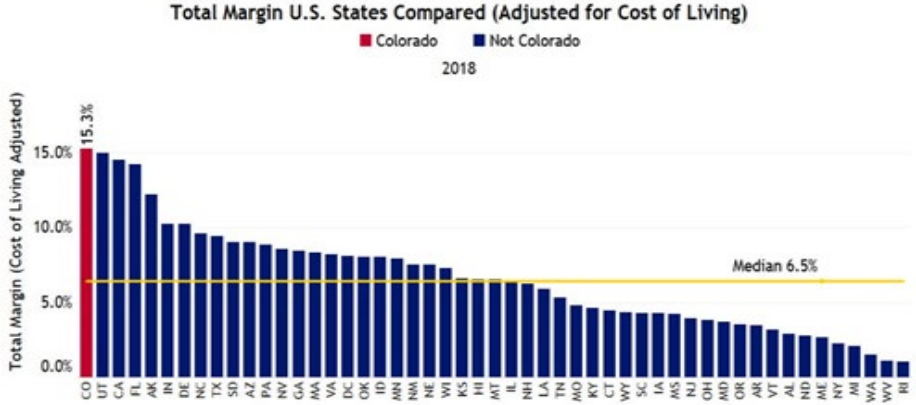
Hospital Cost, Price, Profit Analysis

- *National Rankings*
- *Data Source/Metrics*
- *Findings*
- *Community Benefit*

Transparency: Medicare Cost Reports, 2018
CO Rankings: 6th Price, 9th Cost, 1st Total Profit

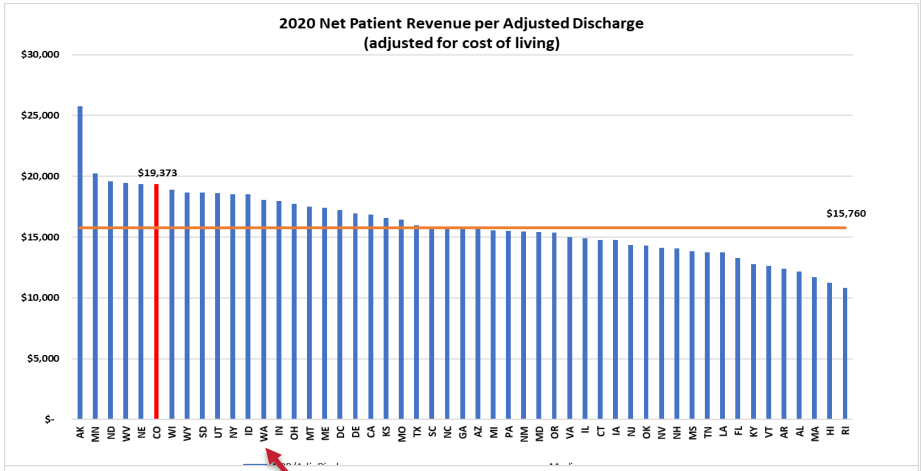


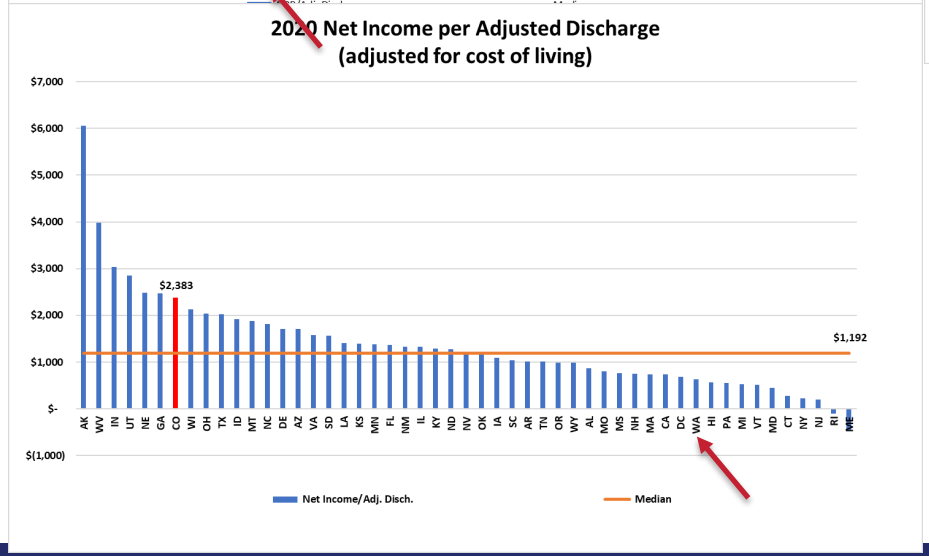


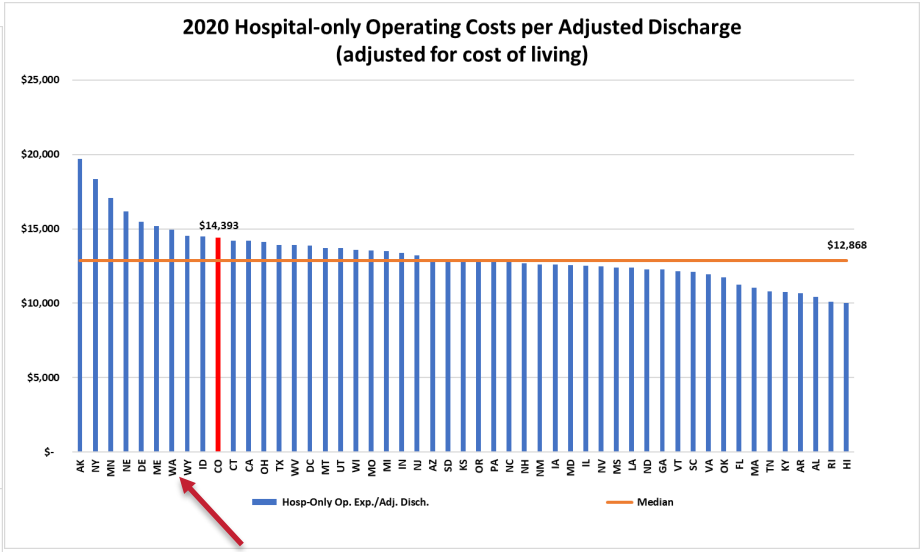


Opportunity for collaboration with hospitals to reduce prices and bring profits more in line with national median. Seeing movement: Centura, SCL, University – *but more needed!*

Transparency: Medicare Cost Reports, 2020
CO Rankings: 6th Price, ~~9th~~10th Cost, ~~1st~~7th Total Profit



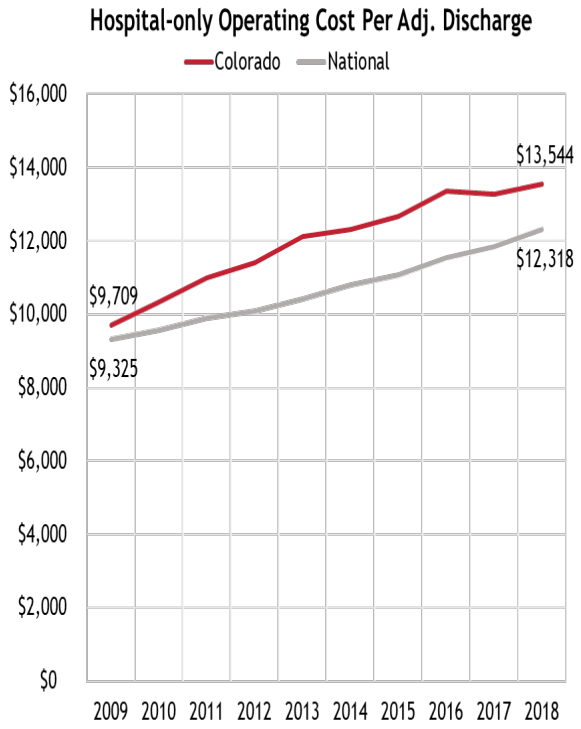


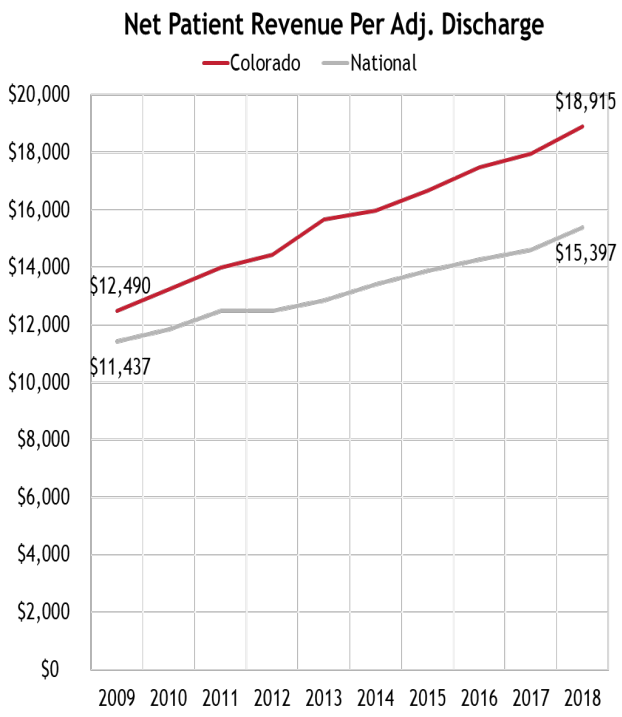


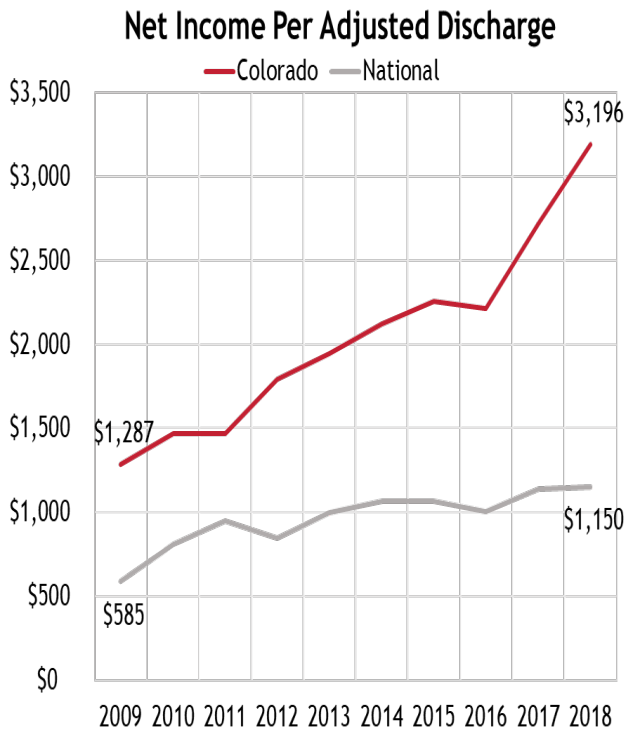
Updated data to 2020

- State of Washington identified with arrow
  - WA 14% higher than National Median on Price per patient
  - Ranked 7th highest Costs per patient

Colorado Hospital Cost, Price & Profit Trends





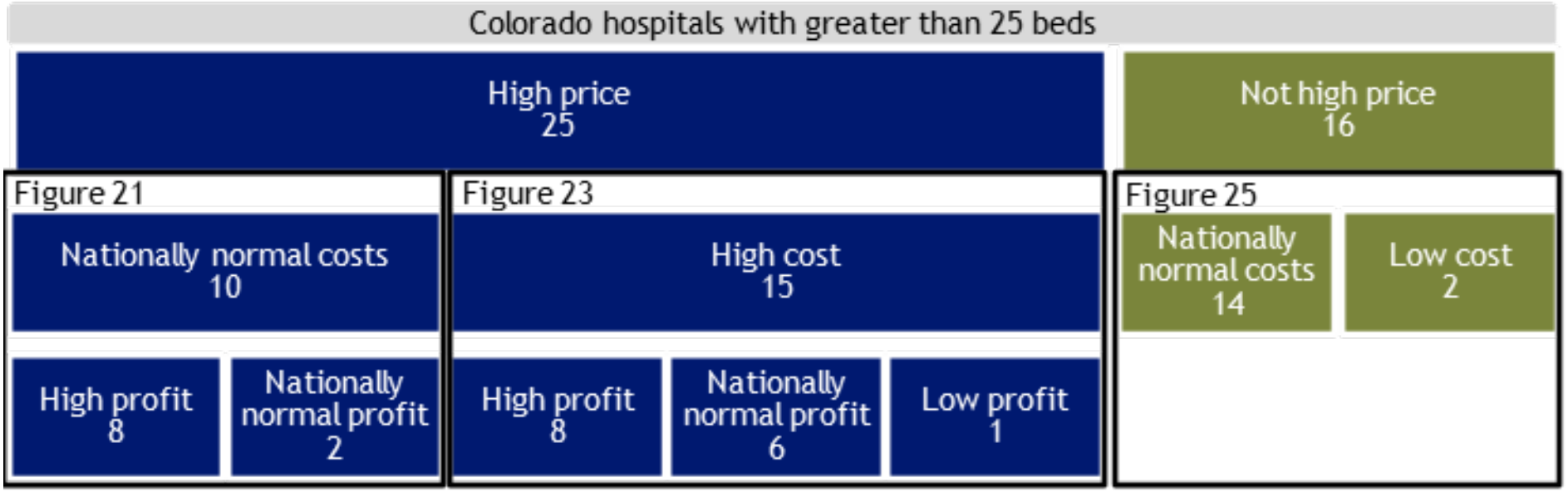


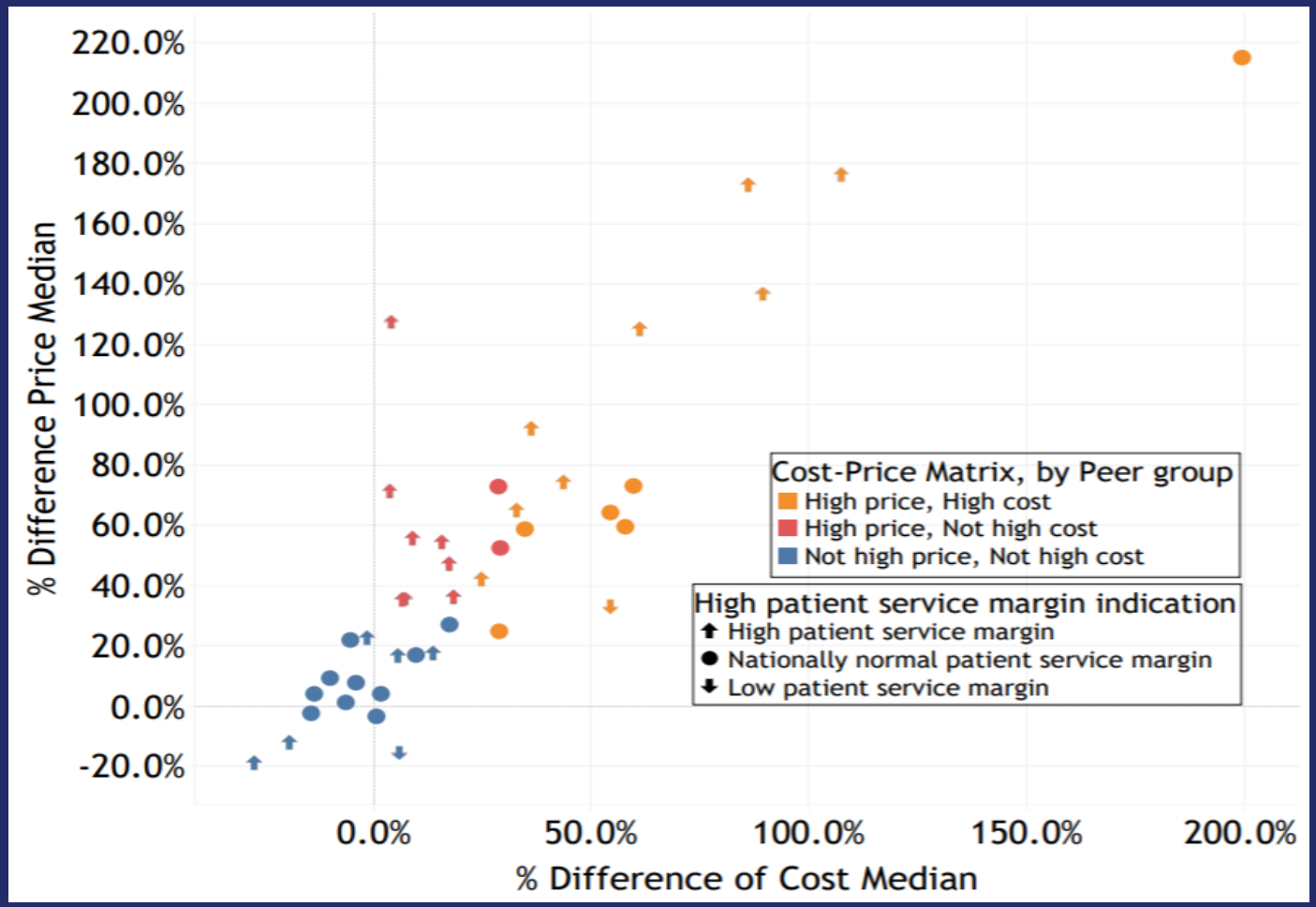
2018 Income Statement, All Colorado Hospitals; Two Types of Profit

Statement Line	Colorado
Net Patient Revenue	$ 16,862,512,337
Hospital-Only Operating Expense	12,073,928,031
Non-Hospital Operating Expense	3,301,592,506
Total Operating Expenses	15,375,520,537
Patient Services Net Income	1,486,991,800
Plus: Other Non-Patient Income	1,371,040,633
Less: Other Non-Operating Expenses	8,546,621
Net Income	$ 2,849,485,812
Total Margin	15.6%

Non-Profit Hospitals Net Income: 58% of total	$ 1,659,344,433

Colorado Hospital Groupings
Hospital with > 25 beds

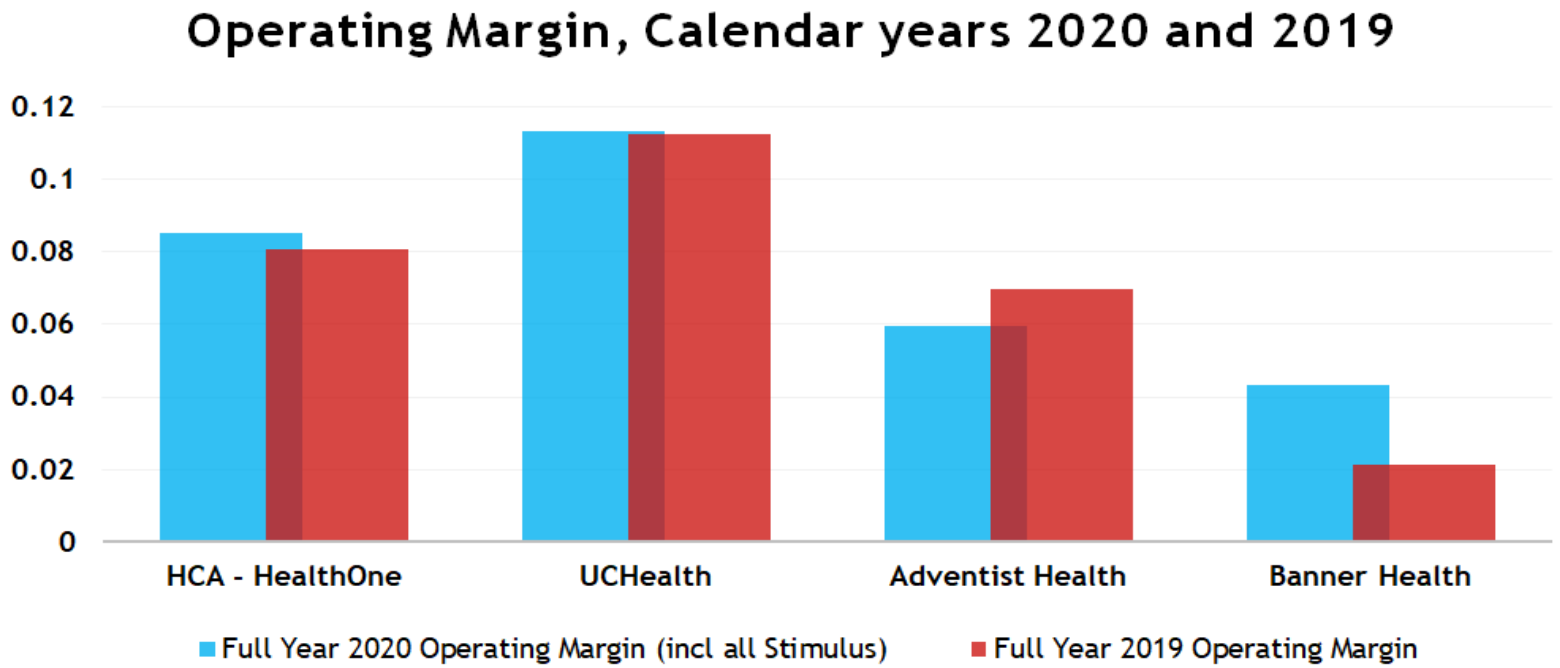




National Median Cost-Price Scatterplot of Colorado Hospitals, including Net Income/Profit

Opportunity to rein in the outliers

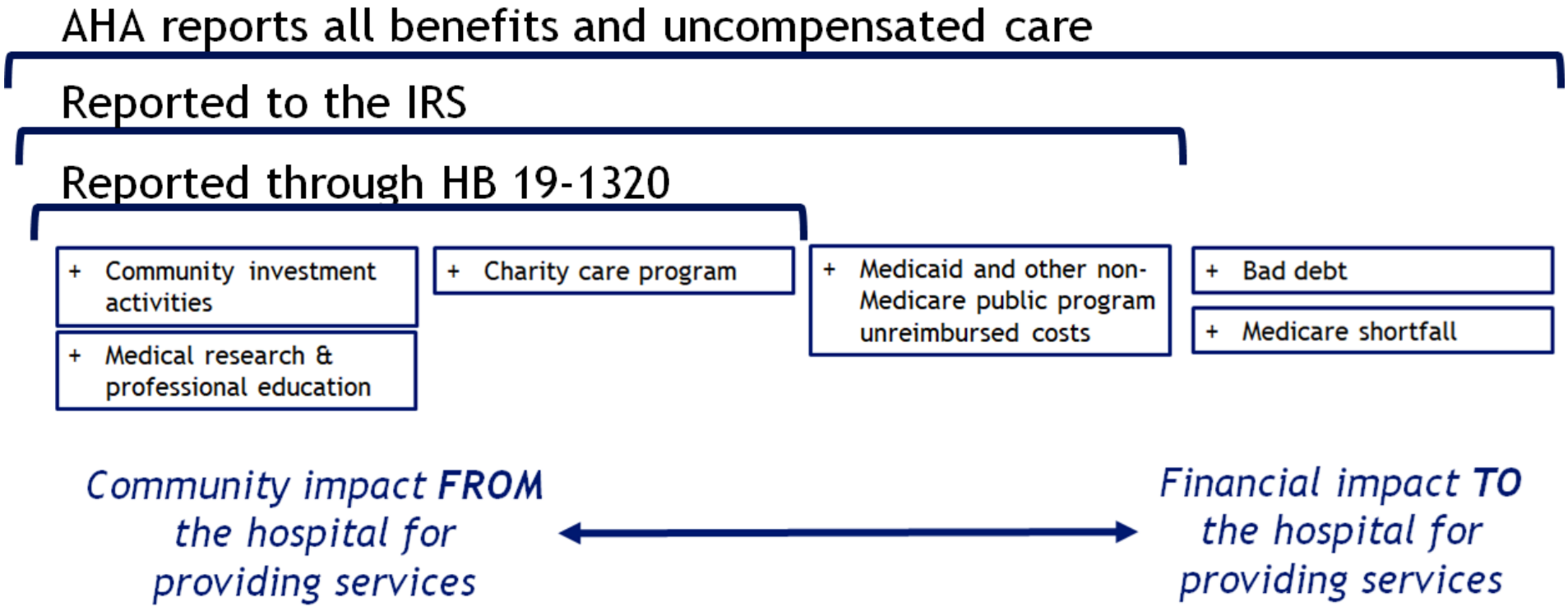
COVID-19 & Hospital Finances



- HCA-HealthOne has returned their stimulus disbursements
- SCL Health Operating margin end of 2019 was 5.8% and through Sep 2020 it was 8.3%

Community Benefit

Community Benefit can be Represented in Different Ways

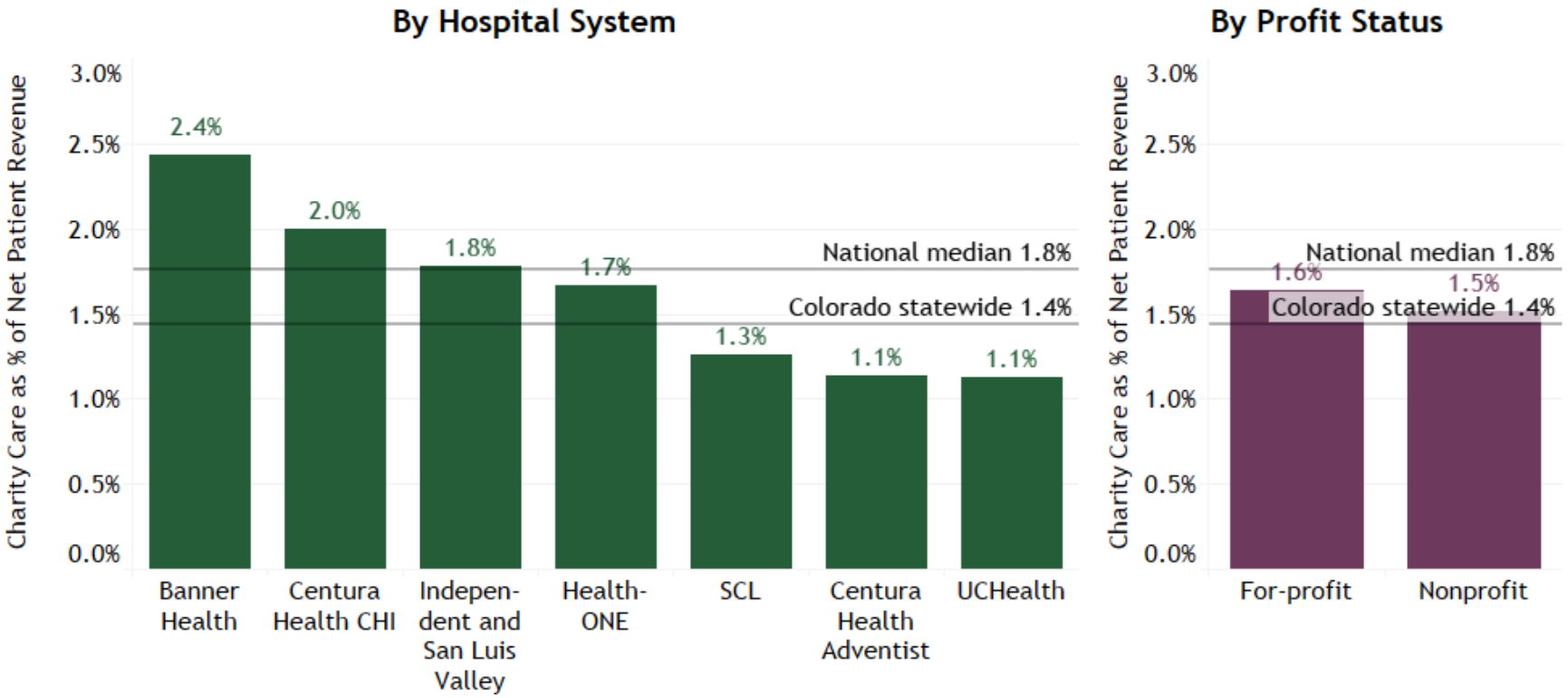


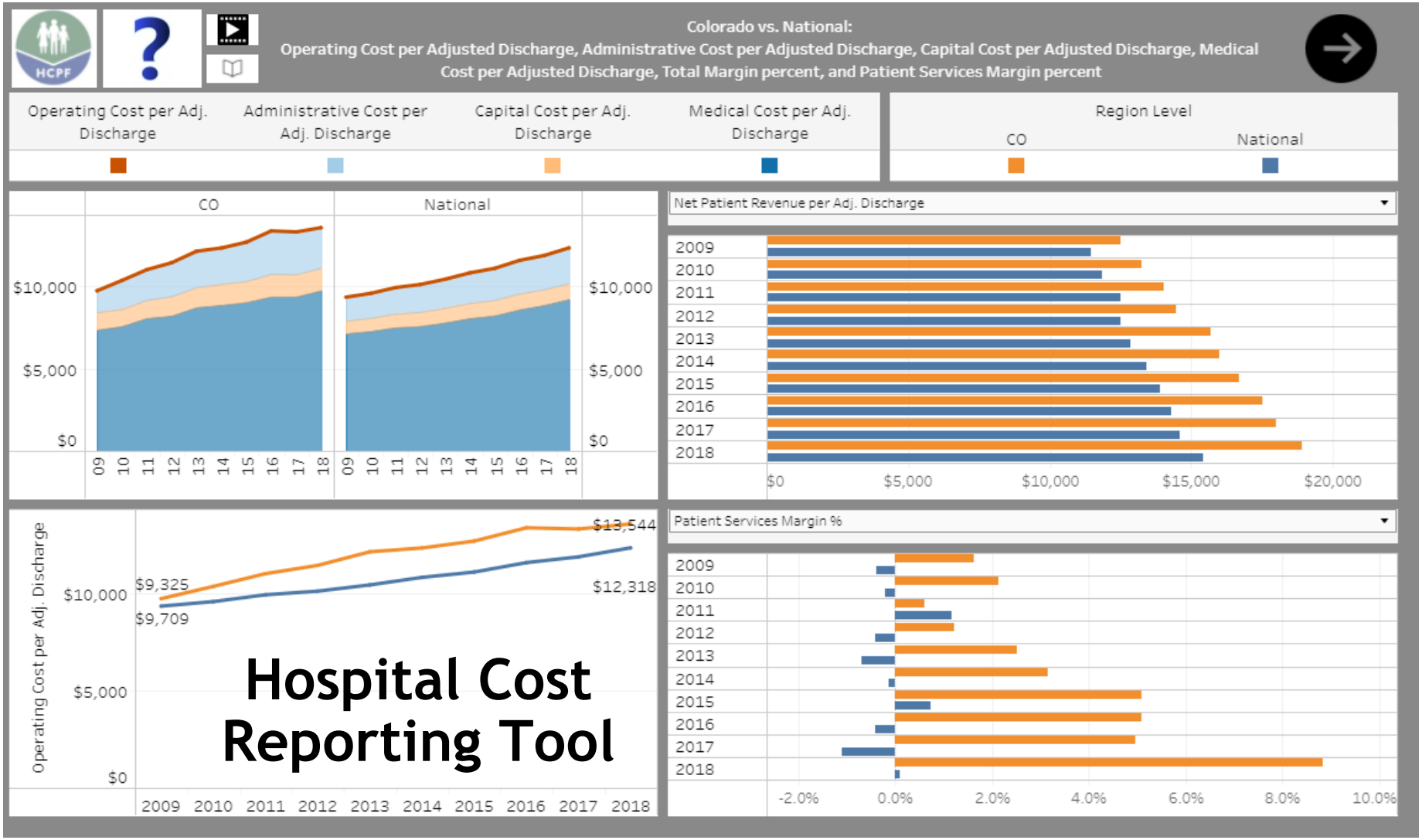
2017 Community Benefit Categories and Percent of Total Expenses

Community Benefit Category	Percent of total expense	Typical for nonprofit hospitals?	Typical for for-profit hospitals?
Financial assistance, unreimbursed Medicaid, unreimbursed costs from means-tested government programs	6.4%	✓	✓
Medicare shortfall	3.1%	✓	✓
Bad debt expense attributable to financial assistance	0.4%	✓	✓
Subtotal attributable for both nonprofit and for-profit	**9.9%**		
Health professions education	1.7%	✓	
Medical research	0.5%	✓	
Cash and in-kind contributions to community groups	0.3%	✓	
Community building activities	0.1%	✓	
Other (community health improvement, subsidized health)	1.7%	✓	
Total	**13.8%**		
Percent of total that is attributable for both nonprofit and for-profit	**71.7%**		

Total does not sum due to rounding.

2018 Charity Care as a Percent of Net Patient Revenues




Colorado vs. National:
Operating Cost per Adjusted Discharge, Administrative Cost per Adjusted Discharge, Capital Cost per Adjusted Discharge, Medical Cost per Adjusted Discharge, Total Margin percent, and Patient Services Margin percent
Operating Cost per Adj. Discharge
Administrative Cost per Adj. Discharge
Capital Cost per Adj. Discharge
Medical Cost per Adj. Discharge
Region Level
CO
National
CO
National
$10,000
$5,000
$0
09 10 11 12 13 14 15 16 17 18
Net Patient Revenue per Adj. Discharge
2009 2010 2011 2012 2013 2014 2015 2016 2017 2018
$0 $5,000 $10,000 $15,000 $20,000
Operating Cost per Adj. Discharge
$13,544
$9,325
$12,318
$9,709
Hospital Cost Reporting Tool
Patient Services Margin %
-2.0% 0.0% 2.0% 4.0% 6.0% 8.0% 10.0%

Questions?

Washington State Health Care Authority

Grant proposal in development: Policy Support Unit

TAB 8

Grant Proposal: review and feedback

Washington State Health Care Authority

Washington State Context

- WA State embraces health care innovation
  - Medicaid waiver, Cascade care, public option, APCD, ACH, Direct primary care contracting, surprise billing, HHS coalition (IT priorities).
- HCA is largest purchaser in the state.
- Sue Birch is the Director of the HCA, and Chair of Cost Transparency Board
- New Cost Transparency Board
  - Bi-partisan, cross market purchasers. Advised by cross section of carriers, providers and data experts.
  - Authority to call for data from all markets.
  - HCA administration provides coordination and access to state SME and data resources.
  - Charged with developing cost driver analyses and making reports to the legislature.

Grant vision

- Provide both analytic and policy development resources to reduce the cost of health care.
- Provide Washington-specific, cross-market, state-wide analysis.
- Develop partnerships and expertise to support broad-based analysis from existing public data sources.
- Develop tools to aid in effective control of health care costs while maintaining/improving population health.
- Support innovative data strategies for the public good.
- Transition from philanthropic to public funding at end of grant.

Grant Initial Focus

- Support the Health Care Cost Transparency Board in its responsibility to make legislative recommendations to curb spending growth and achieve the benchmark target.
- Identify the key cost drivers of overall healthcare spend and their impact on annual growth.
  - Phase 1 analyses: changes in spending and utilization (e.g. Cost Driver analysis).
  - Phase 2 analyses: deeper dives into identified cost drivers.
  - Additional drivers: population growth; demographic changes, disease burden trends.
- Develop relevant and timely reports supporting legislative recommendations to curb spending growth and achieve the benchmark target.

Policy Support Unit (PSU)

- Capabilities:
  - Distributed data management
  - Deep analytic capacity: data analysis
  - Computing infrastructure: storage and computing bandwidth
  - Collaborative management: working with experts in agencies and organizations
  - Policy awareness: from analysis to practical and implementable policy options
- 2-Stage Development Approach
  - Incubation period – 3 years
    - Funded by catalytic philanthropy
    - Establish value measured by funding shift from philanthropy to state resources
  - Sustained Operations – ongoing
    - State budgeted resources
    - Full organizational accountability
    - Well defined operational processes

Start-up: the Incubation Period

- Identify appropriate PSU “incubator” that accelerates access to critical capabilities
  - Dedicated staff exclusively focused on supporting Cost Board efforts at cost containment.
  - Candidates: Institute for Health Metrics and Evaluation (IHME) at the University of Washington, Health Care Authority, Other?
- Create accountability for the PSU activities, funding use and transition
- Establish access to necessary data sources

Discussion

- What feedback would you give to the Board about this proposal? Is it practical? Achievable?
- What are some of the challenges you see in trying to implement the proposal? Staffing? Data Access? Other?
- What changes would you recommend to the proposal to improve its chances for success?

Washington State Health Care Authority

INDEX – Grant development concept paper

TAB 9

Overview

This document provides a brief description of the opportunity in Washington State to control healthcare costs, how a Policy Support Unit (PSU) could accelerate progress towards this goal and the anticipated short, medium and long term impact of a PSU.

Problem Statement and Opportunity

In June of 2020, Governor Inslee of Washington State, signed the Health Care Cost Transparency Board (HCCTB) into law. The goal of the HCCTB is to reduce health care cost growth and increase price transparency. The HCCTB aims to achieve this goal by 1) determining the state's total health care expenditures; 2) identifying cost trends and cost drivers in the health system; 3) setting a health care cost growth benchmark for payers and providers; and 4) reporting annually to the legislature, including providing recommendations for lowering health care costs.

The HCCTB was able to make significant progress on objectives 1 and 3 over the past two years (2020 – 2021) with support from the Peterson-Milbank Program for Sustainable Health Care Costs, a philanthropic effort that provides participating states with technical assistance to develop targets for per-capita trends as well as analyze the underlying drivers of cost.

As support from the Peterson-Milbank Program for Sustainable Healthcare Costs ends in December 2022, the HCCTB/HCA has identified limits in its analytic capability related to goal 2. Without addressing these limits, the state's efforts to control cost growth through market and regulatory interventions will not realize the full potential of the HCCTB, which should ideally progress to sophisticated interpretative analytics based on integration of abundant existing state data resources. This level of analytic capability is a critical element in the development of effective cost control strategies.

An opportunity exists to combine insightful analysis of large, complex health data within Washington with the design of a range of interventions to reduce the growth of healthcare expenditures while maintaining or improving health outcomes. A Policy Support Unit (PSU) embedded within the Health Care Authority can accelerate the use of data-informed interventions to control healthcare expenditures. The PSU will support the HCCTB and the Health Care Authority in fulfilling their responsibilities to the Washington legislature. Once the value of the PSU is established the Health Care Authority will make a legislative request to secure public funds to sustain the PSU following the initial 3 year project period.

Context – Washington State Healthcare Authority and the Cost Transparency Board

- The Washington state government has initiated several policy innovations to improve health care delivery while controlling healthcare costs:
    - A Medicaid waiver with a focus on value-based reimbursement.
    - Cascade Care: a public option for the residents of Washington state.
    - All Payer Claims Database which includes approximately 75% of the state's population
    - Accountable Health Communities that integrate healthcare, health, and SDOH priorities in defined communities.
    - Direct primary care contracting currently includes 44 practices and approximately 20,000 enrollees.
    - Transparency and surprise billing requirements that preceded federal regulations.

    - Washington State health agencies have recently made progress in coordinating their IT efforts to the extent that Federal approval for matching funds have been expedited.
- The Washington State Healthcare Authority (HCA) purchases health care for more than 2.5 million Washington residents. HCA is the largest healthcare purchaser in the state. Sue Birch is the Director of the HCA and is the Chair of the Cost Transparency Board.
- In June 2020, bipartisan legislation was passed establishing the Health Care Cost Transparency Board (HCCTB), supported by the HCA. Members of the HCCTB include director level staff from HCA, the Office of the Insurance Commissioner, the Washington Health Benefits Exchange, and the Department of Labor and Industries, and 12 additional members representing different purchasing sectors. The primary responsibilities of the HCCTB are to (1) analyze annual total health care expenditures and growth in Washington state and (2) establish a health care cost growth benchmark. The HCCTB will issue annual reports that will identify providers and payers whose cost growth exceeds the benchmark. The HCCTB has been directed to submit recommendations to the legislature related to lowering health costs, focusing on both public and private sector purchasers.
- The HCCTB is empowered to conduct a state-wide data call of purchaser(s) to determine total health care expenditure. This cross-market call will include Medicaid, Medicare, commercial (both fully and self-insured), worker's compensation and Department of Corrections spending. The HCCTB has access to important cost and spending data housed within different state agencies. For example, the HCCTB can also analyze claim specific data in the All-Payer Claims database, state-collected prescription drug data, and other sources to be determined.
- The HCCTB has established 2 advisory committees to provide input and recommendations on their work. The Advisory Committee of Health Care Providers and Carriers is composed of 18 representatives from provider and health insurers doing business in Washington, including the hospital association, medical association, and every major health carrier. The Advisory Committee on Data Issues has 19 representatives with proven actuarial and data experience from every sector, including commercial carriers, government, providers and academia.
- The cost growth benchmark was established based on the historical growth of median wages in Washington and the Potential Gross State Product. The benchmark was calculated by weighting the median wage growth at 70% and the growth in PGSP at 30%.
- The HCCTB has established the following cost growth benchmarks:
    - 3.2% for 2022 – 2023
    - 3.0% for 2024-2025
    - 2.8% for 2026

  If these cost growth targets are met, the HCCTB estimates $3.8B in Medicaid savings and $7.0B in private insurance savings. Note – these are currently the lowest benchmark targets in the US. The 20 year average growth rate in Washington State is 6.7%.
- The HCCTB is currently staffed with a Board Manager, one full time analyst, and consultant support provided through a Peterson Milbank grant.
- HCA is initiating the process of calculating the total health care expenditure (THCE). First, a data call will be made in July 2022 for baseline data (likely 2018 and 2019 to avoid the impact of the Covid pandemic). Subsequent annual data calls will take place in July of each year to provide the necessary data to establish a statewide growth trend. The sources of data will be all payers in Washington state, including state and federal government (Medicaid, Medicare, Advantage), commercial (both self-insured and fully insured),

workers' compensation (Department of Labor and Industries) and corrections health spending (Department of Corrections). Additional sources will be considered in future years including VA and Tribal spending.

- The data is high level, aggregate spending data. All analysis and reporting will be conducted by HCA staff led by the assigned HCCTB analyst. Conclusions will be presented to the HCCTB and its committees and form the central subject of an annual report to the legislature beginning in late 2022.
- The HCCTB is beginning the development of the cost driver analysis, as required by its legislative mandate. The initial analyses (Phase 1) will utilize Washington's All Payer Claims Database (APCD) to analyze spend. The current reports include variation by geographic area, by spend and utilization, by condition, and by demographics. This reporting will be included in the legislative report in late 2022. In future years, the HCCTB will determine areas for a deeper dive, likely using additional data sources (Phase 2). This initial cost driver analysis will be conducted through a contract with On Point and funded by a Milbank Memorial Fund grant allocation ($200,000.) designated specifically for cost driver analysis. The MMF grant expires 12/31/20222.

Policy Support Unit Capabilities

- A Policy Support Unit (PSU) can provide analytic and policy development resources to initially support the HCCTB's cost driver analysis, benefitting market participants, the legislature, and HCA and other state agencies integral to developing effective control of healthcare costs while maintaining and/or improving population health.
- Critical capabilities of the PSU include:
    - Distributed Data management: HCA has secured access to different data sources which are distributed across multiple state agencies. Each agency will have different architecture that must be bridged, and regulations that must be followed to access these data.
    - Deep analytic capacity: a wide variety of approaches will likely be necessary to identify opportunities for reducing costs and maintaining or improving health outcomes. The ability to disaggregate and analyze the data by patients, providers, geography, health condition, type of service, and demographic segments are an initial set of analyses.
    - Stakeholder/partner management: The PSU will need to work with experts in other state agencies, research centers and the private sector who may provide data for analysis**,** recommend use cases and/or provide insight to build better analytics and interventions. For example, the PSU may need to work with employers to help with benefit plan design or purchasing interventions. Building confidence in both the agencies which are providing data and public/private stakeholders who may be impacted by the analyses developed by the PSU will be critical for establishing and maintaining credibility.
    - Computing infrastructure: significant data storage and computing bandwidth will likely be required to enable the data management and analysis. Understanding the cost and performance trade-offs for using cloud-based or local solutions will be important for cost effective use of resources.
    - Healthcare business expertise: An understanding of the business strategies and tactics employed by healthcare providers, pharmaceutical payments and reimbursements, and insurers is critical to creating insight and developing potential interventions to control healthcare costs.
    - Embedded resources: PSU resources will work side by side with HCA staff. Embedding with the HCA will enable a constant flow of information and perspectives to inform the analyses and recommendations developed by the PSU.

- Use case development: developing alternative approaches to inquiry to identify high leverage opportunities to reduce cost without compromising quality or access. Build capability to know what questions to ask, how to develop the analytical capability to provide answers, and translating resultant insights into actionable options.
- Intervention and Analytics co-development: Translating analysis into practical, implementable interventions requires a dynamic interplay between analytics and intervention design. Creating an environment where these two areas of expertise converge will be critical for interventions to realize their potential to control healthcare costs.

- A PSU Steering Committee will be established to ensure alignment with the primary state agency that serves as the PSUs primary focus (likely the Washington State Healthcare Authority) and the principal philanthropic donors (Petersen Center on Health Care and Gates Ventures). The primary sponsor of the PSU's work should likely be the chair of the HCCTB (Sue Birch) and the initial deployment of the PSU would be to serve the HCCTB in their analysis of cost drivers of health in Washington State.
- The incubator will strive to develop a "self-contained unit" exclusively focused on supporting the Washington state cost containment effort. A dedicated full-time staff will be recruited and brought on-board within the first twelve months of the grant award and will be incubated over a 3 year period. It is the intent of the Healthcare Authority to request on-going funding from the legislature to sustain the operations of the PSU. For public funding to be available at the end of the grant, the legislative request will be made at the grant's midpoint (18 months). Once public funding is made available, the PSU will be transferred to the appropriate state agency and continue to provide analytic and policy development support to the Healthcare Authority and other agencies as recommended by the Steering Committee.

Policy Support Unit Outputs and Outcomes

- Outputs are deliverables created by the PSU. This list is not exhaustive but describes some of the key outputs that will establish the value of the PSU.
  - Data strategy documenting data sources, compliance with data use regulations, and processes for incorporating new data sources.
  - Data access agreements to enable access and processes to incorporate each data source.
  - Analytic framework to describe and ensure data is comprehensively integrated into the cost driver analysis.
  - Annual cost driver analyses based on the prioritized areas defined by the HCCTB.
  - Annual recommendations for additional data to improve the cost driver analyses.
  - By Year 2, an operating budget to inform a request for state budget allocation to support ongoing PSU operations.

- Outcomes are the results achieved by the PSU. Outputs are often used to help achieve outcomes. Outcomes for the PSU are described in short-, medium- and long-term timeframes.
  - *Short Term:* (3 months -1.5 years) *Knowledge & Awareness*
    - Increase in HCCTB and HCA members' ability to define WA data use strategy, including cost driver analytic framework
    - Increase in HCCTB understanding of the drivers of cost in WA
    - Increase in HCCTB understanding of political feasibility of specific interventions

  - *Medium Term*: (1.5-3 years) *Behavioral*
    - Increase in cost mitigation recommendations supported by cost driver analyses

    - Improved sustainability of WA's cost growth benchmarking efforts through legislative allocation of funds to PSU staffing & technical assistance
    - Increase in cost mitigation recommendations implemented in public-private sector

- *Long Term*: (3-7 years) *Environmental*
    - Improved sustainability of PSU through transition and integration into appropriate state agency
    - Increased understanding by PCH and GV around key elements (required skill sets, level of funding and infrastructure) necessary to support long term sustainability of cost growth benchmarking initiatives.
    - Improved policy dialogue and healthcare interventions by the state of Washington resulting from data-informed decision-making
    - Increased affordability of healthcare for Washingtonians

Washington State Health Care Authority

INDEX – WA-APCD – HCA truncation analysis

TAB 10

Supporting Documentation

Washington State Health Care Authority – Truncation Analysis

Release Date: April 2022

This document was prepared by ONPOINT Health Data

Purpose and Background

The Washington State Health Care Authority (HCA) is tasked with analyzing average spending among patients in Washington to evaluate growth in spending over time to inform policies to curb this growth. As part of this effort, HCA is interested in quantifying baseline spending in the state. Total costs for outlier members – members with particularly high costs – have often been truncated by states in similar analyses to keep these members from having substantial influence on cost growth trends and obscuring growth trends among other members.

HCA plans to truncate high-cost outlier spending by market (e.g., commercial, Medicaid, and Medicare). To inform appropriate levels of truncation, HCA and Onpoint Health Data completed a sensitivity analysis of dollars spent by outlier members at different levels. Included below are the methods applied by Onpoint when performing this analysis.

Methods

Membership Specifications

This study utilizes claims covering the period from January 1, 2017 through December 31, 2019 collected from carriers who provide data to Washington's All Payer Claims Database (WA-APCD).

Patients with both medical and pharmacy coverage during the time period were included, with three months of claims run-out. Because Medicare Fee-For-Service (FFS) is only available through 2017, Medicare FFS data were only included for 2017, while other product types included more recent years. Analyses of dual eligible patients were also limited to 2017 because of the lack of Medicare FFS data in 2018 and 2019. Medicaid FFS claims were not included in this analysis.

There were no exclusions of types of plans (e.g., Exchange, PEBB, SEBB) for this analysis.

Eligibility: For this project, the number of eligible members were extracted from eligibility data at the monthly level. While members could be attributed to multiple product types during the year if their coverage shifted, only primary eligibility was included. Supplemental plans were not included. Eligibility was used to calculate distinct members in the population and whether the patient was living in Washington (only WA residents were included in this analysis).

Claims: Claims were paired with eligibility data for each month of coverage. Only claims with supported eligibility for the same product type were included. Claims were limited to those paid as primary. For each service, the payments (both plan and member-paid) were aggregated.

Table 1. Summary of Membership Specifications

Date Restriction	Eligibility: Members with coverage between Jan 1, 2017, and Dec 31, 2019. Claims: Restricted to claims with first service date between Jan 1, 2017, and Dec 31, 2019.
Insurance Type	Commercial, Medicaid Managed Care, Medicare Advantage (2017-2019); Medicare FFS (2017 only)
Type of Coverage	Limited to medical eligibility and claims only. Pharmacy eligibility not required
Claim Types	All claim types; medical and pharmacy included
Age Group	All ages
Residence	WA residents only
Primary Payers	Restricted to claims paid as primary and primary eligibility; secondary and supplemental coverage not included.

Total Allowed Amounts

Allowed amounts included the amount paid by the plan plus the amount paid by the member (copays, coinsurance, and deductibles). Where available in the data, fee-for-service-equivalents were included instead of plan paid amounts. The sum of all of these fields in both pharmacy and medical claims were aggregated at the member level to obtain total payments during the year for each member for each product. Allowed amounts were not weighted by member months of coverage.

Eligibility and Claims

Eligibility: For this project, the number of eligible members and member months were extracted from eligibility data at the monthly level. Members were attributed to multiple carriers, age groups, and ZIP Codes during the year if their eligibility data changed. For example, if an individual was covered for half the year by one carrier and half the year by another, he/she would have 6 months of coverage in each carrier's membership. Eligibility was used to calculate distinct members in the population, eligible member months, eligible average members – the denominator of the entire population that had coverage (but may or may not have had a claim).

Claims: For each service, carrier, age, and ZIP Code were extracted from the information on the claim. Data from the claims were used to bucket members into diagnosis categories to calculate the number of services, distinct members with services, percent claims denied, and utilization rate. Patients with eligibility during the year but no claims were included in the analysis with $0 total cost.

Geography

Each member's county of residence was assigned based on their ZIP Code in the eligibility file. Out-of-state members were excluded, but out-of-state claims for WA residents were included.

Dual Eligibles

Patients who had both Medicare FFS and Medicaid eligibility during the same months of 2017 were considered "dually eligible". The truncation points for these patients were calculated separately from those who had only Medicare or only Medicaid coverage. Both Medicaid FFS eligibility and Medicaid managed care were used in the identification of these patients. For Medicaid, only managed care patients are included in the truncation analysis. For Medicare, all dual eligibles were included.

Truncation Points

Two approaches were used to evaluate truncation points.

Evaluation of specific dollar cut-offs: The number and percentage of members exceeding specific dollar cut-offs for each product, the percentage of total spending that was above the threshold, and the percentage of total spending for members who exceeded the threshold was evaluated. The following dollar cut-offs were tested:

- $75,000
- $100,000
- $125,000
- $150,000
- $175,000
- $200,000

Evaluation of specific percentage cut-offs: For specific percentiles, dollar cut-offs were identified. The number of members, percentage of total spending above the cutoff, and percentage of spending for members who exceeded the cut-off of total were quantified. The following percentage cut-offs were tested:

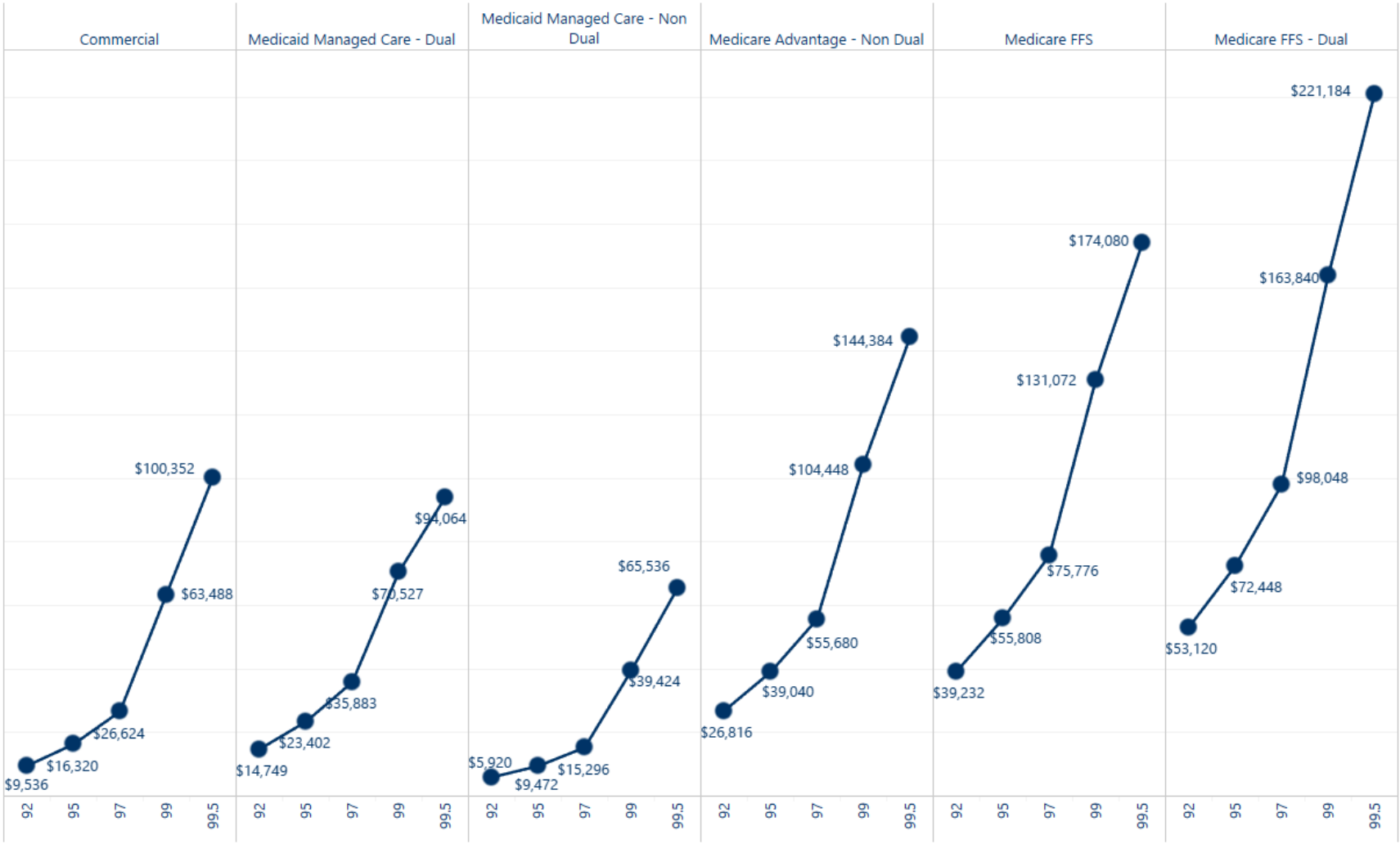
- 92%
- 95%
- 97%
- 99%
- 99.5%

The dollar cut-offs identified for each percentile and each product are presented in **Table 2** below. **Figure 1** below shows the dollar cut-offs by product for the most recent available year to provide a glimpse of how the products compare.

Table 2. Dollar Cut-Offs for each Percentile Tested

Product	Year	92nd Pctile	95th Pctile	97th Pctile	99th Pctile	99.5th Pctile
Commercial	2017	$9,184	$15,488	$25,216	$61,440	$96,256
Commercial	2018	$8,960	$15,328	$25,088	$61,440	$98,304
Commercial	2019	$9,536	$16,320	$26,624	$63,488	$100,352
Medicaid - Dual	2017	$14,749	$23,402	$35,883	$70,527	$94,064
Medicaid Managed Care – Non Dual	2017	$5,008	$8,192	$12,736	$32,768	$55,296
Medicaid Managed Care – Non Dual	2018	$5,392	$8,672	$13,888	$35,840	$60,416
Medicaid Managed Care – Non Dual	2019	$5,920	$9,472	$15,296	$39,424	$65,536
Medicare - Dual	2017	$53,120	$72,448	$98,048	$163,840	$221,184
Medicare Advantage – Non Dual	2017	$26,304	$39,936	$60,416	$143,360	$225,280
Medicare Advantage – Non Dual	2018	$26,048	$38,144	$53,760	$101,376	$139,264
Medicare Advantage – Non Dual	2019	$26,816	$39,040	$55,680	$104,448	$144,384
Medicare FFS – Non Dual	2017	$39,232	$55,808	$75,776	$131,072	$174,080

Figure 1. Dollar Cut-Offs for each Percentile Tested, Most Recent Year of Data



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Washington All-Payer Claims Database (WA-APCD)

Truncation Analysis

Release Date: April 2022

For assistance or technical questions, please contact the Washington Health Care Authority at [HC
contact information here.]

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1. Data Dictionary

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Field Name
Year
Product
Dollar Threshold
Percentile Threshold
Dollar Cutoff for Percentile
Total Members
Number of Members Exceeding Threshold
Percentage of Members Exceding Threshold
Total Allowed Amount, All Patients
Allowed Amount Exceeding Threshold
Percentage of Spend Exceeding Threshold
Total Expenditures (Above and Below Threshold) for Members Exceeding Threshold
Percentage of Total Spend Attributed to Members Exceeding Threshold

Description
Calendar year of claims data (2017, 2018, or 2019)
Insurance product (Commercial, Medicaid Managed Care - Non Dual Eligible, Medicaid Managed Care - Dual Eligible, Medicare Advantage, Medicare FFS - Dual Eligible, Medicare FFS - Non Dual Eligible, Medicare)
Dollar cut point tested in the analysis ($75,000; $100,000; $125,000; $150,000; $175,000; $200,000). Members exceeding this dollar cut point were identified as "above the threshold".
Percentile cut point tested in the analysis (92%; 95%; 97%; 99%; 99.5%). Members exceeding these percentile cut-points were identified as "above the threshold"
Dollar cut point corresponding to each percentile threshold
Number of distinct members in the Washington APCD for each given product and year. This includes memebrs above and below the threshold
Number of distinct members in the Washington APCD for each given product and year who exceeded the given threshold.
Number of members exceeding the threshold divided by total members
Total allowed amount (plan plus member responsibility) for pharmacy and medical claims for all patients in the product and year
For patients exceeding the threshold, this is the total aggregated amount of athe dollars spent **above the threshold level.** For example, for the $100,000 threshold, a patient with $105,000 woud contribute $5,000 to this aggregate amount. This is the amount that would be excluded if all patients' spending was truncated at the cut point.
Allowed amount exceeding threshold/ Total allowed amount, all patients
For patients exceeding the threshold, this is the total aggregated amount of athe dollars spent **above or below the threshold level**. For example, for the $100,000 threshold, a patient with $105,000 woud contribute $105,000 to this aggregate amount. This is the amount that would be excluded if patients above the threshold were excluded from the analysis altogether
Total Expenditures (Above and Below Threshold) for Members Exceeding Threshold/ Total allowed amount, all patients

2. Dollar Cut-Offs for Each Percentile

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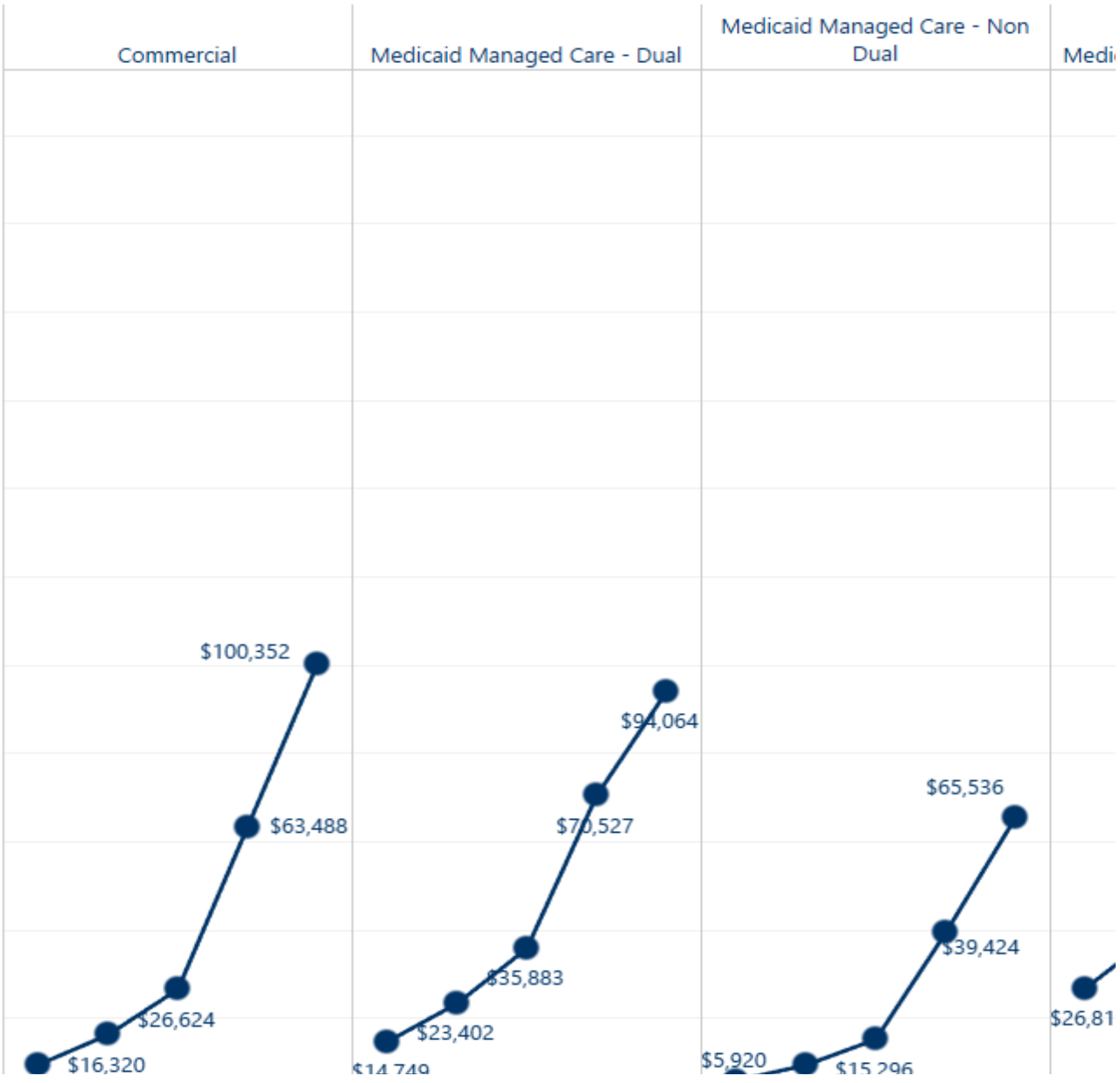
		Dollar Cutoff for Percentiles				
Product	**Year**	**92**	**95**	**97**	**99**	**99.5**
COMMERCIAL	2017	$ 9,184	$ 15,488	$ 25,216	$ 61,440	$ 96,256
COMMERCIAL	2018	$ 8,960	$ 15,328	$ 25,088	$ 61,440	$ 98,304
COMMERCIAL	2019	$ 9,536	$ 16,320	$ 26,624	$ 63,488	$ 100,352
MEDICAID - DUAL	2017	$ 14,749	$ 23,402	$ 35,883	$ 70,527	$ 94,064
MEDICAID MANAGED CARE - NON DUAL	2017	$ 5,008	$ 8,192	$ 12,736	$ 32,768	$ 55,296
MEDICAID MANAGED CARE - NON DUAL	2018	$ 5,392	$ 8,672	$ 13,888	$ 35,840	$ 60,416
MEDICAID MANAGED CARE - NON DUAL	2019	$ 5,920	$ 9,472	$ 15,296	$ 39,424	$ 65,536
MEDICARE - DUAL	2017	$ 53,120	$ 72,448	$ 98,048	$ 163,840	$ 221,184
MEDICARE ADVANTAGE - NON DUAL	2017	$ 26,304	$ 39,936	$ 60,416	$ 143,360	$ 225,280
MEDICARE ADVANTAGE - NON DUAL	2018	$ 26,048	$ 38,144	$ 53,760	$ 101,376	$ 139,264
MEDICARE ADVANTAGE - NON DUAL	2019	$ 26,816	$ 39,040	$ 55,680	$ 104,448	$ 144,384
MEDICARE FFS - NON DUAL	2017	$ 39,232	$ 55,808	$ 75,776	$ 131,072	$ 174,080




care Advantage - Non Dual
Medicare FFS
Medicare FFS - Dual
$221,184
$174,080
$163,840
$144,384
$131,072
$104,448
$98,048
$75,776
$72,448
$55,680
$55,808
$53,120
$39,040
$39,232
6

3. Analysis of Spending and Members by Dollar Thresholds

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Year	Product	Dollar Threshold	Total Members	Number of Members Exceeding Threshold
2017	COMMERCIAL	$ 75,000	1,727,333	11,829
2017	COMMERCIAL	$ 100,000	1,727,333	6,957
2017	COMMERCIAL	$ 125,000	1,727,333	4,639
2017	COMMERCIAL	$ 150,000	1,727,333	3,257
2017	COMMERCIAL	$ 175,000	1,727,333	2,370
2017	COMMERCIAL	$ 200,000	1,727,333	1,795
2018	COMMERCIAL	$ 75,000	1,752,916	11,763
2018	COMMERCIAL	$ 100,000	1,752,916	7,141
2018	COMMERCIAL	$ 125,000	1,752,916	4,806
2018	COMMERCIAL	$ 150,000	1,752,916	3,396
2018	COMMERCIAL	$ 175,000	1,752,916	2,447
2018	COMMERCIAL	$ 200,000	1,752,916	1,875
2019	COMMERCIAL	$ 75,000	1,788,913	12,771
2019	COMMERCIAL	$ 100,000	1,788,913	7,997
2019	COMMERCIAL	$ 125,000	1,788,913	5,416
2019	COMMERCIAL	$ 150,000	1,788,913	3,850
2019	COMMERCIAL	$ 175,000	1,788,913	2,893
2019	COMMERCIAL	$ 200,000	1,788,913	2,208
2017	MEDICAID - DUAL	$ 75,000	10,982	96
2017	MEDICAID - DUAL	$ 100,000	10,982	48
2017	MEDICAID - DUAL	$ 125,000	10,982	27
2017	MEDICAID - DUAL	$ 150,000	10,982	16
2017	MEDICAID - DUAL	$ 175,000	10,982	<10 Members
2017	MEDICAID - DUAL	$ 200,000	10,982	<10 Members
2017	MEDICAID MANAGED CARE - NON DUAL	$ 75,000	1,806,855	4,681
2017	MEDICAID MANAGED CARE - NON DUAL	$ 100,000	1,806,855	2,697
2017	MEDICAID MANAGED CARE - NON DUAL	$ 125,000	1,806,855	1,748
2017	MEDICAID MANAGED CARE - NON DUAL	$ 150,000	1,806,855	1,191
2017	MEDICAID MANAGED CARE - NON DUAL	$ 175,000	1,806,855	865
2017	MEDICAID MANAGED CARE - NON DUAL	$ 200,000	1,806,855	662
2018	MEDICAID MANAGED CARE - NON DUAL	$ 75,000	1,802,815	5,396
2018	MEDICAID MANAGED CARE - NON DUAL	$ 100,000	1,802,815	3,151
2018	MEDICAID MANAGED CARE - NON DUAL	$ 125,000	1,802,815	2,017
2018	MEDICAID MANAGED CARE - NON DUAL	$ 150,000	1,802,815	1,409
2018	MEDICAID MANAGED CARE - NON DUAL	$ 175,000	1,802,815	1,021
2018	MEDICAID MANAGED CARE - NON DUAL	$ 200,000	1,802,815	770
2019	MEDICAID MANAGED CARE - NON DUAL	$ 75,000	1,811,670	6,069
2019	MEDICAID MANAGED CARE - NON DUAL	$ 100,000	1,811,670	3,463
2019	MEDICAID MANAGED CARE - NON DUAL	$ 125,000	1,811,670	2,172
2019	MEDICAID MANAGED CARE - NON DUAL	$ 150,000	1,811,670	1,512
2019	MEDICAID MANAGED CARE - NON DUAL	$ 175,000	1,811,670	1,071
2019	MEDICAID MANAGED CARE - NON DUAL	$ 200,000	1,811,670	798
2017	MEDICARE - DUAL	$ 75,000	165,917	7,741
2017	MEDICARE - DUAL	$ 100,000	165,917	4,668
2017	MEDICARE - DUAL	$ 125,000	165,917	3,028
2017	MEDICARE - DUAL	$ 150,000	165,917	2,006
2017	MEDICARE - DUAL	$ 175,000	165,917	1,402

2017	MEDICARE - DUAL	$ 200,000	165,917	955
2017	MEDICARE ADVANTAGE - NON DUAL	$ 75,000	373,862	8,458
2017	MEDICARE ADVANTAGE - NON DUAL	$ 100,000	373,862	5,900
2017	MEDICARE ADVANTAGE - NON DUAL	$ 125,000	373,862	4,405
2017	MEDICARE ADVANTAGE - NON DUAL	$ 150,000	373,862	3,412
2017	MEDICARE ADVANTAGE - NON DUAL	$ 175,000	373,862	2,689
2017	MEDICARE ADVANTAGE - NON DUAL	$ 200,000	373,862	2,137
2018	MEDICARE ADVANTAGE - NON DUAL	$ 75,000	452,698	7,698
2018	MEDICARE ADVANTAGE - NON DUAL	$ 100,000	452,698	4,364
2018	MEDICARE ADVANTAGE - NON DUAL	$ 125,000	452,698	2,728
2018	MEDICARE ADVANTAGE - NON DUAL	$ 150,000	452,698	1,744
2018	MEDICARE ADVANTAGE - NON DUAL	$ 175,000	452,698	1,137
2018	MEDICARE ADVANTAGE - NON DUAL	$ 200,000	452,698	763
2019	MEDICARE ADVANTAGE - NON DUAL	$ 75,000	521,021	9,243
2019	MEDICARE ADVANTAGE - NON DUAL	$ 100,000	521,021	5,380
2019	MEDICARE ADVANTAGE - NON DUAL	$ 125,000	521,021	3,316
2019	MEDICARE ADVANTAGE - NON DUAL	$ 150,000	521,021	2,142
2019	MEDICARE ADVANTAGE - NON DUAL	$ 175,000	521,021	1,374
2019	MEDICARE ADVANTAGE - NON DUAL	$ 200,000	521,021	921
2017	MEDICARE FFS - NON DUAL	$ 75,000	393,938	11,863
2017	MEDICARE FFS - NON DUAL	$ 100,000	393,938	6,832
2017	MEDICARE FFS - NON DUAL	$ 125,000	393,938	4,249
2017	MEDICARE FFS - NON DUAL	$ 150,000	393,938	2,747
2017	MEDICARE FFS - NON DUAL	$ 175,000	393,938	1,808
2017	MEDICARE FFS - NON DUAL	$ 200,000	393,938	1,193

Percentage of Members Exceeding Threshold	Total Allowed Amount, All Patients	Allowed Amount Exceeding Threshold	Percentage of Spend Exceeding Threshold	Total Expenditures (Above and Below Threshold) for Members Exceeding Threshold
0.68%	$ 6,691,384,269	$ 892,276,226	13.33%	$ 1,779,451,226
0.40%	$ 6,691,384,269	$ 663,616,066	9.92%	$ 1,359,316,066
0.27%	$ 6,691,384,269	$ 521,883,407	7.80%	$ 1,101,758,407
0.19%	$ 6,691,384,269	$ 425,014,440	6.35%	$ 913,564,440
0.14%	$ 6,691,384,269	$ 355,492,710	5.31%	$ 770,242,710
0.10%	$ 6,691,384,269	$ 303,759,627	4.54%	$ 662,759,627
0.67%	$ 6,657,165,289	$ 905,007,665	13.59%	$ 1,787,232,665
0.41%	$ 6,657,165,289	$ 674,996,199	10.14%	$ 1,389,096,199
0.27%	$ 6,657,165,289	$ 528,451,716	7.94%	$ 1,129,201,716
0.19%	$ 6,657,165,289	$ 427,796,953	6.43%	$ 937,196,953
0.14%	$ 6,657,165,289	$ 355,505,817	5.34%	$ 783,730,817
0.11%	$ 6,657,165,289	$ 301,863,475	4.53%	$ 676,863,475
0.71%	$ 7,251,584,428	$ 1,044,189,126	14.40%	$ 2,002,014,126
0.45%	$ 7,251,584,428	$ 790,401,169	10.90%	$ 1,590,101,169
0.30%	$ 7,251,584,428	$ 625,685,359	8.63%	$ 1,302,685,359
0.22%	$ 7,251,584,428	$ 511,074,367	7.05%	$ 1,088,574,367
0.16%	$ 7,251,584,428	$ 427,290,592	5.89%	$ 933,565,592
0.12%	$ 7,251,584,428	$ 363,987,355	5.02%	$ 805,587,355
0.87%	$ 54,222,843	$ 4,451,610	8.21%	$ 11,651,610
0.44%	$ 54,222,843	$ 2,844,898	5.25%	$ 7,644,898
0.25%	$ 54,222,843	$ 2,002,764	3.69%	$ 5,377,764
0.15%	$ 54,222,843	$ 1,445,840	2.67%	$ 3,845,840
NA	$ 54,222,843	NA	NA	NA
NA	$ 54,222,843	NA	NA	NA
0.26%	$ 3,661,747,963	$ 342,196,842	9.35%	$ 693,271,842
0.15%	$ 3,661,747,963	$ 253,394,646	6.92%	$ 523,094,646
0.10%	$ 3,661,747,963	$ 198,842,494	5.43%	$ 417,342,494
0.07%	$ 3,661,747,963	$ 162,818,898	4.45%	$ 341,468,898
0.05%	$ 3,661,747,963	$ 137,449,313	3.75%	$ 288,824,313
0.04%	$ 3,661,747,963	$ 118,539,297	3.24%	$ 250,939,297
0.30%	$ 3,969,905,103	$ 407,300,892	10.26%	$ 812,000,892
0.17%	$ 3,969,905,103	$ 303,901,890	7.66%	$ 619,001,890
0.11%	$ 3,969,905,103	$ 240,929,416	6.07%	$ 493,054,416
0.08%	$ 3,969,905,103	$ 198,662,199	5.00%	$ 410,012,199
0.06%	$ 3,969,905,103	$ 169,053,550	4.26%	$ 347,728,550
0.04%	$ 3,969,905,103	$ 146,685,297	3.69%	$ 300,685,297
0.33%	$ 4,299,640,367	$ 419,264,919	9.75%	$ 874,439,919
0.19%	$ 4,299,640,367	$ 304,526,808	7.08%	$ 650,826,808
0.12%	$ 4,299,640,367	$ 235,244,013	5.47%	$ 506,744,013
0.08%	$ 4,299,640,367	$ 190,091,667	4.42%	$ 416,891,667
0.06%	$ 4,299,640,367	$ 158,333,326	3.68%	$ 345,758,326
0.04%	$ 4,299,640,367	$ 135,006,909	3.14%	$ 294,606,909
4.67%	$ 2,750,323,338	$ 520,807,945	18.94%	$ 1,101,382,945
2.81%	$ 2,750,323,338	$ 369,402,794	13.43%	$ 836,202,794
1.83%	$ 2,750,323,338	$ 275,123,280	10.00%	$ 653,623,280
1.21%	$ 2,750,323,338	$ 212,881,368	7.74%	$ 513,781,368
0.85%	$ 2,750,323,338	$ 170,964,686	6.22%	$ 416,314,686

0.58%	$ 2,750,323,338	$ 141,653,087	5.15%	$ 332,653,087
2.26%	$ 4,215,699,053	$ 1,089,166,932	25.84%	$ 1,723,516,932
1.58%	$ 4,215,699,053	$ 912,731,885	21.65%	$ 1,502,731,885
1.18%	$ 4,215,699,053	$ 785,022,524	18.62%	$ 1,335,647,524
0.91%	$ 4,215,699,053	$ 687,615,096	16.31%	$ 1,199,415,096
0.72%	$ 4,215,699,053	$ 612,146,693	14.52%	$ 1,082,721,693
0.57%	$ 4,215,699,053	$ 552,016,582	13.09%	$ 979,416,582
1.70%	$ 3,939,636,930	$ 442,722,683	11.24%	$ 1,020,072,683
0.96%	$ 3,939,636,930	$ 296,679,122	7.53%	$ 733,079,122
0.60%	$ 3,939,636,930	$ 210,235,807	5.34%	$ 551,235,807
0.39%	$ 3,939,636,930	$ 155,269,170	3.94%	$ 416,869,170
0.25%	$ 3,939,636,930	$ 119,860,172	3.04%	$ 318,835,172
0.17%	$ 3,939,636,930	$ 96,597,145	2.45%	$ 249,197,145
1.77%	$ 4,634,395,260	$ 508,144,432	10.96%	$ 1,201,369,432
1.03%	$ 4,634,395,260	$ 330,763,432	7.14%	$ 868,763,432
0.64%	$ 4,634,395,260	$ 224,892,707	4.85%	$ 639,392,707
0.41%	$ 4,634,395,260	$ 157,874,428	3.41%	$ 479,174,428
0.26%	$ 4,634,395,260	$ 114,137,973	2.46%	$ 354,587,973
0.18%	$ 4,634,395,260	$ 85,800,432	1.85%	$ 270,000,432
3.01%	$ 4,771,360,338	$ 642,109,113	13.46%	$ 1,531,834,113
1.73%	$ 4,771,360,338	$ 414,410,548	8.69%	$ 1,097,610,548
1.08%	$ 4,771,360,338	$ 279,422,836	5.86%	$ 810,547,836
0.70%	$ 4,771,360,338	$ 193,215,934	4.05%	$ 605,265,934
0.46%	$ 4,771,360,338	$ 137,169,664	2.87%	$ 453,569,664
0.30%	$ 4,771,360,338	$ 99,935,228	2.09%	$ 338,535,228

Percentage of Spend Attriuted to Members Exceeding Threshold
26.59%
20.31%
16.47%
13.65%
11.51%
9.90%
26.85%
20.87%
16.96%
14.08%
11.77%
10.17%
27.61%
21.93%
17.96%
15.01%
12.87%
11.11%
21.49%
14.10%
9.92%
7.09%
NA
NA
18.93%
14.29%
11.40%
9.33%
7.89%
6.85%
20.45%
15.59%
12.42%
10.33%
8.76%
7.57%
20.34%
15.14%
11.79%
9.70%
8.04%
6.85%
40.05%
30.40%
23.77%
18.68%
15.14%

12.10%
40.88%
35.65%
31.68%
28.45%
25.68%
23.23%
25.89%
18.61%
13.99%
10.58%
8.09%
6.33%
25.92%
18.75%
13.80%
10.34%
7.65%
5.83%
32.10%
23.00%
16.99%
12.69%
9.51%
7.10%

4. Analysis of Spending and Members by Percentile Thresholds

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Year	Product	Percentile Threshold	Dollar Cutoff for Percentile	Total Members
2017	COMMERCIAL	92	$ 9,184	1,727,333
2017	COMMERCIAL	95	$ 15,488	1,727,333
2017	COMMERCIAL	97	$ 25,216	1,727,333
2017	COMMERCIAL	99	$ 61,440	1,727,333
2017	COMMERCIAL	99.5	$ 96,256	1,727,333
2018	COMMERCIAL	92	$ 8,960	1,752,916
2018	COMMERCIAL	95	$ 15,328	1,752,916
2018	COMMERCIAL	97	$ 25,088	1,752,916
2018	COMMERCIAL	99	$ 61,440	1,752,916
2018	COMMERCIAL	99.5	$ 98,304	1,752,916
2019	COMMERCIAL	92	$ 9,536	1,788,913
2019	COMMERCIAL	95	$ 16,320	1,788,913
2019	COMMERCIAL	97	$ 26,624	1,788,913
2019	COMMERCIAL	99	$ 63,488	1,788,913
2019	COMMERCIAL	99.5	$ 100,352	1,788,913
2017	MEDICAID - DUAL	92	$ 14,749	10,982
2017	MEDICAID - DUAL	95	$ 23,402	10,982
2017	MEDICAID - DUAL	97	$ 35,883	10,982
2017	MEDICAID - DUAL	99	$ 70,527	10,982
2017	MEDICAID - DUAL	99.5	$ 94,064	10,982
2017	MEDICAID MANAGED CARE - NON DUAL	92	$ 5,008	1,806,855
2017	MEDICAID MANAGED CARE - NON DUAL	95	$ 8,192	1,806,855
2017	MEDICAID MANAGED CARE - NON DUAL	97	$ 12,736	1,806,855
2017	MEDICAID MANAGED CARE - NON DUAL	99	$ 32,768	1,806,855
2017	MEDICAID MANAGED CARE - NON DUAL	99.5	$ 55,296	1,806,855
2018	MEDICAID MANAGED CARE - NON DUAL	92	$ 5,392	1,802,815
2018	MEDICAID MANAGED CARE - NON DUAL	95	$ 8,672	1,802,815
2018	MEDICAID MANAGED CARE - NON DUAL	97	$ 13,888	1,802,815
2018	MEDICAID MANAGED CARE - NON DUAL	99	$ 35,840	1,802,815
2018	MEDICAID MANAGED CARE - NON DUAL	99.5	$ 60,416	1,802,815
2019	MEDICAID MANAGED CARE - NON DUAL	92	$ 5,920	1,811,670
2019	MEDICAID MANAGED CARE - NON DUAL	95	$ 9,472	1,811,670
2019	MEDICAID MANAGED CARE - NON DUAL	97	$ 15,296	1,811,670
2019	MEDICAID MANAGED CARE - NON DUAL	99	$ 39,424	1,811,670
2019	MEDICAID MANAGED CARE - NON DUAL	99.5	$ 65,536	1,811,670
2017	MEDICARE - DUAL	92	$ 53,120	165,917
2017	MEDICARE - DUAL	95	$ 72,448	165,917
2017	MEDICARE - DUAL	97	$ 98,048	165,917
2017	MEDICARE - DUAL	99	$ 163,840	165,917
2017	MEDICARE - DUAL	99.5	$ 221,184	165,917
2017	MEDICARE ADVANTAGE - NON DUAL	92	$ 26,304	373,862
2017	MEDICARE ADVANTAGE - NON DUAL	95	$ 39,936	373,862
2017	MEDICARE ADVANTAGE - NON DUAL	97	$ 60,416	373,862
2017	MEDICARE ADVANTAGE - NON DUAL	99	$ 143,360	373,862
2017	MEDICARE ADVANTAGE - NON DUAL	99.5	$ 225,280	373,862
2018	MEDICARE ADVANTAGE - NON DUAL	92	$ 26,048	452,698
2018	MEDICARE ADVANTAGE - NON DUAL	95	$ 38,144	452,698
2018	MEDICARE ADVANTAGE - NON DUAL	97	$ 53,760	452,698

2018	MEDICARE ADVANTAGE - NON DUAL	99	$	101,376	452,698
2018	MEDICARE ADVANTAGE - NON DUAL	99.5	$	139,264	452,698
2019	MEDICARE ADVANTAGE - NON DUAL	92	$	26,816	521,021
2019	MEDICARE ADVANTAGE - NON DUAL	95	$	39,040	521,021
2019	MEDICARE ADVANTAGE - NON DUAL	97	$	55,680	521,021
2019	MEDICARE ADVANTAGE - NON DUAL	99	$	104,448	521,021
2019	MEDICARE ADVANTAGE - NON DUAL	99.5	$	144,384	521,021
2017	MEDICARE FFS - NON DUAL	92	$	39,232	393,938
2017	MEDICARE FFS - NON DUAL	95	$	55,808	393,938
2017	MEDICARE FFS - NON DUAL	97	$	75,776	393,938
2017	MEDICARE FFS - NON DUAL	99	$	131,072	393,938
2017	MEDICARE FFS - NON DUAL	99.5	$	174,080	393,938

Number of Members Exceeding Threshold	Percentage of Members Exceeding Threshold	Total Allowed Amount, All Patients	Allowed Amount Exceeding Threshold	Percentage of Spend Exceeding Threshold
137,219	7.94%	$ 6,691,384,269	$ 3,448,039,802	51.53%
85,375	4.94%	$ 6,691,384,269	$ 2,769,599,552	41.39%
50,933	2.95%	$ 6,691,384,269	$ 2,133,000,470	31.88%
16,081	0.93%	$ 6,691,384,269	$ 1,079,046,476	16.13%
7,541	0.44%	$ 6,691,384,269	$ 690,714,345	10.32%
139,090	7.93%	$ 6,657,165,289	$ 3,500,947,127	52.59%
86,471	4.93%	$ 6,657,165,289	$ 2,808,246,510	42.18%
51,747	2.95%	$ 6,657,165,289	$ 2,157,471,017	32.41%
16,331	0.93%	$ 6,657,165,289	$ 1,092,231,123	16.41%
7,353	0.42%	$ 6,657,165,289	$ 687,277,101	10.32%
142,264	7.95%	$ 7,251,584,428	$ 3,771,884,033	52.01%
88,236	4.93%	$ 7,251,584,428	$ 3,017,692,064	41.61%
52,603	2.94%	$ 7,251,584,428	$ 2,319,346,578	31.98%
16,867	0.94%	$ 7,251,584,428	$ 1,213,194,326	16.73%
7,943	0.44%	$ 7,251,584,428	$ 787,595,080	10.86%
878	7.99%	$ 54,222,843	$ 22,871,545	42.18%
549	5.00%	$ 54,222,843	$ 16,844,680	31.07%
329	3.00%	$ 54,222,843	$ 11,567,529	21.33%
109	0.99%	$ 54,222,843	$ 4,903,860	9.04%
54	0.49%	$ 54,222,843	$ 3,136,263	5.78%
143,565	7.95%	$ 3,661,747,963	$ 1,989,871,685	54.34%
88,363	4.89%	$ 3,661,747,963	$ 1,630,077,928	44.52%
53,136	2.94%	$ 3,661,747,963	$ 1,321,293,380	36.08%
17,155	0.95%	$ 3,661,747,963	$ 726,898,268	19.85%
8,042	0.45%	$ 3,661,747,963	$ 462,859,484	12.64%
142,823	7.92%	$ 3,969,905,103	$ 2,169,464,652	54.65%
89,079	4.94%	$ 3,969,905,103	$ 1,799,019,344	45.32%
53,174	2.95%	$ 3,969,905,103	$ 1,444,270,583	36.38%
17,192	0.95%	$ 3,969,905,103	$ 789,951,832	19.90%
7,888	0.44%	$ 3,969,905,103	$ 502,306,769	12.65%
143,807	7.94%	$ 4,299,640,367	$ 2,308,553,157	53.69%
89,585	4.94%	$ 4,299,640,367	$ 1,906,179,094	44.33%
53,236	2.94%	$ 4,299,640,367	$ 1,508,077,514	35.07%
17,105	0.94%	$ 4,299,640,367	$ 788,506,040	18.34%
7,782	0.43%	$ 4,299,640,367	$ 484,565,958	11.27%
13,163	7.93%	$ 2,750,323,338	$ 743,414,218	27.03%
8,186	4.93%	$ 2,750,323,338	$ 541,118,378	19.67%
4,849	2.92%	$ 2,750,323,338	$ 378,696,391	13.77%
1,631	0.98%	$ 2,750,323,338	$ 187,929,991	6.83%
737	0.44%	$ 2,750,323,338	$ 123,934,218	4.51%
29,688	7.94%	$ 4,215,699,053	$ 1,836,888,113	43.57%
18,364	4.91%	$ 4,215,699,053	$ 1,520,065,596	36.06%
10,982	2.94%	$ 4,215,699,053	$ 1,229,461,949	29.16%
3,663	0.98%	$ 4,215,699,053	$ 711,132,609	16.87%
1,691	0.45%	$ 4,215,699,053	$ 503,960,248	11.95%
35,931	7.94%	$ 3,939,636,930	$ 1,273,163,263	32.32%
22,363	4.94%	$ 3,939,636,930	$ 928,881,587	23.58%
13,351	2.95%	$ 3,939,636,930	$ 658,819,596	16.72%

4,236	0.94%	$ 3,939,636,930	$ 290,769,040	7.38%
2,108	0.47%	$ 3,939,636,930	$ 175,941,587	4.47%
41,362	7.94%	$ 4,634,395,260	$ 1,470,825,819	31.74%
25,785	4.95%	$ 4,634,395,260	$ 1,070,390,192	23.10%
15,286	2.93%	$ 4,634,395,260	$ 739,454,948	15.96%
4,895	0.94%	$ 4,634,395,260	$ 307,953,022	6.64%
2,348	0.45%	$ 4,634,395,260	$ 170,460,514	3.68%
31,288	7.94%	$ 4,771,360,338	$ 1,346,306,707	28.22%
19,472	4.94%	$ 4,771,360,338	$ 934,423,701	19.58%
11,668	2.96%	$ 4,771,360,338	$ 632,979,387	13.27%
3,818	0.97%	$ 4,771,360,338	$ 255,025,556	5.34%
1,836	0.47%	$ 4,771,360,338	$ 138,847,696	2.91%

Total Expenditures (Above and Below Threshold) for Members Exceeding Threshold	Percentage of Spend Attriuted to Members Exceeding Threshold
$ 4,708,259,098	70.36%
$ 4,091,887,552	61.15%
$ 3,417,326,998	51.07%
$ 2,067,063,116	30.89%
$ 1,416,580,841	21.17%
$ 4,747,193,527	71.31%
$ 4,133,673,998	62.09%
$ 3,455,699,753	51.91%
$ 2,095,607,763	31.48%
$ 1,410,106,413	21.18%
$ 5,128,513,537	70.72%
$ 4,457,703,584	61.47%
$ 3,719,848,850	51.30%
$ 2,284,046,422	31.50%
$ 1,584,691,016	21.85%
$ 35,821,273	66.06%
$ 29,692,126	54.76%
$ 23,372,882	43.11%
$ 12,591,287	23.22%
$ 8,215,713	15.15%
$ 2,708,845,205	73.98%
$ 2,353,947,624	64.28%
$ 1,998,033,476	54.57%
$ 1,289,033,308	35.20%
$ 907,549,916	24.78%
$ 2,939,566,268	74.05%
$ 2,571,512,432	64.78%
$ 2,182,751,095	54.98%
$ 1,406,113,112	35.42%
$ 978,868,177	24.66%
$ 3,159,890,597	73.49%
$ 2,754,728,214	64.07%
$ 2,322,375,370	54.01%
$ 1,462,853,560	34.02%
$ 994,567,110	23.13%
$ 1,442,632,778	52.45%
$ 1,134,177,706	41.24%
$ 854,131,143	31.06%
$ 455,153,031	16.55%
$ 286,946,826	10.43%
$ 2,617,801,265	62.10%
$ 2,253,450,300	53.45%
$ 1,892,950,461	44.90%
$ 1,236,260,289	29.33%
$ 884,908,728	20.99%
$ 2,209,093,951	56.07%
$ 1,781,895,859	45.23%
$ 1,376,569,356	34.94%

$	720,197,776	18.28%
$	469,510,099	11.92%
$	2,579,989,211	55.67%
$	2,077,036,592	44.82%
$	1,590,579,428	34.32%
$	819,225,982	17.68%
$	509,474,146	10.99%
$	2,573,797,523	53.94%
$	2,021,117,077	42.36%
$	1,517,133,755	31.80%
$	755,458,452	15.83%
$	458,458,576	9.61%