

# Advisory Committee on Data Issues

September 8, 2021

## Advisory Committee on Data Issues Meeting Materials Book

September 8, 2021  
2:00 p.m. – 4:00 p.m.

**(Zoom Attendance Only)**

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Recap of feedback on Methods to Ensure the Accuracy and Reliability of benchmark .....	4
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# Agenda

## TAB 1

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## Advisory Committee on Data Issues

September 8, 2021  
2:00 p.m. – 4:00 p.m.  
Zoom Meeting

### AGENDA

#### Committee Members:

<input type="checkbox"/>	Megan Atkinson	<input type="checkbox"/>	Jarred Collings	<input type="checkbox"/>	Dave Mancuso
<input type="checkbox"/>	Amanda Avalos	<input type="checkbox"/>	Jerome Dugan	<input type="checkbox"/>	Ana Morales
<input type="checkbox"/>	Allison Bailey	<input type="checkbox"/>	Leah Hole-Marshall	<input type="checkbox"/>	Thea Mounts
<input type="checkbox"/>	Jonathan Bennett	<input type="checkbox"/>	Karen Johnson	<input type="checkbox"/>	Hunter Plumer
<input type="checkbox"/>	Purav Bhatt	<input type="checkbox"/>	Scott Juergens	<input type="checkbox"/>	Mark Pregler
<input type="checkbox"/>	Bruce Brazier	<input type="checkbox"/>	Lichiou Lee	<input type="checkbox"/>	Julie Sylvester
<input type="checkbox"/>	Jason Brown	<input type="checkbox"/>	Josh Liao		

#### Committee Facilitator:

J.D. Fischer

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, call to order, and agenda review	1	J.D. Fischer Health Care Authority
2:05-2:10 (5 min)	Approval of meeting minutes	2	J.D. Fischer Health Care Authority
2:10-2:15 (5 min)	Topics we will discuss today	3	January Angeles and Michael Bailit Bailit Health
2:15-2:25 (10 min)	Recap of feedback on methods to ensure the accuracy and reliability of benchmark performance measurement	4	January Angeles and Michael Bailit Bailit Health
2:25-3:05 (40 min)	Key questions to address for provider-level reporting	5	January Angeles and Michael Bailit Bailit Health
3:05-3:45 (40 min)	Analyses to inform cost growth mitigation strategies	6	January Angeles and Michael Bailit Bailit Health
3:45-3:55 (10 min)	Public comment		J.D. Fischer Health Care Authority
3:55-4:00 (5 min)	Wrap-up and adjournment		J.D. Fischer 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.*

# August meeting minutes

## TAB 2

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# Advisory Committee on Data Issues meeting minutes

August 10, 2021  
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  
Amanda Avalos  
Ana Morales  
Bruce Brazier  
Dave Mancuso  
Hunter Plumer  
Jared Collings  
Jerome Dugan  
Jonathan Bennett  
Julie Sylvester  
Karen Johnson  
Leah Hole-Marshall  
Lichiou Lee  
Mark Pregler  
Purav Bhatt  
Scott Juergens  
Thea Mounts

## Members absent

Jason Brown  
Josh Liao  
Megan Atkinson

## Agenda items

### Welcome, Roll Call, Agenda Review

J.D. Fischer, committee facilitator, called the meeting to order at 10:02 a.m.



## New Member Introduction

Jared Collings, Regence Blue Shield

The Cost Board appointed Mr. Collings to the Advisory Committee on Data Issues in July. Mr. Collings introduced himself to the Committee, sharing his background and expertise in measuring, tracking, and assessing health care cost and utilization patterns.

## Approval of Minutes

Mr. Fischer provided a recap of the July Committee meeting, and the Committee approved the July meeting minutes.

## Topics for Discussion

Topics relating to the cost growth benchmark measurement, reporting, and analysis presented to the Committee included the following:

- Overview of preliminary benchmark decisions and measurement.
- Reporting performance against the cost growth benchmark.
- Methods to ensure the accuracy and reliability of benchmark performance measurement.

## Overview of Preliminary Benchmark Decisions and Measurement

January Angeles and Michael Bailit, Bailit Health  
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented an overview of the Board's preliminary benchmark decisions to the Committee. The Board made the preliminary decision to set the benchmark value using a 70/30 hybrid of historical median wage and potential gross state product. The benchmark would phase down over time:

- 2022-2023: 3.2%
- 2024-2025: 3.0%
- 2026: 2.8%


Ms. Angeles and Mr. Bailit reviewed what constitutes total health care expenditures (THCE) measured against the cost growth benchmark. THCE comprises total medical expense (TME) and the net cost of private health insurance (NCPHI). To collect data for benchmark performance analysis, commercial, Medicare Advantage, and Medicaid managed care plans must submit aggregate claims and non-claims data for provider entities, stratified by market segment. HCA staff will collect supplementary data from other sources, including Centers for Medicare & Medicaid Services (CMS) for Medicare fee-for-service (FFS) claims and Part D spending, Medicaid FFS spending, other sources of public health coverage (e.g., Veteran's Health Administration, Department of Corrections, workers' comp., etc.), and regulatory reports for NCPHI.

## Reporting Performance Against the Cost Growth Benchmark

January Angeles and Michael Bailit, Bailit Health  
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented material to the Committee relating to reporting performance against the cost growth benchmark, beginning with comparing the benchmark analysis (i.e., how the Board will determine the cost growth from one year to the next) with the data use strategy (i.e., how the Board will determine what is driving overall cost and cost growth). Other states have typically reported benchmark performance at four levels:





statewide (THCE), market segments (THCE), payers (THCE), and large provider entities (TME only). Ms. Angeles provided examples for each report level from other states and noted that the Board will need to address the method of specifically defining and identifying provider entities whose performance will be measured against the cost growth benchmark. Mr. Bailit reiterated the important connection between the data use strategy and the benchmark analysis, where the latter heavily supports the former.

## Methods to Ensure the Accuracy and Reliability of Benchmark Performance Measurement

January Angeles and Michael Bailit, Bailit Health  
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented to the Committee topics related to ensuring accuracy and reliability in the benchmark performance measurement, including:

- Statistical testing on benchmark performance data.
- Mitigating the impact of high-cost outliers.
- Applying risk adjustment.
- Ensuring sufficient population sizes.

### **Statistical testing on benchmark performance data:**


Ms. Angeles and Mr. Bailit presented the option of developing confidence intervals around benchmark performance which would allow the Board to state a 95% confidence that the interval between the lower bound and upper bound contains the true rate of cost growth for a given entity. In determining performance with the use of confidence intervals, the performance *cannot be determined* when the upper or lower bound intersects with the benchmark but *can be determined* when either the lower bound is fully over the benchmark or the upper bound is fully below the benchmark. One committee member asked how confidence intervals would apply to the statewide analysis, and Ms. Angeles and Mr. Bailit confirmed that a confidence interval would not be necessary for statewide analysis due to the size of the data set. Ms. Angeles and Mr. Bailit asked if the Committee wished to recommend applying statistical testing and using confidence intervals to determine entities' benchmark performance.

Committee members supported this recommendation. One Committee member supported the use of confidence intervals provided there is clear documentation within the reports pertaining to the methodology used to construct the confidence intervals.

### **Mitigating the impact of high-cost outliers:**

Ms. Angeles and Mr. Bailit presented mitigation strategies for addressing the impact of high-cost outliers, i.e., members/patients with extremely high levels of annual health care spending. While such patients represent real spending, they often present randomly within a population and there are limits to how much of their spending can be influenced due to the medical complexity of their condition(s) and high resource intensity care needs. A common practice to address such outliers is to *truncate* expenditures to prevent high-cost outliers from significantly affecting providers' per capita expenditures. Truncation involved capping individual patient spending at a high level (e.g., between \$100k and \$150k for commercial populations). Mr. Bailit noted that truncating high-cost outliers will shrink the confidence interval and make it easier for the Board to draw a conclusion about whether an entity performed above or below the benchmark. Mr. Bailit provided an example from Rhode Island of how the inclusion of high-cost outlier spending affected a provider entity's cost growth by several percentage points, and how the state consequently changed its methodology to use truncation to mitigate the impact of high-cost outliers. One Committee member noted how quickly annual costs can rise for certain patients with oncologic conditions and who are on biologics and suggested different truncation points. Another Committee member noted that differential treatment of high-cost outliers based on disease would make data collection complex. Most

Advisory Committee on Data Issues meeting minutes  
08/10/2021



Committee members agreed to recommend to the Board that they utilize the truncation of high-cost outliers' spending when measuring insurer and provider entity benchmark performance. One Committee member did not support the recommendation and indicated that there was a need to evaluate the use of truncation along with other mitigation strategies. Another Committee member suggested while the Board should utilize truncation, outlier costs should be retained for the data use strategy for additional analysis.

**Applying risk adjustment:**

Ms. Angeles and Mr. Bailit described how states typically risk adjust data to account for population changes over time and reviewed various risk adjustment models, such as clinical risk adjustment and adjusting for utilization. They explained that risk adjustment is only performed at the carrier and provider levels. Further, HB 2475 requires the Board to *“annually calculate total health care expenditures and health care cost growth... for each health care provider or provider system and each payer, taking into account the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices.”* Ms. Angeles and Mr. Bailit described the difficulties of risk-adjusting based on utilization, service intensity and regional pricing differences, and recommended addressing these in the data use strategy instead of the reporting of benchmark performance. Committee members agreed to make this recommendation to the Board. Mr. Bailit described other states' experience with risk adjustment and associated challenges associated with the impact of provider claim coding practices on risk scores. One state has decided to only risk-adjust by age and sex due to rising risk scores, which is significantly driven by improvements in documentation of patient condition on claims rather than changes in the population's underlying risk. This had the effect of essentially raising the cost growth benchmark value. Committee members generally agreed that risk-adjusting by age and sex to assess benchmark performance seems reasonable. However multiple Committee members were concerned about the missed opportunity to understand variation across entities within a given reporting period, and to compare total cost vs. trend. One Committee member indicated that risk-adjusting by age and sex would only work assuming there isn't significant movement in patients/members across provider entities/insurers. Multiple Committee members expressed a desire to get additional input from actuaries and carrier and provider organizations before making a recommendation to the Board.

**Ensuring sufficient population sizes:**

Mr. Bailit described the need to gather benchmark data and report benchmark performance only for entities with “sufficient” population sizes. Three questions drive the determination of the minimum population sizes:

- How many enrolled lives must a payer have to report THCE?
- How many attributed lives must a provider entity have with a payer for its TME to be reported?
- How many lives must a payer/provider entity have in a line of business for its performance to be publicly reported?

Mr. Bailit provided a summary of how other states have determined thresholds for payer reporting and public reporting of provider performance. Mr. Bailit's recommendation based on other states' experience was to require all Medicaid managed care organizations and carriers with commercial or Medicare Advantage market share at five percent or higher to submit data reports and deferring the provider entity thresholds until Oregon and Connecticut have completed their pre-benchmark analyses that will inform the population size at which point confidence intervals become so large as to make a benchmark performance determination difficult. One Committee member requested additional information about Washington State markets to make a more informed recommendation, but did not oppose the strategy itself, and other members agreed. One Committee member noted how the individual market makes up a small portion of the commercial market (approximately four percent) but includes 13 carriers. Mr. Bailit agreed to bring additional market level information to the Committee at a future meeting.



### Public Comment

There was no public comment.

### Wrap Up and Adjournment

Meeting adjourned at 11:58 a.m.

### Next meeting

Wednesday, September 8, 2021

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.

# Topics we will discuss today

## TAB 3

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## Topics we will discuss today:

1. Recap of the Committee's feedback on methods to ensure the accuracy and reliability of benchmark performance measurement.
2. Questions to address for provider-level reporting.
3. Analyses to inform cost growth mitigation strategies.

# Recap of feedback on methods to ensure the accuracy and reliability of benchmark performance measurement

## TAB 4

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Recap of the Advisory Committee on  
Data Issues' feedback on methods to  
ensure the accuracy and reliability of  
benchmark performance  
measurement

# Advisory Committee on Data Issues' feedback on use of confidence intervals

- The Committee supported the use of confidence intervals to assess benchmark performance.
- One Committee member indicated that it would be important to provide clear documentation within the reports on how the confidence intervals were constructed.



# Advisory Committee on Data Issues' feedback on truncation

- Most Committee members supported the use of truncation for high-cost outlier spending.
  - One member did not support it, indicating a need to further understand the interaction with other strategies.
- Some Committee members expressed differing opinions on how to set truncation points.
  - One member suggested setting truncation points by disease type/prevalence.
  - Another member responded by stating that doing so would make data collection more complex.
  - Another suggested setting different truncation points for pharmacy and non-pharmacy spending.

## Advisory Committee on Data Issues' feedback on how to account for utilization, service intensity, and regional pricing

- The Committee recommended addressing the legislative directive to account for “utilization... intensity of services... and regional differences in input prices” by using the Data Use Strategy, and not benchmark risk adjustment.

*Reminder:* The Data Use Strategy refers to a complementary set of APCD analyses to understand what is driving spending and spending growth.

# Advisory Committee on Data Issues' feedback on risk-adjustment

- The Committee generally supported risk-adjusting by age and sex instead of using clinical risk scores.
  - However, some members wanted additional input from actuaries and provider and carrier organizations before making a recommendation to the Board.
- Committee member concerns around using age and sex risk-adjustment included the following:
  - There would not be an ability to understand variation across entities and perform comparisons of total cost vs. trend.
  - Age and sex risk-adjustment would not yield accurate results if there is a significant shift in a payer or provider entity's population over a year.

## Advisory Committee on Data Issues' feedback on minimum population size

- The Committee requested additional information about the Washington State market before making a recommendation to the Board.
- One Committee member noted that the individual market is a small portion of the overall commercial market but includes 13 carriers.

# Next steps on methods to ensure the accuracy and reliability of benchmark performance measurement

- Staff will present the feedback to the Board after the Board finalizes the benchmark methodology and value.
- In the interim:
  - There is a new option for addressing rising risk scores that staff are in the process of exploring for presentation to the Committee.
  - Staff are gathering and analyzing data on market share.
- We will try to wrap up this discussion at the next Committee meeting.

# Key questions to address for provider-level reporting

## TAB 5

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# Key questions to address for provider-level reporting

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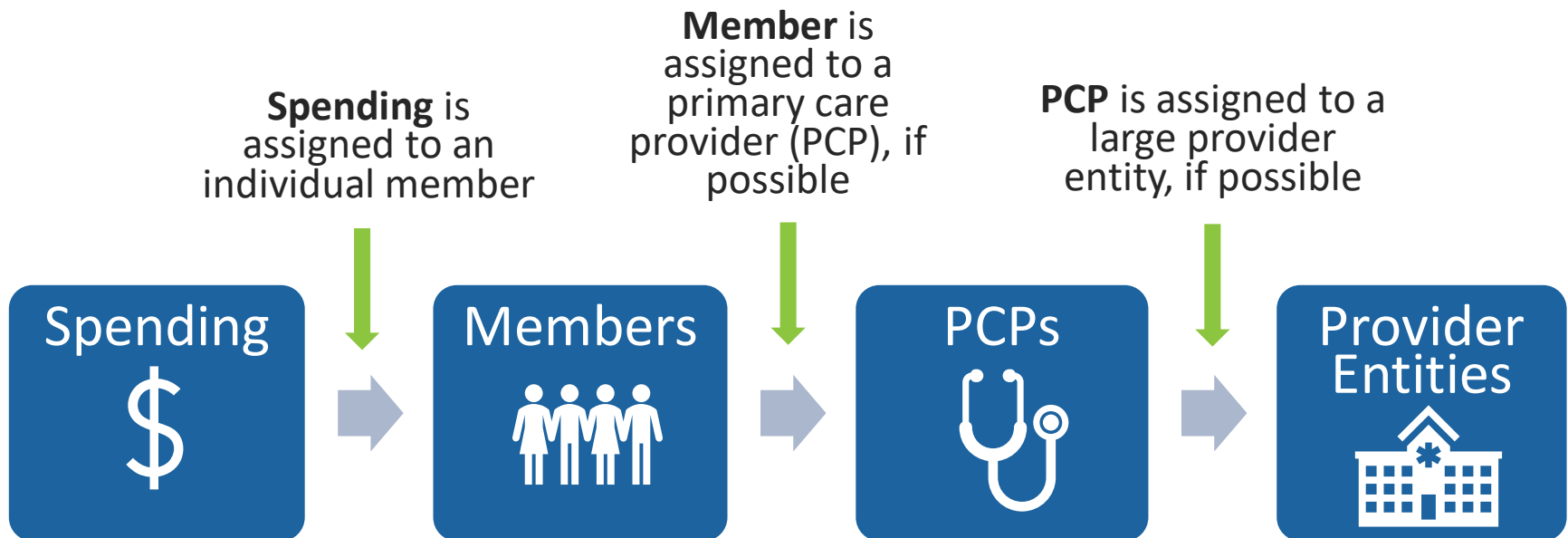
How should members be attributed to a provider entity?



How should clinicians be organized into provider entities (for the purpose of reporting)?



# Resident and provider attribution for benchmark performance reporting



Insurers report spending by large provider entity. Insurers report spending in aggregate for members who cannot be assigned to a PCP and for PCPs who cannot be assigned to a large provider entity.

# 1. How should members be attributed to clinicians?

- Members need to be “attached” to a clinician for the costs incurred by that member to be “attributed” (“assigned”) to a clinician.
- Attribution is performed routinely by insurers for value-based contracts when clinicians and provider entities are held accountable for quality and/or the cost of care.
- Insurers also attribute members to clinicians and provider entities for their own internal analyses. Some states and quality improvement organizations do the same.

# Attribution in the context of reporting on the cost growth benchmark

- Being attributed to a clinician for the purpose of analyses does not mean that:
  - The member was required to see that clinician; or
  - The clinician delivered all the care the patient received.
- Attribution is used, however, to indicate that a clinician had a caregiving relationship with a member and the clinician helped to direct the member's care in some manner.

# Two approaches to attributing members to clinicians

Method	Pros	Cons
Members are attributed using a <b>common methodology</b> , where insurers work together to agree upon the methodology and apply it to this process	Supports potential Comparisons of performance across insurers	Adds a layer of complexity to the process
Members are attributed using each <b>insurer's own methodology</b> employed with its value-based payment contracts or for other purposes	Makes reporting easier for insurers	Variation in methodology would produce inconsistent results and not be ideal for supporting provider comparisons across insurers

# Member attribution approach in other cost growth benchmark states

- Massachusetts, Delaware, Rhode Island, Connecticut, and Oregon have all taken a similar approach, leaving the **exact methodology up to each insurer**.
- All states are using a primary care attribution model. Massachusetts and Oregon add some specificity by allowing payers to use their own attribution methodology, so long as it follows a hierarchy:
  1. Member selection
  2. Contract arrangement
  3. Utilization



## Design recommendation: Member attribution to providers

- Does the Committee wish to recommend to the Board that payers report health care cost growth data using:
  - Their own attribution methodologies?
  - A common, to-be-determined, member attribution methodology?

## 2. How should clinicians be organized into larger entities?

- To report data, payers need technical instructions on how to organize clinicians into provider entities.
- Cost growth benchmark states have taken very different approaches to organizing clinicians into large entities whose benchmark performance can be reported upon. We will review each of these approaches.

# Massachusetts matches NPIs to physician groups

	A	B	C
1	NPI Number	OrgID	TME Physician Group
2	1033171749	10910	Acton Medical Associates
3	1043292360	10910	Acton Medical Associates
4	1053302158	10910	Acton Medical Associates
5	1184690505	10910	Acton Medical Associates
6	1447365408	10910	Acton Medical Associates
7	1538170774	10910	Acton Medical Associates
8	1588861660	10910	Acton Medical Associates
9	1922205020	10910	Acton Medical Associates
10	1124019765	10995	Affiliated Pediatric Practices (APP)
11	1164412839	10995	Affiliated Pediatric Practices (APP)
12	1245221019	10995	Affiliated Pediatric Practices (APP)
13	1356332985	10995	Affiliated Pediatric Practices (APP)
14	1396736161	10995	Affiliated Pediatric Practices (APP)
15	1497748834	10995	Affiliated Pediatric Practices (APP)
16	1528059128	10995	Affiliated Pediatric Practices (APP)
17	1568664795	10995	Affiliated Pediatric Practices (APP)
18	1578554713	10995	Affiliated Pediatric Practices (APP)
19	1679835011	10995	Affiliated Pediatric Practices (APP)
20	1881685485	10995	Affiliated Pediatric Practices (APP)
21	1891909305	10995	Affiliated Pediatric Practices (APP)
22	1922061878	10995	Affiliated Pediatric Practices (APP)
23	1215305040	11764	Allied Pediatrics of Greater Brockton, Inc.
24	1780849943	11764	Allied Pediatrics of Greater Brockton, Inc.
25	1942301239	11764	Allied Pediatrics of Greater Brockton, Inc.
26	1003044272	9995	Atrius Health
27	1003939703	9995	Atrius Health
28	1013975457	9995	Atrius Health
29	1023074366	9995	Atrius Health
30	1023445228	9995	Atrius Health

- Massachusetts has a provider directory where individual physician NPI numbers were mapped to physician groups. Insurers then report at the physician group level.
  - Several states use Tax ID Numbers (TINs) to assist with linking individual physicians to their affiliated entities but do not include TINs in the directory.
  - NPIs alone provide an unreliable view of the number of organizations represented in a provider directory.



# Rhode Island identifies the largest Accountable Care Organizations (ACOs)

ACO
Blackstone Valley Community Health Care
Coastal Medical
Integra Community Care Network
Integrated Healthcare Partners
Lifespan
Providence Community Health Centers
Prospect CharterCARE
Members Not Attributed to an ACO/AE

- Total cost of care (TCOC) contracts require a listing of which individual primary care clinicians belong to an ACO.
- RI identified the commercial and Medicaid ACOs in the state.
- Insurers identify the individual clinicians’ “underneath” those ACOs, consistent with their own total cost of care contracts.

## Connecticut developed a list based on carrier feedback on TCOC contracts

- Connecticut developed a list of 11 large provider entities based on feedback from carriers regarding their total cost of care contracts with “Accountable Networks” – providers with value-based payment contracts – and other known large provider entities in the state.
  - The state developed an initial larger list and asked its largest carriers which of the large provider entities were engaged in a TCOC contract.
  - *For purposes of its baseline analysis only*, the state then narrowed the list to those large provider entities that had significant overlap in TCOC contracts across the carriers.

# Oregon asks payers to report by TINs

- Oregon did not provide a pre-defined list of provider organizations.
- The state asks payers to report provider organizations by their TINs. The state will then analyze the submissions and determine which provider entities to report on.

PRV01	PRV02
free text	text, 9 digits including leading zero
<b>Provider Organization Name</b>	<b>Provider Organization TIN</b>



## Design recommendation: How to identify large provider entities

- What recommendation does the Committee wish to make about how to organize clinicians into larger entities for the purposes of reporting benchmark performance?

# Analyses to inform cost growth mitigation strategies

## TAB 6

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Washington State  
Health Care Authority

# Analyses to inform cost growth mitigation strategies



# Reminder: The logic model for a cost growth benchmark



# Reminder: Cost growth benchmark analysis vs data use strategy



How will we determine the level of cost growth from one year to the next?

## Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data Type:** Aggregate data that allow assessment of benchmark achievement at multiple levels, e.g., state, region, insurer, large provider entity.
- **Data Source:** Insurers and public payers.



How will we determine what is driving overall cost and cost growth? Where are there opportunities to contain spending?

## Data Use Strategy

- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters).
- **Data Source:** Typically, the APCD.



# Peterson-Milbank framework for a Data Use Strategy

The framework guiding the construction of analyses to inform efforts to slow health care cost growth is organized around three major questions:

## Where is spending problematic?

- High spending
- Growing spending
- Variation in spending
- Spending in comparison to benchmarks

## What is causing the problem?

- Price
- Volume
- Intensity
- Population characteristics

## Who is accountable?

- State
- Market
- Payer
- Provider org

# Two major types of analysis

## Phase 1

**What:** standard analytic reports produced on an annual basis at the state and market levels

**Purpose:** inform, track, and monitor the impact of the cost growth benchmark

## Phase 2

**What:** ad hoc in-depth reports; supplemental standard analytic reports

**Purpose:** supplement Washington's ability to identify opportunities for actions to reduce cost growth

<https://www.milbank.org/publications/a-data-use-strategy-for-state-action-to-address-health-care-cost-growth/>

# Recommended phase 1 analyses

The Peterson-Milbank Program for Sustainable Health Care Costs recommends that states start with 11 standard analyses, produced annually. These should:

- Examine the effects of price, volume, service intensity, and population characteristics in the context of broader changes to spending and spending growth.
- Use at least two years of data.
- Be produced on a total and per capita spending basis.
- Be released concurrently with public reporting of performance relative to the cost growth benchmark.

## Recommended phase 2 analyses

Once a state has established a regular cadence for the recommended standard reports, it should develop supplemental reports to enhance its ability to identify opportunities for action to reduce cost growth. Reports might include:

- Provider entity and payer-level analysis.
- Variation across payers, providers, and geographies.
- Focus on provider supply, market consolidation, and pharmacy as cost drivers.
- Benchmark analysis.
- Site-of-care and professional specialty analysis.

<https://www.milbank.org/publications/a-data-use-strategy-for-state-action-to-address-health-care-cost-growth/>

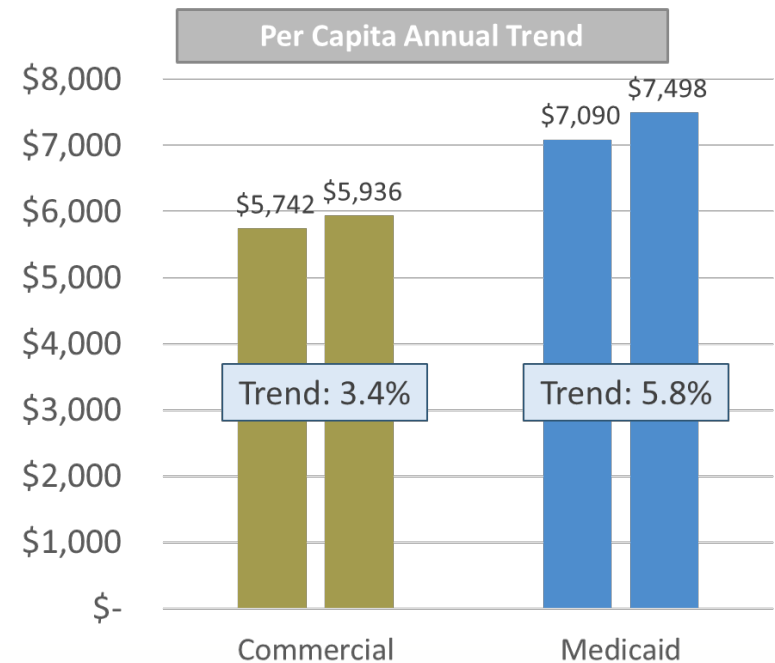
# Potential types of phase 1 analyses to consider

- The next group of slides provide examples of analysis of cost growth drivers, cost drivers, and impact of a cost growth benchmark. For each, we ask you to:
  - Confirm these should be performed.
  - Recommend appropriate definitions or categorizations for drill-down analyses.
  - Help identify appropriate data sources.
- After reviewing all analyses, we will ask you to:
  - Identify other analyses that should be performed.
  - Recommend prioritization of the analyses.

# Analyses 1 and 2: Spend and trend by market

<b>What</b>	<ul style="list-style-type: none"> <li>High-level analysis on spending and spending growth by commercial, Medicaid and Medicare markets.</li> </ul>
<b>Potential Data Sources</b>	<ul style="list-style-type: none"> <li>APCD</li> </ul>
<b>Notes</b>	<ul style="list-style-type: none"> <li>Can drill down on price vs utilization vs intensity.</li> <li>Will <i>not</i> align with payer-reported data for performance relative to the benchmark.</li> </ul>

*Example from Rhode Island*





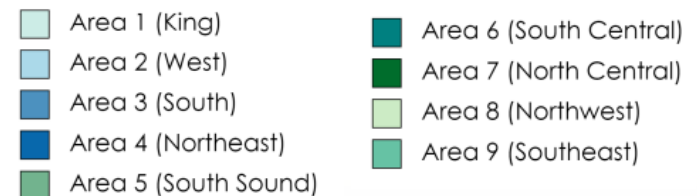
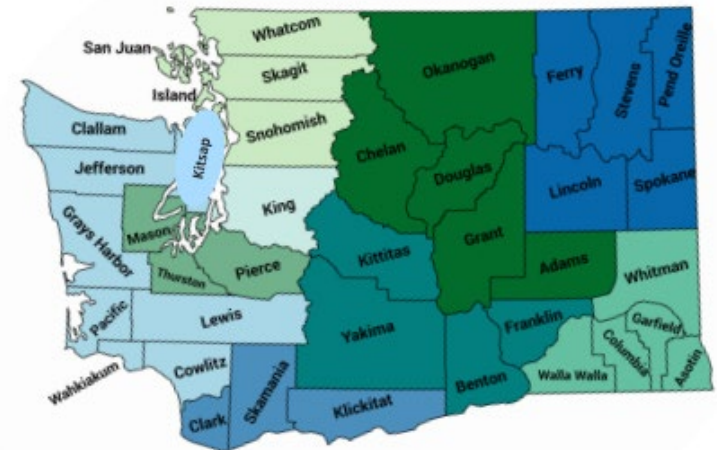
## Design recommendation: Spend and trend by market

- Does the Committee wish to recommend including a high-level analysis on spending and spending growth by insurance market?
- Does the Committee wish to recommend a drill-down analysis that looks at the relative impact of price, utilization, and service intensity?
- In addition to the APCD, what sources of data does the Committee recommend looking at to conduct the analysis?

# Analyses 3 and 4: Spend and trend by geography

*Washington geographic rating areas*

<b>What</b>	<ul style="list-style-type: none"> <li>Spend and trend from previous analysis stratified by geographic rating area.</li> </ul>
<b>Potential Data Sources</b>	<ul style="list-style-type: none"> <li>APCD</li> </ul>
<b>Notes</b>	<ul style="list-style-type: none"> <li>HB2457 requires analyses by geographic rating area.</li> <li>Can combine geographic rating areas in certain regions.</li> </ul>







## Design recommendation: Spend and trend by geography

- Analysis by geographic rating area is required by HB2457. Does the Committee wish to recommend additional analyses using a different geographic configuration?
- In addition to the APCD, what sources of data does the Committee recommend looking at to conduct the analysis?

# Analyses 5 and 6: Spend and trend by service category

**What**

- Analysis of spending for defined service categories and sub-categories.

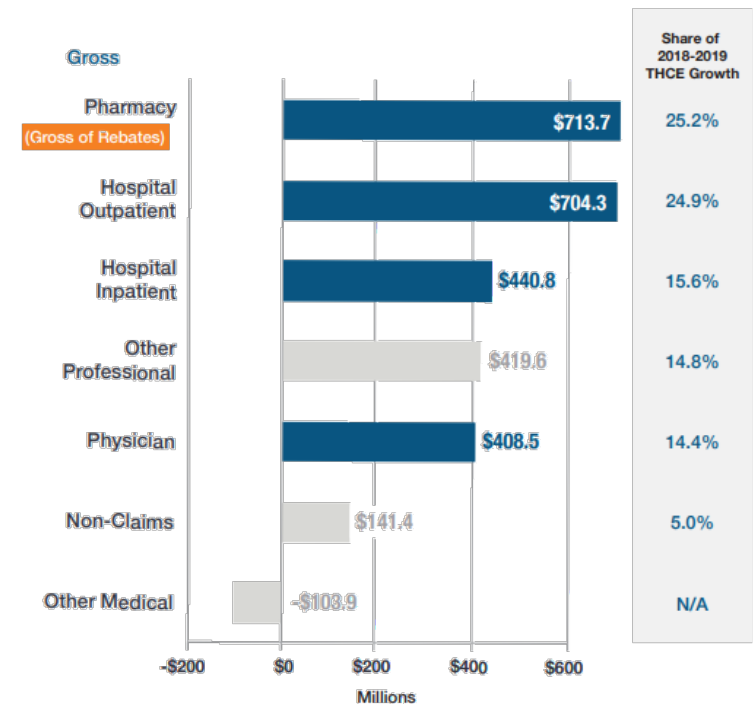
**Potential Data Sources**

- APCD
- Drug price transparency data

**Notes**

- Further work will be needed to define the service categories.

*Example from Massachusetts*





## Design recommendation: Spend and trend by service category

- Does the Committee wish to recommend including analysis on spending and spending growth by service category?
- In addition to the APCD, what sources of data does the Committee recommend looking at to conduct the analysis?

# Analyses 7 and 8: Spend and trend by health condition

*Example from Connecticut*

## What

- Analyses to detect whether and how changes in health conditions influence service utilization.

## Potential Data Source

- APCD

## Notes

- Further work will be needed to determine the conditions to analyze.

Condition	2018		
	Members with condition	%	PMPY for members with this condition
All members	455,780	100.0	\$6,151
Hyperlipidemia	73,081	16.0	\$11,842
Hypertension	70,419	15.5	\$13,739
Rheumatoid Arthritis/Osteoarthritis	67,943	14.9	\$13,866
Depression	50,979	11.2	\$13,501
Diabetes	28,608	6.3	\$14,197
Anemia	26,723	5.9	\$25,355
Acquired Hypothyroidism	25,918	5.7	\$12,911
Glaucoma	18,035	4.0	\$9,004
Chronic Kidney Disease	17,732	3.9	\$24,029
Asthma	17,500	3.8	\$16,887
One or more of 27 chronic conditions	218,598	48.0	\$10,336
Two or more of 27 chronic conditions	115,855	25.4	\$14,379



## Design recommendation: Spend and trend by demographics

- Does the Committee wish to recommend including analysis on spending and spending growth by health condition?
- In addition to the APCD, what sources of data does the Committee recommend looking at to conduct the analysis?

# Analyses 9 and 10: Spend and trend by demographics

*Example from Connecticut*

<b>What</b>	<ul style="list-style-type: none"> <li>Analysis of how trends differ among communities with different demographic characteristics</li> </ul>
<b>Potential Data Source</b>	<ul style="list-style-type: none"> <li>APCD</li> </ul>
<b>Notes</b>	<ul style="list-style-type: none"> <li>Need to determine demographic variables.</li> </ul>

Decile	Percentage white	Median family income	PMPM (adj.)
All	0 – 100	\$97,310	\$526.69
1	0 – 31	\$45,663	\$545.33
2	31 – 50	\$68,060	\$561.26
3	50 – 61	\$82,466	\$562.29
4	61 – 71	\$105,442	\$494.28
5	71 – 77	\$103,407	\$497.68
6	77 – 82	\$122,067	\$499.30
7	83 – 87	\$149,181	\$506.68
8	87 – 91	\$127,302	\$481.19
9	91 – 94	\$118,223	\$484.70
10	94 – 100	\$112,875	\$526.69
Ratio of 1st to 10th decile		0.40	1.09



## Design recommendation: Spend and trend by demographics

- Does the Committee wish to recommend including analysis on spending and spending growth by demographics?
  - If so, what demographic characteristics should be prioritized?
- In addition to the APCD, what sources of data does the Committee recommend looking at to conduct the analysis?
  - What are good sources of data for the demographic variables that the Committee wishes to recommend analyzing?

# Analysis 11: Negative impacts

<b>What</b>	<ul style="list-style-type: none"> <li>Selected indicators to monitor for potential negative impacts of the cost growth benchmark</li> </ul>
<b>Potential Data Source</b>	<ul style="list-style-type: none"> <li>To be determined</li> </ul>
<b>Notes</b>	<ul style="list-style-type: none"> <li>Need to determine what areas to prioritize.</li> </ul>

## Potential analyses include:

- Quality measures assessing utilization of preventive and chronic illness care
- Patient self-reported access to care, including but not limited to access to specialty care.
- Changes in provider entity patient panel composition.
- Stratified analyses to assess specific and disparate impact of the benchmark on economically and socially marginalized groups.



# Connecticut's strategy for measuring unintended adverse consequences

- Connecticut has developed a measurement plan focused on three main domains of analyses:
  1. Underutilization
  2. Consumer out-of-pocket spending.
  3. Impact on marginalized populations.
- For each domain, Connecticut's plan identifies:
  - Potential measures that can be implemented immediately.
  - Potential measures that require further development.
  - Level of analysis (e.g., market, provider organization, etc.).
  - Data source(s)
  - Accountability for data collection and analysis.



## Design recommendation: Negative impacts

- Does the Committee wish to recommend including analysis to track potential negative impacts of the cost growth benchmark?
  - If so, what potential impacts does the Committee recommend monitoring?
- In addition to the APCD, what sources of data does the Committee recommend looking at to conduct the analysis?



## Design recommendation: Overarching data use strategy

- Are there other analyses that the state should include in its regular reporting?
  - If so, what types of analyses would you recommend?
- How should the Health Care Authority (HCA) prioritize the analyses that the Committee recommends conducting on a regular basis?
  - What types of analyses should HCA seek to measure immediately?