Measuring Non-Claims-Based Primary Care Spending

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ABSTRACT

The Centers for Medicare and Medicaid Services, states, and private payers are investing in the primary care infrastructure to improve health care quality and outcomes and to strengthen health care system performance. Research demonstrates that greater relative investment in primary care compared to specialty care leads to better patient outcomes, lower costs, and improved patient experience of care. States' actions to encourage primary care investment include measuring primary care spending as a percentage of total health care expenditures and establishing expectations or requirements to increase primary care spending. Yet there is little uniformity in defining primary care spend, particularly non-fee-for-service spending. This brief proposes a standard definition and measurement methodology that will allow policymakers to quantify total investment in primary care and enable comparisons of spending across states and within a state by region, payer, and health care system.

INTRODUCTION

Payer and purchaser strategies to strengthen primary care include investing in models to transform primary care delivery (e.g., patient-centered medical homes) and implementing student loan forgiveness programs for primary care physicians. Newer state strategies include measuring primary care spending as a percentage of total health care spending and setting primary care spending targets, yet there is little uniformity in state approaches to measurement.[1] Standardizing measurement of primary care spending can focus attention on increasing overall investment in the primary care infrastructure. Although identifying spending associated with primary care in no way guarantees the provision of efficient, equitable, and effective primary care, it is an important marker of the extent to which a health care payer, a delivery system, or a community is supporting that goal.

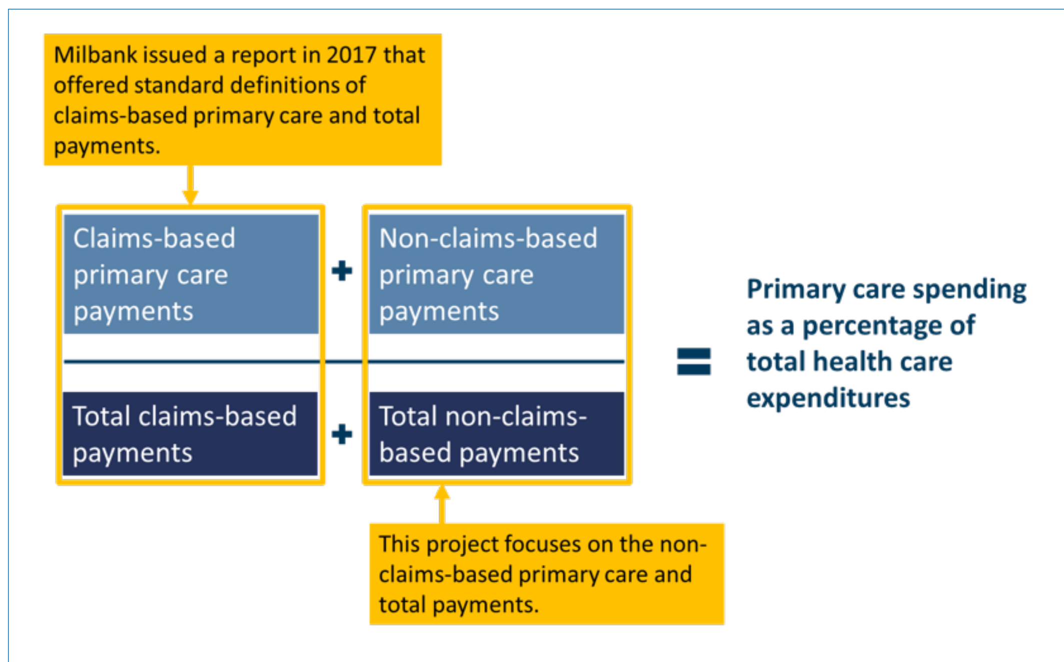
Quantifying investment in primary care requires measuring claims-based and non-claims-based payments. (See Figure 1.) Existing data sources can be leveraged to measure claims-based primary care spending, yielding a more consistent data collection process across states. The Milbank Memorial Fund (Milbank) has supported research to determine the feasibility of measuring claims-based primary care spending using all-payer claims databases and insurer self-report using commercial claims.[2,3] The research called for additional work to develop a standard method for measuring non-claims-based payments.[4]

"Non-claims-based" means payments that are for something other than a fee-for-service claim. States today are applying different definitions of what constitutes non-claims-based spending and utilizing different data collection processes to obtain non-claims-based payment information. As a result, there is significant variation in how states are measuring primary care spending. This report proposes a methodology for collecting and analyzing non-claims-based primary care spending to complement the more standard claims-based reporting.

Assessing claims-based and non-claims-based primary care spending in a standardized way enables states to:

- Meaningfully quantify current and future health system investment in primary care;
- Objectively compare primary care spending geographically and across payers and health care systems;
- Facilitate analysis of primary care spending relative to total health care costs and to other services (e.g., specialty and institutional);
- Promote transparency in primary care spending and overall investment in primary care; and
- Adopt policies pertaining to investment in primary care.

Figure 1: Measuring Primary Care Spending as a Percentage of Total Health Care Spending



Source: Adapted from the Oregon Health Authority. https://www.oregon.gov/oha/HPA/ANALYTICS/PCSpending-Docs/2019-Oregon-Primary-Care-Spending-Report-Legislature.pdf. Accessed February 22, 2021.

METHODOLOGY

Milbank engaged Bailit Health Purchasing, LLC (Bailit Health) to develop a methodology to measure non-claims-based primary care spending. Bailit Health then convened an advisory group of state officials, payers, and providers to inform the recommendations presented here. Appendix A includes the list of advisory group members. Through four virtual meetings, the group discussed key policy and design questions to shape the proposed methodology.[5] Bailit Health also solicited feedback from payers in Colorado and Rhode Island to confirm that the proposed approach was sound and feasible.

KEY TERMS AND CONCEPTS

The authors adopted the following definitions to develop these recommendations.

Non-claims-based: Payments that are made for something other than a fee-for-service claim. Non-claims-based payments can be based on historical claims data, but they are not paid on a fee-for-service claims basis.

Primary care services: All medical services delivered by family medicine, general internal medicine, general pediatrics, and general practice physicians and their non-physician practice colleagues, as well as by geriatric and adolescent medicine physicians and their non-physician practice colleagues.[6]

Primary care spending: Payments to organizations that deliver primary care services or that contract with payers on behalf of providers of primary care services. This may include organizations that deliver services beyond primary care.

Recommendations for Collecting Non-Claims-Based Primary Care Spending Data

The following recommendations establish a methodology for measuring non-claims-based primary care spending and propose a uniform data collection process. A non-claims-based primary care spending methodology relies on (a) defining the non-claims-based payments that should be included in calculations and (b) determining the portion of spending that is associated with primary care. The recommendations offer a reporting framework through which states can collect non-claims-based payment information from payers[7] and identify a methodology for attributing non-claims-based spending to primary care.

Recommendation 1: States should adopt standard categories of non-claims-based payments, which include subcategories, and collect non-claims-based payments by subcategory.

There are six primary categories (i.e., payment types) of non-claims-based payments through which there might be spending for primary care (Table 1). This includes an "other" category. Subcategories identify specific non-claims-based payment types within a category. The identified categories and subcategories serve as the framework for payers to report non-claims-based spending to states. These recommendations propose that payers report non-claims-based spending by subcategory, providing detail that will allow states to gain insight into the composition of non-claims-based primary care payments—for example, the percentage of primary care payments that are for services, infrastructure investments, or performance incentives. This allows states to evaluate the impact of value-based payment models and understand the distribution of different payment types in its market. Disaggregated reporting also provides a way for states to validate data by detecting if a major category of spending is missing or if a payer submission requires further investigation.

Criteria for inclusion of categories in this framework included feasibility to report and value in collecting the information. The framework intentionally focuses on the *purpose* of the payment rather than the *modality* of the payment and acknowledges that payments are in support of primary care activities and functions. Appendix B includes descriptions of each subcategory and its application to primary care.

Table 1: Categories of Non-Claims-Based Primary Care Spending

Category	Subcategory
1. Prospective capitated case rate, or episode-based payments	• Capitation payments • Global budget payments • Prospective case rate payments • Prospective episode-based payments
2.Primary care performance incentive payments	• Risk-based payments (shared savings distributions, shared risk recoupments) • Retrospective/prospective incentive payments (pay-for-performance, pay-for-reporting)
3. Payments for primary care provider salaries	• Provider salary payments (physician and nonphysician)
4. Payments to support population health and practice infrastructure	• Care management/care coordination/population health • Electronic health records/health information technology infrastructure and other data analytics payments • Medication reconciliation • Patient-centered medical home recognition payments • Primary care and behavioral health integration
5. Recovery	• Recoveries, or payment received that are later recouped by the payer
6. Other payments	• Other, such as governmental payer shortfall payments, grants, or other surplus payments.

Note: These categories focus on payment arrangements with organizations that include primary care providers in whole or in part. Payments to organizations that are comprised of specialists and/ or hospitals without primary care clinicians would be reported separately.

Non-claims-based categories technical notes: This framework assumes payers would report payments incurred during the year, which includes services that were delivered or payments that are being recouped or recovered for a given year. Payers may need to re-report historical data to account for spending that is recouped during later years (e.g., payers may report preliminary 2019 data in 2020 and final 2019 data in 2021). Using an incurred time frame (versus a paid time frame) ensures that claims payments (which are typically paid and incurred in the same year) and non-claims payments (which are sometimes paid in the year after which they are earned) are attributed to the same year.[8]

Recommendation 2: States should apply a default percentage to each non-claims-based payment subcategory to determine the primary care portion of non-claims-based payments to health systems or other multispecialty provider organizations that include primary care.

The second component of reporting involves identifying the primary care portion of non-claims-based spending (i.e., the numerator). This is straightforward for primary care–only entities because the primary care portion is represented in the total amount of non-claims-based spending. Likewise, entities that do not include primary care clinicians would report total non-claims-based spending because there is no portion of payment to primary care.

However, this is more complicated when payments are made to health care systems, multi-specialty provider groups, multiple entity accountable care organizations, or independent physician associations (IPAs) because a portion of the total payment is likely to go to primary care. Payers do not know how those organizations distribute payments. A payer needs information about the percentage of dollars that went to primary care providers or to each contract, or needs to make an assumption that would apply across contracts. Payments for services are straightforward, but infrastructure and incentive payments are more complex. Furthermore, the percentages of payments received by primary care providers at a multispecialty group or integrated health care system will vary based on the composition of the group and the types of non-claims-based payments included in the payer-provider contracts.

For the third scenario, payments to health care systems and other multispecialty provider organizations (e.g., multispecialty group practices, IPAs, accountable care organizations), states can apply a default percentage to the total non-claims-based spending amount in each subcategory to calculate non-claims-based primary care spending. (Research to identify the default primary care spending percentages for each subcategory is an area of proposed future work.) A sample template for collecting non-claims-based payment information for all three scenarios — with tables that contain "live" formulas in Excel—is included in Appendix C.

States can apply default percentages included in the data collection template or modify the percentages based on their own data. The latter approach affords flexibility[9] and acknowledges that some states and payers may have access to precise provider organization-specific data on non-claims-based primary care spending. Cross-state comparison is still achievable but would require recalculation. The advisory group recommended that Milbank pursue further work in this area with provider organizations of different configurations to inform the selection of default percentage values.

> The recommendations for attributing payments to primary care include payments made to provider entities. As a result, payments made to non-provider entities to develop and/or maintain public or multi-provider infrastructure are not included here. It is possible that a state may wish to include such payments in its definition of primary care spend. (For example, Rhode Island currently includes payer investment in a health information exchange in its definition of primary care spend.) This issue was identified during interviews Bailit Health conducted with payers on the proposed approach.

This methodology also acknowledges that states have limited regulatory authority over nonhospital providers compared to insurers. To achieve the goal of standardized measurement of primary care spend, it is best to focus on approaches that do not require data from providers.

Recommendation #3: States should include all non-claims-based spending for primary care and non–primary care in the total non-claims-based spending denominator.

The total non-claims-based spending denominator should *include* pharmacy rebates and *exclude* long-term care and dental services from the total non-claims-based spending denominator. Pharmacy rebates are a substantial non-claims-based offset to pharmacy spending. They serve as a "negative payment" applied to the denominator of the non-claims-based, non–primary care spending calculation. Including the rebates in the total non-claims-based denominator will yield a more precise estimate of non-claims-based, non–primary care spending as a percentage of total non-claims-based spending. In addition, long-term care and dental services are typically only covered by Medicaid. Excluding these categories supports comparison of spending across Medicaid, Medicare, and commercial populations.

Recommendation #4: States should collect and report data at the state, market, insurer (by market), and large provider entity levels.

States should collect and report data at various levels to increase visibility into and analysis of the payments that are being implemented in its health care system. Those levels include state, market, insurer (by market), and large provider groups. States can integrate their cost growth target and primary care spending programs to streamline data collection and reporting.

State-level reporting provides a snapshot of the level of investment payers and providers in the state are making toward primary care. Reporting at the market level acknowledges differences in spending patterns by covered population that may be attributed to demographic differences and payment policies. The degree of influence (or lack thereof) of insurers to direct spending toward primary care is the reason to collect information by insurers, by market.

Large provider entities, particularly those assuming risk and employing clinicians, can influence the distribution of non-claims-based payments among providers, which also impacts spending on primary care. Collecting and reporting non-claims-based primary care spending at the large provider organization level promotes transparency and can identify variation in adoption of value-based contracting. Spotlighting variation may spur the adoption of value-based contracting among plans and providers. The data will also provide insight into how non-claims-based payments are distributed by payers to providers and by populations within the state.

Recommendation #5: States should convene a technical advisory group to support implementation of this approach.

Each state should create a technical advisory group or groups comprising state officials, analysts, insurers, and providers. States with operational all-payer claims databases (APCDs)

should be sure to include analysts involved in both claims-based and non-claims-based data reporting in the advisory group. Technical advisory groups can assist states in implementing the recommended measurement approach, developing a process for collecting and validating data from payers, and creating alignment between primary care spending efforts and other statewide efforts (e.g., cost growth target programs). These groups can also facilitate documentation of how states have categorized certain types of payments to ensure consistency in intra-state and cross-state comparisons. States should be encouraged to publicize their decision-making rationale and provide specificity and guidance for payers.

Recommendation #6: States should define the population for which data will be collected.

States can define the population for which data will be collected by (a) the location of the resident and provider or (b) the situs of the insurance contract. The approach will depend on the unique factors and dynamics in each state, and there are advantages and disadvantages to each approach.

Location of the resident and provider: Using the location of the resident and the provider aligns with primary care spending target programs and studies in Connecticut, Delaware, Oregon, and Rhode Island, and through the New England States Consortium Systems Organization, as well as with cost growth benchmark programs. In addition, APCDs, which states can use to measure claims-based primary care spend, are organized to capture spending for state residents. Finally, this approach may produce a more stable year-over-year population that is less sensitive to fluctuations associated with corporations shifting office locations. One drawback to this approach is that states lack regulatory authority over contracts that are written in other states, even if the contracts cover state residents. Another disadvantage is that it might be challenging for payers to identify how to allocate non-claims-based payments to only residents of a state if the contract covers care for non-state residents. If states choose to adopt this approach, they should collect data for state residents, regardless of whether the care was delivered by an in-state or out-of-state provider.

Situs of the insurance contract:[10] Situs means the jurisdiction in which services are issued or delivered as stated in the contract.[11] An advantage to this approach is that states regulate insurance contracts in their state. However, if contracts cover different populations, it may be inappropriate to combine data for aggregate statistics or for calculating the share of spending through alternative payment models. For example, it would be unreasonable for a state to compare two contracts, A and B, with a situs in Wyoming, where 95% of contract A's members are Wyoming residents, but only 50% of contract B's members are Wyoming residents. This approach also does not align with current state primary care spending target and cost growth benchmark programs. Further, collecting data based on the situs of the insurance contract does not include data for all state residents. Experience in Colorado and Oregon shows that this could result in missing 5% to 50% of residents for a given payer.

NEXT STEPS

Finalizing the methodology and encouraging state adoption will require additional actions, including the development of an integrated claims-based and non-claims-based measurement methodology, research into the default percentages for determining spending associated with primary care, and cross-state learning opportunities. The following discussion provides additional details on each of those steps.

Integrated claims-based and non-claims-based framework

An integrated framework that encompasses both non-claims-based and claims-based components of primary care spending should be developed for states. This will provide states with the full methodology for measuring primary care spending and may expedite adoption. It will also promote standardized measurement for primary care spending and facilitate cross-state comparisons.

Research to inform default percentages

Research will need to be performed to inform the default percentages that will apply to each non-claims-based payment type. Interviewing provider organizations to obtain this data will yield a more precise estimate of the percentages to use as defaults for the primary care portion of non-claims-based spending.

Cross-state learning opportunities

States that are measuring primary care spending annually should convene to share learnings, experiences, and insights. Those opportunities to exchange information could also potentially inform modifications to these recommendations. States that are interested in developing primary care spending targets should also be included. The members of the advisory group that consulted on this proposed methodology anticipate significant innovation in payment models over the next five to 10 years and expect that newer models may not fit neatly into the categories defined. To achieve consistency over time, states will need guidance as newer payment models are introduced and implemented.

Together, these additional steps may facilitate accelerated adoption of a standardized measurement for primary care spending.

The authors thank Blue Cross and Blue Shield of Rhode Island, Tufts Health Plan, UnitedHealthcare, and Rocky Mountain Health Plans for their insightful feedback on the proposed model. The authors also thank Rachel Block and Richard Slusky for their contributions to the project.

NOTES

[1] First Rhode Island and then Oregon established primary care spending requirements in regulation. Connecticut and Pennsylvania are in the process of setting voluntary primary care spending targets. Colorado, Delaware, Washington, and the remaining New England states (Maine, Massachusetts, New Hampshire, and Vermont) are focusing on measuring primary care spending.

[2] Milbank previously supported the RAND Corporation and Bailit Health to develop a methodology to calculate claims-based primary care spending as a percentage of total health care spending by commercial health plans. See Bailit MH, Friedberg MW, Houy ML. *"Standardizing the Measurement of Commercial Health Plan Primary Care Spending."* July 25, 2017.

[3] New England States Consortium Systems Organization, OnPoint Health Data, and consultants. *The New England States' All-Payer Report on Primary Care Payments.* Shrewsbury, MA: New England States Consortium Systems Organization; December 22, 2020.

[4] Milbank subsequently supported RAND to perform follow-up work to address issues identified in the Bailit, Friedberg, Houy 2017 report. See Carman KG, Reid RO, Damberg CL. *"Advancing the Development of a Framework to Capture Non–Fee-for-Service Health Care Spending for Primary Care."* Santa Monica, CA: RAND Corporation, 2020.

[5] The design questions were informed by the findings from Carmen, Reid, and Damberg in the RAND 2020 research report. Milbank requested that this project explore those questions with the advisory group to develop a methodology.

[6] The group identified as a future area of consideration the inclusion of co-located and integrated behavioral health clinicians who are part of the primary care practice in the operational definition.

[7] Many of these data cannot be found in an all-payer claims database, and, therefore, at least some states that are already measuring primary care spending have been collecting data directly from payers.

[8] This approach is consistent with cost growth target methods in Delaware, Massachusetts, Oregon, and Rhode Island.

[9] Should a state collect data from providers such that default values are not needed, it may elect to change the percentages applied to each subcategory. A health plan could also replace the default percentage should it possess the required values. This might be appropriate for a health plan that contracts primarily or exclusively with one provider organization.

[10] This is the approach recommended in the Carmen, Reid, and Damberg RAND 2020 research report.

[11] Department of Health and Human Services § 158.10.

APPENDIX A: ADVISORY GROUP MEMBERS

Rich Antonelli, Boston Children's Hospital

Vinita Bahl, formerly of the Center for Improving Value in Health Care

Erin Bonney, Center for Health Information and Analysis in Massachusetts

Mark Friedberg, Blue Cross Blue Shield of Massachusetts

Zachary Goldman, Oregon Health Authority

Cory King, Rhode Island Office of the Health Insurance Commissioner

Gary Kirchof, Highmark

Al Kurose, Coastal Medical

Lance Lang, California Health Care Foundation

Mark McClellan, Duke-Margolis Center for Health Policy, Duke University

Katie McGraves-Lloyd, Onpoint Health Data

Ken Provencher, PacificSource Health Plans

APPENDIX B: NON-CLAIMS-BASED PRIMARY CARE SPENDING CATEGORIES

1. Prospective Capitated, Case Rate, or Episode-Based Payments

- **Capitation payments:** Per capita payments to primary care providers to provide primary care services needed by designated patients over a defined period.
- **Global budget payments:** Payments made to primary care providers for either a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain services such as behavioral health or pharmacy are carved out. Services typically include primary care clinician services, specialty care physician services, inpatient hospital services, and outpatient hospital services, at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread. Under a global budget, a portion of spending would need to be allocated to primary care for the purpose of calculating primary care spend.
- **Prospective case rate payments:** Payments received by primary care providers in a given provider organization for a patient receiving a defined set of primary care services for a specific period.
- **Prospective episode-based payments:** Payments received by primary care providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care by multiple providers, including primary care providers, or care for a specific condition over a specific time. Under episode-based payment, a portion of spending would need to be allocated to primary care for the purpose of calculating primary care spending if multiple providers are part of the episode.

2. Primary Care Performance Incentive Payments

- **Risk-based payments:** Payments received by primary care providers (or recouped from providers) based on performance relative to a defined spending target. Risk-based payment methodologies can be applied to different types of budgets, including but not limited to episode of care and total cost of care. There are two main subcategories of risk-based payments: shared savings and shared risk.

  - **Shared-savings distributions:** Payments received by primary care providers if costs of services are below a predetermined and risk-adjusted target. The amount of savings the provider can receive is often linked to performance on quality measures.

  - **Shared-risk recoupments:** Payments payers recoup from primary care providers if costs of services are above a predetermined, risk-adjusted target. This value should be reported as a negative number. Shared-risk arrangements are typically calculated on a total cost of care basis and typically exclude high-cost outliers.

- **Retrospective/prospective incentive payments:** Payments to reward primary care providers for achieving quality and/or efficiency goals. There are two main subcategories of incentive payments:

  - **Pay-for-performance payments:** Payments to reward primary care providers for achieving a set target (absolute, relative, or improvement-based) for quality or efficiency metrics. Payments could include the return of a withhold if not attached to a claim payment.

  - **Pay-for-reporting payments:** Payments to primary care providers for reporting on a set of quality or efficiency metrics, usually to build capacity for future pay-for-performance incentives.

3. Payments for Primary Care Provider Salaries

Provider salary payments: Payments for salaries of primary care providers who provide care. This category may only be applicable for closed health systems (e.g., Kaiser Permanente).

4. Payments to Support Population Health and Practice Infrastructure

- **Care management/care coordination/population health:** Payments to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, patient navigators, or nurse care managers) who help primary care providers organize clinics to function better and help patients take charge of their health.

- **Electronic health records/health information technology infrastructure and other data analytics payments:** Payments to help primary care providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and/or

costs outside of the electronic health records (e.g., software to track patient costs in near-to-real time) and/or the cost of a data analyst to support practices.

- **Medication reconciliation:** Payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.
- **Patient-centered medical home recognition payments:** Payments to primary care providers recognized by the National Committee for Quality Assurance or a state's patient-centered medical home recognition program.
- **Primary care and behavioral health integration:** Payments that promote the appropriate integration of primary care and behavioral health care *that are not reimbursable through claims* (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as) substance abuse or depression screening; b) performing assessment, referral, and warm hand-off to a behavioral health clinician; and/or c) supporting health behavior change, such as diet and exercise for managing prediabetes risk). This excludes payments for mental health or substance use counseling.

5. Recoveries

Payments received by a primary care provider from a payer and then later recouped due to a review, audit, or investigation. This can include infrastructure payments that are recouped under total cost of care arrangements if a provider does not generate savings. Recoveries would be reported as a negative number and should only be reported if not included elsewhere (e.g., if a claims-based payment is reported net of recovery, do not separately report recovery as a non-claims-based payment).

6. Other Payments

Any other payments to a primary care provider not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. For calendar year 2020, this may also include supportive funds made to providers to support clinical and business operations during the COVID-19 pandemic. Only include payments made to providers.

See Appendix C for a proposed framework for insurer reporting of non-claims-based primary care spending.

ABOUT THE AUTHORS

Erin Taylor, MPH, is a senior consultant at Bailit Health with experience in public health, health care policy analysis, and payment and delivery system reform. Ms. Taylor has researched and evaluated value-based payment strategies for individuals with complex care needs, including seniors and individuals with disabilities enrolled in managed care. She has provided technical assistance to Medicaid managed care plans to develop value-based payment strategies for long-term services and supports. Ms. Taylor has analyzed Medicaid managed care financial incentive programs and evaluated a large health care system's process of screening for social risk factors in primary care. She has coauthored briefs on integrating public health functions with health care delivery and value-based payment for Medicaid populations with complex care needs.

Before joining Bailit, Ms. Taylor was a policy analyst at the Massachusetts Office of Medicaid, where she supported the implementation of the state's Financial Alignment Initiative for Medicare and Medicaid enrollees. She also completed a fellowship at Health Leads, where she gained experience with a primary care model that addressed individual social risk factors.

Ms. Taylor earned a bachelor of science degree from the University of Florida and a master of public health degree with a concentration in health law, bioethics, and human rights from Boston University.

Michael Bailit, MBA, is founder and president of Bailit Health. Mr. Bailit's professional interests focus on how purchasers and regulators can influence health care markets to operate as effectively and efficiently as possible. He has worked with an array of state agencies and employer purchasing coalitions in more than 30 states.

Mr. Bailit has worked with clients on payment and delivery system reform, including accountable care organization, medical home, and episode-based payment strategy design and implementation, performance measurement, value-based purchasing, and multi stakeholder change process guidance and facilitation. He has developed payment models for state-facilitated multi-payer medical home/advanced primary care programs, state Medicaid health homes, and pediatric primary care. Mr. Bailit has supported states in developing value-based prospective primary care payment models, formulating and pricing practice team workforce designs, creating and operating state primary care practice recognition programs, implementing quality measurement programs for primary care, establishing state standards for primary care/behavioral health integration, and defining primary care requirements for state Delivery System Reform Incentive Payment program investment. He has also helped states develop spending targets for primary care.

Mr. Bailit earned a bachelor of arts degree from Wesleyan University and an MBA from the Kellogg School of Management at Northwestern University.

Deepti Kanneganti, MPP, is a senior consultant at Bailit Health, where she supports states in establishing cost growth, quality, and primary care spending targets; improving performance measurement programs; and maintaining multi-payer aligned measure sets. She is working with the Connecticut Office of Health Strategy to develop and implement a primary care spend target and a data-use strategy to help stakeholders identify areas of high costs and cost growth drivers. Ms. Kanneganti is helping Delaware and Rhode Island calculate and evaluate performance against each state's cost growth target. She has performed substantial research and applied work related to quality measures. She is working with Rhode Island Medicaid to modify and maintain its accountable entities quality measure slate and methodology, and, supported the development, implementation, and maintenance of multi-payer aligned quality measure sets for Massachusetts, Oregon, Rhode Island, and Vermont. Ms. Kanneganti also performed cost modeling of primary care workforce configurations for the Agency for Healthcare Research and Quality.

Before joining Bailit Health, Ms. Kanneganti performed strategic analysis and competitive market intelligence at Boston Biomedical Consultants. She performed quantitative analyses on submarket and competitor performance for the point-of-care testing in vitro diagnostics market.

Ms. Kanneganti earned a bachelor of science degree from Brandeis University and a master of public policy degree from Harvard Kennedy School of Government.

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