Peterson-Milbank Program for Sustainable Health Care Costs

bailit health

Consensus Administrative Specifications for Health Care Cost Growth Target Programs

Analytic Support Resource

Developed by the Peterson-Milbank Work Group on Health Care Cost Growth Target Measurement and Analytics

JUNE 2025

Developed by Bailit Health with support from
the Peterson-Milbank Program for Sustainable Health Care Costs

Contents

INTRODUCTION

States with cost growth target programs have made great advances gathering, analyzing, and publishing information about health care spending patterns, but as is often the case there are some differences in how they have done so. With the goal of identifying and spreading best practices in cost growth target program analyses, in 2024 Bailit Health convened state officials and state analytic contractors in a **Work Group on Health Care Cost Growth Target Measurement and Analytics** with the support of the Peterson-Milbank Program for Sustainable Health Care Costs.

In addition to strengthening state-level cost growth target programs through the diffusion of best practices, these definitions support cross-state comparison and broader generalizations; this has the potential to strengthen the national discussion around health care cost drivers and cost growth targets, potentially leading to greater attention and uptake of state health care cost growth mitigation policies.

The Work Group's objectives included:

- Understand currently used definitions and methodologies
- Identify consensus definitions that produce valid and meaningful information
- Explore how aligned definitions and methodologies could improve state cost growth target measurement activities
- Identify general and state-specific barriers to implementing aligned definitions and methodologies

Bailit Health and the Peterson-Milbank Program for Sustainable Health Care Costs thank work group participants for their time, knowledge, and active discussion, including state staff from the California Department of Health Care Access and Information, Colorado Division of Insurance, Connecticut Office of Health Strategy, Delaware Department of Health and Social Services, Maine Health Data Organization and Office of Affordable Health Care, Massachusetts Health Policy Commission and Center for Health Information and Analytics, Minnesota Department of Health, New Jersey Office of Health Care Affordability and Transparency, Oregon Health Authority, Rhode Island Office of the Health Insurance Commissioner, Vermont Green Mountain Care Board, and Washington Health Care Authority; staff from the One Utah Health Collaboration; consultants and analysts from Comagine, Freedman HealthCare, Human Services Research Institute (HSRI), Mathematica Policy Research, and Onpoint Health Data (OHD); and the National Association of Health Data Organizations (NAHDO).

SECTION 1:

Measuring Claims-Based and Non-Claims Spending

CONSENSUS ADMINISTRATIVE SPECIFICATION FOR ASSESSING PAYER AND PROVIDER PERFORMANCE:

Total Medical Expenses, Net Cost of Private Health Insurance, and Total Health Care Expenditures

DESCRIPTION

States collect various types of data from reporting entities through cost growth target programs. This data typically includes claims spending, non-claims spending, patient cost-sharing, and pharmacy rebates, which together form Total Medical Expenses (TME). Additionally, states gather data to assess administrative costs associated with health plans, commonly referred to as the Net Cost of Private Health Insurance (NCPHI).

States combine TME and NCPHI to calculate Total Health Care Expenditure (THCE), a metric designed to capture all spending associated with a state, market, or payer entity. As a result, states have multiple measures by which they can evaluate both provider and payer performance relative to a cost growth target.

KEY TERMS

Total Health Care Expenditures (THCE): THCE represents the sum of all health care expenditures for a given calendar year, including Total Medical Expenses (TME)(claims-based and non-claims spending paid to providers, and patient cost-sharing amounts), and the Net Cost of Private Health Insurance (NCPHI). THCE can be evaluated at the state, market, and payer levels.

Total Medical Expenses (TME): TME represents the total claims and non-claims spending for health care services delivered to state residents in a calendar year. It includes:

- All claims-based spending paid (or allowed amounts) to providers by public and private payers (net or gross of pharmacy rebates), including patient cost-sharing amounts, and
- All non-claims payments, including incentive payments and care coordination payments.

TME can be assessed at the state, market, payer, and provider levels.

Net Cost of Private Health Insurance (NCPHI): NCPHI measures the administrative costs associated with private health insurance. It is defined as the difference between premiums earned and benefits incurred, and it includes costs related to bill payments, advertising, sales commissions, administrative expenses, adjustments to reserves, rate credits, dividends, premium taxes, and profits or losses. NCPHI can be assessed at the state, market, and payer levels.

KEY CONSIDERATIONS FOR MEASUREMENT

States should assess payer and provider performance against the cost growth target using TME. However, states should also separately examine the payers' NCPHI and THCE.

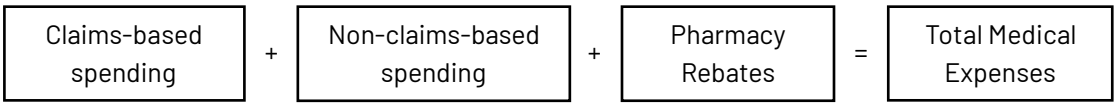
> Rationale: The primary purpose of the target is to measure spending on provider services and to hold payers and provider entities accountable for this spending. THCE and NCPHI can provide additional insights into payer performance; however, spending is typically adjusted through truncation and/or risk adjustment, making it incongruent with unadjusted measures like NCPHI. Moreover, states have other mechanisms (e.g., rate review) to hold entities accountable for NCPHI or its subcomponents.
>
> States should produce internal analyses of payer THCE and NCPHI for monitoring purposes which can be reported publicly on an ad hoc basis.

States should <u>subtract</u> pharmacy rebates when calculating TME at the insurer level but should <u>include</u> rebates when calculating NCPHI.

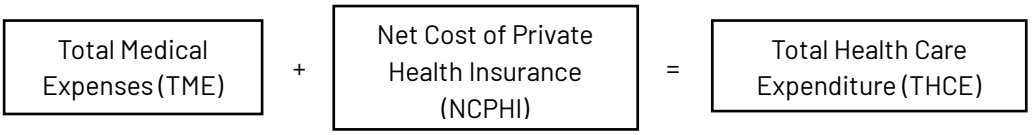
<u>Rationale</u>: Pharmacy rebates are payments made by pharmaceutical manufacturers to payers and/or pharmacy benefit managers for prescriptions filled under a payer's plans. Assessing pharmacy spending and TME net of rebates is advantageous because it provides a more accurate representation of spending growth for healthcare services delivered. Moreover, the inclusion of rebates into NCPHI accurately indicates that payers can allocate these rebates toward expenses that are not payments to providers (e.g., administrative expenses, dividends, profits).

ADMINISTRATIVE SPECIFICATION

Calculating TME:



Calculating THCE:



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CONSENSUS ADMINISTRATIVE SPECIFICATION FOR ASSESSING THE IMPACT OF MEMBERS WITHOUT UTILIZATION

Description

Payer performance against cost growth targets is assessed based on all covered lives, including members who do not utilize any services during the performance year. Provider performance against cost growth targets is assessed based on attributed members. Payers currently attribute members to providers through one or multiple methodologies, including but not limited to member selection, contractual arrangements, and utilization. This attributed population usually encompasses a large portion of each payer's overall membership; however, some enrolled members may remain unattributed (e.g., if the member's PCP is not part of a provider organization who is subject to the cost growth target, or if the member did not utilize health care services during the performance year). Changes in the proportion of members without utilization can impact states' assessment of payer performance against cost growth targets:

- If the proportion of members without utilization stay the same, spending growth overall aligns with the spending growth of members with spending.
- If the proportion of members without utilization increases, payer spending growth is reduced.
- If the proportion of members without utilization decreases, payer spending growth is inflated.

The impact of members without utilization can be substantial enough that a payer meets or exceeds the benchmark while most or all providers perform differently from the payer, including on an aggregate basis. Though not all members without utilization are unattributed, and not all unattributed members are unattributed due to lack of utilization, unattributed members are the best available proxy to assess the impact of members without utilization on payer and provider spending trends.

KEY TERMS

Members without utilization did not utilize any health care services during the performance year. Many members without utilization may be reported as unattributed because they had no access to health care services during the measurement year and are therefore not attributable to a large provider group.

Unattributed members are those not attributable to a provider organization for the purposes of cost growth target reporting. This could be due to members accessing care from a provider group that is not subject to the target or not utilizing any payer-paid health care services during the measurement period (members without utilization). Unattributed members typically have their spending reported separately in cost growth target data submissions.

KEY CONSIDERATIONS FOR MEASUREMENT

States with few unattributed members (e.g., states with high HMO penetration where members select or are assigned PCPs) or that assess cost growth for populations under total cost of care contracts may not require follow-up analyses to evaluate the impact of members without utilization (Step 2, below).

ADMINISTRATIVE SPECIFICATION

States should measure the impact of members without utilization on payer cost growth target performance. To evaluate the impact of members without utilization, states should conduct the following analyses, where unattributed members serve as a proxy for members without utilization:

Step 1: Compare spending trends for members attributed to providers against spending trends for unattributed members

- This analysis allows states to assess the relative spending growth between members attributed to provider organizations and the proxy for members without utilization (unattributed members). If there is a substantial difference between these two trends, the payer's spending is likely impacted by members without utilization.

Step 2: Compare spending growth for members attributed to providers against each payer's overall spending growth

- This analysis enables states to compare the spending growth of members attributed to providers against the payer's overall spending growth. A faster rate of spending growth among attributed members may indicate that overall payer spending growth was moderated by members without utilization.

These analyses, conducted either on an ad hoc basis or longitudinally, can facilitate further discussions with payers and guide future data requests or enforcement actions.

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CONSENSUS ADMINISTRATIVE SPECIFICATION FOR ASSESSING PAYER AND PROVIDER PERFORMANCE:

Using Commercial Full Claims and Partial Claims Spending

DESCRIPTION

Commercial market spending in cost growth target programs is typically collected in two broad categories: full claims and partial claims. These categories enable separate reporting of member data based on the completeness of information available to the insurer. Full claims are comprehensive data where all relevant healthcare services utilized are reported, whereas partial claims are incomplete due to certain services being carved out.

KEY TERMS

Commercial full claims include spending on members enrolled in fully insured or self-insured plans for which all claims data (including claims paid by a delegated entity/carve-out plan) can be reported by the insurer.

Commercial partial claims include spending data from self-insured and fully insured plans that do not encompass all medical claims or all claims made by a delegated entity or carve-out plan. Members for whom commercial partial claims are reported have at least one carved-out service, typically pharmacy benefits. Payers should generate estimates for spending on these carve-out services to make spending reported in this category directly comparable to commercial full claims.

Carve-outs occur when payers delegate ("carve out") coverage for a portion of their benefits to other plans (e.g., behavioral health services, pharmacy benefits), which isolates insurance risk for those services.

KEY CONSIDERATIONS FOR MEASUREMENT

Estimating Spending for Partial Claims: Some states may have only a small portion of their commercial spending and membership reported under commercial partial claims and may consider holding payers and providers accountable solely for full claims spending. In these cases, it is important to carefully assess:

1. The amount of spending for which providers may not be held accountable, and
2. Differences between full and partial claims spending, such as deviations in spending trends and service category allocation between full and partial claims spending.

States should continue to instruct payers to use the state's preferred methodology (if any) for estimating carve-out spending; most states currently ask payers to estimate carved-out spending by assuming that carved-out spending is proportional to the spending seen in members with comprehensive plans.

ADMINISTRATIVE SPECIFICATION

States should hold both payer and provider entities accountable for commercial full claims and commercial partial claims. These categories should be reported separately, with payers calculating estimates for carved-out services as described in *Key Considerations for Measurement* above.

States should collect spending data on carved-out services from the delegating entity and should only hold the delegating payer accountable for carve-out spending.

Additionally, states may consider conducting analyses at both overall and service category levels to monitor differences in trends and spending composition between full claims and partial claims.

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CONSENSUS ADMINISTRATIVE SPECIFICATION FOR DEFINING AND MEASURING NON-CLAIMS PAYMENTS

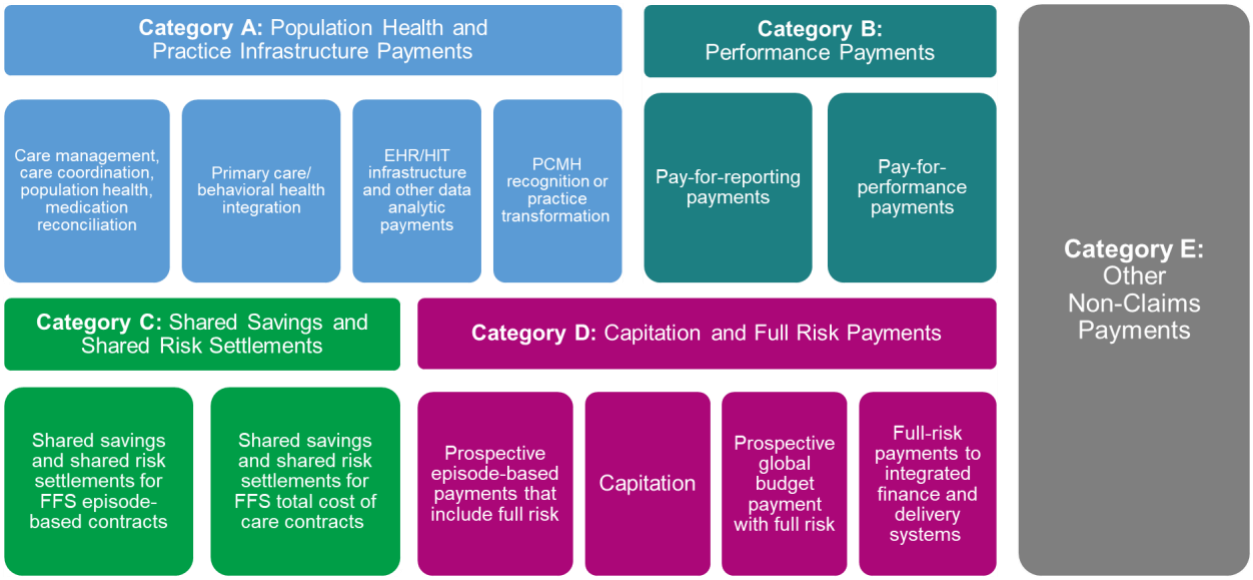
DESCRIPTION

Non-claims payments are payments to providers that are not associated with a claim and include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc. States should use the following framework to classify non-claims payments.[1]

These top-level categories are most important for cross-state comparison and are compatible with the Expanded Non-Claims Payments Framework in use by California and included in the National Association of State Data Organizations (NAHDO) APCD Common Data Layout (APCD CDL™). Note that the Expanded Non-Claims Payments Framework includes Pharmacy Rebates as a stand-alone category; while the Peterson-Milbank framework does not consider pharmacy rebates to be non-claims payments, states may elect to include this additional category if they choose.

[1] California collects non-claims payments according to its Expanded Non-Claims Payments Framework, which is also used by some other states; the framework presented in this specification is closely related to the Expanded Non-Claims Payments Framework.

States that wish to collect more detailed non-claims payment data should use the following sub-categories:



Description of Non-Claims Payment Categories and Sub-Categories:

- **Category A: Population Health and Practice Infrastructure Payments**
  - Payments made to support the infrastructure and resources necessary for coordinating care, improving quality, and/or controlling costs.
  - *Recommended subcategories:* a) care management, care coordination, population health, medication reconciliation, b) primary care/behavioral health/social care integration, c) provider electronic health record (EHR)/health information technology (HIT) infrastructure and other provider data analytic payments, and d) patient-centered medical home recognition or practice transformation.[2]

- **Category B: Performance Payments**
  - Payments made to providers based on their performance on specific metrics, which could be related to quality of care, patient outcomes, or data reporting.
  - *Recommended subcategories:* a) pay-for-reporting payments and b) pay-for-performance payments.

- **Category C: Shared Savings and Shared Risk Settlements**
  - Financial arrangements where providers are rewarded for achieving cost savings and/or quality goals for a defined set of services over a specific period. Providers may share in the savings generated or bear financial risk if costs exceed expectations.
  - *Recommended subcategories:* Shared savings and shared risk settlements a) for fee-for-service episode-based contracts, and b) for fee-for-service total cost of care contracts.[3]

- **Category D: Capitation and Full Risk Payments**
  - Payments made to providers on a per-patient basis, regardless of the amount of care the patient receives, with the provider assuming full financial risk.

[2] The Expanded Non-Claims Payments Framework includes separate sub-categories for primary care/behavioral health integration (Expanded Framework sub-category A2) and social care integration (Expanded Framework sub-category A3).
[3] The Expanded Non-Claims Payments Framework includes four sub-categories for episode-based payments (sub-categories C1-C4) based on payment type (procedure-related vs. condition-related) and whether the payment model includes shared savings and/or risk of recoupments, and two sub-categories for total cost of care arrangements (sub-categories C5-6) based on whether the payment model includes shared savings and/or risk of recoupments.

    - *Recommended subcategories:* a) prospective episode-based payments that include full risk, b) capitation, c) prospective global budget payment with full risk, and d) full risk payments to integrated finance and delivery systems.[4]

- **Category E: Other Non-Claims Payments**
    - All other non-claims payments made pursuant to the insurer's contract with a provider which cannot be properly classified elsewhere.

States that wish to collect even more granular non-claims payment data may wish to refer to California's Expanded Non-Claims Payments Framework, which defines additional subcategories within the topline non-claims payment categories recommended in this specification; these are detailed in footnotes for each topline category. It is recommended that states consider collecting more granular sub-category detail when a subcategory includes a meaningful amount of spending, and/or when a subcategory is of particular policy interest to the state.

KEY CONSIDERATIONS FOR MEASUREMENT

- States may choose to collect these non-claims payments at either the overall category level or the subcategory level (recommended subcategories are listed under primary definitions in the *Description* section), depending on several factors, including but not limited to the state-specific patterns in use of non-claims payments and state-specific policy objectives.
- States may also consider further stratifying non-claims payments by contributions to specific service categories of interest (e.g., primary care, behavioral health) or by differentiating between incentive-based and penalty-based payments.

ADMINISTRATIVE SPECIFICATION

To formulate data requests for non-claims payments:

Step 1: Determine the depth of information desired, including whether the state would like to collect:
- High-level category payments (Categories 1-6)
- Subcategory payments (e.g., Categories 1a-d)
- Service category contributions
- Incentive-based and penalty-based payments

Step 2: Define terms in reporting manuals; incorporate categories into data submission template

Step 3: Report findings at the overall category level and/or the subcategory level, as applicable

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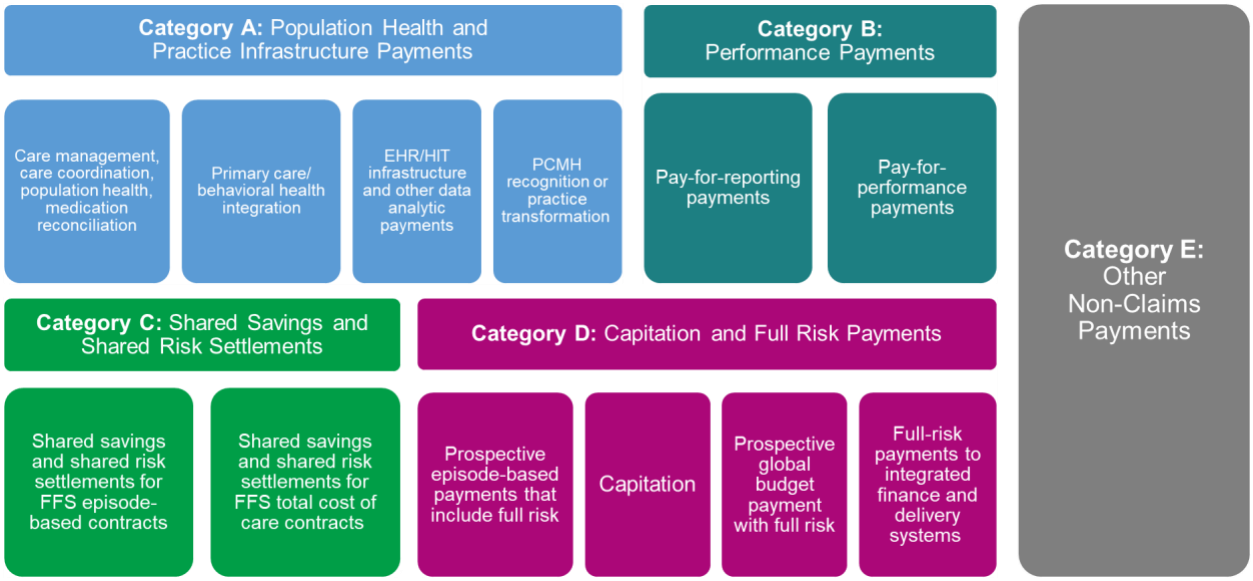
[4] The Peterson-Milbank framework includes two subcategories not included in the Expanded Non-Claims Payment Framework: Prospective episode-based payments that include full risk, and prospective global budget payments with full risk. The Expanded Non-Claims Payments Framework includes five separate capitation sub-categories (D1-D5, for primary care capitation, professional capitation, facility capitation, behavioral health capitation, and global capitation); these are grouped into the Capitation subcategory under the Peterson-Milbank framework.

CONSENSUS ADMINISTRATIVE SPECIFICATION FOR IDENTIFYING NON-CLAIMS PRIMARY CARE AND BEHAVIORAL HEALTH PAYMENTS

DESCRIPTION

Non-claims payments are payments to providers that are not associated with a claim.

Consensus Non-Claims Framework[5]



For states that wish to assign health care payments to service categories of policy interest, it can be challenging to disaggregate non-claims payments, especially where funds for multiple services are bundled together (e.g., capitation arrangements). Nonetheless, it is becoming important allocate non-claims payments to specific service categories to accurately reflect service category level spending trends as non-claims spending increases as a percentage of overall health care expenditures. For many states, primary care and behavioral health as service categories of particular policy interest; a subset of states with Cost Growth Target programs also have primary care and behavioral health spending targets.

KEY CONSIDERATIONS FOR MEASUREMENT AND RATIONALE

States interested in disaggregating non-claims payments into specific service categories should consider the following:

- Disaggregating non-claims payments, particularly capitated payment arrangements, requires careful collaboration with payers to ensure that the chosen methodology or methodologies are applied accurately.
- Disaggregating non-claims payments is especially beneficial when non-claims spending constitutes a substantial portion of overall market or state-level spending.

This process may support state-specific initiatives or goals related to allocating spending toward specific areas of care (e.g., assessing and increasing primary care spending).

[5] California collects non-claims payments according to its Expanded Non-Claims Payments Framework, which is also used by some other states; the framework presented in this specification is closely related to the Expanded Non-Claims Payments Framework.

ADMINISTRATIVE SPECIFICATION

This specification uses primary care as an example of how states should apportion payments to specific service categories or provider types; this method could be conceptually applied to other service categories such as behavioral health, though there are special considerations for each category. The Peterson-Milbank recommended approach to apportioning non-claims primary care payments closely aligns with the methodology developed by the California Department of Health Care Access and Information (HCAI) and Freedman HealthCare, which uses the Expanded Non-Claims Payments Framework payment categories. HCAI anticipates releasing guidance on apportioning non-claims primary care in Spring 2025 and on apportioning behavioral health payments in Spring 2026; this specification will be updated to describe California's methodology as updates are produced.

For additional information on the Expanded Non-Claims Payments Framework, please refer to HCAI's data submission guide: https://hcai.ca.gov/about/laws-regulations/#health-care-affordability.

Category A (Population Health and Practice Infrastructure Payments) and **Category B (Performance Payments)**

States that wish to identify primary care and behavioral health non-claims payments in Categories A and B should request or require that payers disaggregate this data based on payer-provider contracts, allocating payments based on the provider to whom payments were made. Payments can be disaggregated to the level desired by the state; however, some payers may encounter challenges in disaggregating payments.

The example below demonstrates the disaggregation of Category B (Performance Payments).

Entity	Primary Care	Behavioral Health	Other
Provider A	$20,000	0	0
Provider B	$5,000	0	$10,000
Provider C	0	$2,000	$1,000
Payer Total	**$25,000**	**$2,000**	**$11,000**

Category C (Shared Savings and Shared Risk Settlements)

States should request or require that payers utilize a formulaic approach to identify the portion of shared savings and shared risk settlements attributable to primary care:

$$\sum Shared\ Saving\ Payments * \frac{\sum(Primary\ Care\ Claims)}{\sum(Professional, Hospital\ Inaptient\ and\ Hospital\ Outpatient\ Claims)} = Primary\ Care\ Paid\ via\ Shared\ Savings$$

Category D (Capitation Arrangements and Full Risk Payments)

States should request or require that payers utilize a formulaic approach to identify the portion of capitation arrangements and full-risk payments attributable to primary care:

$$All\ Primary\ Care\ Capitation\ Payments + \frac{\sum(\#\ of\ PC\ Encounters * FFS\ Equivalent\ Fee)}{\sum(\#\ of\ all\ Professional\ Encounters * FFS\ Equivalent\ Fee)} * Professional\ Capitation = Primary\ Care\ Paid\ via\ Capitation$$

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SECTION 2:

Methodology and Adjustments

CONSENSUS ADMINISTRATIVE SPECIFICATION FOR DATA COLLECTION AND ANALYSIS: RISK ADJUSTMENT

DESCRIPTION

Risk adjustment methodologies attempt to account for differences in risk between groups or individuals as a result of factors such as demographics (age/sex risk adjustment) and/or health status (clinical risk adjustment). By incorporating risk adjustment into cost growth target programs, states are attempting to ensure that variations in healthcare spending are reflective of true cost growth rather than changing population risk. However, clinical risk adjustment is vulnerable to changes in coding behavior and challenging to compare across payers when different risk adjustment tools are used, and changes in population age/sex demographics may not have a meaningful impact on year-over-year spending growth. Risk adjustment also adds complexity to public communication around health care spending and cost growth target results.

The Peterson-Milbank recommendation is that states should use **either unadjusted spending or age/sex risk adjustment to assess payer and provider performance.** This document offers specifications for states that elect to use age/sex risk adjustment.

KEY TERMS

Age/sex risk adjustment is a methodology that accounts for differences in age and sex demographics within a population without adjusting for clinical risk. By applying age and sex factor weights – which measure relative spending across specific age/sex groups – to the population distribution, states can calculate an entity's overall age/sex risk score. This risk score ensures that cost growth target assessments are adjusted for demographic variations that occur on a year-over-year basis.

KEY CONSIDERATIONS FOR MEASUREMENT

When choosing to apply age/sex risk adjustment, states need to determine 1) the preferred data source to calculate age/sex factor weights, and the 2) frequency of data collection.

- **Data Source:** States pursuing age/sex risk adjustment should collect data from payers to calculate age/sex weights, rather than using APCD data.
    - Rationale: State APCD data is less complete than payer data due to limited inclusion of self-insured data in most states.
    - Where payer data collection is not feasible or where APCD data is more complete, states may choose to calculate age/sex weights from APCD data.
- **Frequency of Data Collection:** States should collect data from payers and recalculate age/sex weights annually.
    - Rationale: While age/sex risk scores should remain relatively stable in the short term, multi-year weights introduce methodological complexity (e.g., submission requirements not consistent across years; would require states to incorporate market changes such as providers entering and leaving the market). In addition, payers may experience difficulties in submissions being revised to include and exclude age/sex factors.

ADMINISTRATIVE SPECIFICATION

States that choose to incorporate age/sex risk adjustment into their cost growth target measurement should complete the following steps to incorporate this data request into the payer data collection process:

Step 1: Determine how often age/sex factor data will be collected (e.g., every two years, every five years)

Step 2: Determine level of applicable weights (e.g., statewide population, market population, insurance category code, payer population)

Step 3: Establish the specific age groupings to be used in the analysis (e.g., 0-18, 19-35, 36-64, 65+)

Step 4: Develop age/sex data collection tabs for inclusion in payer data submission template

- For each combination of age/sex factors (e.g., women 0-18, men 85+), payers must report membership and spending data at the payer and provider level for each insurance category code. *Note: Age/sex spending data should be truncated if the state is utilizing truncation.*

Step 5: Calculate age/sex weights (example below assumes application at insurance category code-level)

1) Calculate average age/sex PMPMs for each insurance category code

    a. If truncation is applied at both the payer and provider levels, perform age/sex risk score analyses for payers and providers separately.

Simplified Age/Sex Bracket *(example)*	**PMPM**
0-18 M	$200
0-18 F	$200
19-64 M	$500
19-64 F	$500
65+ M	$1,000
65+ F	$900
Total	**$550**

2) Calculate Age/Sex Factor Weights

    a. Divide the PMPM for each age/sex bracket by the overall insurance category code PMPM to determine the age/sex factor weights.

Simplified Age/Sex Bracket *(example)*	**Age/Sex Factor Weight**
0-18 M	$200 / $550 = 0.36
0-18 F	$200 / $550 = 0.36
19-64 M	$500 / $550 = 0.91
19-64 F	$500 / $550 = 0.91
65+ M	$1,000 / $550 = 1.82
65+ F	$900 / $550 = 1.64
Total	**$550/$550 = 1.0**

Step 6: Calculate age/sex risk scores

1) Develop age/sex risk scores for each payer or provider entity by applying the calculated age/sex weights to their population distribution.

Simplified Age/Sex Bracket *(example)*	**Baseline Year Population Distribution**	**Baseline Year Age/Sex Bracket Factor Weight**	**Population Distribution * Factor Weight**
0-18 M	0.05	0.36	0.05 * 0.36 = 0.02
0-18 F	0.05	0.36	0.05 * 0.36 = 0.02
19-64 M	0.38	0.91	0.38 * 0.91 = 0.35
19-64 F	0.38	0.91	0.38 * 0.91 = 0.35
65+ M	0.07	1.82	0.05 * 1.82 = 0.13
65+ F	0.07	1.64	0.05 * 1.64 = 0.11
Entity A's Baseline Year Risk Score			**0.97**

2) Apply the same age/sex factor weights for the baseline year to the entity's performance year.

Simplified Age/Sex Bracket *(example)*	**Performance Year Population Distribution**	**Baseline Year Age/Sex Bracket Factor Weight**	**Population Distribution * Factor Weight**
0-18 M	0.04	0.36	0.04 * 0.36 = 0.01
0-18 F	0.05	0.36	0.05 * 0.36 = 0.02

19-64 M	0.37	0.91	0.37 * 0.91 = 0.34
19-64 F	0.39	0.91	0.39 * 0.91 = 0.35
65+ M	0.08	1.82	0.08 * 1.82 = 0.15
65+ F	0.07	1.64	0.07 * 1.64 = 0.11
Entity A's Performance Year Risk Score			**0.98**

Step 7: Adjust cost growth results using age/sex risk scores

1) Divide an entities insurance category code PMPM by the calculated risk score.

Entity	Baseline Year Unadjusted PMPM	Baseline Year Age/Sex Risk Adjusted PMPM	Population Distribution * Factor Weight
Entity A	$500	0.97	$500 / 0.97 = $516

Entity	Performance Year Unadjusted PMPM	Performance Year Age/Sex Risk Adjusted PMPM	Performance Year Age/Sex Risk Adjusted PMPM
Entity A	$515	0.98	$515 / 0.98 = $524

2) Calculate age/sex risk adjusted trend.

Entity	Age/Sex Risk Adjusted Baseline Year PMPM	Age/Sex Risk Adjusted Performance Year PMPM	Age/Sex Risk Adjusted Trend
Entity A	$516	$524	$524 / $516 = 1.5%

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CONSENSUS ADMINISTRATIVE SPECIFICATION FOR MEMBERSHIP THRESHOLDS FOR DATA COLLECTION, PUBLIC REPORTING, AND ACCOUNTABILITY

DESCRIPTION

This specification focuses on determining which payer and provider entities should be subject to data collection, public reporting, and accountability within cost growth target programs based on membership. Membership thresholds seek to limit public reporting and accountability to entities where population sizes are large enough to lend statistical validity.

ADMINISTRATIVE SPECIFICATION

States should assess membership data for both the performance and baseline years to determine whether an entity meets the threshold; if membership in either year falls below the threshold, the analysis may lack sufficient statistical power. Additionally, the same threshold should be used to identify which entities are subject to public reporting and to determine which entities will be held accountable to the cost growth target. This threshold strikes a balance between statistical certainty and the administrative burdens placed on small providers and payers.

> Rationale: When developing confidence intervals to assess an entity's performance against the cost growth target, entities below the minimum threshold of 5,000 members (or 60,000 member-months) will have significantly wider confidence bands compared to those above the threshold. These larger bands indicate lower statistical certainty. Please see the Consensus Administrative Specification for Data Collection and Analysis: Confidence Intervals for more information.

States should perform data collection of providers close to the threshold and conduct regular environmental scans to reassess provider landscape to identify providers who may newly exceed the threshold for reporting and accountability.

States may consider raising or lowering the threshold based on their specific needs. These may include membership thresholds included in state cost growth target statutes; the number of payer and provider entities operating within the state; different thresholds applied to payers and providers, or at the payer market level; or a desired minimum proportion of spending to be captured in cost growth target data collection.

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CONSENSUS ADMINISTRATIVE SPECIFICATION FOR CONFIDENCE INTERVALS

DESCRIPTION

Confidence intervals are utilized in cost growth target programs to account for variability within health care spending data. Other tools, such as risk adjustment and truncation, can account for some of the variability inherent in cost growth spending data. However, many sources of volatility still exist, supporting the use of confidence intervals to ensure accurate and reliable assessments.

KEY TERMS

Confidence intervals are statistical tools used to estimate the range within which the "true" parameter value lies. In the context of cost growth target programs, the parameter of interest is an entity's year-over-year cost growth.

Variance and standard deviation are statistical measures that assess the variability within a sample or group being analyzed. These metrics can be used to quantify the spread seen in a health care spending distribution.[6]

KEY CONSIDERATIONS FOR MEASUREMENT

When determining whether to use confidence intervals as a statistical tool in a state's cost growth target program, it is important to consider the following:

- Confidence intervals help account for variability that cannot be adjusted for, including:
  - Randomness in an individual's health care spending
  - Changes in the population being assessed (e.g., employers/individuals joining or leaving a plan)
  - Changes in the demographic makeup of the population, particularly when no risk adjustment is applied. (See Consensus Administrative Specification for Data Collection and Analysis: Risk Adjustment).
- Confidence intervals tend to scale proportionally with an entity's size. Larger payers and provider organizations generally have tighter confidence intervals, reflecting higher statistical certainty due to large population size, compared to smaller entities which exhibit wider confidence intervals due to greater variability within smaller populations.

ADMINISTRATIVE SPECIFICATION

Generating confidence intervals requires comprehensive implementation in both the data collection and data analysis phases.

Data Collection

- States must collect standard deviations from all payers for each provider at the market level and for the payer overall at the market level for each measurement year.
- If the state is utilizing truncation, payers are required to calculate standard deviations using truncated spending data.
- For each individual member, the member's spending should be evenly distributed across all months during which they were enrolled or attributed to a provider organization. Standard deviations should be calculated using only claims data (excluding non-claims data).

[6] Variance = (Standard Deviation)^2

Calculating Standard Deviation

$$\sigma = \sqrt{\frac{\sum_I (X_i - \bar{X})^2}{N}}$$

Where:

σ = standard deviation

X_i = value of one observation

$\bar{X}$ = the mean value of all observation

N = the number of observations (count of member months)

Pooling Standard Deviations

- States need to establish an internal process to pool standard deviations for providers, as multiple payers are likely to report standard deviations for each provider organization.
    - Pooling standard deviations is most efficiently done using statistical software, such as R.
- The following formula can be used to pool standard deviations:

$$V_{pool} = \frac{\sum_i N_{X_i} \sigma^2_{R_i, X_i}}{\sum_i N_{X_i}} + \frac{\sum_{i<j} N_{X_i} N_{X_j} (\bar{X}_i - \bar{X}_j)^2}{(\sum_i N_{X_i})^2}$$

Where:

i = carrier index – i = first carrier, j = second carrier, …

N_i = population size for carrier *i*

σ_i = standard deviation for carrier *i*

$\bar{X}_i$ = mean per member per month cost for carrier i (market population-level mean)

R_i = indicator that value is risk adjusted; if the state is utilizing risk adjustment, standard deviations should be adjusted using the following formula[7]:

$$\sigma^2_{R_i, X_i} = \frac{\sigma^2_{X_i}}{R^2_{X_i}}$$

Calculating Confidence Intervals

- Once all variances have been calculated, confidence intervals can be generated for all entities using the following formula:

$$CI = \frac{\bar{X}_{BY}\bar{X}_{PY} \pm \sqrt{\bar{X}^2_{BY}\bar{X}^2_{PY} - \left(\bar{X}^2_{BY} - t^2_{\widehat{df},\alpha}\frac{V_{BY}}{N_{BY}}\right) * \left(\bar{X}^2_{PY} - t^2_{\widehat{df},\alpha}\frac{V_{PY}}{N_{PY}}\right)}}{\bar{X}^2_{BY} - t^2_{\widehat{df},\alpha}\frac{V_{BY}}{N_{BY}}}$$

[7] States collect unadjusted claims data, which are then risk-adjusted using age/sex risk scores. Because payers report variance based on unadjusted spending, this unadjusted variance does not reflect the variance of the risk-adjusted population. To calculate the approximate variance of the risk-adjusted population, the squared risk score is applied to the unadjusted variance.

Where:

N_i = population size for year i

$\bar{X}_i$ = mean per member per month cost for year i for the population

V_i = variance for entity being assessed for year i (pooled variance for provider entities)

BY = baseline year value

PY = performance year value

$t^2_{\widehat{df},\alpha}$ = the t-statistic value given the degrees of freedom ($\widehat{df}$) and the value of alpha (α). For the 95% confidence interval, α is 0.05.

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CONSENSUS ADMINISTRATIVE SPECIFICATION FOR TRUNCATION

DESCRIPTION

Truncation is a methodology used in cost growth target programs to mitigate the impact of random annual changes in the occurrence high-cost outliers — individuals whose volatile spending, driven by high utilization and/or high prices for services. In large populations (e.g., an entire state market), these outliers have minimal impact. However, in smaller provider or payer populations, an annual increase or decrease in high-cost outliers can meaningfully skew results, and their impact on trends can cause an entity to meet or exceed the benchmark.

Truncation can help states more accurately and fairly assess an entity's year-over-year spending growth.

KEY TERMS

Truncation point is the threshold above which an individual's spending is excluded from payer and provider cost growth target analyses. Truncation is applied to an individual's total spending within the measurement period.

KEY CONSIDERATIONS FOR MEASUREMENT

Truncation points will likely vary by market, as consumer behavior and health care costs differ based on payer-specific service prices and utilization patterns. For example, members in the commercial market tend to be younger and healthier than those covered by Medicare, so we would expect most commercial markets to have lower truncation points. In contrast, Medicaid covers a large portion of individuals who require long-term care services, leading many Medicaid members to consistently incur high levels of spending; therefore, Medicaid members will likely require a higher truncation point.

ADMINISTRATIVE SPECIFICATION

Step 1: Using payer stop-loss thresholds to set truncation points

To set truncation points, states should meet with payer entities to understand their individual stop-loss thresholds. Payers and providers in downside risk contracts use stop-loss thresholds to limit financial exposure from a small number of high-cost members—essentially paying a premium to spread the risk from catastrophic expenses. Stop-loss insurance is commonly used by self-funded plans, as well as by Medicaid Managed Care and Medicare Advantage plans, to manage downside risk when assuming responsibility for a population's health care costs.

Because plans may use multiple stop-loss thresholds, states should consider using the median of the thresholds reported across insurers in a given market.[8] If states observe significant variation in payer stop-loss thresholds, they could consider taking this into account in setting truncation points as well.

Step 1a: Updating truncation points

Truncation points tend to lose their effectiveness over time as overall health care spending increases. As a result, more members may exceed the truncation threshold over time, leading to a greater amount of

[8] When engaging with commercial insurers about stop-loss thresholds, clarify that thresholds used for large employers are most relevant, as those for smaller employers tend to be lower and specific to populations much smaller than those represented in cost growth target programs.

spending being excluded from analysis—and reducing the portion of total spending for which the state holds accountable a given payer or provider entity.[9]

To make regular adjustments to truncation points, states can consider the following two options:

- Meet with payers periodically (every 2-4 years) to discuss changes in their stop-loss thresholds. While stop-loss thresholds—and, by extension, truncation points—may not change every year, they are often closely tied to insurers' perceptions of risk, which are informed by internal analyses of their covered populations. Therefore, adjustments to stop-loss thresholds by payer entities can serve as a reasonable basis for updating truncation points.
- Adjust truncation points based on spending trends observed in the corresponding market no less than every four years. Because spending trends reflect the annual increase in per-member spend, indexing truncation points to market spending trends helps minimize the erosion of a truncation point's effectiveness over time.

Step 2: Applying truncation points

Truncation points must be applied individually at both the payer and provider levels. If a member is attributed to two different provider entities during the measurement period, truncation should be applied separately to the portion of spending attributed to each provider.

Example: Truncation Point of $150,000 for Member A

Entity	**Spending before truncation**	**Months Enrolled**	**Spending after truncation**	**Spending Removed from Payer Analysis**
Insurer A	$750,000	9	$150,000	$600,000
Entity	**Spending before truncation**	**Months Enrolled**	**Spending after truncation**	**Spending Removed from Provider Analysis**
Provider X	$550,000	6	$150,000	$400,000
Provider Y	$200,000	3	$150,000	$50,000

The Peterson-Milbank Program for Sustainable Health Care Costs is also exploring a regression-based statistical methodology using APCD data as a promising alternative for determining appropriate truncation points.

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[9] While using lower thresholds is not inherently problematic, it may be misaligned with the intent of truncation, which is to account for changes in the occurrence of high-cost outliers. If an increasing number of members exceed the truncation point each year, it suggests that the threshold is less likely isolating random, extreme cases and more likely reflecting a broader increase in population-level spending. It is important to note that truncation points will also apply to members who consistently require high-cost care. However, the purpose of this methodology is to minimize, as much as possible, the impact of outliers whose high costs are less predictable and less consistent.