



State Models for Health Care Cost Measurement: A Policy and Operational Framework

by Rachel Block

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Foreword

The Milbank Memorial Fund is pleased to present this report on total cost of care measurement activities in four states—Maryland, Massachusetts, Oregon, and Vermont.

The report examines these state government-led efforts to measure total costs of health-care, their rates of increase over time, and the policy priorities in the states that are driving these activities.

The Fund commissioned this report for three important reasons:

- We were asked to do so by these states. They wanted to learn from one another and share their lessons within their home states. The Fund finds this sort of peer-to-peer learning to be particularly effective.
- The topic is important. Dollars spent on health care are dollars not available for other uses. Understanding the rate at which costs are growing—and the growth rate the economy can bear—is important for the financial and population health of any state.
- We think other states can benefit from these lessons. The Fund is committed to compiling the best evidence and experience to help leaders and decision makers improve the health of populations. With provider consolidation on the rise, Medicaid costs continuing to grow, and more high-cost drugs in the pipeline, state and employer health care budgets will continue to expand. A collective view of health care expenses reduces the temptation to shift costs to other payers and increases focus on underlying cost drivers.

We appreciate the generosity of the staff in these four states who shared their time and insights with us in the compilation of this report, as well as those experts who reviewed earlier drafts.

Each state's total cost of care measurement and its use are different in important ways—reflecting the distinct social values, political cultures, health care system characteristics of each state, and the exploratory nature of this work. Time and evidence will determine their efficacy. Other states may use a total cost of care yardstick in new ways. We think the experiences of these “policy pioneers” can instruct all of us.

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Introduction

State Models for Health Care Cost Measurement: Key Definitions and Concepts

A growing number of states are undertaking broad health care transformation initiatives, many influenced by the Triple Aim for health system improvement: to achieve better health and better care with lower cost. An intrinsic property of this three-pronged strategy is the development of measures to define the current state and goals for improvement within each of the three domains.

States have considerable experience establishing measures and setting priorities for population health and quality improvement using existing public health and health care statistics. However, the measurement of cost across a state's health care system—let alone setting targets for cost reduction—is a relatively new focus, and it requires significant new policies and operational activities.

In order to advance this broader health system perspective, states need to start with some basic questions:

- What is the denominator for total health care spending in a particular state?
- What is the scope or unit of cost analysis?
- What are the data sources to be used, and how well do they correspond to the desired measures?
- How should cost measures be combined with other measures to evaluate total system performance?

Recent state initiatives for health care transformation are more comprehensive and complex compared to previous efforts because they strive to focus on the entire population of a state and to coordinate state policy actions across the full spectrum of the health care system.

Traditionally, most states have focused on cost controls and new delivery models for their Medicaid programs. Medicaid has used its own policy levers, but they may have had limited impact on the system as a whole. In addition, single sector interventions have often resulted not in cost control but in cost shifting to other sectors.

With many states implementing coverage expansions as a result of the Affordable Care Act, there is greater need to focus on sustainable levels of cost growth. From a delivery system or population perspective, more states are now implementing broader initiatives to align incentives, focus on consistent measures, and invest in care improvements across all payers. By looking at total costs, states, payers, and providers can facilitate system-wide improvements driven by new regulatory authorities and/or market-based strategies that affect all payers and populations.

Design of the State Models for Health Care Cost Measurement Study

The Milbank Memorial Fund launched this study based on the work of four states—Maryland, Massachusetts, Oregon, and Vermont—all of which have committed to explicitly address health care costs as one of the fundamental reforms in their health care systems. Specifically, these states have developed comprehensive and up-to-date measures of health care costs for their populations, and they are purposefully using that information in conjunction with various state policy levers to set limits on cost growth.

The study was conducted using four sources of input:

- Regular group conference calls with representatives from the four states;
- Regular one-on-one calls between individual states and the author;
- Review of policy documents and meeting notes posted on each state's website; and
- Review of a draft of this report by the four states and also by a larger group of states that the Fund considers to be an important audience for the final document.

This report was prepared at the request of the participating states, for three purposes:

- To document and compare each state's approach to total cost measurement and setting targets or limits on systemic cost growth in order to identify common themes and issues, including potential road blocks and/or solutions that can advance their efforts;
- To establish a common understanding of these issues with the Centers for Medicare & Medicaid Services (CMS) in order to facilitate Medicaid and Medicare participation as a key component of their statewide, population-based, cost control models; and
- To assist the growing number of states and other stakeholders that are considering adopting similar strategies.

By further advancing the efforts of the participating states and helping other states and stakeholders implement a policy and technical roadmap focused explicitly on total cost measures and growth, this report encourages state leadership to improve quality and cost-effectiveness, to better serve current populations, and to invest in infrastructure and care delivery to serve newly covered populations. Linking health care cost increases more closely to economic growth creates opportunities for states to align spending priorities within the health care sector and relative to other state policy priorities.

The report is organized into four sections:

I. Broad Strategies and Goals Related to Total Cost of Care Measurement

Each of the four states in this study is advancing a comprehensive, statewide strategy to create a better, more sustainable health care system. These broad strategies and goals

provide context and inform each state's approach to measuring total cost of care and establishing limits on cost growth.

II. Governance and Authority for Total Cost of Care Measurement

Most of the states adopted new legislation, which both consolidated and expanded their regulatory scope to implement total cost measures and limits on cost growth. They also established new structures—often separate from existing agencies—to govern their comprehensive reforms and formally engage stakeholders in advisory and operational roles.

III. Key Policy and Operational Activities

Total cost measurement and setting limits on cost growth require defining the scope, methodologies, applications, and data sources for total cost of care. While each state has a different starting point and trajectory, they are all dealing with similar policy and operational issues. The federal government plays a significant role with respect to policy, data, and funding (matching funds and grants), particularly through the State Innovation Models (SIM) initiative.

IV. Future Policy and Operational Issues

As the states move forward with their initiatives, they will face challenges related to state regulatory strategies, additional uses and sources of data, and ways to better capture consumer perspectives on cost.

Broad Strategies and Goals Related to Total Cost of Care Measurement

State models focused on total cost of care measurement have been developed as part of a broader policy context, which addresses:

- The overall policy theory and comprehensive approaches that drive states' strategies for using cost measures; and
- Complementary policy goals that can be advanced in conjunction with state total cost models.

Examples of State Policy Levers

The states are utilizing a variety of policy levers, often in combination, to measure and set limits on total health care costs. A growing number of states are implementing these policies in conjunction with section 1115 demonstration waivers and SIM grants.

- **Data Collection**

- Many states have adopted laws and regulations requiring data submission by insurers and other payers (for example, third-party benefits administrators).
- Cost is represented in the amounts paid for covered services provided to insured populations.

- Requirements specify who is obligated to report, what the data elements and definitions are, processes for data validation, and formats and time frames for reporting (for example, monthly or quarterly).
- States may also rely on voluntary data submission to address some or all of their data needs.
- **Data Reporting**
 - States are publishing aggregate cost measures and trends, for example, per capita expenditures for major categories of health care services.
 - States may create and publish population-based measures, such as costs associated with ambulatory care-sensitive causes of hospital admissions or racial and ethnic disparities.
 - In addition to claims and expenditures data, states are collecting information about types of alternative payment methodologies used by public and private payers.
- **Hospital Revenue Limits**
 - States may use hospital revenue limits—or budgets—as a primary strategy to measure and control costs.
 - The budgets are based on projected revenue for all providers of hospital services, which include hospital-based or hospital-owned physician practices.
 - The annual rate of growth is capped, and actual revenue is monitored regularly to ensure compliance.
- **Rate Setting for Accountable Care-Type Arrangements**
 - Oregon is measuring the total cost for Oregon Health Plan beneficiaries under its 1115 waiver; its rate-setting system for its coordinated care organizations (CCOs) includes a combination of capitation and fee-for-service (FFS) payments.
 - Under its SIM program, Vermont is establishing total costs for Medicaid and commercial payers covering the state's accountable care organizations (ACOs).

Primary Strategies

There are two primary strategies being implemented across the four states participating in this study: each state has committed to broad health system transformation driven by (1) payment reforms that are aligned with total cost of care measures for populations and/or services and (2) transparency in health care system performance, including total cost measures. While managing cost is a primary focus, the states are equally concerned with improving quality and population health as components of their strategies.

All of the states are striving to promote value-based methods of health care financing and delivery. Their goal is to implement these strategies broadly—in particular across all payers. But each state is using different policy levers and phasing in its approach based on specific policy and market circumstances. Three of the states are directly regulating total cost of care through a rate-setting process; each of these states has a specific implementation focus: rates for hospital payments or budgets (Vermont and Maryland), rate setting for ACOs (Vermont), and CCOs (Oregon). One state—Massachusetts—is principally focused on calculating and publicizing aggregate and sector-specific cost measures as a strategy to influence market behavior.

Complementary Goals

The state total cost models are addressing complementary goals outside the direct spheres of payment reform and transparency. Some states plan to utilize their cost measurement strategies to reduce cost shifting among payers and/or price variation among providers, as desired attributes of their health care systems. Addressing this goal requires that states account for these variances as total cost of care measures or benchmarks are established.

Each state is targeting investments, generally using payment incentives and/or appropriations, to ensure that key players in the health care system are prepared to participate and succeed, including but not limited to primary care physicians, community health centers, and community hospitals. These investments may be identified as a specific element in the total cost of care methodology. For example, a specific percentage of the total cost formula may be allocated to support these activities, and expenditures in this category could be monitored to ensure their appropriate use.

Table 1. Broad Strategies for Total Cost of Care Measurement

Maryland	Massachusetts
<ul style="list-style-type: none">The state's broad focus for the all-payer modernization system is to establish accountability for the total cost of care through new policies governing hospital payment.The strategy includes setting limits on statewide cost growth by using the hospital rate-setting system to negotiate each hospital's revenue target and by monitoring actual cost trends to determine compliance with these targets.	<ul style="list-style-type: none">The Commonwealth's broad strategy focuses on payment reforms to reward quality, improve outcomes, and promote cost efficiency.The Health Policy Commission sets health care cost growth targets based on analysis of system cost performance by the Center for Health Information and Analysis (CHIA) and subsequently evaluates and makes policy recommendations based on system cost trend data.Additional elements of the strategy include monitoring use of alternative payment methodologies and changes in market structure that may impact cost.

<p>Oregon</p> <ul style="list-style-type: none"> The state's coordinated care strategy is focused on reducing Medicaid cost growth while improving quality and access. The next phase of the state's strategy will focus on measuring total costs, aligning care models for additional payers and populations, and developing policies to increase cost transparency, reduce cost shifting, and control insurance rates. 	<p>Vermont</p> <ul style="list-style-type: none"> The state is advancing a comprehensive strategy designed to improve health care system performance, including cost growth limits for all payers and better population health outcomes. Central components of the current strategy are review and approval of hospital budgets, including overall limits on cost growth. Additional strategies are focused on total cost through ACO payment standards for Medicaid and commercial payers. The state has authority to establish, but has not yet implemented, a total health care budget and provider rate setting.
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Governance and Authority for Total Cost of Care Measurement

To address total cost of care effectively, states need to:

- Determine what they can do within the current scope of their legal or regulatory powers and enact additional powers if necessary; and
- Consider how to engage public and private organizations as part of the policy development and implementation process.

Consolidation and Expansion of Authority

All of the states had some preexisting authority and structure, but most of the states also approved major legislative changes creating new or enhanced regulatory powers to implement total cost controls and oversee the operation of the overall health care system. Vermont transferred many existing regulatory functions along with its new measures to a single entity. Maryland and Oregon added new functions to existing entities, while Massachusetts established a new organizational structure on top of its existing regulatory agencies. The experiences of these four states show that legislative support and adoption of sweeping new measures can redefine the parameters for state action and may represent a degree of political consensus as to the approach.

Coordination of State Policy Levers

Each state's governing model provides an organizational focal point of accountability, which exerts clear and consistent direction across state policy domains and in concert with the private sector.

To accomplish this, all of the states have utilized or created independent governing boards and advisory groups that bring health care stakeholders—employers, plans, providers, and consumers—more directly into the policy development process, measures that can further reinforce buy-in and consensus among key players. In some cases, these boards have operational roles and responsibilities and decision-making power. Oregon's Health Policy Board is advisory but is well integrated into the state's policy and implementation activities.

However, even with their broad reach, the lead agencies need to coordinate with other state agencies that retain traditional regulatory jurisdictions. For example, they may work with state insurance departments if total cost measures are factored into insurance rate review (Vermont's board has responsibility for this function) or with Medicaid agencies to incorporate total cost measures into new provider or health plan rate-setting models. States may also track health care cost measures and growth targets as a component of the state budget process, for example, as part of a state agency or program performance scorecard.

Table 2. Governance and Authority for Total Cost of Care Measurement

Maryland	Massachusetts
<ul style="list-style-type: none">Legislation enacted in 1971 created the Health Services Cost Review Commission, composed of seven members appointed by the governor.The commission has the authority to regulate hospital payment rates—the original program was phased in from 1971 to 1974, and in 1977, a Medicare waiver established all-payer authority.An expanded all-payer model was approved by CMS in 2014.The commission has appointed an all-payer modernization advisory council and established work groups on physician alignment, payment models, performance measures, and data infrastructure.	<ul style="list-style-type: none">Original health reform legislation established authority to collect data about health system performance.Legislation enacted in 2012 created two new entities:<ul style="list-style-type: none">The Health Policy Commission is charged with advancing health care transformation, including total cost measures; its 11 members are appointed by the governor, the attorney general, and the state auditor.CHIA is responsible for total health care cost data collection and analysis.The commission has established an advisory council, work groups on cost trends and market performance, and payment reform and care delivery models.

<p>Oregon</p> <ul style="list-style-type: none"> Legislation enacted in 2009 created the Oregon Health Policy Board (OHPB), composed of eight members nominated by the governor and approved by the senate. OHPB oversees the Oregon Health Authority, particularly its health care transformation activities; OHPB also develops recommendations for alignment of policies with the broader health care system. CMS approved an 1115 waiver in 2012 to establish a coordinated care strategy for Medicaid, to impose specific cost growth targets, and to invest a portion of savings in new care models. OHPB has established work groups on CCO metrics and scoring (including total cost growth), sustainable health expenditures (to establish baseline and potential measures beyond Medicaid), and coordinated care models alignment with other payers; an all-payer, all-claims technical advisory group focuses on enhanced total cost data resources. 	<p>Vermont</p> <ul style="list-style-type: none"> Legislation enacted in 2011 created the Green Mountain Care Board, composed of five members appointed by the governor. The legislation gave the board authority for existing and additional regulatory functions in order to impact total health care costs. The legislation also established an advisory committee to the board, as well as a steering committee and work groups to support SIM activities, including payment reform and performance measures (including cost).
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Key Policy and Operational Activities

To implement total cost of care measures and targets or controls on cost growth, states have to address:

- The scope of services and/or populations for which total cost measures will be calculated, and limits on cost growth applied;
- The specific methodologies for defining total cost and growth rates;
- Clear delineation of the policy purposes to be achieved by this work;
- Systematic planning for total cost measurement data infrastructure and requirements; and
- Ensuring alignment and support between federal and state initiatives, including Medicare and Medicaid participation in total cost initiatives.

Scope

Each state has adopted a different scope for its total cost of care measurement. Ultimately, each state wants to evaluate and impact the total cost of care, but each one is starting at a different point based on its own legislative authority. The initial scope for total cost of care measurement may be defined by service categories: Vermont and Maryland have started with explicit controls on hospital budgets; Oregon is focusing initially on total cost of care for Medicaid beneficiaries and services; and Massachusetts is looking at broad total cost measures and cost growth trends for insured services.

Methodologies

The states' methodologies for total cost measurement and controls on cost growth start with the scope of services and populations.

- **What Is Being Counted**

Based on their initial regulatory scope, Maryland and Vermont started by measuring and capping hospital revenue, which includes inpatient and outpatient services.

In addition, all four states are measuring, capping, and/or monitoring total cost for some portions of their insured populations and services based on payer data.

Each of the states is working toward standardizing expenditure categories, and several are cross-referencing their state data with the national health expenditures accounting typology, which provides a structure to measure the same things in the same way.

- Maryland's all-payer system currently measures total costs but must separately account for Medicare costs for hospital inpatient and outpatient services, as reflected in revenue data collected from hospitals.
- Massachusetts is measuring total statewide health care expenditures for insured services, as reflected in expenditure data collected from payers, and attributed to payers and primary care groups.
- Oregon's methodology operates at two levels: the state is accountable for measuring total Medicaid costs and growth under its 1115 waiver terms and conditions, and the CCOs are accountable for total costs for their covered populations and services.
- Vermont's approach includes three different views of total cost: hospital revenue budgets for inpatient and outpatient services; insurance premium rates; and total cost of care for most (but not all) Medicaid and commercial insured services included in the state's ACO model.

- **How It Is Being Counted**

States have utilized different measures for cost growth benchmarks. In general, the states have applied these measures to broad categories of services or organizations,

and they have not yet implemented provider-specific total cost measures. While there is great interest in current data, total cost measures are also intended to discern trends over time.

- Maryland used a 10-year average for gross state product growth as a starting point for its all-payer cost growth target methodology. The state also negotiated a cap on per beneficiary Medicare cost growth not to exceed 0.5 percent less than the national trend and a minimum of \$330 million in Medicare savings, over its five-year CMS demonstration period.
- Massachusetts has started with projected gross state product (PGSP) growth rates as the basis for evaluating total health care expenditure (THCE) growth—total health care costs should grow at a rate not to exceed the state's overall economic growth rate. The PGSP and THCE benchmarks will be established annually, and the Health Policy Commission will consider reductions in its total cost growth rates after a few years of experience with the current measures.
- Oregon's model includes a formula for expected Medicaid spending growth rates and a reduction in Medicaid per capita cost growth to be imposed during the last three years of the five-year waiver; both rates were negotiated with CMS.
- Vermont set a 3 percent fixed growth rate for hospital net patient revenues for a three-year period. The Medicaid and commercial total cost measures are calculated for ACOs based on expected and targeted per-member-per-month (PMPM) expenditures for acute and primary care services and expected savings formulas; additional service categories may be included in future years.

What Are the Policy Applications for Cost Measures?

States are applying their total cost measures within four broad policy domains:

- **Transparency and Monitoring**

States are measuring and publishing total cost baseline and trend data in support of transparency and monitoring of performance at an overall system level, for particular service categories, and/or at the individual provider or payer level. This is a significant focus for the Massachusetts initiative.

- **Contract Requirements**

States are considering how to incorporate total cost and growth measures into payer contracts for Medicaid and state employees. States can require or encourage other payers to include common measures in their contracts. Massachusetts, Oregon, and Vermont are utilizing this approach in various ways.

- **Enforcement or Incentives**

If cost growth exceeds the target rate, states may take enforcement actions. The Massachusetts Health Policy Commission can recommend prohibiting market structure changes that could increase costs over the defined threshold. Oregon has implemented performance measures for the CCOs; bonus payments are awarded to organizations that achieve specified goals, including cost reduction. Vermont is applying shared savings incentives in its Medicaid and commercial ACO programs. All of the states are considering ways to measure and reduce cost shifting.

- **Compliance with Federal Requirements for Participation**

States participating in a federal waiver or demonstration must comply with terms and conditions establishing specific requirements regarding total cost measurement and control. As noted above, all of the states are addressing requirements for their SIM grants; Oregon has an 1115 waiver; and Maryland has a CMS demonstration program.

Data Infrastructure and Requirements

Measuring total cost of care and setting targets for total cost growth rates is a data-intensive—and therefore often can be a resource-intensive—process.

- **Data Sources**

States are utilizing existing data sources—including claims data from their Medicaid programs and from all-payer claims databases (APCDs), as well as hospital revenue data reported for hospital budget reviews. However, most of the states are collecting additional data to generate total cost and cost trend measures due to limitations of these existing data sources.

- **Data Issues**

- **Resources for Data Collection and Analysis**

States need to plan for and develop estimates of the costs for total cost data collection and analysis, which includes requirements analysis, funding, and timetables for new systems or enhancements. States are using their SIM and rate review grants from CMS to incorporate data enhancements and analytic tools that can assist with total cost measures. Given the cost and complexity of setting up new data systems, states are trying to leverage their APCDs to support multiple functions and stakeholders, which could result in better data at a lower cost.

- **Development of Aggregate versus Provider-Specific Measures**

Computing total cost or a growth rate target is generally based on an annual, aggregate data set, while monitoring and enforcing growth rates against a cap may require more regular data collection and reports. Additional data are required if measures are going to be risk-adjusted and attributed to a provider or health system.

- **APCDs**

A state's APCD may be operated by a state agency or component outside the organization responsible for total cost activities. Since extracting and analyzing data requires significant resources, these total cost activities may be competing with other priorities. Also, the data submission requirements may need to be changed, requiring negotiation with or new mandates for data reporters. Significant changes in data fields need to be well documented and factored into comparative or benchmarking analyses from year to year. “All-payer” databases may not include data from all payers; states generally do not have Medicare claims data, and they may not capture data from self-insured plans or self-pay consumer payments. Medicaid claims data are available in every state, but they may not be integrated into the APCD.

- **Data Matching and Identifiers**

Total cost of care measures require data for person-level and population-level costs on a longitudinal basis. States must either develop the capacity to link disparate data sources (which is complicated and resource-intensive) or request specific data sets that match service costs to member/patient identifiers (which places an additional reporting burden on payers).

- **Data Validation and Completeness**

The validity of total cost measures relies on the integrity of the data used. States need to develop policies and processes for data validation that look at the completeness and consistency of the data. Claims data may not be readily available under alternative payment methodologies. Encounter data can be used as a substitute, but not all plans and provider organizations have the capacity to provide such data, and they need to be validated for comparability with regular claims data.

State-Federal Alignment and Support

Given the significant federal roles governing Medicaid and Medicare, CMS officials and individual states need to work together on initiatives to measure and control total cost for the entire population and health care system in a particular state.

States could include Medicaid enrollment and claims data as part of a total analysis of expenditures in order to calculate total cost measures for their own initiatives. However, CMS approval would be required for states to implement new models to control total cost growth rates as they could affect important Medicaid program features required by law, including potential impacts on mandated benefits, adequacy of provider and health plan rates, and quality and access measures. Several states—including Oregon—have opted to seek 1115 waiver authority to implement the waiver’s cap on Medicaid total cost increases, as this provides states with the most flexibility in Medicaid program design.

CMS has primary responsibility for the Medicare program, unlike Medicaid, which is overseen by both CMS and individual states; therefore, if states want to include Medicare in their total cost strategies, additional federal approvals will be needed. For example, states

need CMS approval to obtain Medicare data—CMS has streamlined the process for data relating to dual Medicare-Medicaid eligibles, but obtaining Medicare total cost data involves a separate approval process. Only one state—Maryland—has obtained federal approval for Medicare to participate in its all-payer hospital rate-setting system. CMS and states will need new operating rules to facilitate further state development of total cost models that include Medicare participation.

The SIM initiative has provided a new avenue for partnership between the state and federal governments, including policy support and resources for state total cost measurement initiatives. As specified in the grant requirements, these models must advance health care transformation and impact total cost of care for a large cross-section of a state's population. Therefore, a central property of a SIM initiative needs to address exactly how those broad results will be achieved. Three of the four states profiled in this report were selected in the first round of grants as “testing models,” which means they were ready for implementation. One state received a “design model” grant, which means it needed to complete additional work prior to implementation; that state has applied for the next round of funding for testing models.

Future Policy and Operational Issues

The states featured in this report have invested considerable resources and made significant progress to measure and regulate health care costs. At the same time, these states—and others that are following similar paths—face challenges in achieving their ultimate goals. Future policy and operational considerations include but are not limited to the following.

Leadership

This report highlights many of the challenges associated with health care transformation in general and with establishing measures and limits on health care costs in particular. It is essential to establish a political consensus, obtain buy-in from key stakeholders, and lay out a clear regulatory or legislative framework in order to successfully launch and sustain cost control measures. There is improved coordination among key state agencies in some instances, but the states generally have not changed the structure or authority of their existing agencies. Further consolidation of policy roles may be necessary to strengthen each state's position to establish, monitor, and enforce global cost measures and controls.

Getting to Total Cost Measures

In general, the states have focused on collecting and reporting data on expenditures (payer perspective) and/or revenues (provider perspective). Total cost is a more complicated concept and measurement challenge.

States have aspired to address all populations and all services in their cost measurement strategies, but there are obstacles relating to data and policy levers. Getting to total cost requires the capacity to link population demographics, service utilization, and claims across a variety of data sources—a process that is complex and costly.

In particular, the current methods of measuring cost do not capture the full spectrum of costs from a consumer perspective. There are some data on health plan cost sharing, but such data will not reflect costs for uninsured populations and many out-of-pocket services.

Different Uses for Cost Measurement

The states are evaluating several different periods of measurement—annual, quarterly, and real time—that will best suit different uses of the data. Massachusetts is focused on annual measures of cost trends, while Maryland is monitoring hospital revenues on a monthly basis to ensure compliance with its Medicare and total revenue caps.

Total cost measures and limits on cost growth have not been widely used as part of the insurance premium review and approval process. In fact, there is some question as to how to align explicit cost limits with the concept of actuarial soundness. Premium review and approval is a significant potential policy lever for total cost, so states need to develop new policies and methodologies to address these issues.

In addition, most states are focusing on new delivery and payment models for primary and acute care services, but they have not extended their policy solutions across the spectrum of behavioral health and long-term or post-acute care, which represent a significant portion of total cost on a statewide basis.

Gaps in Claims Data

States need to integrate Medicaid and Medicare claims data in their all-payer databases. By design, alternative payment models may bundle costs and services in different ways. States need to consider how to collect and evaluate these data in a consistent manner with other claims data. In addition, some states currently may not collect claims data or their equivalent from self-insured plans and payers, which may constitute a significant portion of a state's "insured" population. Changes in state laws and practices may be necessary to address this issue.

Standardizing Cost Models

Each state is developing a model for cost measurement, representing the early evolution of this field. As more states pursue these initiatives, it may be time to consider the need for a national set of standards. The use of standard models would facilitate broader comparisons of performance and reduce measurement burden; it would also support more robust methodologies for public reporting at a system or provider level.

Consumer Focus

The states have mainly concentrated on uses of the cost data by payers and providers, although a focus on consumer uses of this information remains a stated goal for the future.

Conclusion

Total cost of care measurement and controls have emerged as a central part of states' health care reform playbooks. Still, it is clear that this policy focus is new and will continue to evolve in conjunction with other components of the health care transformation process.

The states featured in this report have invested a lot of resources in data collection and analysis—the next steps will be connecting those findings to actions. Thus, it is essential for policymakers to understand that total cost of care measurement is not primarily a technical exercise, even though data collection and analysis are very important and require a commitment of resources to be done well.

Fundamental policy questions still need to be addressed: What is the unit of focus for measurement? How does it tie to a state's policy levers? What will states do with cost measurement information? How can states develop more robust "total cost" measures? Are the measures clearly linked to remediation or improvement actions? How often should cost measures be evaluated? How can states connect cost measures more directly to the consumer's experience? The policy pioneers featured in this report—and the states that are following close behind—will continue to create policy and technical capabilities to address these questions.

Resources

Maryland

Health Services Cost Review Commission Website:

<http://www.hscrc.state.md.us/>

Background on Maryland's All-Payer Waiver:

<http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>

<http://www.hscrc.state.md.us/hscrc-stakeholders.cfm>

Presentation on Total Cost of Care Models:

<http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/pay/2014-10-01/2-Total-Cost-of-Care-Update-to-Payment-Models-WG-09-30-14-v4.pdf>

Massachusetts

Authorizing Statute:

<https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>

Health Policy Commission (HPC) Webpage:

<http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/>

HPC 2014 Cost Trends Report:

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