A Public Comment on the Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team.

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I am in the healthcare policy and information technology (HIT) sector in Connecticut. I work with small startups and major corporations, hospitals, non-profits, and academic institutions (Yale & UConn Universities). I was part of the State Innovation Model (SIM) program in the Practice Transformation Task Force (PTTF) group and currently serve in the Consumer Advisory Council of the Connecticut State Office of Health Strategy. Please consider the following comments in the further development of the 'Healthcare Cost Growth Benchmark'.

Data Use Strategy

I will confine my comments in the Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team Report[2] to the 'Data Use Strategy – Preliminary Recommendations' section. The 'Data Use Strategy' is pivotal in managing the 'Healthcare Cost Growth' – from setting annual targets to analyzing Primary Care spending data. Its usage is also critical in addressing 'Health Equity' aspects in the healthcare system. The matter of data completeness (including REL data codification) and data quality are described in the HEDA Team report[3]. The new 'State Health Information Exchange (Connie)'[4] plans to bring disparate sources of data together[5]. This is known to be a difficult endeavor – given prior attempts and also the fact that data success is also a matter of organizational culture[6]. There are numerous organizations that are the data sources and need to be orchestrated by 'Connie'. This

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orchestration is no easy task as it calls for exceptional 'data sharing' and the eradication of 'data silos'[7].

All-Payer Claims Database (APCD)

There is an emphasis in the 'Data Use Strategy' for the use of the 'All-Payer Claims Database' (APCD)[8]. APCD databases accumulate data from public and private stakeholders and it includes data about pharmacy prescriptions, medical, dental, and insurance information. APCDs can be a beneficial tool to track spending trends and cost drivers[9]. However, it is constrained by legal barriers and the cooperation of the stakeholders within the healthcare system[10]. Such limitations may be addressed by (future) regulatory solutions. Other limitations may be structural and the procedures in how the APCD and other data are managed[11].

Few items to consider[12]:

- Representativeness – Insurance program coverage over time and how captured in the data sample.
- Undercounting and Misclassification – uniform use of the new ICD-10 codes across all data sources. In particular, the use of ICD-10 Z-codes and social determinants of health data[13]. However, more work is needed here and a description of how the 'Connie HIE' is to be used in this complex effort.
- Timeliness and Access – Addressing the time lag in data capture and aggregation. This is critical for the longitudinal analysis of data.

Analysis and Stratification

The use of stratification of data for analysis is stated under the 'Analyzing Primary Care Spending Data' section of the report[14] – *"The Technical Team highlighted the importance of*

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[7] What Managers Need to Know About Data Exchanges - MIT SMR 6/9/2020
https://sloanreview.mit.edu/article/what-managers-need-to-know-about-data-exchanges/
[8] Page 6 in #2 above
[9] Maximizing Use Of Claims Data To Address COVID-19: We Need To Revisit Gobeille v. Liberty Mutual - - Health Affairs 8/7/2020
https://www.healthaffairs.org/do/10.1377/hblog20200805.788636/full/
[10] Strategies for Health System Innovation After Gobeille v Liberty Mutual Insurance Company - JAMA Network 8/9/2016
https://jamanetwork.com/journals/jama/article-abstract/2532230
[11] Health Care Claims Data May Be Useful For COVID-19 Research Despite Significant Limitations - Health Affairs 10/6/2020
https://www.healthaffairs.org/do/10.1377/hblog20201001.977332/full/
[12] ibid
[13] Page 19 in #2 above – the footnote #11 on page 19 states the need for the ICD-10 Z codes and SDOH data.
[14] Page 17 in #2 above. 'Stratification' is also mentioned on Page 19 in #2 above.

stratifying primary care spending data to understand current spending trends and identify opportunities for improvement. The future analyses included stratifying by provider/ACO, race/ethnicity, gender, multiple comorbidities, modality (e.g., telehealth, in-person visits) and payment model (e.g., fee-for-service or alternative payment model)."

However, the process of such algorithmic stratification is not clear. The recent discovery of bias in a decision-making algorithm[15] has garnered interest in the medical press[16], including the State of New York regulatory body[17]. A more recent study found the need for corrections of algorithmic bias across clinical fields – from cardiology to urology[18]. Stratification algorithms need transparency, accountability, and 'explainability' to mitigate legal and ethical issues.

Thank you,

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[15] Dissecting racial bias in an algorithm used to manage the health of populations – SCIENCE - Oct 25, 2019
https://science.sciencemag.org/content/366/6464/447
[16] Discovery of racial bias in health care AI wins STAT Madness 'Editors' Pick' - STAT News 4/6/2020
https://www.statnews.com/2020/04/06/stat-madness-editors-pick-racial-bias-in-health-care-ai/
[17] Algorithmic Bias In Health Care: A Path Forward - Health Affairs 11/1/2019
https://www.healthaffairs.org/do/10.1377/hblog20191031.373615/full/
[18] Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms - NEJM 8/27/2020
https://www.nejm.org/doi/full/10.1056/NEJMms2004740