Nevada Health Care Cost Growth Benchmark Data Request Webinar

May 16, 2022

Agenda

- Overview of Nevada's Health Care Cost Growth Benchmark
- Detailed Review of Total Medical Expense Data Reporting Requirements
  - Explanation of Definitions and Data Collection Methodology
  - Walk-through of Data Submission Template
- Data Reporting, Collection and Validation Process
- Questions

Overview of Nevada's Health Care Cost Growth Benchmark Program

Nevada's Health Care Cost Growth Benchmark

- Nevada's health care cost growth benchmark is the **targeted annual per member growth rate for total health care spending in the state.**
- The benchmark values are based on a methodology that considers forecasted median wage and gross state product (GDP).

Calendar Year	Benchmark Values
2022	3.19%
2023	2.98%
2024	2.78%
2025	2.58%
2026	2.37%

Total Health Care Expenditures

Total Medical Expense (TME)

All incurred expenses for NV residents for all health care services, regardless of where the care was delivered and regardless of the situs of the member's plan.

+

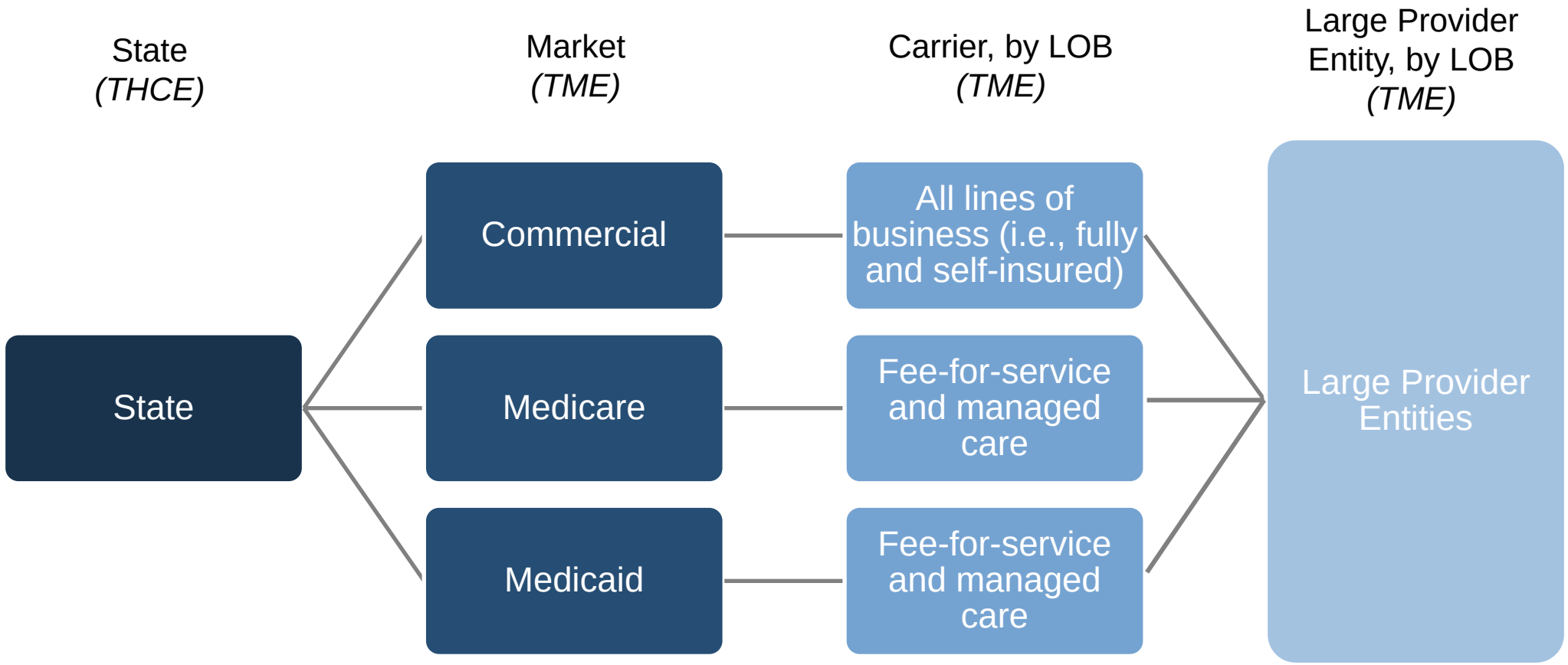
Net Cost of Private Health Insurance (NCPHI)

The **costs to NV residents associated with the administration of private health insurance.**

=

Total Healthcare Expenditures (THCE)

Four Levels of Reporting of Performance Against the Benchmark



Insurance Carriers Reporting Data to Assess Performance Against the Benchmark and Target

Insurer	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care
Aetna	X	X	
Anthem	X	X	X
Centene	X		X
Cigna	X		
Humana	X	X	
Molina Healthcare	X		X
Renown Health	X		
UnitedHealthcare	X	X	X

Total Medical Expense Data Reporting Requirements

Data Specification Manual

- The **Data Specification Manual** is a detailed document that includes:
  - Overview of the cost growth benchmark and how it will be reported
  - Brief description of how performance against the benchmark will be calculated
  - List of insurers that will be required to report, and the data they will be required to submit
  - Timeline and process for submitting data
  - Description of the data submission template, and specifications for how to calculate data elements
  - Definitions of key terms and a data dictionary for each tab in the data submission template

Data Submission Template

Reference Tables	Look-up tables for codes used in Tabs 2-5
1. Cover Page	Insurer identifying information and data attestation
2. TME	Total Medical Expenses for all of the Insurer's members by Insurance Category Code and Large Provider Entity
3. SD	Standard Deviations on per member per month claims spending by market for the insurer overall and for each Large Provider Entity
4. LOB_ENROLL	Insurer's member months by line of business
5. RX_REBATE	Pharmacy rebate data by line of business
6. Mandatory Questions	Data submission confirmation questions
Data Validation	Three tabs with summary tables intended to help insurers validate their data prior to submission

Data Submission Template – Reference Tables

- The data submission template uses various codes to categorize spending, including:
  - Insurance Category codes
  - Market codes
  - Line of Business codes
  - Large Provider Entity codes
  - Insurer codes
- The codes are listed in the Reference Tables tab of the data submission template.

Reference Tables

Data Submission Template – 1. Cover Page

- Contact information
  - Use the name of the individual who should be contacted with data validation questions.
- Attestation
  - Insurers are asked to attest that the information submitted in the template is current, complete, and accurate to the best of their knowledge.

1. Cover Page

Data Submission Template – 2. TME

- The TME tab is for Insurers to report Total Medical Expenses (TME), which the State will use to compute THCE and TME.
- Most of the spending data submitted by insurers will be entered into this tab.

2. TME

Data Submission Template – 2. TME (Cont'd)

- The State is asking Insurers to report on a list of 11 Large Provider Entities and for the Insurer Overall.

Large Provider Entity Code	Large Provider Entity Name*
100	Insurer Overall
101	Bacchus Wakefield Kahan PC
102	Community Care Services
103	First Person Care Clinic
104	Intermountain Healthcare
105	NEM Medical Center
106	Nevada Health Centers
107	Procare Medical Group
108	Robert B McBeath MD II PC
109	Southwest Medical Associates
110	St. Mary's Medical Group
111	UNLV Medicine
999	Members Not Attributed to a Large Provider Entity

*NOTE: The State may revise this list in future years of data collection

Data Submission Template – 2. TME (Cont'd)

- Reporting on Large Provider Entities and Attribution:
  - Insurers must attribute individual patients to a primary care provider, and attribute those primary care providers to a Large Provider Entity.
  - Insurers should use their own primary care attribution methodology to attribute patients to a primary care provider.
  - Primary care provider attribution to a Large Provider Entity should be performed consistent with Insurers' contract with the Large Provider Entity for financial and quality performance assessment purposes.
  - Payments associated with members who could not be attributed to a primary care provider, or whose primary care provider could not be attributed to a designated Large Provider Entity should be reported in aggregate to Large Provider Entity Code 999, Unattributed.

2. TME

Data Submission Template – 2. TME (Cont'd)

- Reporting TME by Insurance Category Code:
  - Insurance Category Codes are mutually exclusive categories that indicate for which business the Insurer is reporting data
  - Commercial has two categories:
    - Full claims – for when the carrier holds the entire medical benefit and has all of the data.
    - Partial claims – for when the carrier holds part of the benefit, and another part is carved out (e.g., pharmacy or behavioral health). Carriers must estimate partial claims data for which it does not have access.

Insurance Category Code	Description
1	Medicare Expenses for Non-Dual Eligible Members
2	Medicaid Expenses for Non-Dual Eligible Members
3	Commercial: Full Claims
4	Commercial: Partial Claims
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible

2. TME

Data Submission Template – 2. TME (Cont'd)

Required Policies	Excluded Policies
Commercial: ✓ self-insured plans ✓ short-term health plans ✓ student health plans ✓ sully insured individual and group plans ✓ Nevada Public Employees' Benefits Program (PEBP) ✓ Federal Employee Health Benefits Program (FEHB) **Medicare:** ✓ Medicare Advantage Health Maintenance Organization (HMO) ✓ Preferred Provider Organization (PPO) ✓ HMO Point of Service ✓ Medicare Medical Savings Account (MSA) ✓ Private Fee-for-Service (PFFS) ✓ Special Needs Plans (SNPs) **Medicaid**: ✓ Medicaid and CHIP contracts with Nevada DHHS	× accident policy × disability policy × hospital indemnity policy × long-term care insurance × Medicare supplemental insurance (AKA Medigap) × stand-alone prescription drug plans × specific disease policy × stop-loss plans × supplemental insurance that pays deductibles, copays, or coinsurance × vision-only insurance × workers compensation × dental-only insurance

2. TME

Data Submission Template – 2. TME (Cont'd)

- General Parameters for Submitting TME
  - Include spending **by or on behalf of Nevada residents** regardless of where care was delivered and the situs of the residents' plan.
  - Report **allowed amounts** (i.e., amounts paid by the insurer and member cost-sharing) for claims based on **date incurred**.
  - Only report spending on claims for which the Insurer was the **primary payer.**
  - Allow for a **claims run-out period** and a **non-claims reconciliation period** of at least **180 days** after December 31 of the performance year.
    - Apply reasonable and appropriate incurred but not reported (IBNR) / incurred but not paid (IBNP) completion factors to each respective TME service category.
    - Apply reasonable and appropriate estimates of non-claims liability that are expected to be reconciled after the 180-day period.

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Claims-Based Spending to Report
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional, Primary Care Providers*
  - Professional, Specialty Providers
  - Professional, Other Providers
  - Long-Term Care
  - Retail Pharmacy
  - Other

**The "Professional, primary care" category has a code-level definition in the Data Specification Manual.*

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Claims-Based Spending to Report
  - **Hospital Inpatient:** The TME paid to hospitals for inpatient services generated from claims. Include all room and board and ancillary payments. Include all hospital types. Include payments for emergency room services when the member is admitted to the hospital, in accordance with the specific Insurer's payment rules. Do not include payments made for observation services. Do not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Do not include inpatient services at non-hospital facilities.
  - **Hospital Outpatient:** The TME paid to hospitals for outpatient services generated from claims. Include all hospital types and includes payments made for hospital-licensed satellite clinics. Include emergency room services not resulting in admittance. Include observation services. Do not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Claims-Based Spending to Report
  - **Professional, Primary Care Providers:** The TME paid to primary care providers delivering care at a primary care site of care generated from claims using the code-level definition in the Data Specification Manual. *This definition excludes OB/GYN.*
  - **Professional, Specialty Providers:** The TME paid to physicians or physician group practices generated from claims, including services provided by a doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition.
  - **Professional, Other Providers:** The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and is not identified as primary care in the first primary care definition.

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Claims-Based Spending to Report
  - **Long-Term Care:** All TME data from claims to providers for nursing homes and skilled nursing facilities, intermediate care and assisted living facilities, and providers of home- and community-based services, including personal care, homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community.
  - **Retail Pharmacy:** The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the Insurer's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the Insurer's medical benefit. Pharmacy payments made under the medical benefit should be attributed to the setting in which it was delivered. Pharmacy data should be reported gross of applicable rebates.

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Claims-Based Spending to Report
  - **Other:** All TME paid from claims to health care providers for medical services not otherwise included in other categories, including durable medical equipment, facility fees of community health services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services.

Data Submission Template – 2. TME (Cont'd)

- Categories of Non-Claims Based Spending to Report
  - Capitation or Bundled Payments
  - Performance Incentive Payments
  - Population Health and Practice Infrastructure Payments
  - Provider Salaries
  - Recovery
  - Other
  - Total Primary Care Non-Claims Based Payments*

**The "Total Primary Care Non-Claims Payments" category is the only category that is not mutually exclusive from the others*

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Non-Claims Based Spending to Report
  - **Capitation or Bundled Payments**: All non-claims-based payments for services delivered under the following payment arrangements: (1) capitation payments; (2) global budget payments; (3) case rate payments (4) prospective episode-based payments.
  - **Performance Incentive Payments**: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Include pay-for-performance, for quality or efficiency metrics, and pay-for-reporting. Include shared savings distributions and shared risk recoupments.
  - **Population Health and Practice Infrastructure Payments:** All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs.

2. TME

Data Submission Template – 2. TME (Cont'd)

- Categories of Non-Claims Based Spending to Report
  - **Provider Salaries**: All payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories.
  - **Recovery**: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigations. This field should be reported as a negative number.
  - **Other**: All other payments made pursuant to the carrier's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere.
  - **Total Primary Care Non-Claims Based Payments**: All non-claims-based payments included in the above six categories that are specifically made to a primary care provider or provider organization. Payments in this category should be a sub-set of payments reported in the other non-claims categories.

Data Submission Template – 2. TME (Cont'd)

- Truncation
  - In the TME tab, Insurers will also submit truncated claims spending and the count of members with claims truncated, using truncation points set for each market.

Insurance Category Code	Description	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$100,000
3	Commercial: Full Claims	$175,000
4	Commercial: Partial Claims	$175,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$100,000

2. TME

Data Submission Template – 2. TME (Cont'd)

- How to Apply Truncation
  - Truncation should be applied to individuals' total spending, inclusive of all medical and pharmacy spending.
  - For Insurers reporting Insurance Category Code 4 (Commercial: Partial Claims), the member-level truncation should be applied after estimates of carve-out spending have been made.
  - For members who are attributed to more than one Large Provider Entity during the year, Insurers should "reset the clock" and calculate truncated spending for the member for each of the Large Provider Entities, and for the Insurer as a whole.

2. TME

Data Submission Template – 3. SD

- The Standard Deviation tab collects data that will be used to conduct statistical testing to assess Insurer and Large Provider Entity performance against the cost growth benchmark
- Insurers should calculate and submit standard deviation data:
  - For each Large Provider Entity, by market
  - For the Insurer, by market

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

3. SD

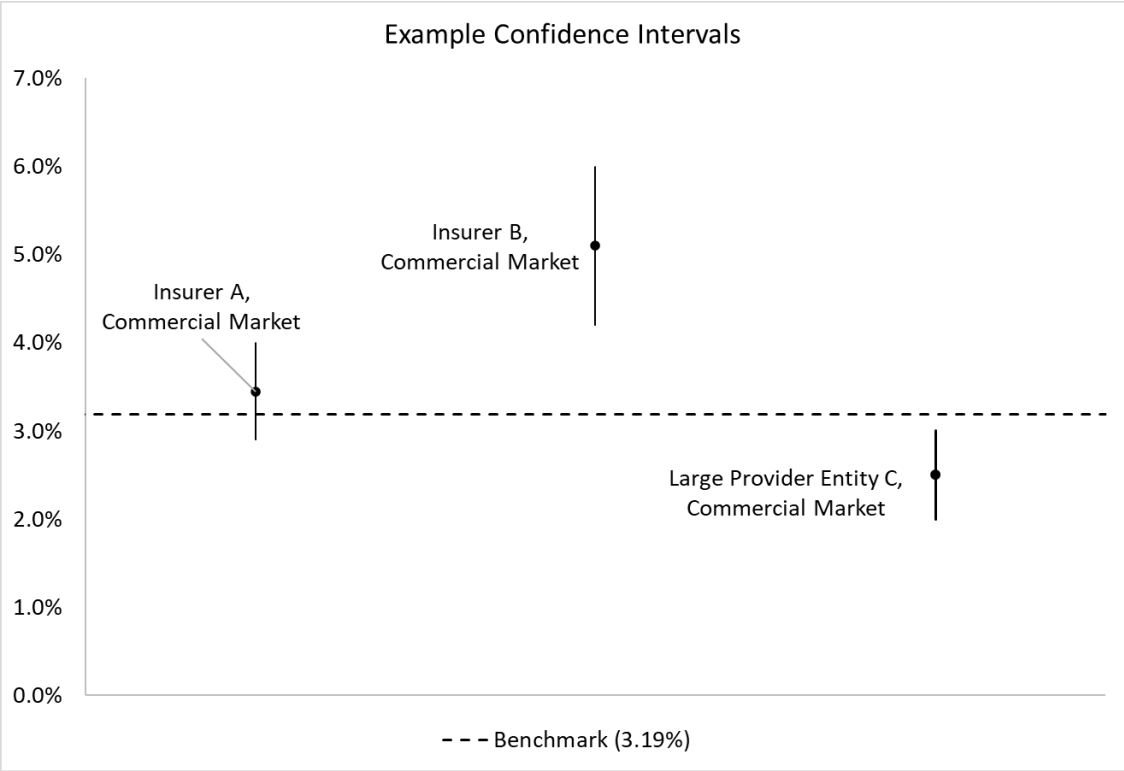
Data Submission Template – 3. SD (Cont'd)

- Calculating Standard Deviation
  - Insurers should include all members attributed to a Large Provider Entity, including members with no utilization.
  - Standard deviation should be based on per-member-per-month (PMPM) spending.
  - Insurers should calculate the standard deviation PMPM after partial claims adjustments.
  - Non-claims expenditures should be excluded from the calculation.

3. SD

Data Submission Template – 3. SD (Cont'd)

- How the State will use confidence intervals to determine performance against the benchmark



- **Unable to determine** performance when upper or lower bound intersects the benchmark (e.g., Insurer A)
- **Benchmark is not met** when lower bound is fully over the benchmark (e.g., Insurer B)
- **Benchmark is met** when the upper bound is fully below the benchmark (e.g., Large Provider Entity C)

3. SD

Data Submission Template – 4. LOB_ENROLL

- The Line of Business Enrollment tab collects member months information so the State can compute NCPHI;
  - Member months by Line of Business category (see table below)
  - **Note:** Total member months should match across 1. TME tab and 4. LOB_ENROLL tab (see Data Validation tab to confirm)

Line of Business Categories	Description
1	Large group (51 + employees), fully insured
2	Small group (2-50 employees), fully insured
3	Self-insured
4	Individual (buy coverage on their own)
5	Student plans
6	Medicare Advantage for Non-Dual Eligible Members
7	Medicaid Managed Care for Non-Dual Eligible Members
8	Medicare Dual Eligible Members
9	Medicaid Dual Eligible Members

4. LOB_ENROLL

Data Submission Template – 5. RX_REBATE

- The Pharmacy Rebate tab is for Insurers to report pharmacy rebates by Insurance Category Code.
  - Insurers should not try to allocate pharmacy rebates at the member or Large Provider Entity level.
- Insurers should report both **retail pharmacy** rebates and **medical pharmacy** rebates.
  - Data should include PBM rebate guarantee amounts or other PBM rebates transferred to carriers.
  - Insurers should apply IBNR factors to preliminary drug rebate data.
- Pharmacy rebates should be reported as a **negative number**.

5. RX_REBATE

Data Submission Template – 6. Mandatory Questions

- The Mandatory Questions tab asks the Insurer to answer a series of questions to confirm that their data submission follows the specifications.
- This tab also includes space for Insurers with self-insured lines of business to provide income from fees of uninsured plans (in aggregate).
  - This information is used to calculate the Net Cost of Private Health Insurance (NCPHI).
  - Insurers must follow the instructions from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE), Part 1, Line 12, Income from Fees of Uninsured Plans.

6. Mandatory Questions

Data Submission Template – Data Validation Tabs

- There are three Data Validation tabs at the end of the data submission template:
  1. **Data Validation Checks** – a series of checks for inconsistencies in the data
  2. **Validation by Market** – PMPM spending on service categories by market
  3. **Validation by Provider Tab** – PMPM spending on service categories by Large Provider Entity by market
- Insurers are asked to review these tabs after inputting data and prior to data submission to ensure data are correct and reasonable.

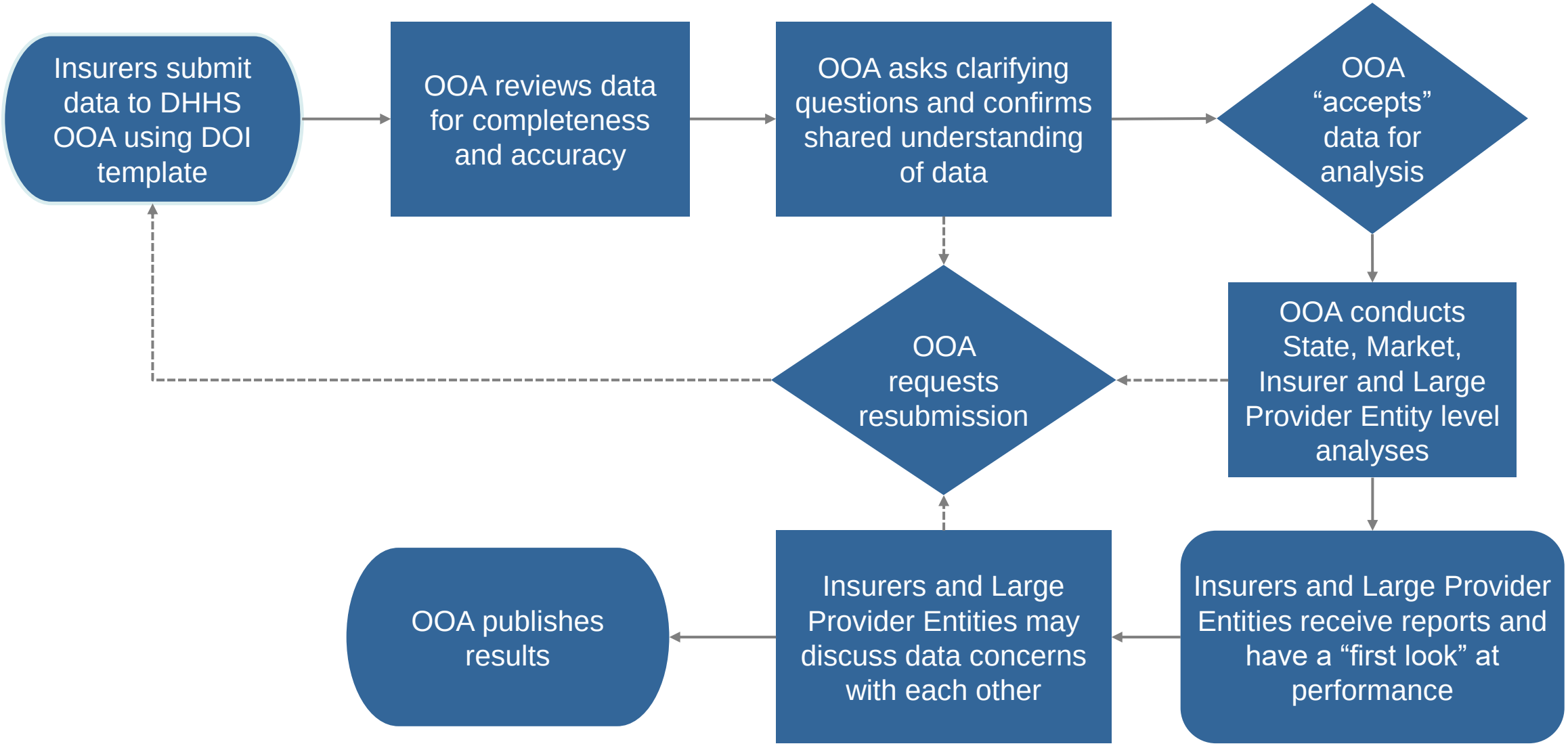
Data Validation

Data Reporting, Collection and Validation Process

Due Date for Data Submission

- For the first round of data collection, the State is collecting 2018, 2019, 2020, and 2021 pre-benchmark data
- Data are due to the State by **August 30th, 2022**
- Electronic files are to be submitted to the DHHS OOA.
  - To set up secure file sharing, please send a request via email to data@dhhs.nv.gov and CC Kyra Morgan, State Biostatistician, at kmorgan@health.nv.gov.

Data Reporting, Validation and Collection Process



Contacts for Questions

- For technical questions, please contact:
  - Melissa Madera (mmadera@dhcfp.nv.gov)