Subcommittee: Stakeholder Advisory Committee to the Patient Protection Commission for the Peterson Milbank Program for Sustainable Health Care Costs

SUMMARY MINUTES

January 28, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order and Approval of October 1, 2021, Summary Minutes

Executive Assistant, Lezlie Mayville, called the Stakeholder Advisory Subcommittee meeting to order at 9:05 a.m. Those in attendance and constituting a quorum were:

Stakeholder Advisory Sub-Committee Members Present

Angela Amar
Chris Bosse
Tom Clark
Vance Farrow
Joseph Greenway
Joan Hall
Maya Holmes
Lawrence Lehrner
Asher Lisec
Karen Massey
Tom McCoy
Kyra Morgan
Stacie Sasso
Bill Welch

Commission Staff Present:
Deputy Attorney General Susanne Sliwa
Lezlie Mayville, Executive Assistant

Absent:

Karla Bee, excused
Elizabeth Bolhouse, excused
Phil Burrell, excused

Jody Domineck, excused
Todd Sklamberg, excused
Jennifer Wakem, excused

MOTION was made to approve minutes of the October 1, 2021, meeting by Stacie Sasso and seconded by Tom Clark. Carried without dissent.

Agenda Item II - Public Comment

No public comment

Agenda Item III - Review of Executive Order
Michael Bailit, M.B.A., President of Bailit Health

Mr. Bailit gave a brief review of Governor Sisolak's December 29, 2021, Executive Order establishing cost growth benchmarks for 2022-2026. He also gave a recap of the last Stakeholder Advisory Group and PPC meetings. There were no comments or questions from the subcommittee members.

Agenda Item IV - Discussion of Methodological Questions Related to Measurement of Cost Growth Benchmark (Target) Performance
Michael Bailit, M.B.A., President of Bailit Health

Slide 23-Member Attribution to Clinicians. Mr. Bailit shared what the PPC tentatively recommended for member attribution to physicians which was: Agreement on allowing insurers to use their own attribution methodologies and asking each insurer to disclose that methodology. The PPC also recommended performing an analysis in the future to see whether the differences in methodologies are substantive enough to warrant a common methodology. Comments included agreement in allowing insurers to use their own methodology because it would slow down the process too much if we required standardization, another agreed with looking at it as it evolves, another asked if would be required of insurers to disclose their methodology or just ask. Mr. Bailit answered the PPC's recommendation should require them to disclose their attributions methodology, but it will be up to the state whether they do that.

Slide 29-How to Organize Clinicians into Large Provider Entities: Mr. Bailit let them know the PPC supported the creation and use of a statewide provider directory to attribute clinicians to large provider entities, if feasible. The Nevada Department of Health and Human Services (DHHS) agreed to evaluate the feasibility of this option. The fallback option would be to rely on payers for this information. A member stated, it could take a long time to build an accurate State Directory and if you went by payers based on providers they're contracted with, how do you avoid duplicity, so providers aren't picked up multiple times. Mr. Bailit explained it's unlikely we're going to get duplicate reporting for the same primary care providers for different groups because payers need to know which providers are part of which group. Another wanted to know which one was easier for patients to access or more patient-centered. Mr. Bailit didn't think either was more patientcentered as patients wouldn't be aware because this is about connecting primary care providers to provider organizations. Another asked about new primary care centers that focus on being independent wouldn't necessarily be included or leaving one system for another. Working off contract arrangements would be more dynamic.

Slide 38-Use of Confidence Intervals-Mr. Bailit shared the PPC recommended applying statistical testing and the use of confidence intervals to determine payer and provider entity benchmark performance. Those that commented suggested it would be easy to include confidence intervals and did not see a downside, one subcommittee member asked if anybody ever tried to take top and bottom one percent to narrow and Mr. Bailit said they'd talk about addressing outliers but would narrow confidence intervals.

Slide 43-Truncation of High-Cost Outliers. Mr. Bailit shared the PPC leaned toward supporting truncation of high-cost outliers' spending and recommending an analysis of outliers' spending to identify its causes and opportunities to slow spending growth but did not come to closure. Those that commented included agreement with PPC recommendation, with a couple of questions. One being they would want to understand quantifying the dollar amount to truncate, another felt it was important for the public to feel there wasn't something in place to limit their care. Mr. Bailit will suggest engaging payer and provider organizations to talk about what makes sense and can share what the values are that were adopted in other states. This slide is where the PPC ended during their meeting.

Slide 54-How to Risk Adjust Data, out of the three options. The first question was since the Office of Analytics will only be getting aggregate data, how would this work? Mr. Bailit answered in Massachusetts and Rhode Island, they have historically had insurers submit risk scores using whatever risk grouper software they're using. In answer of how to Risk Adjust Data- There was quite a variation in views, which included, comments such as: Risk Adjustment method took place right around the time the ACA started, which required risk adjustment for commercial payers. This member wonders if it has since stabilized, another commented providers are challenged every day to document why they do what they do also if patients are attributed back to primary care physicians, not all are the same (some focus on substance abuse, behavioral health, etc.) Not sure you can capture just from age/sex, so thinks #1 because it is what it is. Another has seen documentation grow over last 5-6 years but does not include clinical care. He thinks age/sex captures some risk adjustment and may eliminate incentives to bloat clinical record. Another asked why other states have limited it to just age/sex since we've learned there are health disparities and disproportionate impact certain diseases have on brown/black communities. Mr. Bailit answered among other things we're not at a point where we can make adjustments based on race and ethnicity and do so in a manner where we don't think we would be doing more harm than good. A data use strategy can be used to better understand and when Nevada has the APCD up, it will be able to do more. Mr. Bailit said Option #3 would be easiest, no adjustment. #1 you could ask insurers to normalize when they submit it, so not a tremendous amount of work, #2 would be a little more work depending on how you do it. Other commenters supported #2, another #1 and a couple were still evaluating.

Slide 59-Reporting for Sufficient Population Sizes-Minimum Population Sizes-Do they support requiring reporting by all Medicaid managed care organizations and by commercial and Medicare Advantage carriers with market share of 5% or higher or defer a recommendation on provider entity population thresholds until OR and CT have completed their pre-benchmark analyses. Nobody suggested deferring a recommendation until OR and CT have completed their pre-benchmark process, but some comments/questions included a lot of people with self-insured plans are not included, Nevada could be somewhat different on proportion of services through self-insured such as Aetna who offers services to state employees, Aetna is a TPA, they're not actually paying claims, we have United and Anthem and it's worth considering adding Aetna and Cigna (these are the big four insurers) assuming they have a lot of TPA business, even if it's just to see the attributed lives. If it's too small, we don't need to ask them again.

Slide 61-66 Next Steps, The Logic Model for a Cost Growth Benchmark, Timeline for Benchmark Analysis, Timeline for Cost Driver Analysis, Timeline for Policy Initiatives, PPC Future Meetings and Advisory Subcommittee Future Meetings were briefly discussed. There was no further discussion, just thanks and appreciate switching meetings so Advisory Group meeting before PPC reviews topics.

Agenda Item V - Public Comment

No public Comment

Agenda item VI - Wrap-up and Adjournment

Executive Assistant Lezlie Mayville adjourned the Meeting at 10:50 am.

Respectfully submitted,

Lezlie Mayville

Lezlie Mayville
Office of the Patient Protection Commission

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
III. & IV.	Michael Bailit, President, Bailit Health	Review of Executive Order and Presentation of Cost Growth Benchmark Performance Assessment