5
Patient Protection Commission (PPC)
Bill Draft Request (BDR) Proposals for 2023 Session – Ongoing Discussion

Updated 8.15.22

Note: Questions posed to agencies/entities included to:

- DHHS, Division of Health Care Financing and Policy (DHCFP)
- DHHS, Division of Public and Behavioral Health (DPBH)
- DHHS, Division of Child and Family Services (DCFS)
- DHHS, Division of Welfare and Supportive Services (DWSS)
- DHHS, Aging and Disability Services (ADSD)
- Silver State Health Insurance Exchange (SSHIX)
- Public Employees' Benefits Program (PEBP)
- Nevada Deputy Attorney General (DAG)

Subject 1: Improve Health Care Access

PPC Goal: Researching possible changes to state or local policy in this State that may improve the quality, accessibility or affordability of health care in this State – Increasing access to health care for uninsured populations in this State, including, without limitation, retirees and children. - NRS 439.916.1(i)(7).

Subject 1, Topic 1 (*Leanne McAllister, Yarleny Roa-Dugan, Tyler Winkler*)**:**

Explore opportunities to provide basic health care coverage to infants, children and young adults up to age 26 who are ineligible for full Medicaid coverage under federal law due to their current residency or immigration status. This includes hiring an expert vendor to develop recommendations to the PPC on options to achieve this goal with non-federal, available revenue sources, including braiding local government, private grant, philanthropic, and/or state resources to support this effort.

Among the options considered by the vendor shall include a limited, state-funded Medicaid benefit for this population, similar to California's recent effort to cover this population that leverages limited federal Medicaid funds available to this population for emergency services as part of this benefit. The vendor shall also be asked to conduct a return-on-investment study of at least two options selected by the PPC to inform future proposals and budget requests as they relate to addressing the growth in health care costs related to the health status of this population.

The PPC must procure a vendor to complete the analysis at no greater than $200,000.

Subject 1, <u>Topic 1</u> Follow-Up from 7-20-22 PPC Meeting:

Questions Posed:	**Answers Provided:**
Has your Division submitted any budget items that are similar or could relate to this topic? *If yes, please explain.*	• Nothing in DHCFP's proposed budget to address this. Administrator notes in the description above this should be described as a "state funded health care benefit" because federal Medicaid dollars are not available for this population, so it would not be a "Medicaid" benefit. Medicaid funding could be used as it is today to pay for emergency Medicaid only services for this population. DHCFP would be happy to provide information and assist with the study, as needed. • DCFS does not have anything specific to this population. Hired an actuary to review foster rates since they have not been reviewed since 2008. DCFS will be requesting an increase. • N/A to PEBP, must be an employee/retiree/dependent to qualify for PEBP coverage. • DWSS, DPBH, ADSD, SSHIX = No.

Are you currently carrying out an activity that provides basic health care coverage to infants, children and young adults up to age 26 who are ineligible for full Medicaid coverage due to their current residency or immigration status? *If so, please describe the program.* *If not, are you aware of any current initiatives to do this?* *If the State of Nevada were to implement a law requiring this coverage, are their consequences to any of the other programs you currently administer?*	• SSHIX - NOT CURRENTLY CARRYING OUT; NO CURRENT INITIATIVES TO OFFER A BASIC HEALTH PROGRAM (BHP) ON THE EXCHANGE; AND NO CONSEQUENCES PROGRAM IS IMPLEMENTED (AND DEPENDING ON FEDERAL POVERTY LEVELS THAT THE BASIC HEALTH CARE COVERAGE WOULD APPLY TO) - THERE COULD BE CONSEQUENCES TO ACA QUALIFIED HEALTH PLANS CURRENTLY SOLD ON THE EXCHANGE IN TERMS OF REDUCED ENROLLMENT DUE TO COMPETITION. INFORMATION ON MINNESOTA'S BHP (MINNESOTACARE) CAN BE FOUND HERE: https://www.lrl.mn.gov/docs/2021/other/210956.pdf • DCFS, DWSS, DPBH, ADSD =NO
Are there components (in whole or in part) of this topic that may be carried out without a legislative BDR? *If so, please highlight components and provide reasoning or current process how this could be completed/implemented without legislation.*	**DAG:** Does the PPC have the funds designated to hire the expert? Where will the funds be coming from? Unless the PPC will be trying to amend a statute to allow the PPC to hire the vendor, use funds, etc. I think the PPC could hire the vendor without a BDR. **PPC ED Response:** While the PPC could hire the vendor without a BDR, the PPC does not currently have funding to hire the expert. The BDR is needed to allow/provide for the funding of this study. The DHHS PPC could be the responsible agency charged to complete this study, in which case DHHS PPC would assign a fiscal note of up to $200,000 as noted in this proposed BDR topic.

Subject 1, Topic 1 Documentation and Analysis:

Updated information as of 6/21/22:

Regarding national statistics per a recent affinity group announcement through State Health and Value Strategies, immigrants (including "lawfully present" and undocumented individuals) make up 23 percent of uninsured people nationally, and those who have coverage experience high rates of churn. Regarding Nevada's uninsured population, please see the underlying Guinn report, available here.

Medicaid Coverage & Waivers

Sections 1115 and 1915(b) of Title XIX of the Social Security Act provide an avenue for states to seek federal waivers of Medicaid requirements. However, these waivers do not allow states to waive the prohibition on federal Medicaid funds being used by states to cover ineligible immigrants (e.g., undocumented residents and lawful immigrants who have not met the 5-year residency rule for coverage). See Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and sections 1115 and 1915(b) of the Social Security Act.

Federal law does provide for an exception to this general prohibition with respect to emergency services. States can use federal Medicaid dollars to help pay for treatment of emergency medical conditions if the individual meets all other Medicaid eligibility rules in the state (e.g., income and state

residency) but does not have an eligible immigration status or proper documentation. States may also choose to take up an option to cover pregnant women during pregnancy regardless of their immigration status. Nevada recently took up this option during the last legislative session.

Several states have been exploring options for addressing the gap in coverage for this immigrant population with non-federal funds. For example, California recently established a new slimmed down package of basic health care services, which includes preventative, primary care, behavioral health, and emergency care, under its Medi-Cal program (Medicaid), for young adults (19-25) regardless of immigration status. According to state officials, the state is braiding federal Medicaid funds for emergency services with state dollars to cover this new benefit. To ensure federal compliance, the state must ensure no federal funds are used to cover the other non-emergency portions of this new benefit. Early estimates for this new benefit for young adults had a state price tag of $98 million, with the offset of the federal Medicaid share of emergency services making up only $24 million of this total.

Nevada could consider a similar approach and establish a non-federally funded Medicaid benefit for this population for young adults. Unless other private or local resources are included, this benefit would need to be fully state funded. The fiscal impact of a new state-funded benefit is unknown at this time.

Exchange Plans & 1332 Waivers

With respect to the exchange, certain individuals are ineligible to shop for qualified health plans and cannot receive federal advanced premium tax credits (APTCs) due to their immigration status. It is largely unknown and debatable, at this time, whether the federal government would approve a 1332 waiver of the Affordable Care Act to waive the federal restrictions on eligibility that are based on immigration status. (See 45 CFR 155.305.) However, Washington recently submitted a 1332 Waiver to the federal government for approval of such a waiver and expects an answer to this request by September of this year.

If approved, the 1332 waiver will provide access to federally *non-subsidized* health and dental coverage (i.e., qualified health plans) that are available through Washington's state exchange to all Washington residents, *regardless of immigration status*, starting in plan year 2024. The key phrase here is non-subsidized. If approved, undocumented immigrants could apply for qualified health plan coverage on the Washington Exchange, but advanced premium tax credits would not be applied to reduce the cost of this coverage.

The Centers for Medicare and Medicaid Services (CMS) also recently approved a 1332 waiver from Colorado, which includes, among other items, permission for the state to use new federal pass-through funds from the establishment of standardized health plans to support state-based subsidies to improve the affordability of health insurance in the state. Those eligible for the state-based subsidies include those who are eligible for federal APTCs through the exchanges as well as Coloradans without proper immigration documentation.

Subject 2: Increase Transparency and Address Patient Affordability

PPC Goal: Examine the cost of health care and primary factors impacting those costs. - NRS439.916(c).

Subject 2, Topic 1 (*Sandra Ruybalid, Bobbette Bond, Lilnetra Grady*)**:**

Codify the Nevada Health Care Cost Growth Benchmark Program as set forth in Executive Order 2021-29, and include a requirement to measure and report on primary care spending.

Subject 2, Topic 1 Follow-Up from 7-20-22 PPC Meeting:

Questions Posed:	Answers Provided:
Has your Division submitted any budget items that are similar or could relate to this topic? *If yes, please explain.*	• DHCFP is proposing a few FTEs within the Office of Analytics (OOA) to support this work. • DHHS PPC is proposing two new FTEs to support and sustain this work. • DCFS, PEBP, DWSS, DPBH, ADSD, SSHIX = No.
Are you currently carrying out an activity that monitors or reports on health care spending growth across all public and private payers and populations in Nevada? *If so, please describe the program.* *If not, are you aware of any current initiatives to do this?* *If the State of Nevada were to implement a law requiring health care spending monitoring and reporting, are their consequences to any of the other programs you currently administer?*	• PEBP does not have concerns regarding the implementation of a law requiring monitoring and reporting of health care spend. The data is necessary in order to better understand healthcare spending. However, codifying actual benchmarks may be problematic for PEBP, especially given the provider shortages that exist. For example, PEBP has directed the network to contract with more mental health (MH) providers, even if it means negotiating much higher reimbursement rates. MH services are in high demand while providers are in short supply, especially in the North and rurals. PEBP expects to pay more for services such as MH that are in extremely short supply. It is important to note that other states implementing these cost growth benchmarks are not experiencing provider shortages like the situation in Nevada: https://www.beckershospitalreview.com/workforce/this-state-has-the-most-physicians-per-capita.html • DCFS, DWSS, DPBH, ADSD, SSHIX = No.

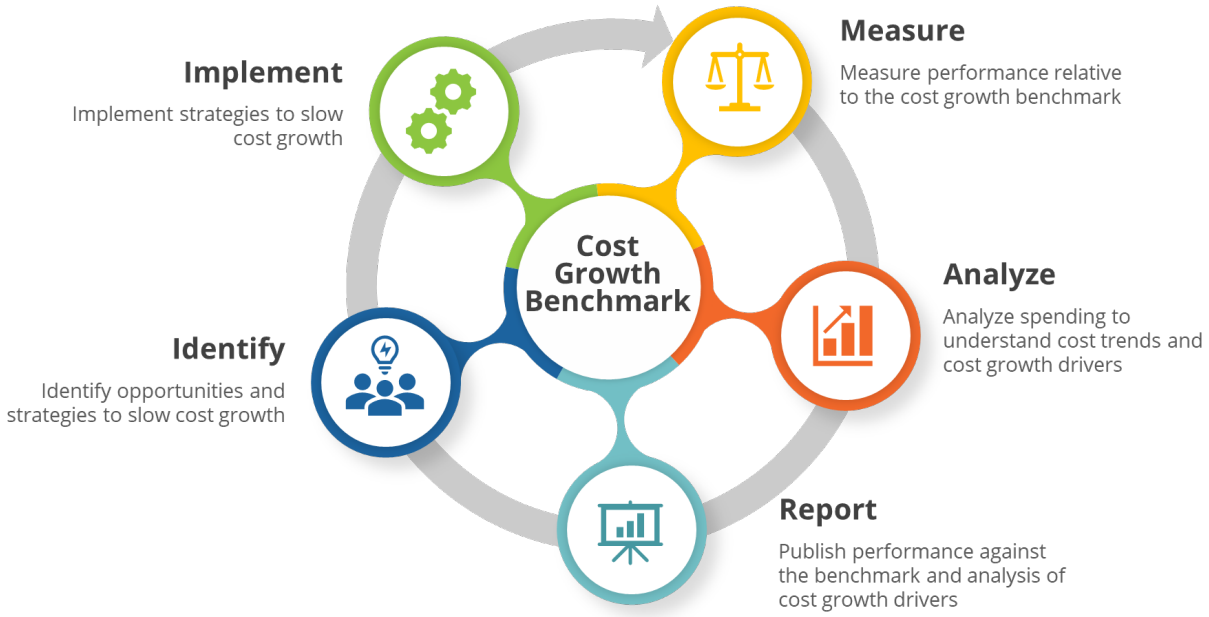
Are there components (in whole or in part) of this topic that may be carried out without a legislative BDR? *If so, please highlight components and provide reasoning or current process how this could be completed/implemented without legislation.*	**DAG:** If the PPC wants to codify the Program in statute, this must be accomplished through the BDR process. I did not see any authority in NRS 439.902-439.918 that allows the PPC to adopt regulations.

Subject 2, Topic 1 Documentation and Analysis:

Health care affordability is a pressing problem for Nevadans. Health care spending growth has been exceeding wage growth, meaning health care spending every year takes a larger chunk out of household income. According to the 2022 Commonwealth Fund State Scorecard, Nevada ranked 46th in the U.S. in 2020 for employee total potential out-of-pocket medical costs as a share of state median income. The state also ranked 39th for the

Executive Order 2021-29 established the Nevada Health Care Cost Growth Benchmark. As noted in the press release on 12/29/21, the executive order sets a benchmark for how much the cost of health care services should grow in a year. It also charges health care payors, namely insurance companies, and healthcare providers to work together to meet these goals. The State is taking a phased in-approach to allow for more collaboration between stakeholders. The Health Care Cost Growth Benchmark is the first step toward making health care more affordable and transparent.

As visually portrayed in the graphic that follows below, the Cost Growth Benchmark strategy has multiple components. The first two involve measurement of spending, including assessment of performance against the benchmark and deep analysis of claims data to understand what is causing spending to grow. The next component is public reporting and discussion of findings. This transparency is intended to promote understanding and accountability. The last two components involve identification of the leading cost and cost growth drivers, and adoption of strategies to mitigate future cost growth.



The State has made major strides toward implementing the Health Care Cost Growth Benchmark strategy.

First, with guidance from Bailit Health, the Department of Health and Human Services Office of Analytics (OOA) and the Public Employees' Benefits Program (PEBP) have each completed and released a five-year cost driver analysis report for Nevada Medicaid and PEBP. This report includes a drill down of the 10 (out of 11) standard Phase 1 analyses as recommended by the Peterson-Milbank Program. OOA and PEBP are currently working on the Phase 2 reports which will include a drill down into service category spend focusing primarily on price and utilization for professional and primary care, in-patient hospital, out-patient hospital, emergency department utilization, and pharmacy. The information was presented to the PPC in April 2022.

Second, on May 16, 2022, Bailit Health hosted a baseline data request informational webinar for all Nevada insurers to provide an overview, data specification manual, and technical assistance with the baseline data request and analyses. Payers were requested to report data in August 2022 for commercial, Medicaid, and Medicare. OOA staff will analyze the submissions and report findings to the PPC and the public in the first quarter of 2023.

Third, the PPC has received a presentation on cost growth mitigation strategies being pursued in other cost growth benchmark states. Considering that information and the April cost growth driver analyses using Medicaid and PEBP data, the PPC will consider cost growth mitigation strategies for recommendation later in 2022.

It is now necessary to commit to a long-term effort to address health care affordability for Nevadans by making the Nevada Health Care Cost Growth Benchmark program permanent. While the passage of AB348 during the 2021 Session designated the PPC as the "sole state agency responsible for

administering and coordinating matters relating to the participation of this State in the Peterson-Milbank Program for Sustainable Health Care Costs", legislation would ensure long-term engagement by the PPC and the Department of Health and Human Services in the Health Care Cost Growth Benchmark program. In so doing, Nevada would join California, Connecticut, Delaware, Massachusetts, Oregon and Washington as states with cost growth benchmark programs in statute.

To augment the Health Care Cost Growth Benchmark, Nevada should strengthen its primary care infrastructure. Nevada current ranks very poorly among states for some key measures of primary care, including 47th for diabetic adults without a hemoglobin A1c test and 50th for children without a medical home (2022 Commonwealth Fund State Scorecard). While there are many possible steps to improve primary care within the state, one is to ensure that there is adequate investment in primary care. To date, six states have set primary care investment targets (CO, CT, DE, OR, RI and WA), while others are measuring or have committed to measure primary care spending relative to total medical spend. Nevada should take a first step to address a pressing problem with profound consequences for the health of Nevadans by measuring and reporting on primary care spending relative to a primary care investment target that would be applied to commercial fully insured spending and Medicaid managed care spending.

PPC Goal: Researching possible changes to state or local policy in this State that may improve the quality, accessibility or affordability of health care in this State – Increasing transparency concerning the cost or provision of health care [NRS 439.916.1(i)(2)].

Subject 2, Topic 3 *(Bobbette Bond):*

Address the rising costs created by health care market consolidation by prohibiting hospitals and possibly some other facilities, such as freestanding ERs, from hiring physicians. Revise the exemptions now in law to ensure only community hospitals and academic institutions are exempted.

Subject 2, Topic 3 Follow-Up from 7-20-22 PPC Meeting:

Questions Posed:	Answers Provided:
Has your Division submitted any budget items that are similar or could relate to this topic? *If yes, please explain.*	• PEBP, DWSS, DPBH, DCFS, ADSD, SSHIX = No.

Are you currently carrying out an activity that addresses the prohibition of the corporate practice of medicine in Nevada?
 	
If so, please describe the program.
 	
If not, are you aware of any current initiatives to do this?
 	
If the State of Nevada were to implement a law clarifying the prohibition on the corporate practice of medicine, are their consequences to any of the other programs you currently administer?
	• DPBH, Bureau of Health Care Quality and Compliance (HCQC):
	  ○ If the BDR is written so this is required in NRS Chapter 449 (private hospitals) then enforcement would fall under HCQC's current NRS Chapter 449 process. If the BDR just notes that a hospital cannot directly employ a physician and only enter into a contract with a physician, then there is no estimated fiscal impact to HCQC because it would give them the flexibility to incorporate it into their regular survey workload process in a manner that does not significantly increase work hours. On the other hand, if the BDR specifies how this is to be carried out then yes there may be a fiscal impact because HCQC may need to hire staff to carry out any additional work duties.
	  ○ For the public hospitals – that is in NRS Chapter 450 – HCQC also licenses these hospitals in accordance to NRS Chapter 449, so would assume a change in NRS 449 would be sufficient, but LCB would determine.
	  ○ In the end, HCQC would want the authority for both public and private hospitals to be NRS Chapter 449, whether that be making a reference in NRS 449 to a change requiring it NRS 450 or putting it directly in NRS 449, so that HCQC can follow all of their current enforcement processes. Adding additional or new duties or processes creates extra work, that may result in fiscal impact of up to $90,000 annually for 1 full-time equivalent (FTE) annually including base pay, benefits, and all other position related expenses).
	  ○ Additionally, DPBH Administrator notes an exception may also be sought for the State hospitals, as they employ mostly contractors but do have some state FTE physicians; further, an Audit Committee in the recent past noted concern the Division did not employ more state FTE physicians and heavily relied on contractors.
	• DCFS, PEBP, DWSS, ADSD, SSHIX = No.

Are there components (in whole or in part) of this topic that may be carried out without a legislative BDR? *If so, please highlight components and provide reasoning or current process how this could be completed/implemented without legislation.*	**DAG:** Any modification to existing law (Nevada Revised Statutes) must be done through the BDR process. Although no specific statutes are mentioned, modifying existing law would most likely involve changes to NRS Chapter 449 and possibly NRS Chapter 630.

Subject 2, <u>Topic 3</u> Documentation and Analysis:
Prohibition on the Corporate Practice of Medicine

- The corporate practice of medicine doctrine has been long established in the state of Nevada through various Attorney General Opinions. Most recently, it was addressed in Attorney General Opinion No. 2010-03 in March 5, 2010 ("AG Opinion") **– Please see for reference, PDF attachment labeled "Corporate Practice of Medicine AGO 2010" in the PPC ED Update 8.12.22 email**.
- Exceptions to the corporate practice of medicine prohibition can be found in state law (e.g., NRS 450.180(2), NRS 630.365). However, express language on the underlying prohibition that these exceptions are meant to address, along with the enforcement and penalties for the same, are not currently delineated in Nevada Revised Statute.
- In the AG Opinion, then Attorney General Cortez Masto, provided an opinion to the Administrator of Nevada's Department of Health and Human Services stating, in relevant part, "(I)t has been longstanding practice in Nevada that physicians only work as contractors for private hospitals, and not as employees. To depart from this practice would mark a significant change that would be tantamount to a change in state public policy. ***Ideally such change should occur through the legislative process in order to ensure full deliberation of the affected policies and interests of the public, physicians and hospitals***." (***emphasis*** added)
- The American Medicine Association has raised a number of public policy concerns with the corporate practice of medicine, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation's obligation to its shareholders may not align with a physician's obligation to his patients, and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgment. (see **AMA Advocacy Resource Center**, *Issue Brief: Corporate practice of medicine* at Issue brief: Corporate practice of medicine (ama-assn.org), 2015).
- Exceptions to the corporate practice of medicine have been addressed by the Nevada legislature over the years with these concerns in mind (e.g., research, public non-profits, academics). However, the underlying prohibition has not been addressed by the legislature and as such no clear mechanism for enforcement of corporations exists. However, licensed professionals can be disciplined under the authority of their respective boards.

Reasons to ensure corporate practice of medicine does not allow hospitals to hire a physician to practice solely at a hospital facility or for one hospital system are:

i. Hospitals are extremely competitive, particularly in Nevada where very few statutes exist to compel hospitals to provide needed services or to restrict them from expanding into high profit services already available in the geographic area.
ii. Hospitals depend on having physicians that will use their skill and training to provide services at the hospital.
iii. If hospitals and free-standing Emergency Rooms (ERs) can become the sole employer for a physician, that physician is unable to provide services to other hospitals in the community, which disenfranchises those hospitals, and reduces competition.
iv. Physicians being owned by hospitals also causes a conflict for the physician that can put the interests of the hospital ahead of the interests of the patient, such as keeping the patient longer than the patient needs to be at the hospital, refusing to refer a patient to a competing facility, and other types of behavior that serve the needs of the hospital. This has been raised by the American Medical Association (AMA). See attached document.
v. Physicians do not need to be employed by a hospital to have privileges there – they can work at all hospitals by having privileges at the hospital. All hospitals offer privileges to doctors to work at their facilities without hiring them. But if they do hire them, that physician can no longer work elsewhere.

vi. The Nevada Hospital Association has attempted in several legislative cycles to pass a law allowing hospitals to hire physicians. These efforts have failed. However, some hospitals are hiring physicians anyway. This is because NRS does not clearly state that Nevada does not allow physicians to be hired by hospitals – it instead states when a physician can be hired by a hospital- so the statutory assumption exists without the language. It is unclear when or how the prohibition became confused in statute.

vii. In addition to revising the statute to specifically state that physician employment by a hospital is prohibited, the current exceptions, that allow a physician to be hired, and are in statute, should be reviewed and clarified to ensure only academic institutions and public hospitals can directly employ physicians.

viii. Many states have corporate practice of medicine laws, and Nevada has had a practice and an understanding that physicians cannot be hired by hospitals, but it needs codification.

Added by Commissioner McAllister – The PPC may want to consider a state-wide ban on physician non-compete clauses. Many states, and D.C., have such bans in place aimed at increasing competition to lower costs for patients. This video from Nevada's own (he used to practice here) ZdoggMD is short and to the point on why "Non-Compete Clauses Hurt Both Doctors and Patients".

Subject 2, Topic 6 *(Tyler Winkler):*

Create a Prescription Drug Affordability Board. Expand on NRS 439B.630 and set "allowable rates" for certain high-cost drugs identified by the Board. (Updated 8.8.22)

Withdrawn language*: Create a Health Plan Review Board, with similar function as above but for commercial health insurance plans.*

Subject 2, Topic 6 Follow-Up from 7-20-22 PPC Meeting:

Questions Posed:	**Answers Provided:**
Has your Division submitted any budget items that are similar or could relate to this topic? *If yes, please explain.*	• DCFS, PEBP, DWSS, DPBH, SSHIX = No.

Are you currently carrying out an activity that addresses affordability of prescription drugs or commercial health insurance plans? *If so, please describe the program.* *If not, are you aware of any current initiatives to do this?* *If the State of Nevada were to implement a law establishing a prescription drug affordability board or a health plan review board, are their consequences to any of the other programs you currently administer?*	• ADSD- We have a BDR to create flexibility within our Senior and Disability Prescription Drug Program (SRx/DRx). This will only enable us to provide a voucher to cover out of pocket expenses for individuals qualifying for the program. But it does not address any of the system issues related to Rx costs. The Board being proposed would be helpful to SRx/DRx as they could direct the program in how best to meet the needs; we have no clinical staff to provide this type of direction to the program. • PEBP continuously considers several different programs aimed at curbing the cost of drugs. One concern with capping the cost of drugs for members, is that the cost will ultimately be borne on the health plan. In the case of PEBP (and other health plans) the total costs gets spread among all members and eventually becomes part of the overall cost of the plan. In other words, the costs gets passed on to the member in the long run in the form of higher premiums. • DHHS: see Colorado example provided by Dr. Beth Slamowitz under Subject 2, Topic 6 Documentation and Analysis section below noting estimated fiscal impact to state expenditures by about $800,000 and 5.0 full-time equivalent (FTE) in Year 1 and $500,000 and 4.0 FTE in subsequent years. Similar estimates would be predicted for Nevada. • DWSS, DPBH, SSHIX = No.
Are there components (in whole or in part) of this topic that may be carried out without a legislative BDR? *If so, please highlight components and provide reasoning or current process how this could be completed/implemented without legislation.*	**DAG:** Any modification to statute must be done through the BDR process. Would the Prescription Drug Affordability Board's creation be codified in statute? If so, a BDR would be necessary. If that Board would be a subcommittee of the PPC a BDR would not be needed.

Subject 2, <u>Topic 6</u> Documentation and Analysis:

Provided by Commissioner Winkler: A prescription drug affordability review board gives states the ability to limit how much its residents pay for certain high-cost drugs. A drug affordability review board would bring the parties together, increase transparency, and set an upper payment limit/cost sharing arrangement.

This proposal Directly address accessibility, affordability, and quality of health care as well as leverages the Peterson-Millbank cost growth benchmark. Several analyses have shown prescription drugs to be one of the main drivers of cost growth. In several states, there has been significant interest in legislation to further regulate drug prices, and it offers an opportunity for a coordinated strategy.

Affordability review boards follow directly from the data we are collecting and analyzing as a cost mitigation strategy to ensure the Benchmark strategy is successful. If these boards would function similar to/or perhaps as a part of the PPC, the costs would likely be nominal or could be assumed by the

appropriate state agencies.

Prescription Drug Affordability Boards (PDAB) – *report provided by Tyler Winkler (6/28/22); modified to only speak to PDABs on 8/8/22 per Commissioner Winkler's direction.*

Nevada has already taken steps to address prescription drug affordability, and a PDAB is a natural step along with our cost growth benchmark to ensure patients receive their healthcare. Nevada, pursuant to NRS 439B.630, requires the Department of Health and Human Services (DHHS or the Department) to compile a list of prescription drugs essential for treating diabetes (Essential Diabetic Drugs or EDDs), a list of those Essential Diabetic Drugs that had a significant price increase as well as other medication that had a significant price increase and cost more than $40 per course of therapy in Nevada.

All manufacturers that produce medication included in Nevada's Essential Diabetes Drug List are required to submit to DHHS a report with data outlining drug production costs, profits, financial aid, and other drug-specific information and pricing data (NRS 439B.635). For drugs that experienced a recent significant price increase, manufacturers are required to submit a report that provides a justification for these price increases (NRS 439B.640).

Pharmacy Benefit Managers (PBMs) are required to submit reports regarding rebates negotiated with manufacturers for drugs on both the Diabetic Essential Drug List and the Over $40 Drug List (NRS 439B.645). DHHS is also required to maintain a registry of pharmaceutical sales representatives that market prescription drugs in Nevada (NRS 439B.660). These representatives are required to annually submit a list of health care providers and other individuals to whom they provided drug samples and/or individual compensation events exceeding $10 or total compensation exceeding $100 during the previous calendar year. Along with the work the PPC has done in establishing the cost growth benchmark and all payer claims database (APCD) these measures establish a firm footing to meaningful address rising costs through the establishment of a PDAB.

Prescription Drug Affordability Boards (PDAB) – *report provided by Dr. Beth Slamowitz (6/24/22)*

The price of drugs continues to escalate – even during a global pandemic. A June 2020 Gallup survey found that 90% of Americans worry that drug companies will take advantage of the pandemic to raise drugs prices. One hundred companies raised prices on 636 drugs in the first days of 2021 with the median increase of 5% and those were only the early announcements. In 2020, prices were raised an average of 5.5% on 860 drugs. The public has reason to worry. List prices are the basis of what pharmacies pay and what patients pay.

Drugs prices consistently rise faster than inflation and rise higher than other consumer goods. As a result, drugs are increasingly unaffordable for the average consumer; escalating drug prices force insurers to increase premiums for all of us. Government programs are similarly challenged to manage ever rising drug costs in the context of budgets that must provide an array of services to large and diverse populations.

Affordability starts with the idea that at a certain cost, health plans can afford to provide ready access to needed treatments. When drug costs put stress on the healthcare financing system, patients and consumers suffer with high out of pocket costs and lack of access and insurance premiums rise.

The drug industry wants us to see each drug as a separate financing issue when in fact, our healthcare financing systems (health plans, government, patients and consumers) must pay for all drugs for all the people who need them.

A PDAB would not regulate manufacturer list prices. The PDAB would regulate in-state the charges and payments made for a particular drug among state-licensed healthcare entities – wholesalers, other distributors, pharmacies, hospitals, physicians, and insurers.

The overarching goal of any PDAB is to find an Upper Payment Limit (UPL) at which insurers, purchasers, and government programs can afford to provide the drug to everyone in the state who should get the drug. The point of an UPL is to *expand* sales and patient access. The purpose is not to reduce manufacturer revenue. The PDAB function is not punitive.

A PDAB will need to access publicly available pricing and cost information – some of which will come from subscription data services, called "drug pricing files". Medispan and FirstDataBank are two such services. Both services require paid subscriptions to access drug prices and price increases. The cost of the subscription is often determined by how the data is intended to be used. As of 2021, there were Prescription Drug Affordability Boards in Colorado, Maryland, and Oregon. Maine, New Hampshire, and New York also have boards.

Key issues to consider when designing and implementing a PDAB include:

1. Designing the scope
    a. Which drugs will be subject to review by the board?
    b. Which payers will have access to the prices?
    c. What information and data will the board consider when setting limits?

2. Determining the timeline
    a. Will there be a review process for board recommendations?
    b. Over what time period would any recommendations be implemented?

Drug Affordability Boards must be able to consider the following:

1. Availability and efficacy of therapeutic alternatives
2. Out of pocket costs and impact of availability and costs on health and financial wellbeing of patients
3. Decisions on whether to do an affordability review **and** whether to deem drug unaffordable must be done in public meeting, with opportunity for public comment.

Oregon – In 2021, Oregon passed SB 844, which created a PDAB. Senate Bill 844 (SB 844) enacted a PDAB charged with conducting an affordability review of identified drugs that meet a certain threshold and further establish an upper payment limit for these drugs. The threshold for such a review includes: 1) brand-name drugs or biologics with a launch wholesale acquisition cost (WAC) of $30,000 or more per year or a $3,000 WAC increase over 12 months, or2) generics with a WAC of at least $100 that increased by 200% or more over a year, or 3) other drugs that could create affordability challenges for the state. In addition, the PDAB will analyze the cost of administering and delivering the drug to patients to aid in determining an upper

payment limit.

Maryland – The drug affordability board is run by an independent state agency. https://pdab.maryland.gov/

Colorado –In June 2021, Governor Jared Polis signed into law Senate Bill 21-175 establishing the Colorado PDAB. This bill requires the PDAB to identify drugs with 1) an initial wholesale acquisition cost (WAC) of $30,000 or more for a 12-month supply or for a course of treatment that is less than 12 months in duration; or 2) an increase in the WAC of $3,000 or more during the immediately preceding 12 months for a 12-month supply or for a course of treatment that is less than 12 months in duration. The PDAB is then charged with establishing an upper payment limit for any of these drugs deemed unaffordable for Colorado consumers, limited to taking action on more than 12 prescription drugs in a year. The drug affordability board is run out of the Dept of Insurance, and the Medicaid pharmacy Dept is only involved in a consulting capacity. https://doi.colorado.gov/insurance-products/health-insurance/prescription-drug-affordability-review-board. The bill called to increase state expenditures by about $800,000 and 5.0 full-time equivalent (FTE) in Fiscal Year (FY) 2021-22 and $500,000 and 4.0 FTE in subsequent years through the program's repeal date, which is assumed to fall in FY 2027-28. The following expenditures were included:

Cost Components	**FY 2021-22**	**FY 2022-23**
Department of Regulatory Agencies		
Personal Services	$200,297	$200,297
Operating Expenses	$4,050	$4,050
Capital Outlay Costs	$18,600	-
Consultant	$75,000	
All-Payer Health Claims Database Fees	$50,000	$34,000
Legal Services	$382,824	$191,412
Centrally Appropriated Costs1	$112,796	$85,720
FTE – Personal Services	3.0 FTE	3.0 FTE
FTE – Legal Services	2.0 FTE	1.0 FTE
Total	$843,567	$515,479
Total FTE	5.0 FTE	4.0 FTE

Virginia – Virginia proposed an amendment to its PDAB bill (SB 376), to include potential general fund provisions. This amendment provides $385,000 and five positions the first year and $770,000 and five positions the second year from the general fund to implement the provisions of Senate Bill 376. creating a Prescription Drug Affordability Board. The board chair shall hire an executive director, general counsel, and staff to support the board. The cost estimates are based on two states that recently created similar boards, Maryland and Colorado.

Maine – There is a Prescription Drug Affordability Board in Maine. The PDAB is focused on public payors except for the Medicaid program. The PDAB falls under their Department of Administration and Finance.

It was legislation from NASHP that helped Maine get their PDAB established – NASHP currently has an RFP out to help states with data NASHP Announces RFP to Support PDAB States — Due July 26, 2022 - The National Academy for State Health Policy

Prescription Drug Affordability Boards are not without merit but can be labor intensive and resource heavy. The state must ensure that there is access to appropriate data, adequate oversight and that there is adequate funding and FTEs to ensure proper and valuable execution.

Subject 3: Improve Health Care Quality

PPC Goal: Reviewing proposed and enacted legislation, regulations and other changes to state and local policy related to health care in this State. - NRS 439.916.1(h).

Subject 3, Topic 1 *(Mason Van Houweling, Bobbette Bond, Tyler Winkler):*

1. *Mandating that all providers of health care and custodians of healthcare records implement an interoperable electronic health care records system*.
    i. NRS 629.051 states that healthcare records "may be retained, authenticated, and stored" in an electronic computer system. Mandating providers to maintain an electronic healthcare record to assist patients with access and sharing of their medical records.
    ii. Support/consider mandating providers maintaining an electronic healthcare record or other tools to assist patients. Ensure categories of clinical information to be reported, including, claims data, diagnostic data, (demographics, clinical care documents, lab results, or radiology reports).
    iii. Allow for a provision to permit a period of 5 years for compliance with mandate for rural providers or those lacking the resources.
2. *Expand immunity for provider compliance with providing and receiving electronic medical records:*
    i. To encourage participation and alleviate concerns of risks, expand immunity under NRS 439.593 to health care providers for acts related to submitting, accessing, utilizing, disclosing, or relying upon information within the health information exchange.
3. *Revision of NRS 439.584 with relation to HIE and other areas identified:* Ensure this recommendation is compliant with current State and Federal law. Maintain language that supports exchange of patient medical records electronically.

In addition, PPC supports exploring funding options:

i. Provide funding for technical support and resources for providers to allow for integration of systems and ensure fully electronic record access and exchange of information.
ii. Provide funding for patient education with relation to access.
iii. PPC recommends maintaining current HIPAA rules expanded under the Emergency Waivers to allow for continued patient access to information.

Subject 3, Topic 1 Follow-Up from 7-20-22 PPC Meeting:

Questions Posed:	Answers Provided:
What are the requirements of health care providers being mandated to input vaccination information into WebIZ? Do Vaccines for Children (VCF) providers have different requirements?	• **DPBH, Nevada State Immunization Program (NSIP)**: all immunizations must be reported, *regardless of the funding source*. NRS 439.265 (https://www.leg.state.nv.us/nrs/nrs-439.html#NRS439Sec265) and NACs 439.870-897 (https://www.leg.state.nv.us/nac/nac-439.html#NAC439Sec870) govern Nevada's immunization information system (NV WebIZ), and require the reporting of all immunizations administered (to all ages) in Nevada, unless the patient signs a form to opt-out of inclusion. If enrolled with the NSIP to receive publicly funded vaccines (VFC or otherwise), the provider must also manage their inventory quantities in NV WebIZ.
Has your Division submitted any budget items that are similar or could relate to this topic? *If yes, please explain.*	• Need more information to determine whether this concept aligns with any proposed initiatives in DHCFP's budget. • DCFS, PEBP, DWSS, DPBH, ADSD, SSHIX = No.
Are you currently carrying out an activity that addresses health care record interoperability? *If so, please describe the program.* *If not, are you aware of any current initiatives to do this?* *If the State of Nevada were to implement a law mandating that all providers of health care and custodians of health care records implement an interoperable electronic health care records system, are their consequences to any of the other programs you currently administer?*	• DHCFP – Yes, as an insurer regulated by the Centers for Medicare and Medicaid services (CMS) DHCFP is compliant with the Patient Access and Interoperability rule https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet. DHCFP provides a mobile application for Medicaid members that allows them access to the Medicaid Provider Directory, pharmacy formulary, and their claims history. • DCFS, PEBP, DWSS, DPBH, ADSD, SSHIX = No.
Are there components (in whole or in part) of this topic that may be carried out without a legislative BDR? *If so, please highlight components and provide reasoning or current process how this could be completed/implemented without legislation.*	**DAG:** Any modification of statute needs to be accomplished through the BDR process.
Subject 3, Topic 1 Documentation and Analysis:	

1. HEALTHCARE INTEROPERABILITY:

Background:

Care coordination has been identified as a top patient priority and requires the integrity of the medical record to have complete/accurate information available at the point of care; as well as ensuring patients are able to access their medical record and share that information with the medical provider of their choice. Patient education with relation to use and access along with provider support are key to creating interoperability.

Summary of Proposal.

The Patient Protection Commission has a duty to "[e]stablish, submit to the Director and annually update a plan to increase access by patients to their medical records and provide for the interoperability of medical records between providers of health care in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any other applicable federal law or regulations." NRS 439.918. This proposal is intended to facilitate patient access and interoperability via the following policy and legislative changes:

1. *Mandating that all providers of health care and custodians of healthcare records implement an interoperable electronic health care records system*.
    iv. NRS 629.051 states that healthcare records "may be retained, authenticated, and stored" in an electronic computer system. Mandating providers to maintain an electronic healthcare record to assist patients with access and sharing of their medical records.

    v. Support/consider mandating providers maintaining an electronic healthcare record or other tools to assist patients. Ensure categories of clinical information to be reported, including, claims data, diagnostic data, (demographics, clinical care documents, lab results, or radiology reports).

    vi. Allow for a provision to permit a period of 5 years for compliance with mandate for rural providers or those lacking the resources.

2. *Expand immunity for provider compliance with providing and receiving electronic medical records:*
    i. To encourage participation and alleviate concerns of risks, expand immunity under NRS 439.593 to health care providers for acts related to submitting, accessing, utilizing, disclosing, or relying upon information within the health information exchange.

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In addition, PPC supports exploring funding options:

ii. Provide funding for technical support and resources for providers to allow for integration of systems and ensure fully electronic record access and exchange of information.
iii. Provide funding for patient education with relation to access.
iv. PPC recommends maintaining current HIPAA rules expanded under the Emergency Waivers to allow for continued patient access to information.

B. Impacted Sections of the Nevada Revised Statutes (non-exclusive):

NRS CHAPTER 629 (NRS 629.051, NRS 629.061)
NRS CHAPTER 439 (NRS 439.581 to NRS 439.595)