Cost Growth Benchmark Performance Assessment

Nevada Patient Protection Commission Advisory Subcommittee

March 9, 2022

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Where We Are & Where We Are Going: Meetings and Topics

PPC Meeting Date	Primary Topics of Discussion
February 16th	Methods to ensure the accuracy and reliability of benchmark performance measurement; transparency and accountability
March 16th	Three bill drafts to prioritize and request for 2023 legislative session; process for identification and prioritization of cost growth mitigation strategies
April 5th - CANCELLED	Advisory Subcommittee Meeting
April 20th	Introduction to data use strategy; Review findings of Medicaid & PEBP Phase 1 cost driver analyses
May 3rd	Advisory Subcommittee Meeting
May 18th	Cost growth mitigation strategies to ensure the benchmark strategy is successful; review three bill drafts to request for 2023 legislative session
June 15th	Discuss bill draft; Review quality benchmark work of other states; Review opportunities for quality improvement in Nevada
September 21st	Presentation from another cost growth state (potentially OR)
October 19th	Discuss pre-filing requirements

Agenda

1. Cost Growth Benchmark Transparency & Accountability
2. Data Use Strategy
3. Next Steps

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1. Cost Growth Benchmark Transparency & Accountability
2. Data Use Strategy
3. Next Steps

Defining Terms

- Transparency
  - Public reporting
  - Public hearing
- Accountability
  - Procedures when a payer or provider entity fails to remain at or below the cost growth benchmark

Transparency: A Key Element of the Benchmark Logic Model

The Logic Model for a Cost Growth Benchmark

Measure
Measure performance relative to the cost growth benchmark

Analyze
Analyze spending to understand cost trends and cost growth drivers

Report
Publish performance against the benchmark and analysis of cost growth drivers

Transparency

Identify
Identify opportunities and strategies to slow cost growth

Implement
Implement strategies to slow cost growth

Transparency: Three Primary Modes for Releasing Data (1 of 3)

1. Development and Publication of Reports

The primary mechanisms for transparency will be the development of public-facing reports that will be used to inform all audiences.

- Reports may be static or interactive, and may involve supplemental material like chart packs.
- Reports will likely evolve over time (new analyses, ad hoc topics, etc.).
- Reports will be published on the PPC's website.

Transparency: Three Primary Modes for Releasing Data (3 of 3)

2. Public Hearings

The Patient Protection Commission could make recommendations on whether to conduct annual hearings, and if so, on their frequency and format.

The purpose of these hearings could be to:

- Report out on performance relative to the cost growth benchmark, and on complementary analyses of cost drivers
- Foster open dialogue around challenges and opportunities for improving care and reducing costs
- Introduce policy recommendations for slowing cost growth

Transparency: MA's Approach to Public Hearings

- **Timing**: Two-day public hearing following an annual report on performance against the cost growth benchmark
- **Entity Calling Hearings**: The Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis.
- **Public Hearing Content:**
  - Request for pre-filed testimony from payers and providers
  - Report out on performance against the cost growth benchmark
  - Testimony from executive and/or legislative branches
  - Testimony from a cross-section of the health care market on challenges and opportunities for improving care and reducing costs
  - Public comment

Transparency: Questions to Consider

The PPC agreed that a) payer and provider entity actual rate of cost growth should be publicly reported and b) annual hearings should be held, commensurate with Nevada's capacity to do so.

- What process(es) should be in place for reporting cost growth benchmark performance?
- How should performance be reported?
  - Report only whether the entity met or exceeded the benchmark?
  - Report entity's actual rate of cost growth?
- Should there be annual hearings to accompany the release of benchmark performance results?
- What other activities, if any, should be pursued to foster transparency of benchmark performance?

Defining Terms

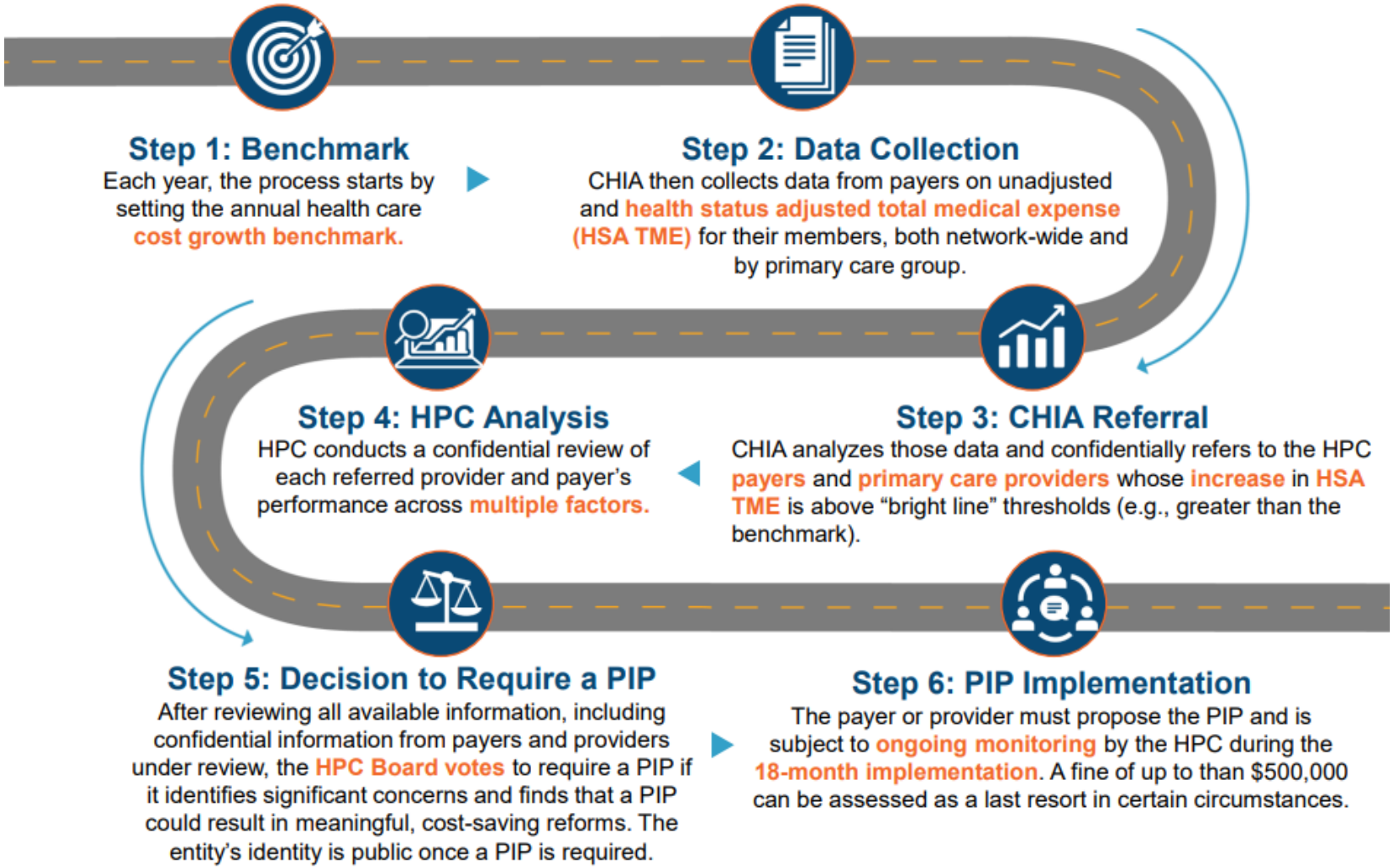
- Transparency
  - Public reporting
  - Public hearing
- Accountability
  - Procedures when a payer or provider entity fails to remain at or below the cost growth benchmark

Accountability Strategies Used by Other States

Two states have created consequences for insurers and provider entities that exceed the cost growth benchmark. (Note: the Governor's Executive Order does *not* direct any accountability mechanisms.)

- Performance Improvement Plans (PIPs)
  - Massachusetts, Oregon
- Financial Penalties
  - Oregon

Massachusetts' Accountability Process



SOURCE: David Seltz, Presentation on the Benchmark Modification Process, March 25, 2021, available at: https://www.mass.gov/doc/presentation-benchmark-hearing-march-25-2021/download.

Massachusetts' Health Policy Commission (HPC) Requires Its First Performance Improvement Plan

PRESS RELEASE

HPC FINDS MASS GENERAL BRIGHAM COST TRENDS AND EXPANSIONS THREATEN STATE HEALTH CARE AFFORDABILITY EFFORTS

HPC requires MGB to develop public performance improvement plan to reduce cost growth; Proposed MGB expansions would further increase commercial health care spending by at least $46 million to $90 million per year

FOR IMMEDIATE RELEASE:

1/25/2022

Massachusetts Health Policy Commission

- "A thorough examination of MGB's spending trends found that from 2014 to 2019, MGB has had more cumulative commercial spending in excess of the benchmark than any other provider, totaling $293 million."
- "The proposed PIP must contain specific cost-reducing action steps, savings goals, process and outcome metrics, timetables, and supporting evidence, among other requirements."

MA's HPC Recommends Stronger Accountability Tools

The HPC's 2021 Annual Health Care Cost Trends Report recommends that MA should "**strengthen accountability for excessive spending**" by:

- Using metrics other than health status-adjusted total medical expense (TME) growth to identify entities contributing to concerning spending;
- Increasing financial penalties for above-benchmark spending or non-compliance, and
- Considering additional tools that ensure the benchmark reflects and responds to underlying variation in the relative level of provider prices.

SOURCE: MA HPC, 2021 Annual Health Care Cost Trends Report, September 2021, available at: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download

Oregon's Accountability Process

Oregon's HB 2081 passed its Senate on May 10, 2021, establishing authority to use accountability tools with providers and payers for which health care cost growth in the previous calendar year exceeded the health care cost growth benchmark, including:

- Requiring the provider or payer to develop and undertake a **performance improvement plan** (PIP)
- Imposing a **financial penalty** on any provider or payer that exceeds the cost growth benchmark without reasonable cause in three out of five calendars years, or on any provider or payer that does not participate in the program

OR's benchmark became effective January 1, 2021, so accountability tools have not yet been applied.

SOURCE: OR Legislative Assembly, 2021 Regular Session, House Bill 2081, May 2021, available at: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled

Accountability: Questions to Consider

The PPC agreed that it would like to discuss quality benchmarks and strategies complementing the cost growth benchmark in a future meeting.

It would also like to review Nevada's current quality reporting and performance to compare against quality performance in other states.

- What additional feedback and/or comment(s) would you like to add?

Agenda

1. Transparency & Accountability
2. Data Use Strategy
3. Next Steps

Cost Growth Benchmark Analysis vs. Data Use Strategy

How will we determine the level of cost growth from one year to the next?

Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data Type:** Aggregate data that allow assessment at four levels: 1) provider level, 2) insurer level, 3) market level, and 4) statewide.
- **Data Source:** Insurers and public payers
- **State Resources to be Used:** Staff from the DHHS Office of Analytics have been assigned to this work.

How will we determine the drivers of overall cost and cost growth? Where are there opportunities to contain spending?

Data Use Strategy

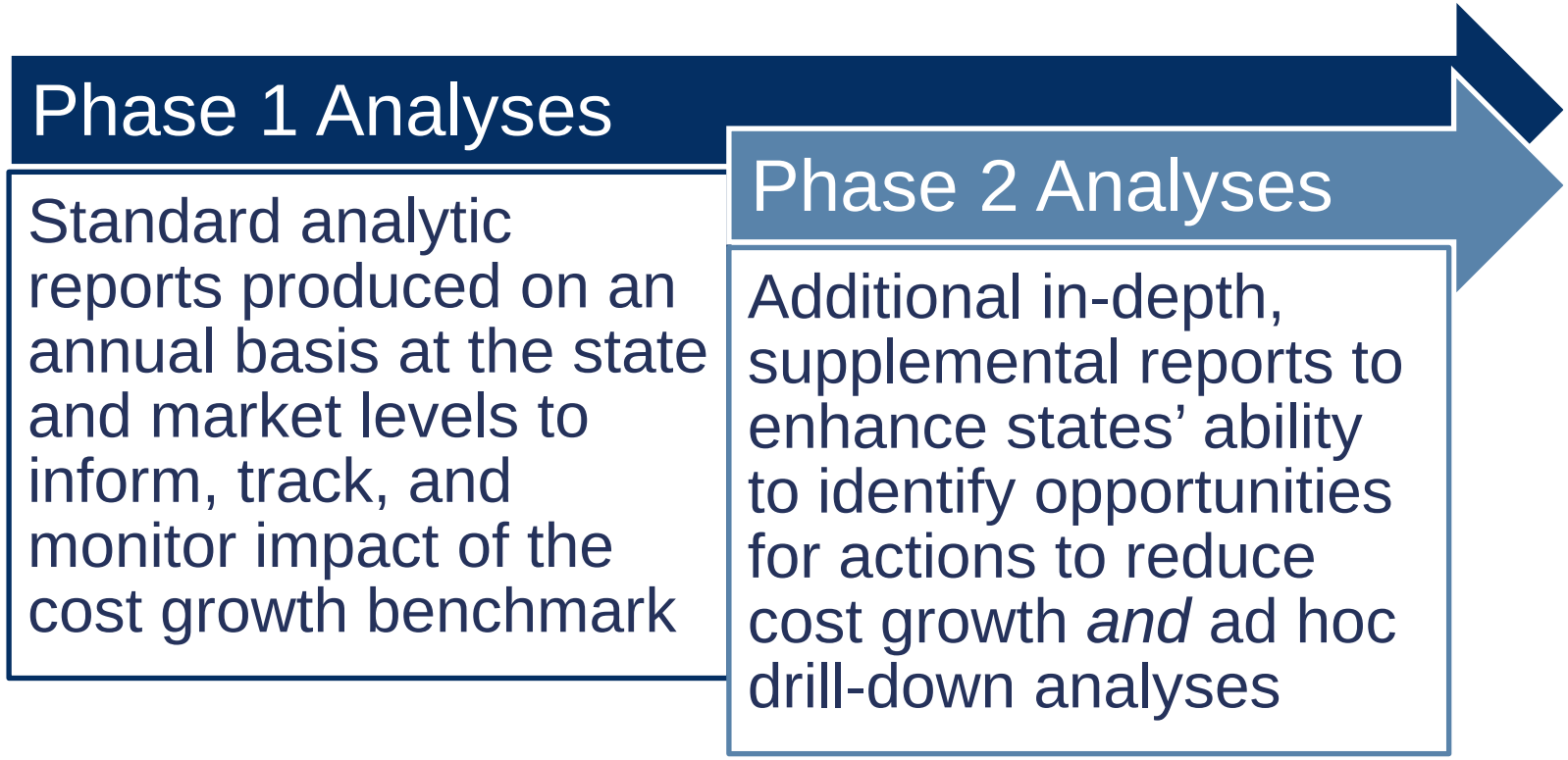
- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters)
- **Data Source:** APCD, when available. Until then, only Medicaid and Public Employees' Benefits Program (PEBP) data will be used.
- **State Resources to be Used:** DHHS Office of Analytics will coordinate the analysis of Medicaid data. PEBP will coordinate the analysis of PEBP data.

Why Implement a Data Use Strategy?

- States with health care cost growth benchmarks need to **understand factors driving health care spending levels and growth**.
- Having done so, they can **identify and implement strategies to mitigate cost growth**.
- We refer to such complementary analyses to a health care cost growth target program as a "**data use strategy**," because our intention is to use the analyses to inform strategic *action*.

Types of Analyses in a Data Use Strategy

There are two types of analyses included in a data use strategy:



The subsequent slides focus on the design of the Phase 1 analyses, which serve as a starting point for understanding health care spending patterns and trends.

Analytic Framework for a Data Use Strategy

The framework to guide construction of analyses to inform efforts to slow health care cost growth is organized around three major questions:

Where is spending problematic?

- High spending
- Growing spending
- Variation
- Benchmark comparison

What is causing the problem?

- Price
- Volume
- Intensity
- Population characteristics

Who is accountable?

- State
- Market
- Payer
- Provider

Where is Spending Problematic?

Answering this question allows states to determine where the greatest opportunity to achieve impact lies.

There are many ways to analyze “problematic” spending:

Spending that is **high at a point** in time and/or is **growing at a high rate** over time	• Spending **by service category** can identify where expenditures are the highest (e.g., pharmaceuticals) • Spending by **rates of growth** can identify what is driving per capita growth over time
Spending that **varies greatly** across regions, payers, or providers	• Reflects the outcome of inconsistent practice patterns, variation in competitiveness and composition of provider markets, and patient population characteristics
Spending that is far **above benchmark measurements**	• Sheds light on spending pattern differences that exist across states using data from CMS, Kaiser, HCCI, RAND, etc.

What is Causing the Problem? (1 of 2)

There are five primary drivers of health care spending and spending growth that will inform the design of the standard analytic reports.

Price	Volume	Intensity	Population Characteristics	Provider Supply
• The amount a payer reimburses for a service, plus patient payments. • The primary driver of health care spending growth in the commercial market.	• The quantity of service units or treatment episodes delivered.	• The scope and types of services utilized for a treatment. • Captures differences in site of care (e.g., inpatient vs. outpatient) and treatment modality (e.g., robot-assisted vs. manual surgery).	• The illness burden (“clinical risk”), demographic characteristics, and social risk of a population that all influence health care needs, access to care, and service utilization.	• The availability of provider resources (e.g., specialists, hospital beds) correlates with increased utilization and spending.

What is Causing the Problem? (2 of 2)

Service	THIS YEAR's Spending (PMPM)	LAST YEAR's Spending (PMPM)	Change (%)	Change (PMPM)	What is contributing to the change in spending? (PMPM) changes in Age/Gender Mix account for:	changes in Service Frequency account for:	changes in Treatment Intensity account for:	changes in Price Level account for:	Total Change in Spending
Pulmonary Edema	$22.90	$21.99	4.2%	$0.92	$0.08	($0.05)	($0.01)	$0.89	$20,612
COPD	$18.99	$17.66	7.5%	$1.33	$0.11	$0.25	$0.44	$0.53	$29,908
Pneumonia	$27.32	$25.40	7.5%	$1.91	$0.17	$0.14	$0.16	$1.43	$43,023
Perc CV Procedures	$26.45	$25.13	5.3%	$1.32	$0.15	$0.03	$0.03	$1.12	$29,756
Circulatory Disorders	$18.88	$18.12	4.2%	$0.76	$0.09	$0.00	$0.01	$0.65	$16,988
Heart Failure	$22.77	$22.31	2.0%	$0.46	$0.06	($0.00)	($0.00)	$0.40	$10,246
Cardiac Arrhythmia	$27.33	$26.51	3.1%	$0.82	$0.09	$0.01	$0.05	$0.66	$18,445
Spinal Fusion	$13.70	$12.88	6.4%	$0.82	$0.06	$0.33	$0.08	$0.35	$18,492
Major Joint Replacement	$16.08	$15.11	6.4%	$0.96	$0.08	$0.14	$0.20	$0.55	$21,706
Cellulitis	$28.26	$25.72	9.9%	$2.54	$0.13	$1.53	$0.01	$0.89	$57,227
Metabolic disorders	$19.26	$17.53	9.9%	$1.73	$0.07	($0.06)	($0.01)	$1.73	$39,006
Urinary Tract Infections	$23.01	$22.55	2.0%	$0.46	$0.03	$0.18	$0.27	($0.01)	$10,355
Septicemia	$10.93	$10.60	3.1%	$0.33	$0.01	$0.12	$0.13	$0.07	$7,377
	$275.87	**$261.51**	**5.5%**	**$14.36**	**$1.13**	**$2.62**	**$1.35**	**$9.27**	**$323,141**
					8%	**18%**	**9%**	**65%**	

SOURCE: Washington Health Alliance

Who is Accountable?

States, insurers, and provider organizations all take actions – intentionally or otherwise – that influence care delivery and spending.

The State should analyze data at four levels to help inform purposeful and coordinated action across these actors.

Level of Analysis	Categories	Potential Subcategories
State	N/A	Region, county, city, zip code
Market	Commercial	Fully insured, self-insured, marketplace
	Medicaid	Managed care, Fee-for-Service
	Medicare	Medicare Advantage, Traditional Medicare
Payer	Individual payer by market	Commercial payer product (e.g., HMO, PPO, other)
Provider Entity	N/A	Practice/practice site, facility, specialty type, site of service

Phase 1 Analyses: Standard Analytic Reports (1 of 2)

- We recommend that states begin their health care spending analyses with 11 standard analytic reports produced on an annual basis at the state and market levels.
- The reports should:
  - Examine the effects of price, volume, population characteristics, and service intensity in the context of broader changes to spending and spending growth;
  - Use an absolute minimum of two years of data but use more when possible to observe longitudinal patterns and trend;
  - Be produced on both a total and per capita spending basis, and
  - Be released at a time to complement public reporting of performance against the cost growth benchmark.

Phase 1 Analyses: Standard Analytic Reports (2 of 2)

#	Description	Drill Down of Trend
1	Spend by Market (PMPM)	None
2	Trend by Market (per capita)	Price, volume, intensity
3	Spend by Geography (PMPM)	Price, volume
4	Trend by Geography	Price, volume, intensity
5	Spend by Service Category	Price, volume
6	Trend by Service Category	Price, volume, intensity
7	Spend by Health Condition	Price, volume
8	Trend by Health Condition	Price, volume, intensity
9	Spend by Demographic Variables	Price, volume
10	Trend by Demographic Variables	Price, volume, intensity
11	Cost Growth Target Unintended Consequences	N/A

Nevada's Phase 1 Analyses (1 of 2)

#	Description
1	**Spend by Market (PMPM)**
2	Trend by Market (per capita)*
3	**Spend by Geography (PMPM)**
4	**Trend by Geography**
5	**Spend by Service Category**
6	**Trend by Service Category**
7	Spend by Health Condition
8	Trend by Health Condition
9	**Spend by Demographic Variables**
10	**Trend by Demographic Variables**
11	Cost Growth Target Unintended Consequences

*Between Medicaid and PEBP, we will have this for 2 of 3 markets.

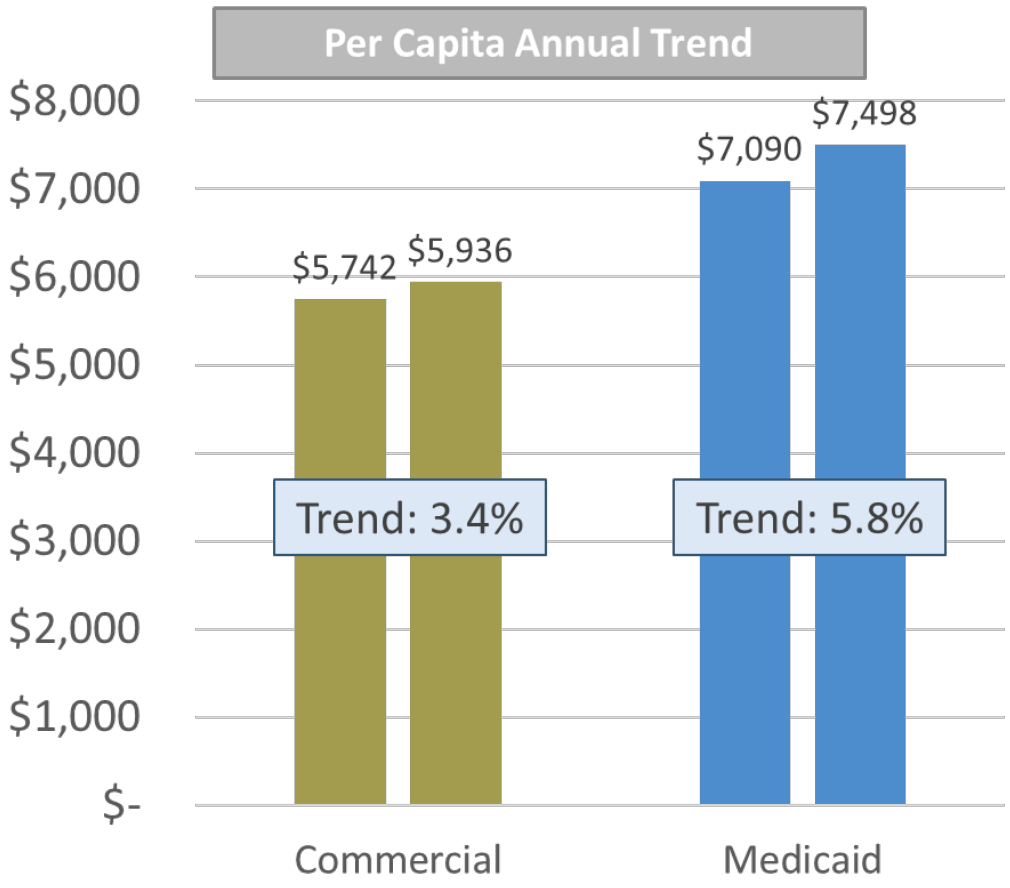
- Until an APCD is available for use, the State will use data from Medicaid and the Public Employees Benefits Program (PEBP). Phase 1 analyses are currently underway for both.
- Analyses in **blue** will be included in Medicaid's and PEBP's Phase 1 report, using data from 2016-2020. Medicaid is also developing analyses in addition to the ones identified here.

Nevada’s Phase 1 Analyses (2 of 2)

- Nevada’s first set of Data Use Strategy reports will provide:
  - An understanding of health care spending patterns and trends from 2016-2020, prior to the effective date of the benchmark.
  - Analyses at the state and market levels only.

Reports 1 and 2: Spend and Trend by Market

- High-level analysis on spending and spending growth by commercial, Medicaid, and Medicare markets
- Will not align with payer-reported data for the state cost growth benchmark because of data missing from APCDs (e.g., commercial self-insured data)

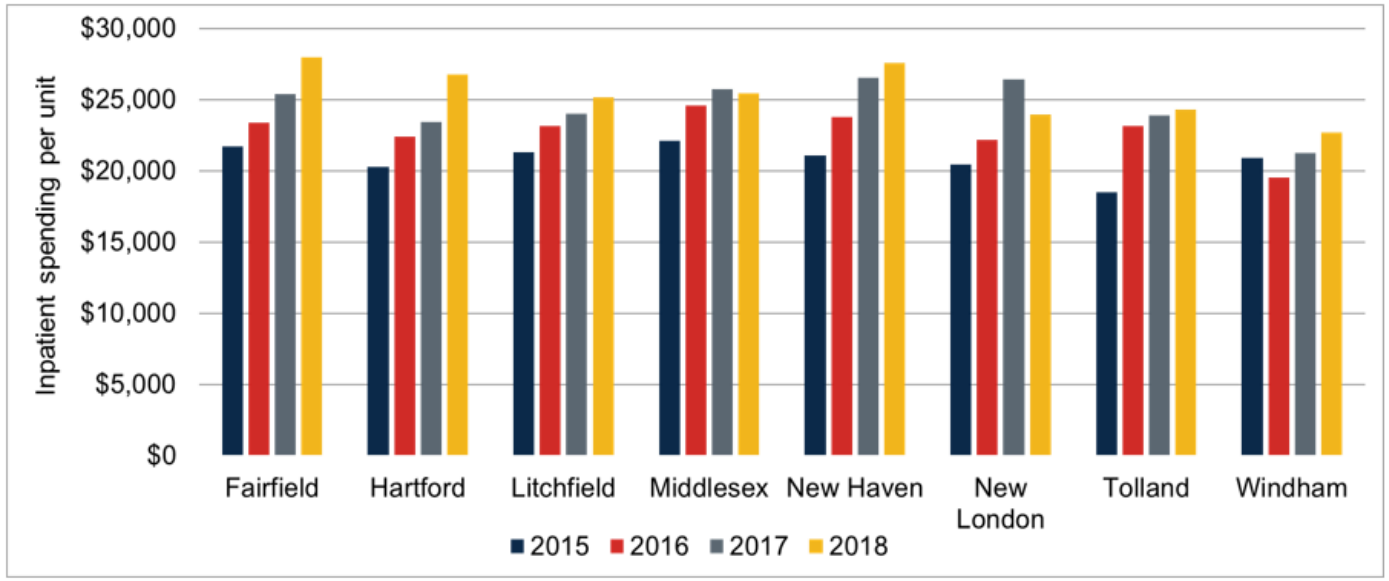


Source: Rhode Island Office of the Health Insurance Commissioner. (2020, August 17). *Baseline 2017-2018 Performance Against the Cost Growth Target*. Presentation.

Reports 3 and 4: Spend and Trend by Geography

- Assesses market spending from Reports 1 and 2 by state geography
- States should define geographic regions that are meaningful within the state (e.g., county, hospital service area, public health region)

Age-gender adjusted inpatient spending per unit was highest for residents of Fairfield and New Haven, lowest in Windham county

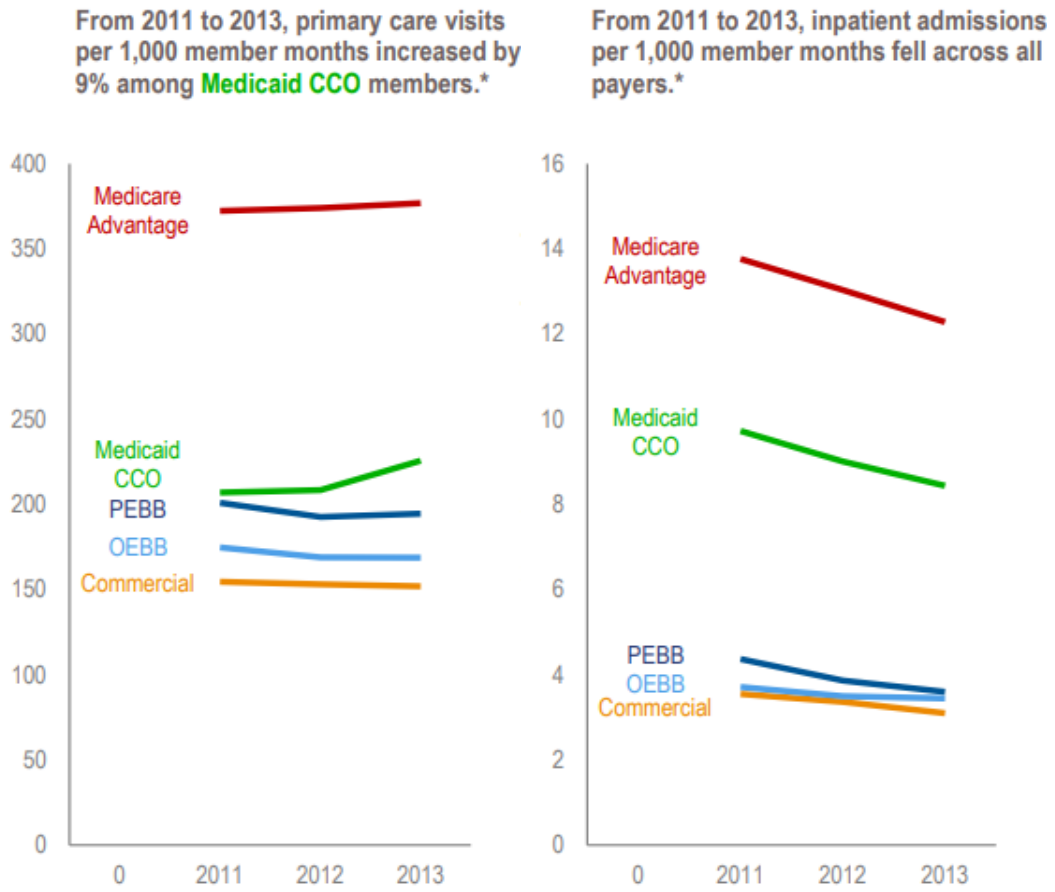


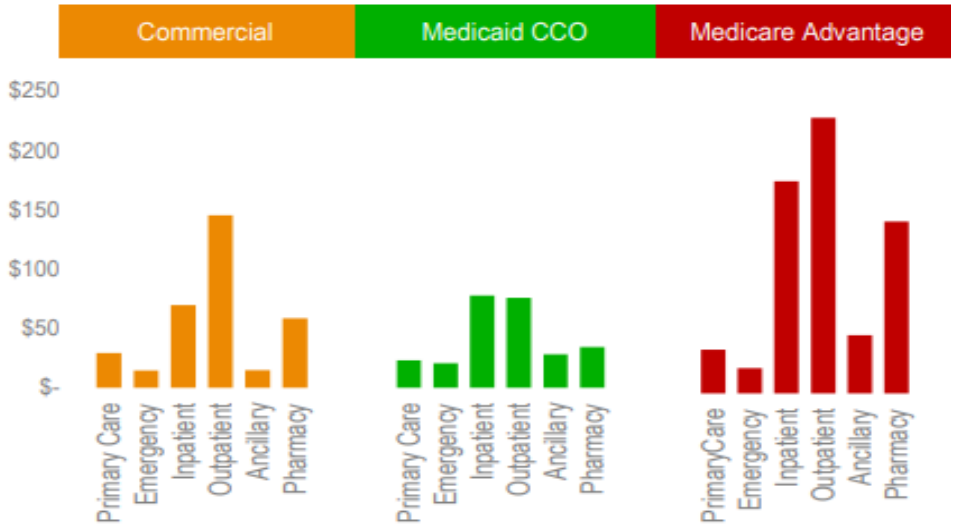
County is based on member residence, which will often differ from the county where care was received. Inpatient stay units defined as discharges, which can include multiple claims. Results are adjusted to control for differences in age-gender mix among counties.

Source: Connecticut Office of Health Strategy. (2021, January 21). *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica.

Reports 5 and 6: Spend and Trend by Service Category

- Analysis of spending for defined service categories and subcategories





- We propose use of categories adapted from the National Health Expenditures Accounts, although Nevada can add categories that may provide additional insight.
- Not all categories are applicable for all markets (e.g., long-term care is primarily relevant for Medicaid).

Source: Oregon Health Authority. (2015, April 30). Leading Indicators for Oregon's Health Care Transformation: Quarterly Data from the All-Payer, All-Claims Reporting Program.

Reports 7 and 8: Spend and Trend by Health Condition

- Helps states understand spend and trend by health conditions and detect if/how they influence service utilization
- We propose use of CMS' Chronic Condition Warehouse, but Nevada can use other methods (e.g., categories from Milliman or AHRQ)

	2018		
Condition	Members with condition	%	PMPY for members with this condition
All members	**455,780**	**100.0**	**$6,151**
Hyperlipidemia	73,081	16.0	$11,842
Hypertension	70,419	15.5	$13,739
Rheumatoid Arthritis/Osteoarthritis	67,943	14.9	$13,866
Depression	50,979	11.2	$13,501
Diabetes	28,608	6.3	$14,197
Anemia	26,723	5.9	$25,355
Acquired Hypothyroidism	25,918	5.7	$12,911
Glaucoma	18,035	4.0	$9,004
Chronic Kidney Disease	17,732	3.9	$24,029
Asthma	17,500	3.8	$16,887
One or more of 27 chronic conditions	218,598	48.0	$10,336
Two or more of 27 chronic conditions	115,855	25.4	$14,379

Source: Connecticut Office of Health Strategy. (2021, January 21). *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica.

Reports 9 and 10: Spend and Trend by Demographic Variable

- Can evaluate how trends differ among communities with different demographic characters (e.g., race/ethnicity, preferred language, English proficiency, income, disability status)
- Demographic data are often missing from APCDs and require data from supplemental sources (e.g., American Community Survey)

Decile	Percentage white	Median family income	PMPM (adj.)	ED visit rate (adj.)	Percentage with condition				
					One or more conditions	Two or more conditions	Hyper-tension	Diabetes	Asthma
All	**0 – 100**	**$97,310**	**$526.69**	**494**	**0.48**	**0.25**	**15.5**	**6.3**	**3.8**
1	0 – 31	$45,663	$545.33	736	0.51	0.30	22.2	11.8	5.6
2	31 – 50	$68,060	$561.26	606	0.49	0.27	18.1	8.6	4.5
3	50 – 61	$82,466	$562.29	591	0.50	0.28	17.3	7.9	4.6
4	61 – 71	$105,442	$494.28	477	0.48	0.26	15.2	6.7	3.7
5	71 – 77	$103,407	$497.68	494	0.48	0.26	16.1	6.6	3.9
6	77 – 82	$122,067	$499.30	434	0.47	0.25	14.1	5.4	3.5
7	83 – 87	$149,181	$506.68	413	0.46	0.23	13.6	5.0	3.5
8	87 – 91	$127,302	$481.19	457	0.47	0.24	14.1	5.0	3.4
9	91 – 94	$118,223	$484.70	493	0.48	0.25	14.7	5.0	3.5
10	94 – 100	$112,875	$526.69	476	0.49	0.26	15.4	5.1	3.7
Ratio of 1st to 10th decile		0.40	1.09	1.55	1.03	1.17	1.44	2.33	1.51

Source: Connecticut Office of Health Strategy. (2021, January 21). *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica.

Report 11: Cost Growth Target Unintended Consequences

- While there is yet no evidence, there is a risk that providers could restrict patients from receiving necessary services to meet the target.
- States should implement oversight programs to detect such possible unintended adverse consequences of the target, which can include:
  - Quality measures assessing utilization of preventive and chronic illness care.
  - Patient self-report of access to care, including specialty care.
  - Assessments of consumer premiums and out-of-pocket spending.
  - Analysis of provider patient panel composition to detect “cherry picking” or “lemon dropping.”
  - Stratified analyses to assess specific and disparate impact of the target on economically and socially marginalized groups.

Phase 2 Analyses: Standard Analytic Reports

Supplemental analytic reports could include the following:

#	Description
1	Provider entity- and payer-level analysis
2	Variation across payers, providers, and geographies
3	Supply as a cost driver
4	Market consolidation as a cost driver
5	Pharmacy cost drivers
6	Out-of-pocket spending
7	Benchmark analysis
8	Site of care
9	Physician specialty analysis

Future Directions

- There is a vast universe of areas of inquiry for states seeking to support cost growth benchmark attainment through analytic reports.
- To build trust among stakeholders and key partners, states are being advised to:
  - begin with simple and easy-to-understand findings to gain familiarity with the data;
  - be transparent with analytic methodologies, and
  - allow payers and providers to review their data before publication.

Transparency: Timeline and Content of Reports (1 of 2)

April 2022

Phase 1 Data Use Strategy Report

- First report analyzing 2016-2020 spending of Medicaid and PEBP.
- Standardized analyses to understand where spending is problematic, and what may be causing the problem

July 2022

Phase 2 Data Use Strategy Report

- Second report analyzing 2016-2020 spending of Medicaid and PEBP.
- Will include more complex analyses and possibly ad hoc drill down analyses prompted by Phase 1 analyses

Transparency: Timeline and Content of Reports (2 of 2)

2023

Baseline Cost Growth Benchmark Report

- Initial look at health care cost growth in 2018-2019 using payer-reported aggregate data
- Will include breakdown by market, and by service categories contributing to spending and trend within each market
- Look at trends pre-COVID-19

Accountability: Questions to Consider

The PPC has not yet discussed Nevada's Data Use Strategy.

- Do you have any initial questions or comments about the planned Data Use Strategy activities?

Agenda

1. Transparency & Accountability
2. Data Use Strategy
3. Next Steps

Timeline for Benchmark Analysis

Measure

Measure performance relative to the cost growth benchmark

Report

Publish performance against the benchmark and analysis of cost growth drivers

Deadline	Key Deliverable
6/30/2022	Issue formal baseline data request to insurers
6/30/2022	Distribute benchmark implementation manual and hold trainings with payers
8/31/2022	Receive aggregate baseline benchmark data from payers
10/1/2022	Complete Medicaid and PEBP updated analyses for 2021 data
Winter 2023	Validate, analyze, and review baseline benchmark findings with PPC and stakeholders

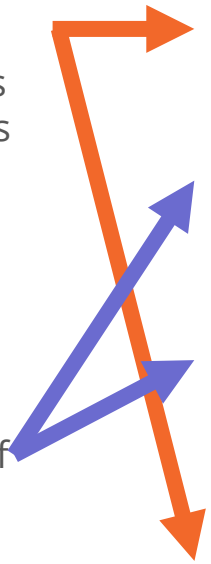
Timeline for Cost Driver Analysis

Analyze

Analyze spending to understand cost trends and cost growth drivers

Report

Publish performance of cost growth drivers



Deadline	Key Deliverable
3/31/2022	Medicaid and PEBP complete Phase 1 of cost driver analysis and begin Phase 2 cost driver analysis
4/30/2022	Review findings of Phase 1 cost driver analyses with the PPC
5/31/2022	Share findings of Phase 1 cost driver analyses with Advisory Subcommittee and other public stakeholders
7/1/2022	Update Phase 1 analysis with 2021 data

Timeline for Policy Initiatives

Identify

Identify opportunities and strategies to slow cost growth

Implement

Implement strategies to slow cost growth

Deadline	Key Deliverable
1/1/2022	Effective date of cost growth benchmark implementation
5/31/2022	PPC to make a decision on what three bills to draft for the 2023 legislative session
7/31/2022	Vote on and submit three bill drafts for 2023 legislative session
10/31/2022	Discuss pre-filing requirements for three bill drafts

Future Meetings

- The Patient Protection Commission will next meet on **March 16th** at 9:00 a.m.
- The Advisory Subcommittee will next meet on **April 5th** at 12:30 p.m.