

Cost Growth Benchmark Program

Nevada Patient Protection Commission

May 18, 2022

Peterson-Milbank Data Analysis Funding Request

- Peterson-Milbank provides up to \$200,000 over the 2-year program for states to supplement their data analytic resources.
- Any requested funding must be spent by 12/31/22.
- No cost to the State to request this funding.
- Funding request summary (estimates provided):
 - Medicaid Health Conditions drill-down: \$40,000
 - PEBP Health Conditions drill-down: \$50,000
 - Training and Capacity Building: \$14,068

Follow-up to April 20th PPC Meeting

PPC Meeting Date	Primary Topics of Discussion
April 20 th	1) Introduction to data use strategy. 2) Review findings of Medicaid & PEBP Phase 1 cost driver analyses. 3) Revisit provider entity population thresholds based on RI's and CT's pre-benchmark analyses.

- Since the last meeting, the DHHS Office of Analytics has firmed up plans for completing certain Phase 2 cost driver analyses by July 31st, delving into the following areas
 - hospital spending
 - pharmacy spending
 - professional services spending
- PEBP will pursue an aligned approach, although the timeline could be a little longer due to a change in vendors.

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

PPC Meeting Date	Primary Topics of Discussion
May 3 rd	<i>Advisory Subcommittee Meeting:</i> 1) Findings of Medicaid & PEBP Phase 1 cost driver analyses; 2) Criteria for prioritizing cost growth mitigation strategies. 3) Cost growth mitigation strategies to ensure benchmark strategy success.
May 18 th	1) Review three bill drafts to request for 2023 legislative session. 2) Cost growth mitigation strategies to ensure the benchmark strategy is successful.
June 15 th	1) Discuss bill drafting. 2) Review quality benchmark work of other states. 3) Review opportunities for quality improvement in Nevada.

Baseline Cost Growth Benchmark Data Request

- On May 16th insurers participated in a two-hour webinar introducing the baseline cost growth benchmark data request and a specially prepared data specifications manual.
- DOI asked the following eight insurers to submit baseline data for 2018-21: Aetna, Anthem, Centene, Cigna, Humana, Molina, Renown and UnitedHealthcare. (Data will be collected from other sources too.)
- Data submissions are due to DHHS by August 26th.
- Results will be reported to the PPC and publicly in Q1 2023 at the state and insurance market levels.
 - Insurer and provider organization-specific data won't be reported until 2024.

Agenda

1. Discuss Bill Draft Requests
2. Cost Growth Mitigation Strategies to Ensure the Benchmark Strategy is Successful
3. Next Steps

Bill Draft Request Poll Results

A web-based poll was issued to Commissioners to prioritize discussion of the 17 total unique bill draft requests that were received.

- Eleven (92%) voting members of the PPC responded
- The six BDRs that received the greatest number of votes are represented in the following slides.

#1 Access to and Interoperability of Electronic Medical Records

This proposal received seven responses (70% of responding members).

Development of the Plan Required by AB 348

- A. Ensure patients have access to and control of their medical records and information, such as test results, diagnostic tests, and health conditions, through a patient portal.
- B. Direct the Nevada Office of Health Information Technology to create programs that allow interoperability of medical records directly among providers as required by CMS interoperability rules.
- C. Provide a mechanism to exchange patient information and lessen the burden on providers utilizing the national and EMR specific direct exchange protocol.
- D. Provide assistance to patients to improve their use and understanding of methods for sharing their medical records with providers and provide assistance to payers and medical providers.
- E. Require all providers, facilities, and payers to participate in the national protocol that drives interoperability across the health care delivery system; direct exchange method. This participation will improve the completeness of the medical information available to providers at the point of care overall improving the continuum of care. Ultimately, this will improve patient outcomes along with improve efficiencies and decrease costs associated with care.
- F. Ensure HIT solutions regarding interoperability include the patient as a record recipient and involve patients' decisions regarding where records are disclosed.

#2 – Codify the Cost Growth Benchmark Program

This proposal received six responses (60% of responding members).

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.

#3 Mental and Behavioral Health Provider Workforce Development

This proposal received six responses (60% of responding members).

Require that health carriers in the state of Nevada have sufficient availability of and access to mental and behavioral health professionals in urban and rural areas throughout Nevada.

- Identify and address mental health-focused physician, nursing and other licensed mental and behavioral health professional shortages:
 - support professional development
 - facilitate improvements to the licensure attainment processes
- Identify and address behavioral health-focused physician, nursing, and other licensed mental and behavioral health professional shortages within health carrier networks to improve access for patients in need.
- Expand the types of health carriers for whom these requirements will apply.

#4 Expand Medicaid Coverage to Residents Regardless of Immigration Status

This proposal received five responses (50% of responding members).

Expand coverage to residents regardless of immigration status.

- Submit a 1332 waiver request.
 - Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (also referred to as “Section 1332 waiver”) to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.
- Develop new state funding mechanisms permitting Medicaid coverage.

#5 – Address the Housing Crisis Through Multiple Means.

This proposal received five responses (50% of responding members).

Address the housing crisis through Medicaid waivers, targeted legislation, infrastructure funding, and adoption of affordable housing policies.

- Establish rent controls. Recommend State pass legislation granting authorization to municipalities to address unaffordable, unsustainable rent increases.
- Develop permanent supportive housing plans.
- Pursue Medicaid state plan and waiver authorities (e.g., 1905(a), 1915(i), 1915(c), or Section 1115) to add certain non-clinical services to the Medicaid benefit package including case management, housing supports, employment supports, and peer support services.

#6 – Improve Access to Telehealth.

This proposal received five responses (50% of responding members).

Insert clear, effective, and sustainable telemedicine language in the Nevada Revised Statutes:

- Codify current COVID-19 related telemedicine provisions; i.e., interstate licensure exceptions.
- Ensure that there is sufficient access to technology and connectivity to support telemedicine in Nevada.
- Address parity of payment.
- Address licensure and adequacy of network issues.

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Summary of Key Findings from Phase 1 Analyses (1 of 2)

1. Prior to the onset of COVID-19 in 2020, annual per capita health care spending growth far exceeded historical annual state median wage growth and state economic growth:

- Medicaid: 5.5% (2016-19)
- PEBP: 13.5% (2017-19)
- Median wage growth: 2.2% (2002-20)
- State economic growth: 4.3% (2002-20)

Summary of Key Findings from Phase 1 Analyses (2 of 2)

2. Annual health care spending growth was **highest for pharmacy** for both Medicaid and PEBP. Hospital outpatient (Medicaid) and professional services (PEBP) were also significant cost drivers.
 - Medicaid:
 - Pharmacy: 12% (2016-19)
 - Hospital Outpatient: 6% (2016-19)
 - PEBP:
 - Pharmacy: 18% (2016-17)
 - Professional: 14% (2016-17)
3. For the areas with the highest spending growth, **high growth in prices** appeared to be the primary reason for spending growth.

Reactions from the Advisory Subcommittee

- The Advisory Subcommittee met on May 3, 2022. It received a condensed version of the presentation the PPC received in April on Medicaid and PEBP cost drivers.
- Advisory Subcommittee members recommended the following in response to the presentation:
 - Perform a price study to better understand the role of price growth in driving overall spending growth
 - Perform root case analyses to better understand unnecessary utilization in Medicaid in the following areas:
 - ED utilization
 - Long-stay (“stuck”) hospital patients
 - Long-stay post-acute care patients

Strategies being pursued in other states to address cost growth

- Strategies used by other cost growth benchmark states to address cost growth generally fall under the following categories:
 - **Market consolidation oversight** (OR, WA)
 - WA OIC reviews consolidation in commercial market
 - AGO oversees anti-trust
 - **Price growth caps** (DE, RI)
 - **Prescription drug pricing legislation** (CT, MA, RI)
 - WA has a drug price transparency program
 - Proposed legislation pending on affordability
 - **Advanced value-based payment models** (OR, RI)

Market consolidation oversight

- Consolidation refers to when two or more health care entities combine.
 - Vertical consolidation is when entities in different lines of work combine, such as when a hospital acquires a physician practice.
 - Horizontal consolidation refers to when entities providing similar services join forces, such as two hospitals merging.
- Reasons for consolidation include increasing negotiating power, gaining economies of scale to offset fixed costs, and to navigate uncertainty surrounding the health care market.

Rationale for addressing market consolidation

- There has been growing evidence that growth in health care costs are mostly attributed to pricing increases, and that provider consolidation has been a significant factor in driving these price increases.
- Furthermore, studies show that health care consolidation leads to higher health care costs without improvements in care quality or patient outcomes.

Oregon's Health Care Market Oversight Program

- In 2021, the Oregon Legislature passed House Bill 2362, directing the Oregon Health Authority (OHA) to oversee “material change transactions,” such as mergers, affiliations and acquisitions.
- OHA will review, and have the authority to approve or reject, material change transactions that:
 - Involve a gain of more than \$1 million in net patient revenue; or
 - Are among organizations that combined had an average of at least \$25 million in total net patient revenue over the three preceding fiscal years.

Considerations for OHA's review of material change transactions

- The framework for OHA's review considers the following issues:
 - Health equity
 - Equitable access to essential and other services
 - Health care quality
 - Ability to achieve Oregon's Sustainable Health Care Cost Growth Target (i.e., its cost growth benchmark)
 - Market share
 - Financial stability

Price growth caps

- Price growth caps place an upper limit on how much an insurer can annually increase the price paid for a service.
 - They do not set prices.
 - Nor do they address already high prices.
- Price growth caps can be structured in a number of ways. For example:
 - Price growth caps can apply to overall prices, or they can be aimed at specific services.
 - The caps can vary based on baseline prices that providers charge, e.g., higher caps for lower paid providers, and lower caps for higher paid providers

Rationale for price growth caps

- Capping price growth can reduce the impact that a provider with significant market power can have, but does not dictate the payment methodology.
 - Depending on how the growth caps are structured, there could be flexibility on by how much specific services can increase, as long as the overall average falls under the cap.
- Similar to the health care cost growth benchmark, they allow for increased spending, but not at an excessive rate.

Rhode Island's Affordability Standards

- The Rhode Island Office of the Health Insurance Commissioner established Affordability Standards and Priorities that commercial insurers must follow to have their premium rates approved.
- These standards include a provision on comprehensive payment reform, which requires insurers to include a set of conditions into their hospital contracts.
 - One of the conditions limits price increases for both inpatient and outpatient services to the Medicare price index plus 1 percentage point.
- A 2019 *Health Affairs* study found that Rhode Island's implementation of the Affordability Standards reduced per enrollee spending, without impacting quality.

Delaware's hospital growth caps

- In 2021 Delaware implemented affordability standards that insurers must meet to have their rates approved, modeled after Rhode Island.
- As part of the affordability standards, the Delaware Department of Insurance requires insurers' average contracted prices with hospitals to grow as follows:
 - For 2022, no more than 3% or core CPI plus 1%, whichever is greater.
 - For 2024 through 2026, no more than 2% or core CPI plus 1%, whichever is greater.

Prescription drug pricing legislation

- Some states have tried to introduce legislation to address prescription drug prices.
- The scope and focus of prescription drug pricing legislation vary:
 - Some aim to increase drug pricing transparency through reporting and notification requirements.
 - Some institute some form of price control, including through fines for unsupported price increases, benchmarking of drug prices, and establishment of drug price affordability review boards to have a more active role in setting drug prices in the state.

Rationale for prescription drug pricing legislation

- 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.

Prescription drug price control legislation

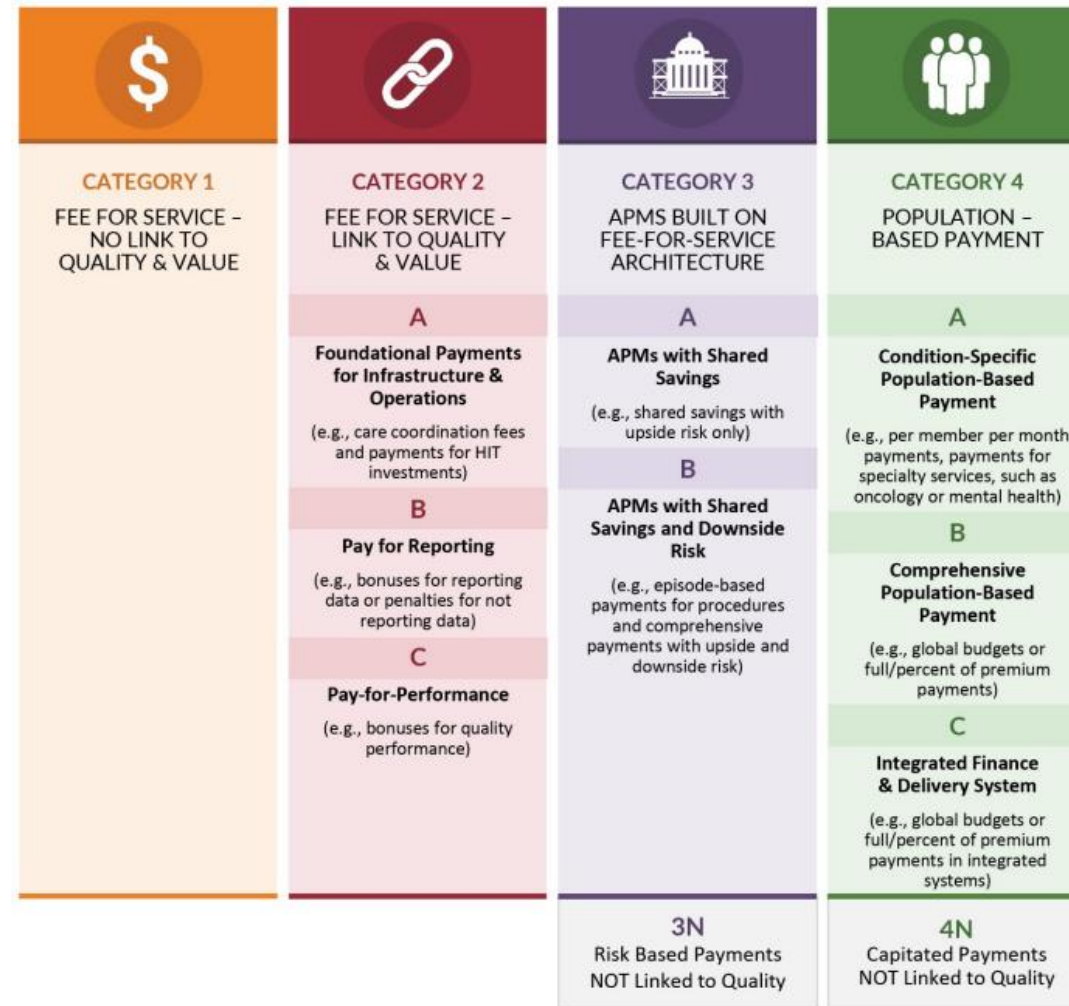
- The Connecticut and Massachusetts governors introduced similar legislative proposals in 2021 and again in 2022 to impose financial penalties on drug manufacturers for excessive price increases.
 - The benchmark for drug price increases is set at the rate of increase in the CPI plus 2%.
 - The penalty would equal 80% of the amount by which the drug's price exceeds the benchmark.
- Rhode Island's cost growth benchmark governance body recommended that the Governor pursue similar pharmacy price penalty legislation.
 - Governor McKee did not act on the recommendation.

Increasing the use of advanced value-based payment models

- A value-based payment (VBP) model is a way of paying for health care services to drive system change towards greater efficiency and improved outcomes.
- VBP models (also referred to as alternative payment models, or “APMs”) reward providers based on achievement of quality goals and, in some cases, cost savings.

Increasing the use of advanced value-based payment models

- VBP models fall into a continuum, as categorized by the LAN framework, based on their link to the fee-for-service architecture.
- Advanced VBP models are those that move further away from the FFS architecture and increase incentives for improved outcomes and efficiency through the use of shared savings/risk or capitation payments.



Rationale for focus on advanced VBP

- The contractual terms of payment between payers and providers create a system of financial incentives that influence health care costs, and such incentives are amenable to modification by the contracting parties.
 - Fee-for-service payment rewards volume.
 - Emphasizing meaningful levels of risk-sharing and incentives for quality performance are designed to promote efficiency and a high quality of care.
- The application of financial incentives to focus on outcomes improve quality through advanced VBPs can support health care cost growth benchmark attainment.

Oregon's advanced VBP initiative

- In October 2020, Oregon's governing body created a set of principles to increase the spread of value-based payment (VBP) models across the state as a strategy to improve quality and lower costs.
- The state established a VBP compact, with 47 signatories, representing a voluntary commitment by payers and providers to advance VBP models.
- Oregon created a value-based payment workgroup to:
 - Identify paths to accelerate the adoption of VBP across the state
 - Highlight challenges and barriers to implementing and recommending policy change and solutions
 - Coordinate and align with other state VBP efforts
 - Monitor progress on achieving the compact's principles, including specific VBP adoption targets.

Rhode Island's advanced VBP initiative

- Independently, Rhode Island's governing body established a VBP subcommittee in the summer of 2021, with a focus on moving away from fee-for-service payment.
- In April 2022, the Subcommittee came to agreement and executed a compact with three payment model elements:
 - Hospital global budgets, inclusive of employed professional services
 - Prospective primary care payment
 - Prospective payment and/or episodes for selected specialties with significant independent practice volume

Discussion: Cost Growth Mitigation Strategies

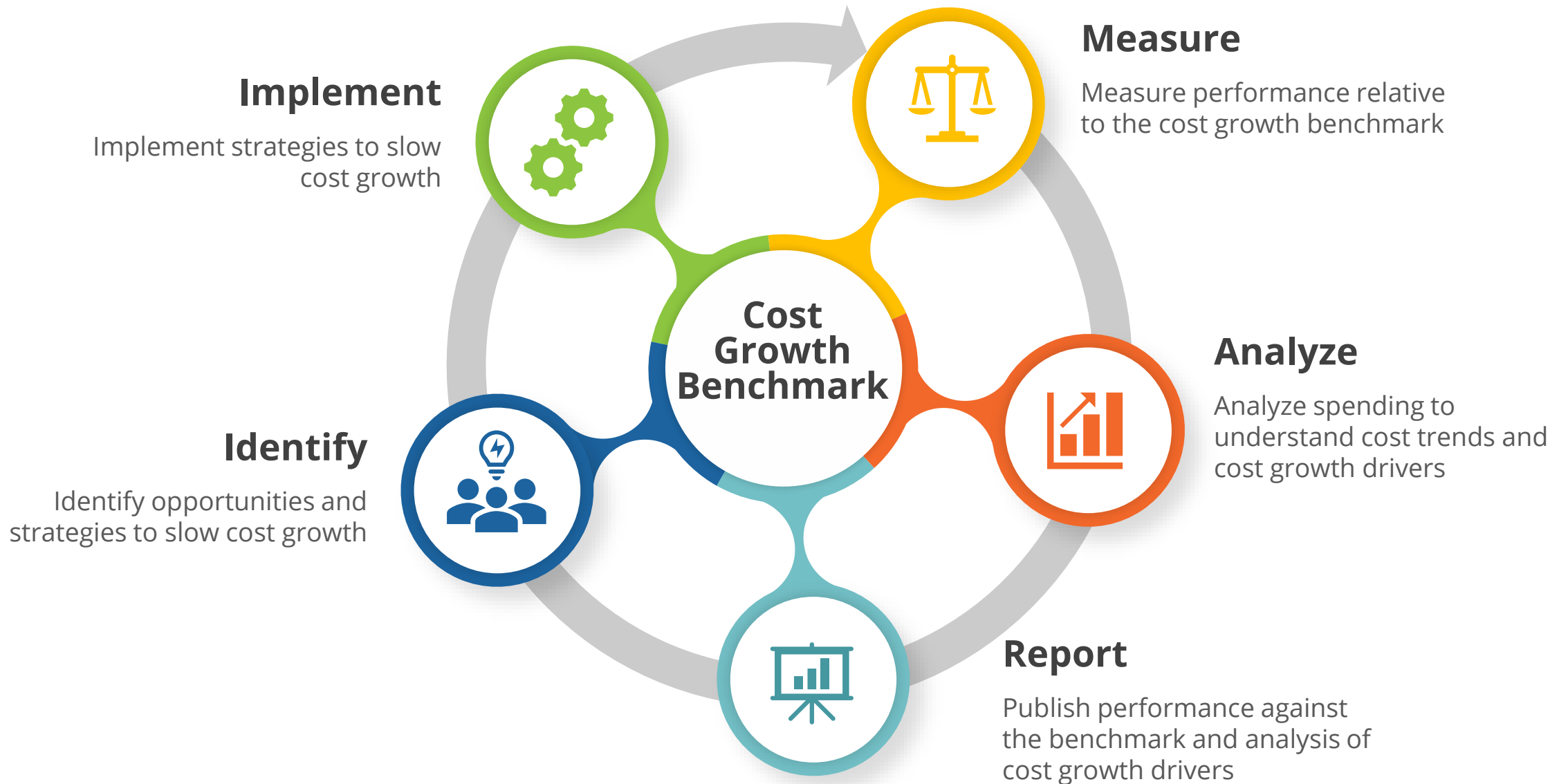


- Based on a) what we have learned from the Phase 1 cost driver analyses, b) input from the Advisory Subcommittee, and c) strategies being pursued in other states, what cost growth mitigation strategies do you propose for future consideration?

Agenda

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The logic model for a cost growth benchmark



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
5/16/2022	Issue formal baseline data request to insurers
5/16/2022	Distribute benchmark implementation manual and hold trainings with payers
8/31/2022	Receive aggregate baseline benchmark data from payers
Winter 2023	Validate, analyze, and review baseline benchmark findings with PPC and stakeholders

Timeline for Cost Driver Analysis



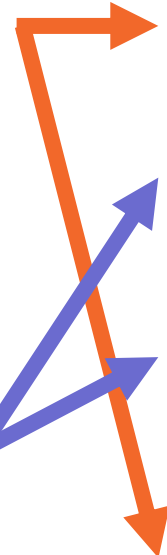
Analyze

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
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 **Wednesday, June 15th at 9:00 a.m.**

Appendix: Survey Results

Survey Results

Placeholder slide to display survey results in more detail.