

# Cost Growth Benchmark Performance Assessment

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*Nevada Patient Protection Commission*

*February 16, 2022*

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

| PPC Meeting Date          | Primary Topics of Discussion   |
|---------------------------|--|
| February 16 <sup>th</sup> | Methods to ensure the accuracy and reliability of benchmark performance measurement; transparency and accountability; data use strategy                      |
| March 16 <sup>th</sup>    | Three bill drafts to prioritize and request for 2023 legislative session; process for identification and prioritization of cost growth mitigation strategies |
| April 20 <sup>th</sup>    | Review findings of Medicaid & PEBP Phase 1 cost driver analyses  |
| May 18 <sup>th</sup>      | Cost growth mitigation strategies to ensure the benchmark strategy is successful; review three bill drafts to request for 2023 legislative session           |
| June 15 <sup>th</sup>     | Discuss vote of bill draft   |
| October 19 <sup>th</sup>  | Discuss pre-filing requirements  |

# Agenda

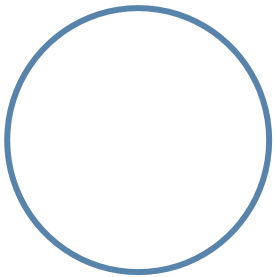
1. Advisory Subcommittee Feedback on Preliminary Recommendations
2. Methods to Ensure the Accuracy and Reliability of Benchmark Performance Measurement (continued from last meeting)
  - a. Recap: Mitigating the Impact of High-Cost Outliers on Per Capita Spending
  - b. Applying Risk Adjustment
  - c. Reporting for Sufficient Population Sizes
3. Transparency & Accountability
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# Member Attribution to Clinicians

The PPC agreed on allowing insurers to use their own attribution methodologies and asking each insurer to disclose that methodology.

The PPC also recommended performing an analysis in the future to see whether the differences in methodologies are substantive enough to warrant a common methodology.



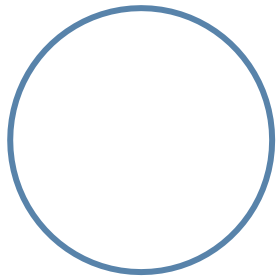
The Advisory Subcommittee agreed with all parts of the PPC's recommendation regarding member attribution methodology.



# How to Organize Clinicians Into Large Provider Entities

The PPC supported the creation and use of a statewide provider directory to attribute clinicians to large provider entities, if feasible.

DHHS has agreed to evaluate the feasibility of this option. The fallback option would be to rely on payers for this information.



The Advisory Subcommittee did not voice any disagreement with the PPC's recommendation to begin with an exploration of whether a statewide provider directory would be feasible.

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# Mitigating the Impact of High-Cost Outlier on Per Capita Spending

- High-cost outliers are member/patients with extremely high levels of annual health care spending
  - The members/patients represent real spending that we need to represent in state and market trend calculations.
  - They mostly present randomly in a population, and there are limits to how much of their spending can be influenced due to their complex medical condition and high intensity care needs.
  - It is not fair to judge insurer and provider performance against the benchmark when it is significantly influenced by spending on high-cost outliers.

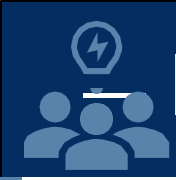
# How to Address High-Cost Outliers

- It is common practice in total cost of care contracts to *truncate* expenditures to prevent a small number of extremely costly members from significantly affecting providers' per capita expenditures.
- Truncation involves capping individual patient annual spending at a high level. For example, that level is often between \$100K and \$150K for commercial population contracts.
- Truncation can be applied to benchmark performance assessment.
  - Spending above the cap can be *excluded* from benchmark performance assessment at the insurer and provider entity levels.
  - Spending above the cap can be *included* in benchmark performance assessment at the state and market levels.



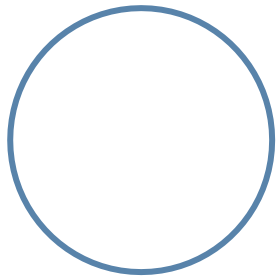
# RI's Experience With High-Cost Outliers

- In RI, analyses showed that high-cost outliers significantly affected performance of provider entities.
  - For one RI ACO, including high-cost outlier spending raised the trend rate by several percentage points, e.g., 3% to 11%.
- The differential treatment of high-cost outliers in the cost growth benchmark program and in TCOC contracts led to confusion and tension around reporting of performance.
- As a result, RI is truncating high-cost outliers starting with 2020 performance data.



# Design Recommendation: Truncation of High-Cost Outliers

The PPC leaned toward supporting truncation of high-cost outliers' spending **and** recommending an analysis of outliers' spending to identify its causes and opportunities to slow spending growth, but did not come to consensus.



The Advisory Subcommittee supported truncating high-cost outliers' spending and working to understand whether there are opportunities to slow spending associated with high-cost outliers.

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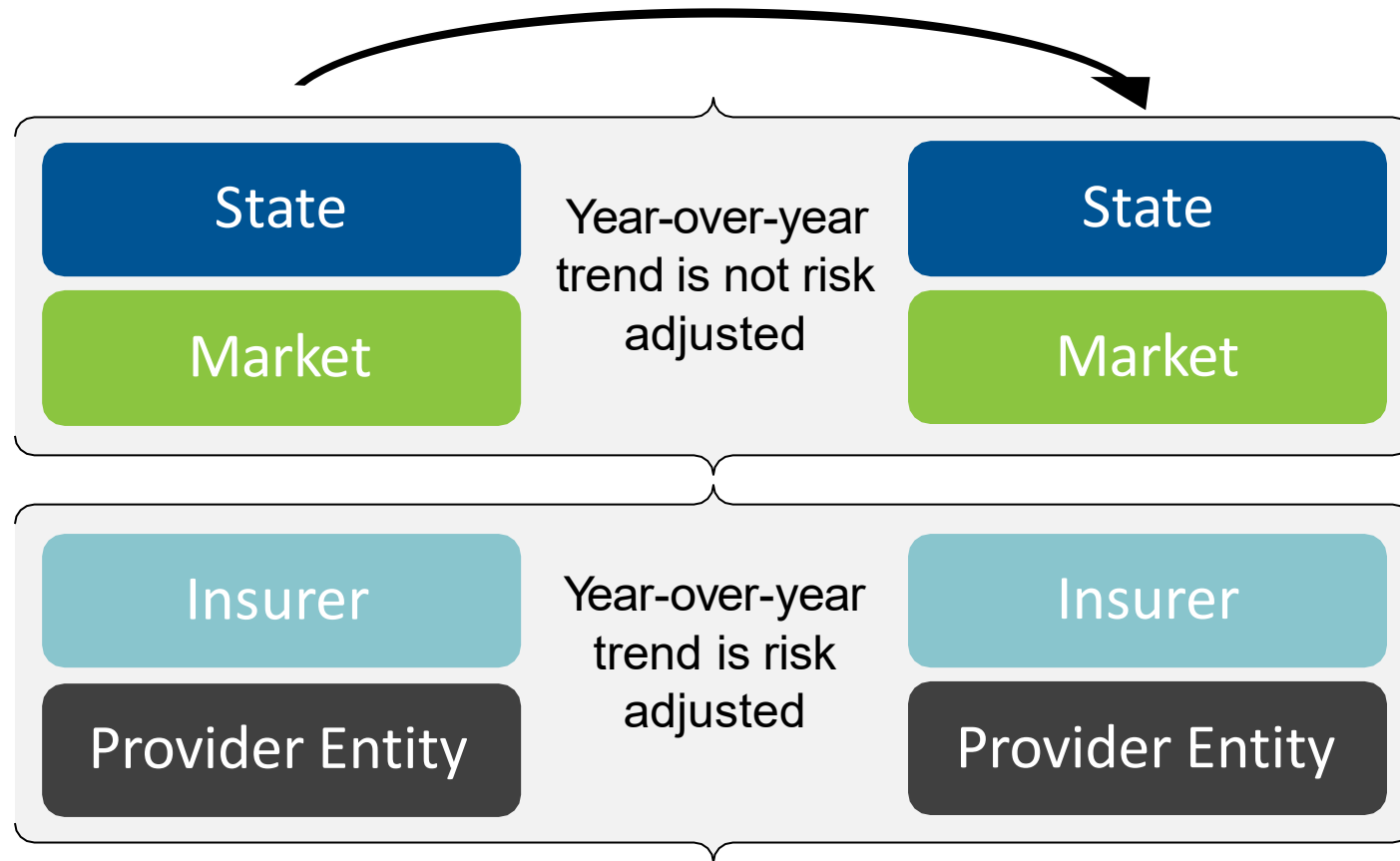
# Applying Risk Adjustment

- Cost growth benchmark states typically risk adjust data to account for population changes over time.
  - The composition of a payer's or provider's population may change over the course of a year.
  - Such changes will impact spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.

# Risk Adjustment Models

- *Clinical risk adjustment* is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
- Available models use claim and encounter data, such as diagnoses, procedures, and prescription drugs.
  - They do not include medical record information (e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information).
- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.\*

# Risk Adjustment Is Only Performed at the Insurer and Provider Levels



# Coding Completeness and Rising Risk Scores

- The health status of a full population is typically fairly stable between consecutive years, because changes in the demographic and health characteristics that might affect an entire population's risk score occur slowly.
- However, clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims.

# MA's Experience with Rising Risk Scores

- MA has observed steadily rising risk scores year after year, amounting to an 11.7% increase between 2013 and 2018.
  - Only a small portion of the increase could be explained by demographic trends or changes in disease prevalence.
  - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in *unadjusted* spending.



# RI's Experience with Rising Risk Scores

- In RI, excluding the duals plans, payer risk scores grew 4.6% from 2018 to 2019.
  - Rising risk scores had the effect of essentially raising the cost growth target value by 3.2%, *doubling* to 6.4% the trend that would meet the cost growth target with an average rising risk score.
  - Consequently, RI decided to only risk-adjust data by age and sex starting with the 2020 performance year.
    - WA has since decided to do the same.

# Recent Research on Rising Risk Scores

*“During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually)...The average gap in risk score growth appears to be the result primarily of HCC coding practices..., suggesting that coding...may account for most of the observed risk score growth for ACO beneficiaries.”*

## ACCOUNTABLE CARE

By Michael E. Chernew, Jessica Carichner, Jeron Impreso, J. Michael McWilliams, Thomas G. McGuire, Sartaj Alam, Bruce E. Landon, and Mary Beth Landrum

### Coding-Driven Changes In Measured Risk In Accountable Care Organizations

**ABSTRACT** Claims data, which form the foundation of risk adjustment in payment for health care services, may reflect efforts to capture more—or more severe—clinical conditions rather than true changes in health status. This can distort payments. We quantify this in the context of Medicare’s accountable care organization (ACO) program by comparing risk scores derived from two different measurement approaches. One approach uses diagnoses coded on claims based on Centers for Medicare and Medicaid Services Hierarchical Condition Categories (HCC), and the other uses self-reported, survey-based health data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). During 2013–16 HCC-based risk scores grew faster than CAHPS-based risk scores (2.1 percent versus 0.3 percent annually), and the gap in HCC- and CAHPS-based risk score growth varied widely across ACOs. The average gap in risk score growth appears to be the result primarily of HCC coding practices rather than poor performance of the CAHPS model, suggesting that coding practices (not necessarily driven by ACO contracts) may account for most of the observed risk score growth for ACO beneficiaries.

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**Jeron Impreso** is an advisory analyst for Medicaid at Mathematica in Washington, D.C. He was a research associate for health policy, Committee for a Responsible Federal Budget, in Washington, D.C., when this work was conducted.

# Three Options for Addressing Changing Population Risk

## 1. Adjust using normalized clinical risk scores.

- Normalization supports recognition of population changes while mitigating overall risk score increases due to coding.
- Requires APCD analysis when performed at the health plan level.
- Normalization does not remove the provider and plan incentive to increase coding completeness, however.

## 2. Adjust performance data using age/sex factors only.

- Using clinical risk scores overcompensates for yearly changes in population health status and creates distortion due to claim coding practices.
- Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.
- Age/sex adjustment will not capture more substantive changes in health status of a population.

# Three Options for Addressing Changing Population Risk

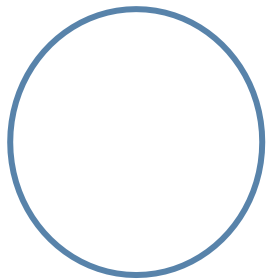
## 3. Make no adjustment for changing population risk.

- Using clinical risk scores overcompensates for yearly changes in population health status and creates distortion due to claim coding practices, and the impact of changes in age/sex composition on an annual basis may not be substantive.
- Making no adjustment could disadvantage a plan or provider entity with a large population change over the course of a year.



# Design Recommendation: How to Risk Adjust Data

The Advisory Subcommittee weighed in on this question. Some supported Option #1 (adjust using normalized clinical risk scores) and one member supported Option #2 (adjust performance data using age/sex factors only). A couple of members asked for more time to digest this information before giving a final opinion.



Which of the three options does the PPC wish to recommend for risk adjustment of benchmark performance data?

1. Adjust using normalized clinical risk scores.
2. Adjust performance data using age/sex factors only.
3. Make no adjustment for changing population risk.

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# Reporting for “Sufficient” Population Sizes

- In determining “sufficient” population sizes, there are two separate but related questions to address:
  1. How many enrolled lives must a **payer** have to report total health care expenditures (THCE)?
  2. How many lives must a **provider entity** have in a line of business for its performance to be publicly reported?



# Population Size Thresholds Established by Other States

| State     | Payers Required to Report   | Thresholds for Public Reporting Provider Performance   |
|-----------|---|--|
| DE and RI | The largest insurers in the state, as determined by the state                                   | By line of business, provider entities with: <ul style="list-style-type: none"> <li>• At least 10,000 attributed commercial or Medicaid lives</li> <li>• At least 5,000 attributed Medicare lives</li> </ul> |
| CT        | The commercial and Medicare insurers representing ~85% of commercial covered lives in the state | TBD  |
| MA        | Payers with at least 3,600 attributed lives   | No published standard for public reporting   |
| OR        | At least 1,000 covered lives across all lines of business                                       | Across all markets, provider entities with at least 10,000 attributed lives  |



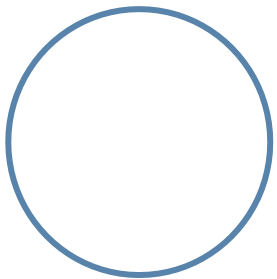
# Determining What Is a “Sufficient” Population Size

- Determining “sufficient” population sizes becomes less pressing with the adoption of confidence intervals.
- OR and CT are collecting “pre-benchmark” data, which should shed light on the population sizes at which confidence intervals become so large as to make it difficult to determine benchmark performance.
- For now, we recommend:
  - Requiring reporting by all Medicaid MCOs and by carriers with commercial or Medicare Advantage market share at 5% or higher.
  - Deferring on provider entity thresholds until OR and CT have completed their pre-benchmark analyses in the next few months.



# Design Recommendation: Minimum Population Sizes

The Advisory Subcommittee leaned toward supporting the draft recommendations below, which would mean requiring reporting from Renown Health (5.11% market share), Humana (13.33%), Anthem (20.91%), and UnitedHealthcare (47.90%). They also discussed requesting from Aetna and Cigna in case the size of their self-funded business warrants inclusion.



Does the PPC support with the following draft recommendations?

- Require reporting by all Medicaid managed care organizations and by commercial and Medicare Advantage carriers with market share of 5% or higher (with or without Aetna and Cigna).
- Defer a recommendation on provider entity population thresholds until OR and CT have completed their pre-benchmark analyses.

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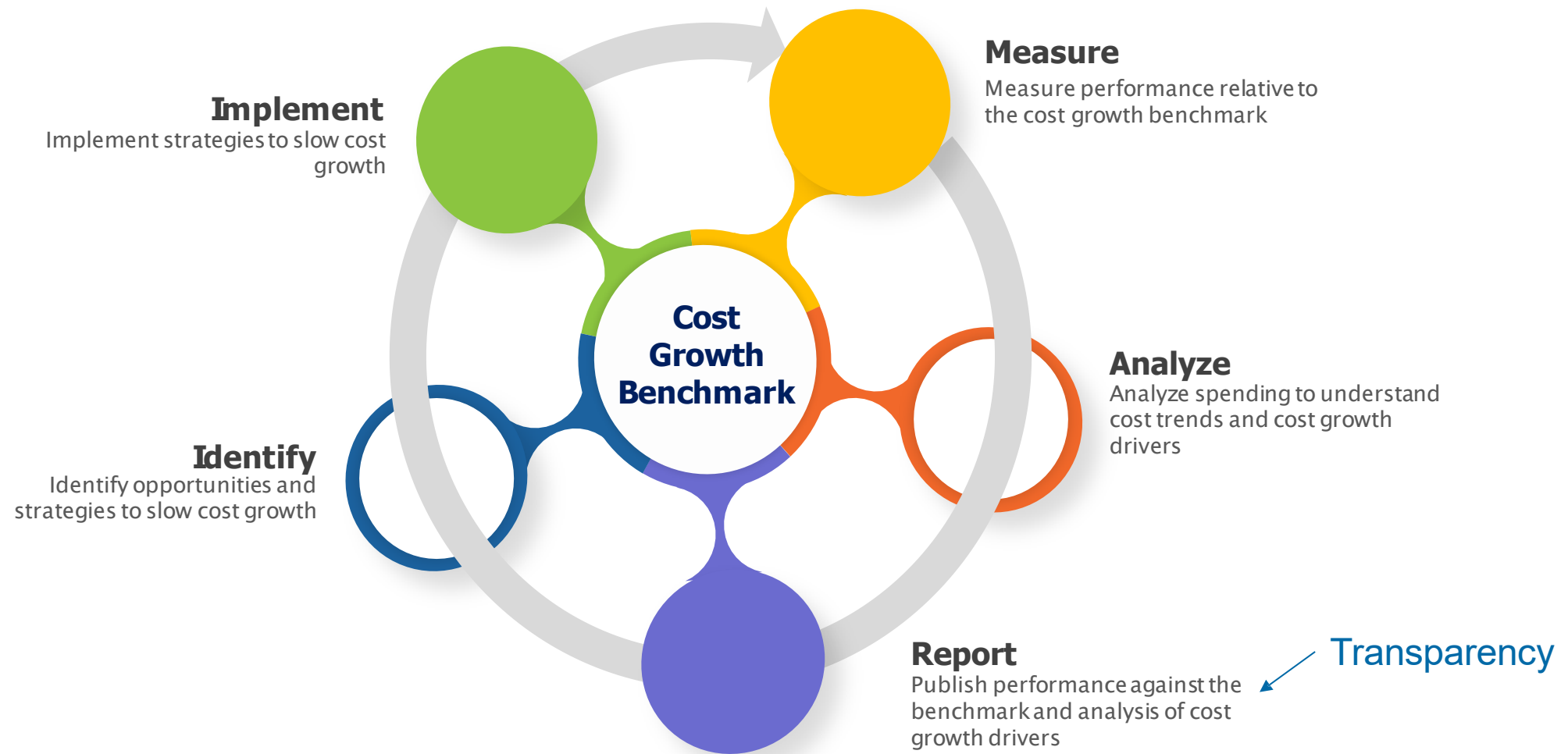
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# Defining Terms

- 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



# 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

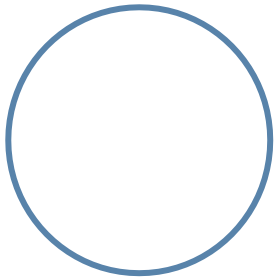
# Transparency: MA's Approach to Public Hearings

- **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 for the PPC to Consider



- 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

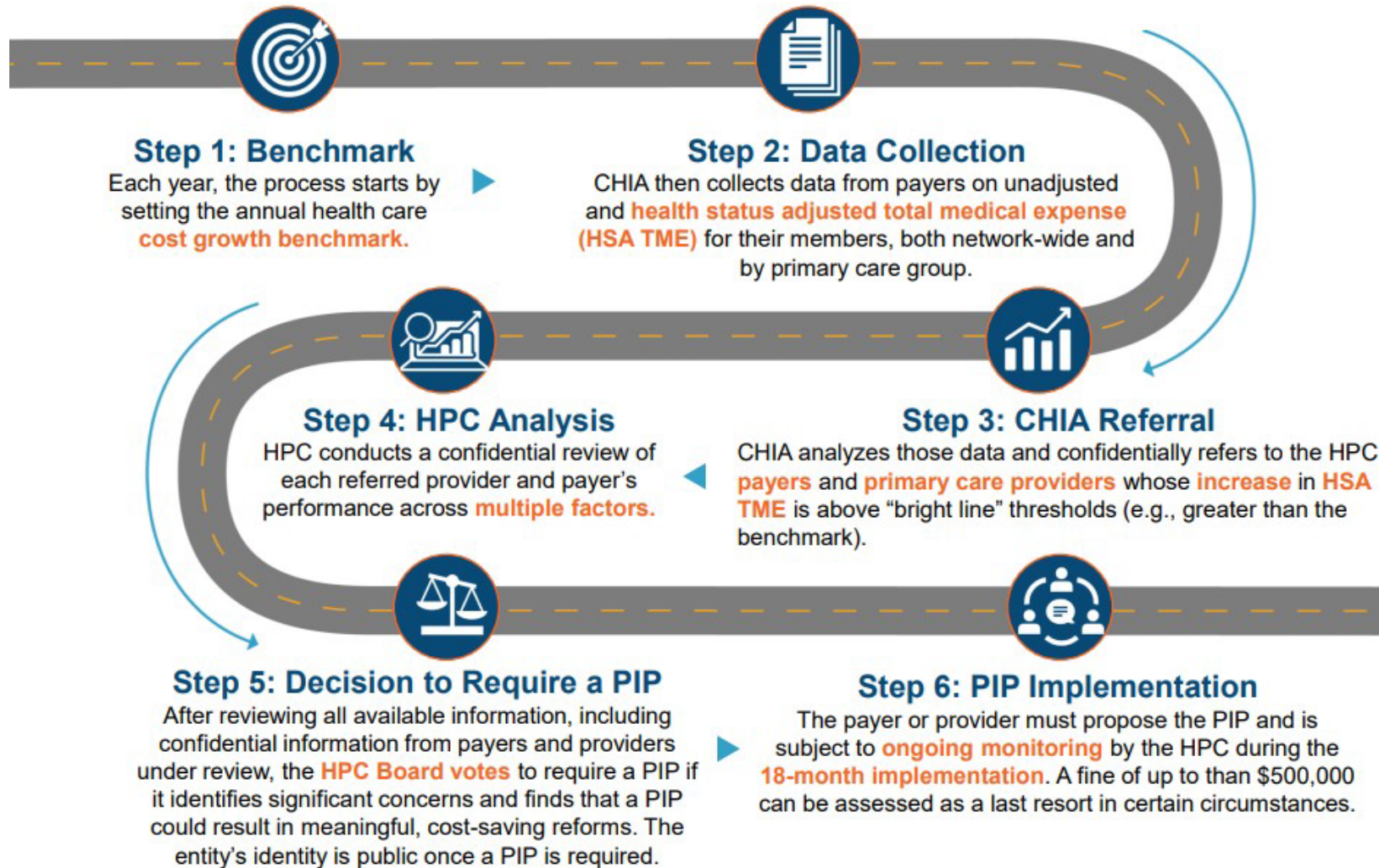
- Procedures when a payer or provider entity fails to remain at or below the cost growth benchmark

# 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



# 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.



# 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.

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# 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

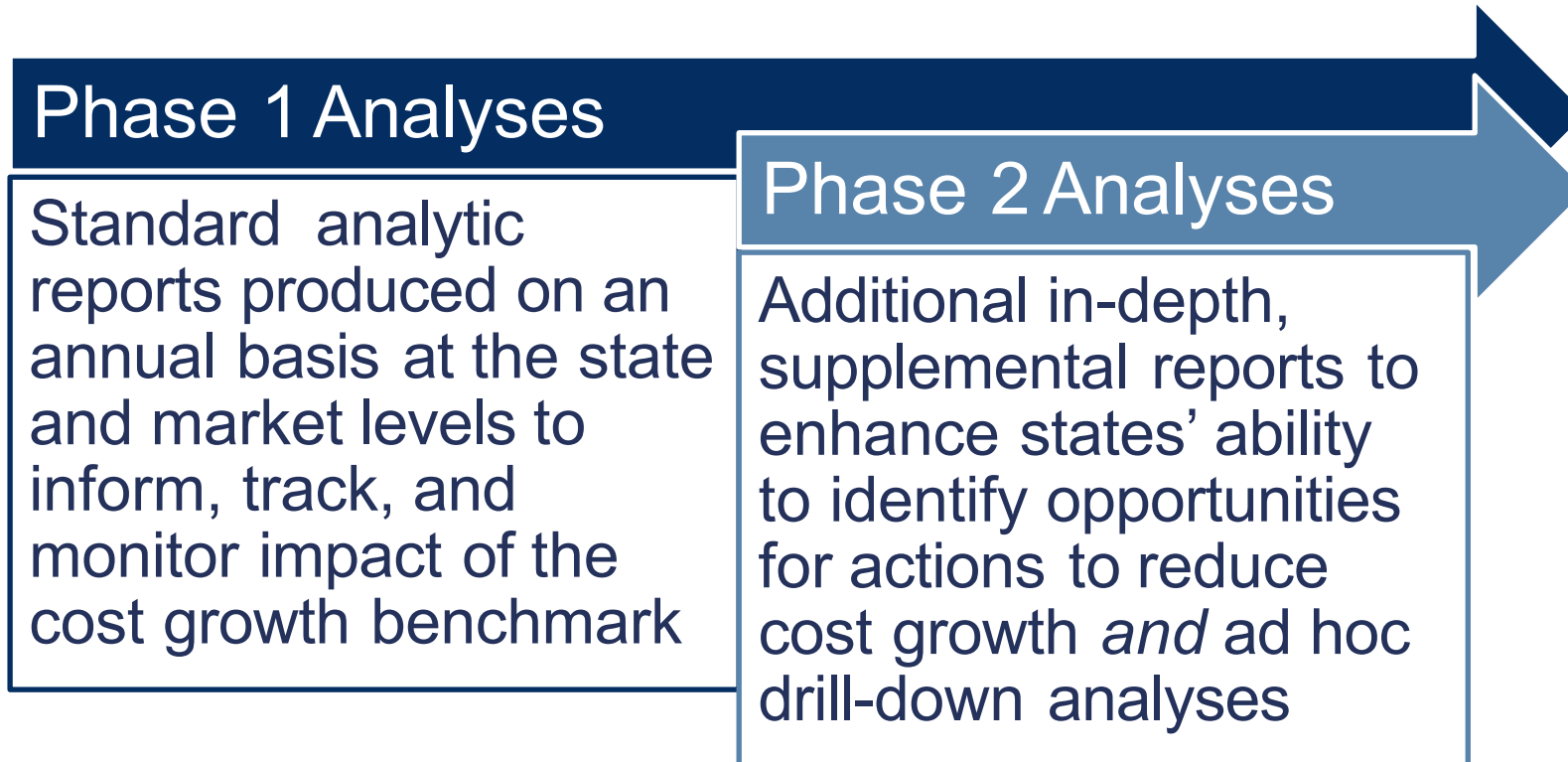
- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters)
- **Data Source:** APCD, when available. Until then, only Medicaid and Public Employees' Benefits 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

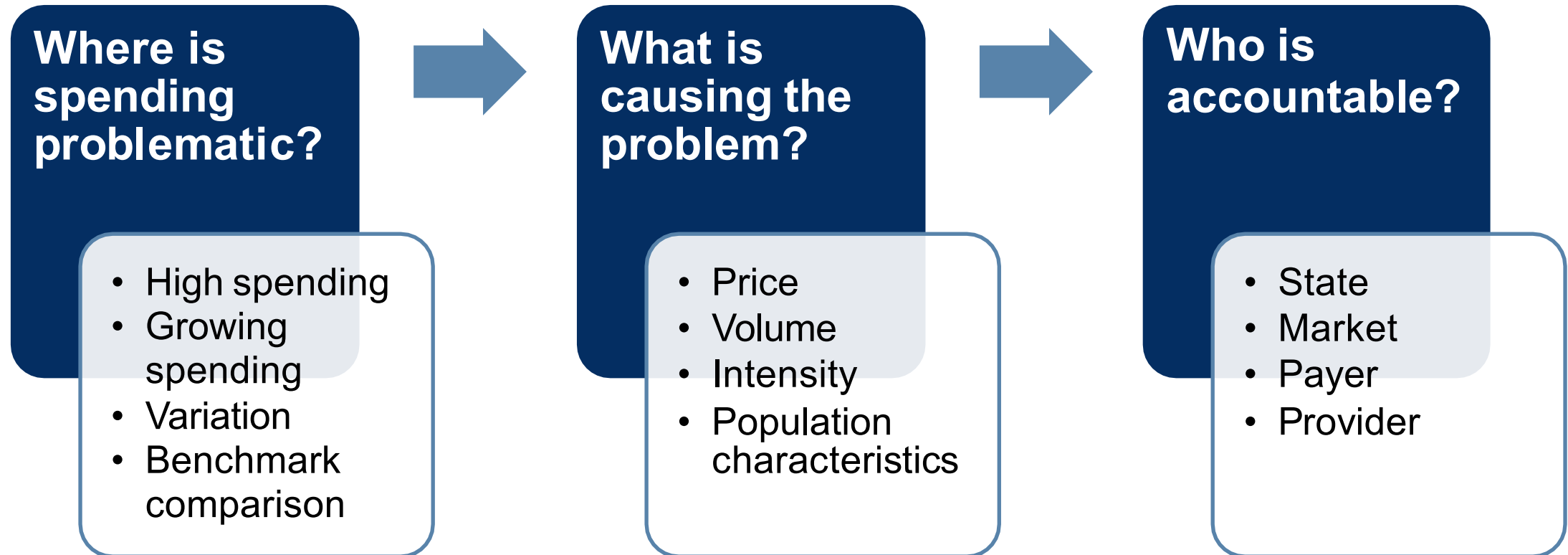
There are two types of analyses included in a data use strategy:



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?

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   |
|---|--|---|---|---|
| <ul style="list-style-type: none"><li>• The amount a payer reimburses for a service, plus patient payments.</li><li>• The primary driver of health care spending growth in the commercial market.</li></ul> | <ul style="list-style-type: none"><li>• The quantity of service units or treatment episodes delivered.</li></ul> | <ul style="list-style-type: none"><li>• The scope and types of services utilized for a treatment.</li><li>• Captures differences in site of care (e.g., inpatient vs. outpatient) and treatment modality (e.g., robot-assisted vs. manual surgery).</li></ul> | <ul style="list-style-type: none"><li>• 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.</li></ul> | <ul style="list-style-type: none"><li>• The availability of provider resources (e.g., specialists, hospital beds) correlates with increased utilization and spending.</li></ul> |

# What is Causing the Problem? (2 of 2)

| Service                  | THIS YEAR's<br>Spending<br>(PMPM) | LAST YEAR's<br>Spending<br>(PMPM) | Change<br>(%) | Change<br>(PMPM) | What is contributing to<br>the change in spending? (PMPM) |  |  |   | Total Change<br>in Spending |
|--------------------------|-----------------------------------|-----------------------------------|---------------|------------------|---|--|--|---|-----------------------------|
|                          |                                   |                                   |               |                  | changes in<br>Age/Gender<br>Mix<br>account for:           | changes in<br>Service<br>Frequency<br>account for: | changes in<br>Treatment<br>Intensity<br>account for: | changes in<br>Price Level<br>account for: |                             |
| 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                     |
|                          | <b>\$275.87</b>                   | <b>\$261.51</b>                   | <b>5.5%</b>   | <b>\$14.36</b>   | <b>\$1.13</b>   | <b>\$2.62</b>                                      | <b>\$1.35</b>  | <b>\$9.27</b>                             | <b>\$323,141</b>            |
|                          |                                   |                                   |               |                  | <b>8%</b>   | <b>18%</b>   | <b>9%</b>  | <b>65%</b>                                |                             |

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

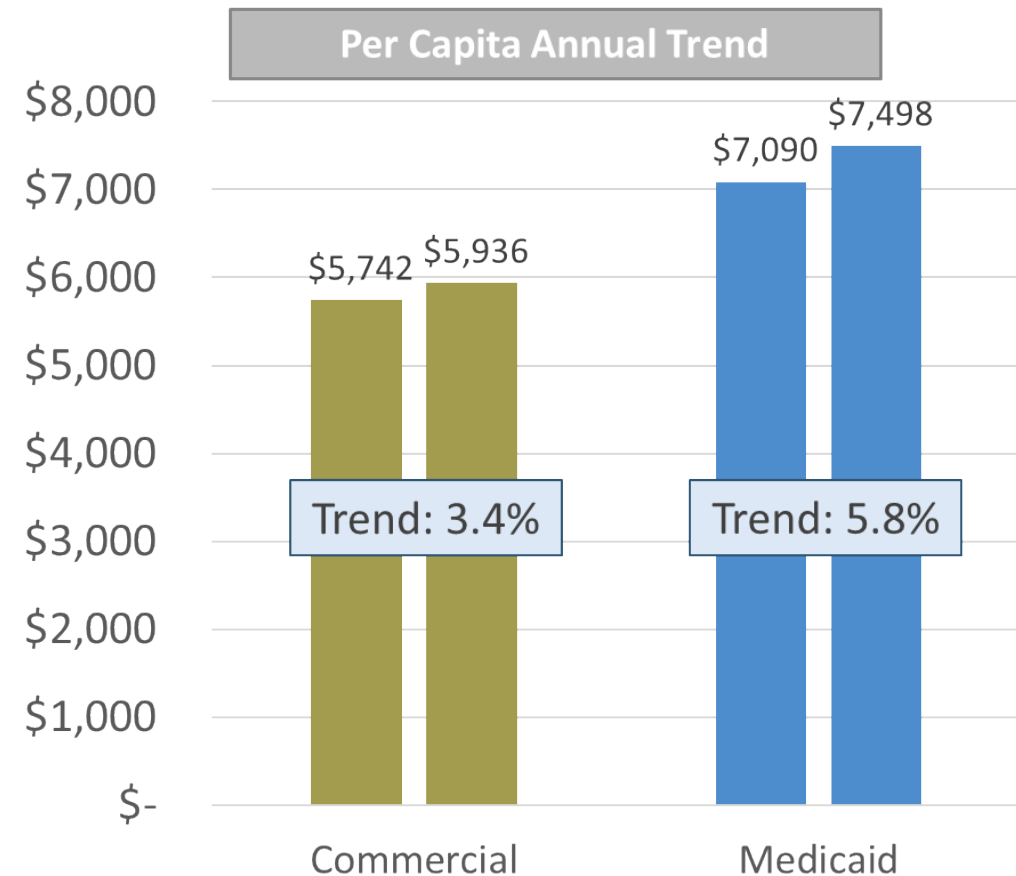
- Until an APCD is available for use, the State will use data from Medicaid and the Public Employees Benefits Program (PEBP). Phase 1 analyses are currently underway for both.
- Analyses in **blue** will be included in Nevada Medicaid's Phase 1 report, using data from 2016-2020. Medicaid is also developing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

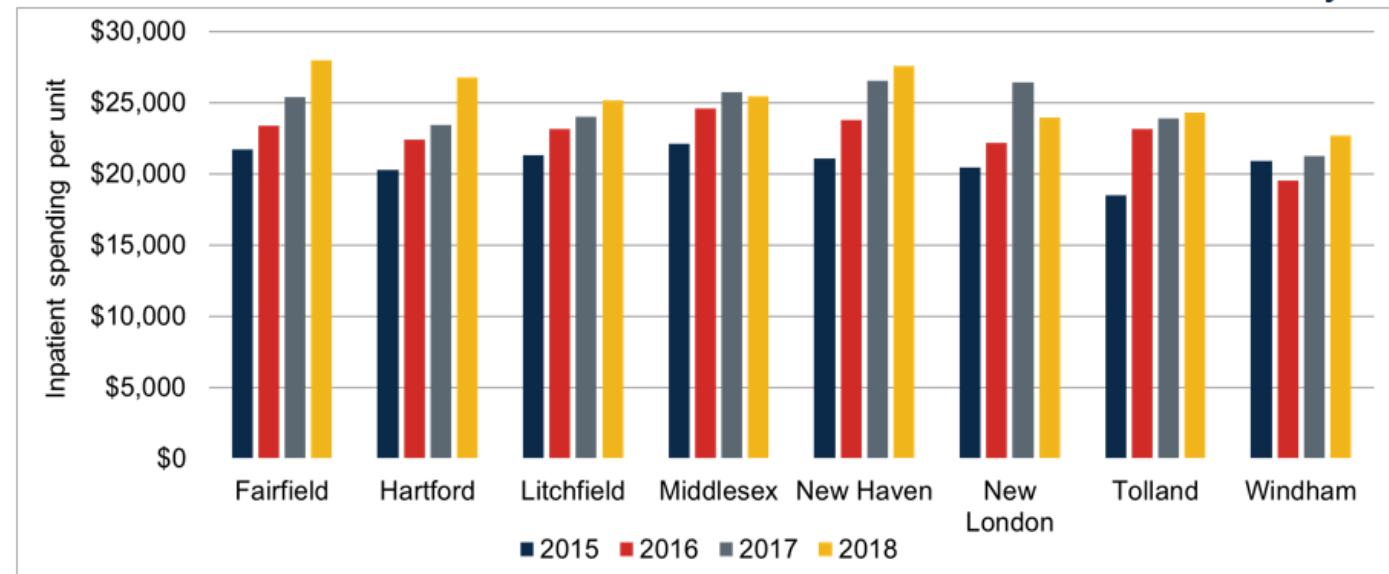


Source: Rhode Island Office of the Health Insurance Commissioner. (2020, August 17). [Baseline 2017-2018 Performance Against the Cost Growth Target. Presentation.](#)

# 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



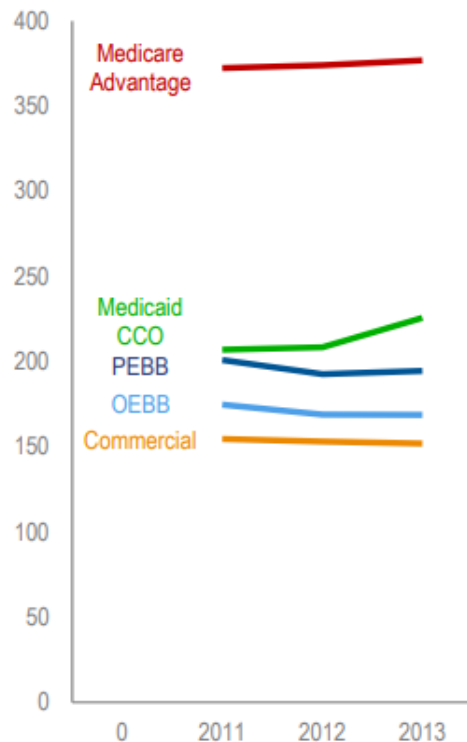
County is based on member residence, which will often differ from the county where care was received. Inpatient stay units defined as discharges, which can include multiple claims. Results are adjusted to control for differences in age-gender mix among counties.

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

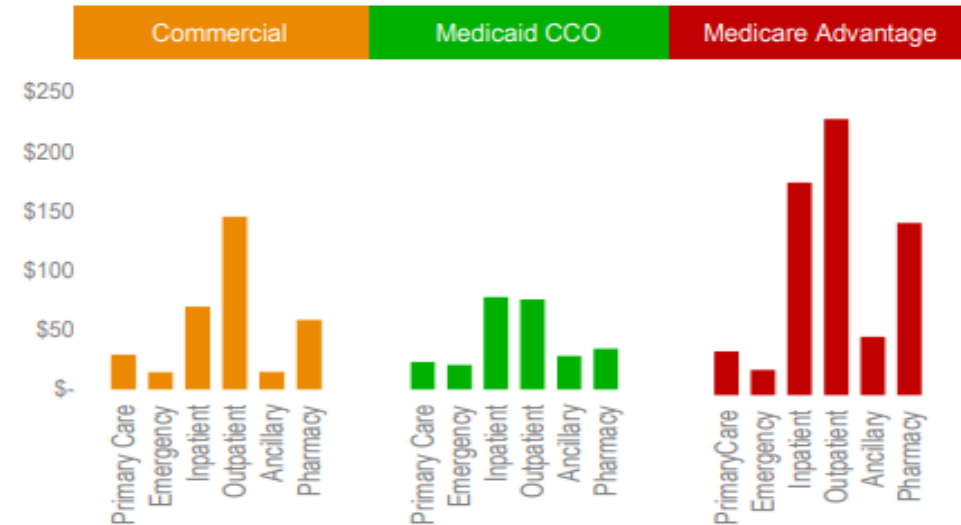
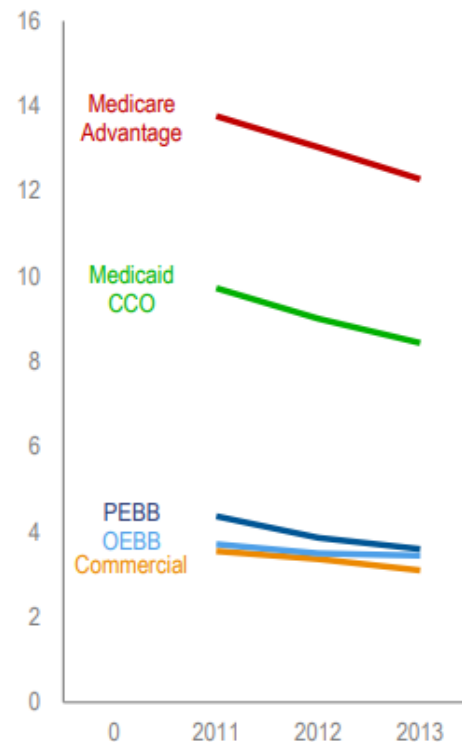
# Reports 5 and 6: Spend and Trend by Service Category

- Analysis of spending for defined service categories and subcategories

From 2011 to 2013, primary care visits per 1,000 member months increased by 9% among **Medicaid CCO** members.\*



From 2011 to 2013, inpatient admissions per 1,000 member months fell across all payers.\*



- 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).

# 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)

| Condition                            | 2018                   |       |                                      |
|--------------------------------------|------------------------|-------|--------------------------------------|
|                                      | 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   |

# 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.
- States should consider a phased approach to publishing health care spending analyses. To build trust among stakeholders and key partners, states should:
  - 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**

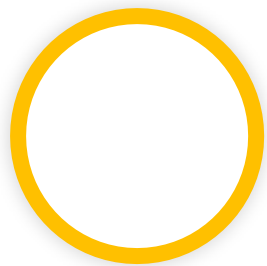
- Initial look at health care cost growth in 2018-2019 using payer-reported aggregate data
- Will include breakdown by market, and by service categories contributing to spending and trend within each market
- Look at trends pre-COVID-19

# Agenda

1. Advisory Subcommittee Feedback on Preliminary Recommendations
2. Methods to Ensure the Accuracy and Reliability of Benchmark Performance Measurement (continued from last meeting)
  - a. Recap: Mitigating the Impact of High-Cost Outliers on Per Capita Spending
  - b. Applying Risk Adjustment
  - c. Reporting for Sufficient Population Sizes
3. Transparency & Accountability
4. Data Use Strategy
5. Next Steps

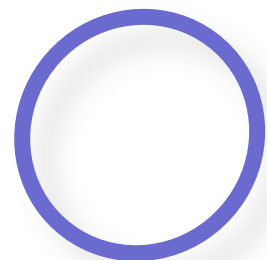


# Timeline for Benchmark Analysis



## Measure

Measure performance relative to the cost growth benchmark



## Report

Publish performance against the benchmark and analysis of cost growth drivers

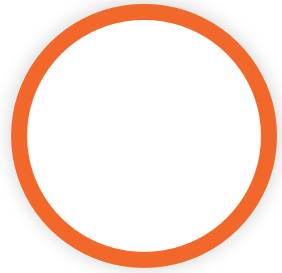


| Deadline    | Key Deliverable   |
|-------------|---|
| 6/30/2022   | Issue formal baseline data request to insurers                                      |
| 6/30/2022   | Distribute benchmark implementation manual and hold trainings with payers           |
| 8/31/2022   | Receive aggregate baseline 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 |



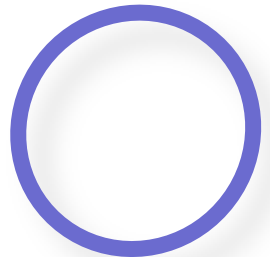


# Timeline for Cost Driver Analysis



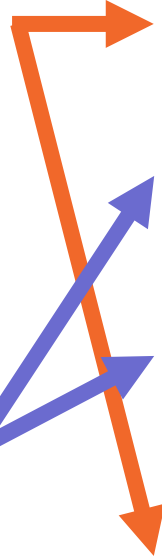
## Analyze

Analyze spending to understand cost trends and cost growth drivers



## Report

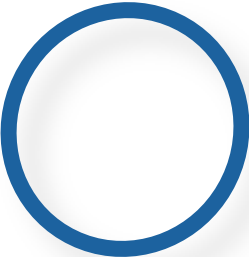
Publish performance of cost growth drivers



| 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 16<sup>th</sup>** at 9:00am.
- Commissioners should consider draft bills to propose in advance of the March meeting. The State proposes that one of the bills establish the cost growth benchmark program in statute.