Cost Growth Benchmark Performance Assessment

Nevada Patient Protection Commission

April 20, 2022

bailit health

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

PPC Meeting Date	Primary Topics of Discussion
April 14th - **Cancelled due to lack of quorum**	*Advisory Subcommittee Meeting*: Review findings of Medicaid & PEBP Phase 1 cost driver analyses
April 20th	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.
May 3rd	*Advisory Subcommittee Meeting*: Cost growth mitigation strategies to ensure the benchmark strategy is successful
May 18th	1) Cost growth mitigation strategies to ensure the benchmark strategy is successful. 2) Review three bill drafts to request for 2023 legislative session.
June 15th	1) Discuss bill drafting. 2) Review quality benchmark work of other states. 3) 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. Data Use Strategy
2. Medicaid Phase 1 Cost Driver Analyses: Review and Discussion of Findings
3. PEBP Phase 1 Cost Driver Analyses: Review and Discussion of Findings
4. Revisit Provider Entity Population Thresholds Based on OR's and CT's Pre-Benchmark Analyses
5. Next Steps

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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

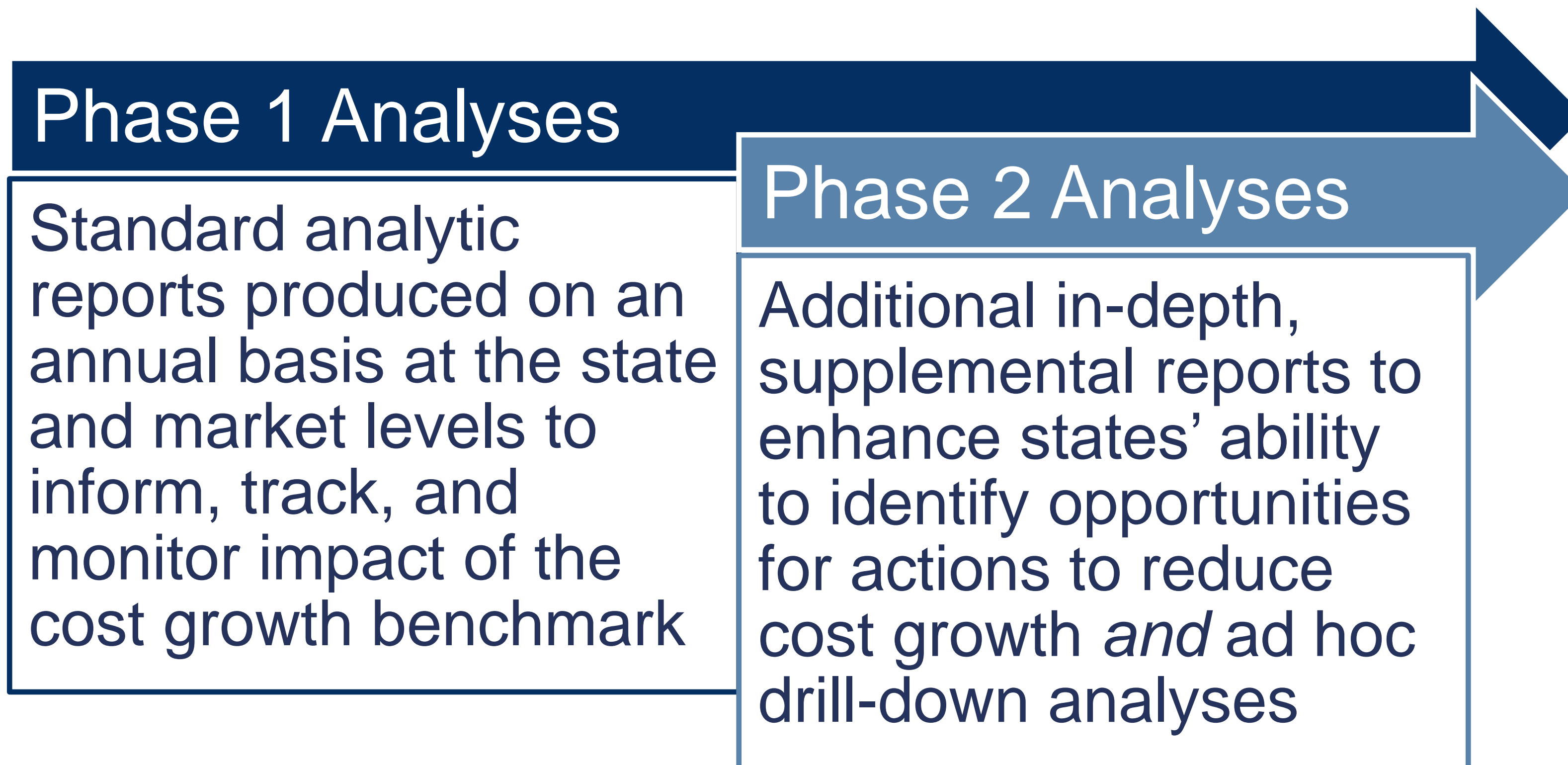
- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters)
- **Data Source:** APCD, when available. Until then, only Medicaid and Public Employees' Benefits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

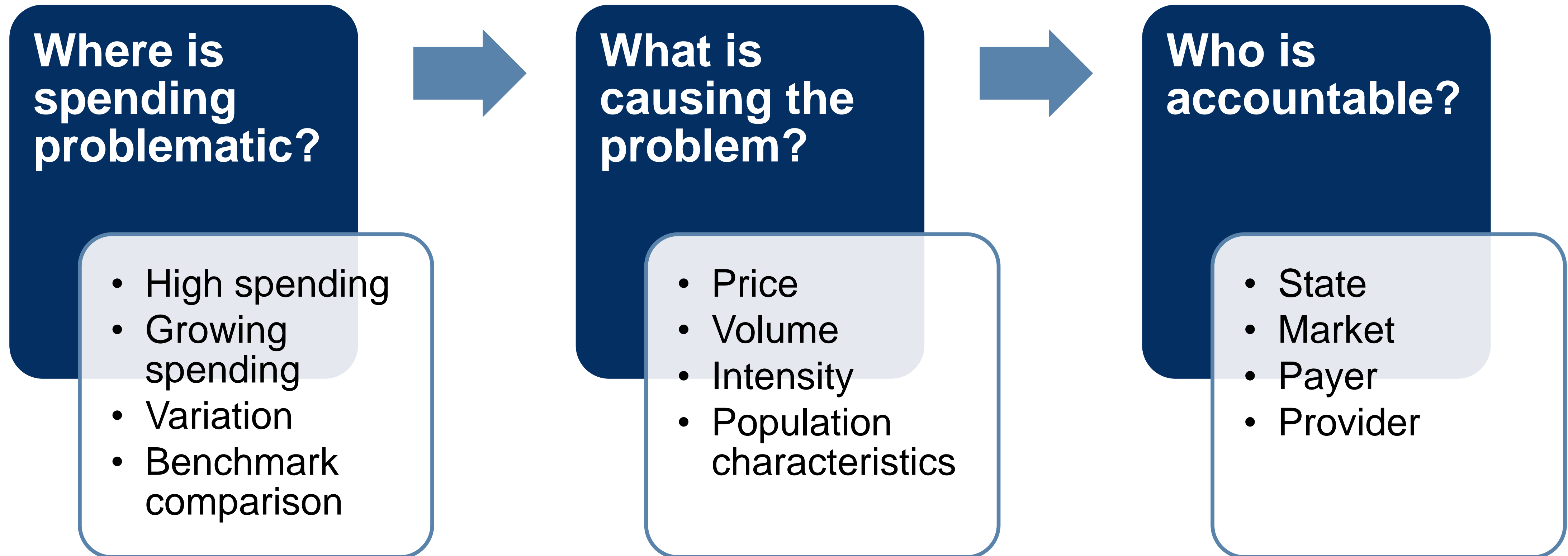
There are two types of analyses included in a data use strategy:



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
• 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 for both will be presented today.
- Analyses in **blue** are 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.

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.

Data Use Strategy Reports

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

Baseline Analysis Report

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

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Medicaid Phase 1 Cost Driver Analyses: Review and Discussion

- Slides for this section have been attached on the PPC website as a separate file.

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PEBP Phase 1 Cost Driver Analyses: Review and Discussion

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Minimum Attributed Lives for Public Reporting in Other States

State	Minimum Attributed Lives for Public Reporting
Delaware	Delaware will publicly report, by line of business, for provider entities that have: ▪ A minimum of 10,000 attributed commercial or Medicaid lives. ▪ A minimum of 5,000 attributed Medicare lives.
Massachusetts	Massachusetts[1] has no published standard for public reporting.
Oregon	Oregon will report provider performance overall and stratified by market. Provider entities must have a minimum count of 10,000 attributed lives for overall (i.e., across market) performance to be publicly reported, and a minimum of 5,000 attributed lives in a market for performance in that market to be reported.
Rhode Island	Rhode Island publicly reports, by line of business, for Accountable Care Organizations that meet the following criteria: ▪ A minimum of 10,000 attributed commercial or Medicaid lives. ▪ A minimum of 5,000 attributed Medicare lives.

[1] While MA has not communicated a standard for public reporting, it did set a minimum threshold for payer reporting to the state at 3,600 attributed lives.

Data Used in Bailit Health's Analysis

- Bailit Health analyzed data from:

1. **CT's 2018-2019 pre-benchmark data collection**

   Included submissions from 6 insurers on spending associated with 11 large provider organizations in the commercial and Medicare Advantage markets.

2. **RI's 2019-2020 benchmark data collection**

   Included submissions from 4 insurers on spending associated with 7 large provider organizations in the commercial, Medicare Advantage, and Medicaid Managed Care markets.

Provider Level Analysis

At the provider level, there were **42 total data points** with which to assess the relationship between attributed lives and confidence interval widths across the commercial, Medicaid, and Medicare Advantage markets.

We compared the sizes of confidence intervals across provider entities with different numbers of attributed lives.

- Confidence intervals shrank significantly when a provider entity reached a minimum threshold of ~5,000 attributed lives
- Confidence intervals shrank even more for provider entities that have ≥15,000 attributed lives. However, the gain in accuracy did not seem to outweigh the significant reduction in the number of provider entities whose performance would be excluded.

Insurer Level Analysis

At the insurer level, there were **20 total data points** with which to assess the relationship between attributed lives and confidence interval widths across the commercial, Medicaid, and Medicare Advantage markets.

We compared the sizes of confidence intervals across insurers with different numbers of attributed lives.

- Populations were much larger at the insurer level, and thus the confidence intervals were much tighter.
- One insurer with ~8,000 members in a market had a confidence interval that was approximately 3x wider than the average.
- In general, however, it is not clear that establishing a minimum threshold above the 5,000 recommended for insurers would have much impact on the variation in the size of confidence intervals.

Recommendations from Bailit Health's Analysis

- We recommend that Nevada adopt a **minimum threshold of 5,000 enrolled / attributed lives** in each market for public reporting of provider entities' and insurers' baseline performance.
- We also recommend revisiting this recommendation once the PPC has two years of benchmark performance data.

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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

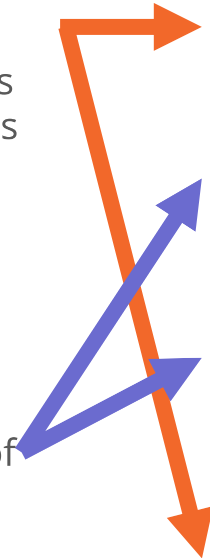
Timeline for Cost Driver Analysis

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 Advisory Subcommittee will next meet on **Tuesday, May 3rd at 12:30 p.m.**
- The Patient Protection Commission will next meet on **Wednesday, May 18th at 9:00 a.m.**

The logic model for a cost growth benchmark