SUMMARY MINUTES

October 19, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present
Sara Cholhagian Ralston
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler
Flo Khan

Commission Members Absent
Bobbette Bond – excused
Lilnetra Grady – excused
Dr. Mark Decerbo – excused

Advisory Commission Members Present
Ryan High, Executive Director, Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS)

Advisory Commission Members Absent
Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI) – excused

Commission Staff Present
Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General
Kiley Danner, Policy Analyst

Agenda Item II – Approval of September 21, 2022, Minutes

Dr. Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the September 21, 2022, meeting.

MOTION was made to approve minutes of the September 21, 2022, meeting as presented, by Commissioner Van Houweling. Seconded by Commissioner Winkler. Carried without dissent.

Agenda Item III - Public Comment:

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed inflationary pressures on health care providers and how it affects cost and access. The cost of labor, supplies, and drugs have increased rapidly. Each has risen more than twice the level of the Governor's cost growth benchmark of 3.19 percent. It is unreasonable to think that healthcare providers can contain costs under 3.19 percent when inflation is surging. It is important to remember that the cost growth benchmark was established when inflation was supposed to be "transitory". Today, everyone agrees that the inflation rate in America is not transitory. In his Executive Order establishing the benchmark, Governor Sisolak recognized that the economy might change. He wrote, *"Should the PPC find that there have been significant changes to the economy after the effective date of this Order, it may recommend to the Governor changes to the cost growth benchmarks"*. The PPC should recommend to the Governor that the targets be modified to reflect inflationary pressures. If the PPC proceeds to codify the provisions of the Governor's Executive Order, codification should include language that accounts for inflation. The Governor's Executive Order also stated that relevant partners should be engaged to develop strategies to help meet the targets that are data-based and practicable. That engagement should be made a condition of PPC action. We offer one strategy that is data-based and practical; increase the number of nurses in Nevada. Nevada's nursing shortage is severe. Earlier in the year, hospitals paid more than $250 an hour for certain nurse specialties. Some nurses were making more than doctors. While prices for traveling nurses have decreased, hourly rates are still exorbitant. The salaries of staff nurses have increased, too. The NHA conducted a survey of its member hospitals. We asked hospitals to provide the number of staff openings they had on July 1, 2022. The number of staff openings for Registered Nurses was 2,393, Licensed Practical Nurses was 188, and Certified Nursing Assistants was 616. We know other healthcare providers have significant openings too. For months, hospitals have averaged approximately 475 patients daily who are medically cleared for discharge by their doctors but cannot be discharged from the hospital. Post-acute providers have the beds, but they don't have the nurses to staff them. Keeping patients in hospitals unnecessarily drives up cost. But more importantly, it causes access problems. Patients cannot access the post-acute care services they need. We do not need a big, expensive study to identify one of the biggest cost growth drivers in Nevada. It is simple; the lack of nurses in this state is a huge cost growth driver and we encourage the PPC to address it swiftly.

Agenda Item IV – Presentation from Health Care Cost Growth Benchmark State: Oregon

Sarah Bartelmann, Cost Growth Program Target Manager at the Oregon Health Authority

Ms. Bartelmann presented Oregon's health care cost growth target accountability mechanisms in detail, how Oregon works with payers, some lessons learned from the data submission, and summarized the Oregon Cost Growth Target setting which uses phased in implementation. Oregon began considering how to address cost containment in 2017. A legislative task force was charged with considering a hospital rate-setting model and recommended a Cost Growth Target approach that led to the establishment of the Cost Growth Target program in 2019. Additionally, an Implementation Committee was launched, and in 2020-2021 developed recommendations to guide the program, established accountability mechanisms, and launched data submission guidelines. In 2022, the Implementation Committee engaged with provider organizations

and began state and market level public reporting. Early next year, in 2023, they will begin payer and provider level reporting and identify strategies to achieve the set target. Performance Improvement Plans (PIPs) will begin in 2024 and financial penalties will begin in 2027. The Implementation Committee set Oregon's cost growth target for ten years with the target set at 3.4 percent for 2021-2025 and 3.0 percent for 2026-2030. The Advisory Committee will revisit the target in 2025 and determine if 3.0 percent is still appropriate. One strategy that has already been launched to address cost growth is the adoption of Advanced Value-Based Payments (VBP) which set targets for Oregon's Medicaid Managed Care Organizations. That work spun off into a voluntary, collaborative partnership with payers and providers to accelerate VBP adoption across markets. Oregon has a broad charge in which the establishing legislation clearly intends for the Cost Growth Target to apply to all providers and payers both public and private. The Implementation Committee recommended the measurement should be inclusive of spending on behalf of Oregon residents who are insured by Medicare including Medicare Advantage, Medicaid including managed care and fee for service, and Commercial insurance including self-insured. Spending through the VA and the Department of Corrections are also included. This adds up to spending on behalf of more than 90 percent of Oregon residents. Due to the large number of plans in the state, the Implementation Committee recommended only collecting data and reporting on cost growth for payers that meet a minimum member population size.

A Commissioner asked when the data is collected from insurers and is on various aspects such as hospital claims or pharmaceutical claims, does Oregon reach out to those entities to talk through the data to better understand the numbers? Is that part of the validation process? Ms. Bartelmann answered that she has only been discussing their process with payers, but they have a separate, parallel, staggered process for the providers. Oregon has about 50 provider organizations that meet the threshold for inclusion. After validation of data with payers, they create a state level data file with data summaries for all provider organizations and then conduct validation processes and individual meetings with all the provider organizations. Another Commissioner asked who in the state is having the meetings and reviewing the data. Ms. Bartelmann answered that her team includes analysts, actuaries, and policy analysts who prepare the data and conduct the meetings. Another Commissioner asked when the data is presented, is it public or just to the Commissioners? Ms. Bartelmann answered that when data is presented for individual payer and provider meetings, they prepare a data summary that is confidential at that stage. The summary is given to them directly for review and discussion and broken out in more granularity than for public reporting.

Ms. Bartelmann continued with her presentation and discussed Oregon's accountability measures. Oregon decided on Performance Improvement Plans (PIPs) and financial penalties, which were codified in legislation. Oregon's approach to accountability includes transparency, performance improvement plans, and financial penalties. The Implementation Committee established early on an understanding that not all cost growth is bad. Ms. Bartelmann stressed the importance of ensuring that nothing in the Cost Growth Target is creating intended or unintentional dampening effect on those policies that they want to see happening across the state. Therefore, before any accountability measures are applied, Oregon will ensure statistical confidence and determine reasonableness. Oregon wants to ensure that this program is not being used to deny coverage or create additional access barriers. A few additional questions were asked by various commissioners and answered by Ms. Bartelmann.

Agenda Item V – Nevada's Health Care Cost Growth Benchmark: Data Update

Malinda Southard, Executive Director

Executive Director Southard provided an update on the status of Nevada's Health Care Cost Growth Benchmark work regarding data submissions. Nevada Health Insurers were requested to submit aggregate, de-identified data for Nevada's Baseline Benchmark analysis for applicable types of plans. Executive Director Southard then discussed the summary table of information provided by the Department of Health and Human Services (DHHS), Office of Analytics (OOA) on the status of data submissions from Nevada Health Insurers. All insurers except for Aetna, who requested an extension, have submitted data. Some insurers are currently

preparing resubmissions and our OOA team has been working with all health insurers to address any questions they have and to provide technical assistance related to the data request. Aetna requested an extension to submit data. Anthem successfully submitted complete data for all three markets in which it operates. Centene did not submit spending data for its self-insured commercial business, as requested. Notably, most health care coverage in Nevada is self-insured. Centene also did not provide aggregate partial claim spending. Partial claims are claims that are paid for self-insured employers who carve out a benefit, most often pharmacy. Cigna successfully submitted data for the one market in which it operates. Humana did not submit aggregate partial claims spending for its self-insured commercial business or Medicare Advantage spending data, as requested. Renown did not submit aggregate partial claim spending for its self-insured commercial business, as requested. Finally, UnitedHealthcare did not submit spending data for its self-insured commercial business nor aggregate partial claims spending, as requested. Executive Director Southard relayed Nevada remains hopeful that the requested data will be submitted in the future, as aligned with the goal to improve transparency and affordability in our health care system.

A Commissioner asked regarding those that have not submitted data yet, have you given them a new timeline or are they still within the timeline to submit? Executive Director Southard answered that some health insurers have requested an extension, and some have submitted all data they wish to at this time.

Agenda Item VI – Presentation of Options for Health Care Cost Growth Mitigation Strategies: Rate Review

Alyssa Vangeli, Senior Consultant, Bailit Health

Executive Director Southard introduced the last two topics on mitigation strategies that are associated with Nevada's benchmark project and encouraged the commission to consider what strategies might work best in our state.

Ms. Vangeli began the presentation with an overview of Health Insurance Rate Review. It is a mechanism that allows state regulators the opportunity to review and, in some cases, disapprove or modify proposed health insurance rate increases. Rate Review is a function of Nevada's Division of Insurance (DOI), and it is important to note that the Rate Review authority of DOI can only be exercised over the fully insured market, and not the self-insured market. Rate Review is an important strategy that can be used to push down premiums in state-regulated health insurance markets. The Affordable Care Act provides a floor for the rate review process. It requires health plans to file and publicly justify the reasonableness of the proposed rate increases in the individual and small group market over a certain threshold, which is currently 15 percent. One important reason to focus on Rate Review is to increase affordability for individuals and businesses. Almost two-thirds (65 percent) of respondents from a recent Nevada survey reported experiencing at least one health care burden in the past year; and 83 percent worried about affording health care in the future. Over half (59 percent) of all survey respondents reported delaying or going without health care in the prior 12 months due to cost. A recent national report showed Nevada among the top eight states for the highest average employee share of premium (9.4 percent) as percent of median state income in 2020. Nevada is also one of the top four states where workers were responsible for 37 percent or more of their family premium. It is important to keep in mind that the Rate Review process does not dictate how much of the insurance premium is paid by the employer and how much employees are responsible for. The current Rate Review authority and process in Nevada requires prior approval by the DOI for any individual or small group rate change.

A Commissioner stated that she has a concern about the term, "affordability". Her concern is that if you artificially cap a premium or a rate increase because of affordability concerns, then you are just cost shifting. Ms. Vangeli answered that one of the reasons to consider incorporating affordability in addition to the other factors is to take into account the other factors that are being considered as to why the premium or rates are increasing and those include underlying costs. Ms. Vangeli reiterated that Rate Review is just one strategy for affordability and that it can be complementary to other potential strategies. The Commissioner commented

that the DOI currently only has authority over a very small portion of the Nevada insurance market and that both large group and self-insured are the largest markets in Nevada. So, if you look at Rate Review in that context, then there would be a lot of cost shifting that could potentially occur. She further stated it is important to look at expanding the authority of the DOI to look at those larger markets.

Ms. Vangeli continued, noting to engage stakeholders, the DOI can communicate with carriers via public meetings to enable open dialogue. If Nevada opts to pursue other affordability goals such as primary care spending investments or value-based payments, the rate review process could be used to obtain information on progress toward those goals. The final option to strengthen Rate Review is to improve monitoring for impact on access, quality, and equity which can protect against unintended negative consequences on access to care and member experience and examine disparities in access to affordable health care coverage. As an example, Rhode Island has a robust rate review process. The Office of Health Insurance Commissioner (OHIC) has authority to review large group policies, as well as individual and small group. OHIC also has the authority to require submission and allow for review of provider-payer contracts. OHIC has a broad charge to protect the public interest and improve the health care system, which applies to the rate review process. They have a highly transparent stakeholder engagement process with regular public meetings, opportunities for written and oral comment, and advisory committees. Lastly, their rate review process is tied to broader affordability goals of adoption of value-based payments, primary care spending, and provider price growth caps.

The commissioners had some questions and discussion. Mr. Bailit commented that in his experience with rate review, a fair amount of focus is looking at the profits or contributions to reserves of the insurers and trying to ensure that the rates that are developed are not in excess of what is required. He acknowledged that there could be an impact on provider contracting, but that a lot of the impact is focused on administrative and margin charges of the insurers. Another Commissioner noted it would be helpful to hear from the Nevada DOI. Additionally, regarding the marketplace, she wants to know what we are looking at in terms of their authority. Where would they like to see their authority grow and do they have the capacity to take that on from a resource standpoint? The Public Employee Benefits Program (PEBP) Executive Officer commented the Cost Growth Benchmark is something that is vital to the PPC as they consider policy recommendations and PEBP is glad to be a part of it, however some of the strategies presented today have the potential of being problematic in Nevada. PEBP is constantly dealing with balancing lower costs with having greater access because access issues in our state are very significant, especially in Northern Nevada, and even worse in rural Nevada. Nevada consistently ranks 48th and 49th in providers per capita regardless of primary care or specialty care. Rhode Island is in the top 5 and Oregon ranks in the top 20. She reiterated that we have a major access problem in Nevada and that is something the PPC should keep in mind as the suggestions and recommendations are being considered. Another Commissioner asked for clarification of the rate review process in Nevada.

Agenda Item VII – Presentation of Options for Health Care Cost Growth Mitigation Strategies: All Payer Value-Based Payments

Michael Bailit, President, Bailit Health

Mr. Bailit presented on the last of the cost growth mitigation strategies; multi-payer value-based payment. Value-based payment (VBP) is a strategy by which health care purchasers and payers use payment to hold provider organizations accountable for quality and cost of care. The term quality is used broadly to talk about processes and outcomes, as well as access, patient experience, and equity. Advanced VBP models transfer some risk to a provider organization and may or may not include prospective payment. VBP models are potentially a cost growth mitigation strategy because they can use a budgeting mechanism to apply to payment. Moving towards VBP models is most effective when multiple payers align around a common model. There are also non-cost growth benchmark states pursuing this model, such as Arkansas. Some examples of multi-payer VBP models include hospital global budgets, episode-based payment, specialty capitation (specialty prospective payment), global capitation, and total cost of care with shared savings.

A Commissioner asked, in terms of engaging in a multi-payer value-based payment model, can we do that through regulation, or do we have to get statutory authority? Mr. Bailit answered that we do not need statutory authority or regulation. These are truly voluntary efforts in Oregon and Rhode Island. Their key stakeholders, meaning their largest provider organizations and largest payers, have all realized the importance and wanted to collaborate. Therefore, we would need to have agreement and collaboration among Nevada's leading provider organizations and leading payers to pursue this model. Another Commissioner opined she would like additional information to consider such as administrative costs of running VBP programs and what happens to patients who are very ill, because providers are encouraged to no longer provide care because of capitation. Mr. Bailit answered that there are two types of costs: the costs associated with planning and the costs associated with implementation and operation. The costs are going to vary based on the model. In response to the question on high-risk, high-need patients, not all these models are capitation. Any payment model that is not fee for service and that is structured so that it is rewarding, reduces rates of spending growth. For all of those, there is some measure of risk that you are creating a financial incentive that could limit access to care for patients. Another Commissioner echoed the concern for chronically ill patients and asked to hear from the provider side and why they are interested in moving to a VBP model. Mr. Bailit answered that providers are supportive for a few reasons: some of these payment models afford providers significant flexibility where fee for service payment does not, some models such as Hospital Global Budget give some degree of revenue certainty, and in some states, there is recognition from provider organizations that patient affordability is a real problem. Additionally, Mr. Bailit gave some examples of mitigating strategies for high-risk patients. Lastly, Mr. Bailit suggested looking at the experience in Nevada such as what has worked and what has not and asking providers and payers about their experiences.

Agenda Item VIII – Presentation on Primary Care Spend Measurement Examples from Other States

Michael Bailit, President, Bailit Health

Executive Director Southard introduced this topic as one that a commissioner had asked to discuss in more detail because one of the Commission's bill draft requests (BDRs) for the 2023 Nevada Legislative Session, to codify the health care cost growth benchmark, does include measurement and reporting on primary care spend and it would be helpful to have examples from other states we might learn from.

Mr. Bailit began the presentation with some reasons why Nevada may want to measure and invest in primary care. Primary care is associated with improved population health and more equitable outcomes. Increased primary care investment translates to expanded care teams, more convenient, low-cost access to care, and strong connections to public health and social supports for people with social risk. Additionally, it reduces the need for emergency department visits and hospital stays and may have a moderating effect on total cost of care. Nevada ranks 48th in the country for primary care physicians per capita. An estimated 67.3 percent of the state's population reside in a federally designated primary care health professional shortage area. Nevada currently ranks poorly among states for some key measures of primary care. The cost growth benchmark BDR leverages the cost growth benchmark data collection processes to collect more detailed information on primary care-related spending. While there are many possible steps to improve primary care within the state, one is to ensure adequate investment in primary care, which first entails the measurement of current primary care spending.

A Commissioner commented that she would like the Commission to consider three things: what other states are doing to increase residency programs or primary care doctors in their states; if other states are doing tuition reimbursement or other things for medical students who commit to staying in primary care for a certain number of years or for a certain percentage of their practice; and third, the impact of quality of life in the state and attracting primary care physicians to our state (school systems that attract young physicians when they are deciding where to set up their practice early in their careers, value children, and economic opportunities

for their spouses). Another Commissioner asked to for future agenda items: if there are any inherent barriers to implementing some of the approaches that were discussed today, and which approach Nevada is best positioned to implement.

Agenda Item IX – Public Comment

Angie Wilson asked when reviewing Medicaid/MCO claims and costs, will you [the PPC] be considering the impact of claims and costs and provider types that are 100 percent FMAP? I ask because the reimbursement rate is set in the federal register and with new designations for tribes, we expect reimbursements to tribes to increase, resulting in higher "perceived" costs to the state although it is reimbursed at 100 percent.

Vice Chair Ruybalid explained to the Commission that FMAP is the federal Medicaid match that is set by the federal government. Mr. Bailit answered that for purposes of measuring benchmark performance, Nevada will look at spending for Medicaid and will not be accounting for the fact that these services will have a higher FMAP than other services, but the services and associated payments referenced will be a very small percentage of total Medicaid spending. Therefore, Mr. Bailit does not believe there will be a substantive impact on the benchmarking analysis due to the marginally higher federal match.

Agenda Item X – Wrap up and Adjournment

Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:10 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

Dr. Ikram Khan, Chair

Date: 12/5/22

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
IV.	Sarah Bartelmann, Cost Growth Program Target Manager at the Oregon Health Authority	Presentation from Health Care Cost Growth Benchmark State: Oregon
V.	Malinda Southard, Executive Director, PPC	Nevada's Health Care Cost Growth Benchmark: Data Update
VI.	Alyssa Vangeli, Senior Consultant, Bailit Health	Presentation of Options for Health Care Cost Growth Mitigation Strategies: Rate Review
VII.	Michael Bailit, President, Bailit Health	Presentation of Options for Health Care Cost Growth Mitigation Strategies: All Payer Value-Based Payments
VIII.	Michael Bailit, President, Bailit Health	Presentation on Primary Care Spend Measurement Examples from Other States