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Nevada Public Option Implementation Design Session #5

Provider Contracting and Networks | Health Plan Rate Setting and Rate Review | Strengthening the Individual Marketplace

January 18, 2022

Welcome to Zoom – Meeting Participation Options

Written Comments:

Participants may submit comments and questions through the **Zoom Q&A box**; all comments will be recorded and reviewed by the State. To submit questions or comments outside of today's session, write to: **NVpublicoption@dhhs.nv.gov**

Spoken Comments:

Participants must "raise their hand" for Zoom facilitators to unmute them to share comments; the facilitators will notify participants of the appropriate time to volunteer feedback.

If you logged on via phone-only

Press "*9" on your phone to "raise your hand"

Listen for your phone number to be called by moderator

If selected to share your comment, please ensure you are "unmuted' on your phone by pressing "*6"

If you logged on via Zoom interface

Press "Raise Hand" in the "Reactions" button on the screen

If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

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Public Comment Opportunities

- Public comment will be taken during the meeting at designated times.
- Individuals will be recognized for up to two minutes and are asked to state their name and organizational affiliation at the top of their statements.
- Participants are encouraged to use the comment box to ensure all feedback is captured or email their comments to **NVpublicoption@dhhs.nv.gov**
- The State will publish a public option FAQ and will continue to use this resource to inform the public and address design questions

Today's Agenda

- Meeting Overview
- Provider Contracting, Reimbursement, and Networks
- Health Plan Rate Setting and Rate Review
- Strengthening the Marketplace
- Next Steps and Public Comment

Meeting Overview

Design Session Schedule

	Session #	Date	Focus
	1	December 8th 2-3 pm PT	• Goals and guiding principles • Overview of legislation and 1332 waivers • Overview of public option designs in other states
	2	December 22nd 2-3 pm PT	• Stakeholder priorities for the design of this public option (e.g., affordability, networks, access, provider reimbursement, etc.)
	3	January 5th 2-3 pm PT	• Target population • Affordability: Cost-sharing and premiums
	4	January 13th 1-2 pm PT	• Benefits • Value-based payment and cost containment
Today	5	January 18th 12-1 pm PT	• Provider contracting and networks • Health plan rate setting and rate review • Strengthening the individual marketplace
	6	January 28th 1-2 pm PT	• Licensure and oversight • Offering the public option in the small group market • Next steps (actuarial analysis, subsequent opportunities for stakeholder feedback, waiver development)

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Today's Goals

Overarching Objective	Develop proposals for the public's consideration related to public option provider contracting and networks, health plan rate setting and review, and strengthening the individual marketplace.

Key questions for the public include:

Provider Contracting and Networks

- Does the State have additional network adequacy initiatives the public option should consider beyond the minimum requirements for the marketplace as outlined in SB 420? Are these initiatives needed to help improve access for consumers enrolled in the public option plans?

Health Plan Rate Setting and Rate Review

- How should State agencies coordinate the rate review process to provide oversight of the mandated premium reduction requirements while balancing administrative burden?

Strengthening the Individual Marketplace

- Should the State pursue policies that could strengthen the Marketplace, and if so, which policies?

Provider Contracting and Networks

Provisions in SB420 already address key design decisions related to provider participation.

SB420 requires providers participating in Medicaid or other State plans to participate in the public option.

The provider participation requirement applies to health care providers who[1]:

- Participate in the Medicaid Program,
- Participate in the Public Employees' Benefits Program (PEBP) [2], or
- Provide care to an injured employee pursuant to the State's workers compensation program[3].

Health care providers meeting the above criteria must:

1. Enroll as a participating provider in *at least* one network of providers established for the public option and
2. Accept new patients who are enrolled in the public option to the same extent as the provider or facility accepts new patients who are not enrolled in the public option.

In addition to provider requirements, the law also requires health plans to submit a good faith proposal to the public option RFP if they bid to participate in the state's Medicaid managed care program.

These requirements may be waived when necessary to ensure that Medicaid enrollees and those receiving benefits under the PEBP have sufficient access to covered services.

Sources: 1. SB420 Text (state.nv.us). 2. Nevada Revised Statutes Chapter 287.043. 3. Nevada Revised Statutes Chapters 616A-616D & 617.

Provisions in SB420 already address key design decisions related to provider reimbursement.

SB420 requires that provider reimbursement rates under the public option are, in the aggregate, comparable to or better than Medicare rates.

The provider reimbursement floor is calculated based on aggregate reimbursement rates under Medicare, which:

✓ Includes any add-on payments or other subsidies that a provider receives under Medicare

Exceptions

For:

For		Exception rate
Providers receiving cost-based reimbursements under Medicare,	the public option reimbursement rate must be comparable to or better than	the cost-based rates provided for that provider by Medicare.
Federally-qualified health centers or rural health clinics,	the public option reimbursement rate must be comparable to or better than	reimbursement rates established by patient encounters under the applicable Prospective Payment System.
Certified community behavioral health clinics,	the public option reimbursement rate must be comparable to or better than	reimbursement rates established for community behavioral health clinics under the Medicaid State Plan.

Source: SB420 Text (state.nv.us).

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Legislative Requirements for Networks and Network Adequacy

SB420 has key network adequacy provisions but provides latitude for additional design considerations.[1]

During the competitive procurement for the public option, the Director shall[2]:

- Reward demonstrated **alignment of Medicaid managed care and public option networks**;
- Include **safety net and other cost-based reimbursement providers**
- Include proposals for **strengthening workforce** across primary care, mental health, and substance use disorder (SUD) and in rural areas of the State; and
- Reward approaches that **decrease disparities** among different populations in the State and **expand access and support culturally competent care.**

CO's Foray in Cultural Competency Network Adequacy Requirements:

So that carriers do not achieve savings by further limiting networks, the network must be no more restrictive than the most restrictive network that the carrier offers in a non-standard plan for that metal tier in that region. Carriers must describe the efforts to construct culturally responsive networks, and they must include a majority of essential community providers in the service area in the network.[3]

Does the State have additional network adequacy initiatives the public option should consider?

Sources:. 1. The Director and Executive Officer of the PEBP can waiver the requirement to participate in the public option in order to ensure access for Medicaid and Public Employees. 2. SB420 Text (state.nv.us) Section 12, 13, 14. 3 Colorado 1332 Waiver – Colorado Option https://drive.google.com/file/d/1mi54sMTLJySOblMm1JmMGEWLJwG5M8rQ/view

Network Adequacy Standards Between Medicaid and Exchange

QHP network adequacy requirements focus on time and distance standards, whereas Medicaid focuses primarily on provider and utilization standards.

Medicaid Network Adequacy[1]

- Medicaid monitors both FFS network adequacy and MCO network adequacy. MCO network adequacy is measured using time and distance standards and provider to member ratios for primary care providers (PCP) and specialists.
- Currently, the quarterly FFS access to care monitoring consists of:
  - Active providers, recipient utilization, recipient penetration rates, and top 10 diagnosis by region comparison.

QHP Network Adequacy

- The Exchange relies on DOI to conduct its network adequacy review for QHP certification (minus Dental).
- As specified in NAC 687B.772, a Network Adequacy Advisory Council provides network adequacy recommendations to the DOI Commissioner (Council's 2021 Update).
  - See Appendix Slide 22 for Time/Distance standards chart.
- Future efforts may include deepening partnership with provider licensing entities, improve workforce data, review other network adequacy measures, and improve data on open/close panels.

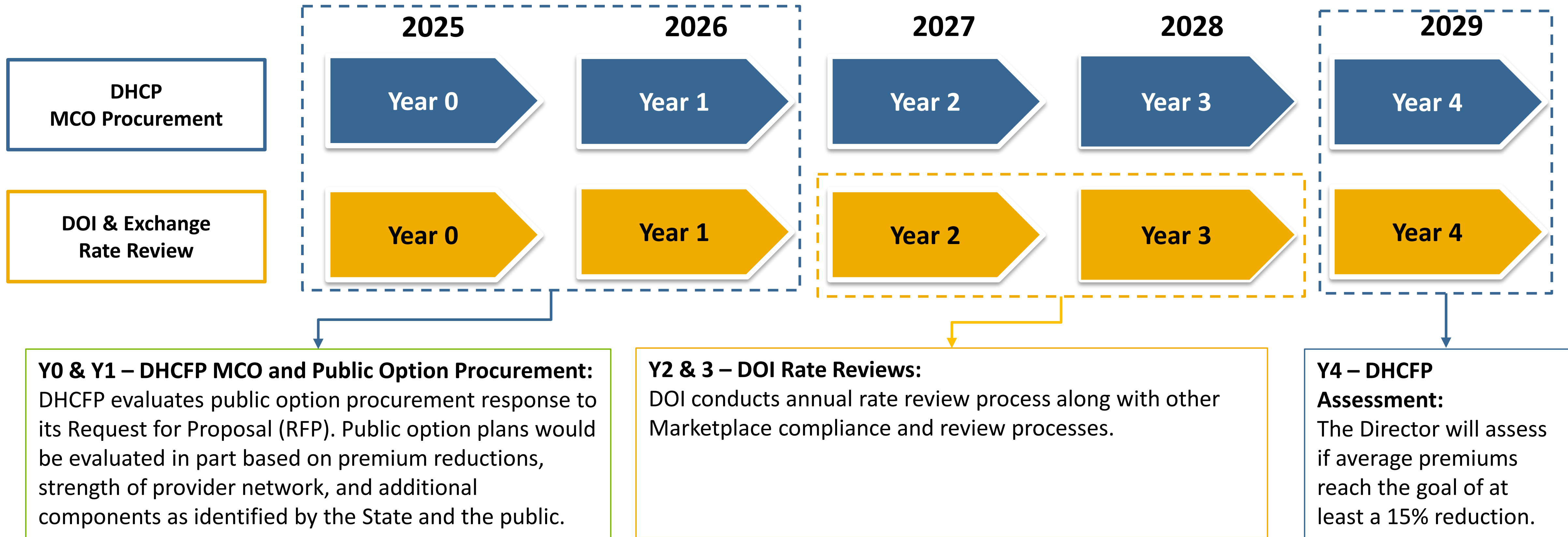
Should DHHS use its contracting authority to require the public option to have network adequacy requirements that go beyond those developed by the Network Adequacy Council and applied to public option plans (e.g., to align with Medicaid network requirements)?

Sources: A Plan to Monitor Healthcare Access for Nevada Medicaid Recipients (2020).

Health Plan Rate Setting and Rate Review

State Oversight and Rate Review Considerations

How can State agencies coordinate the public option rate review process to minimize administrative burden?



Strengthening the Individual Marketplace

'Defining Success' in Strengthening the Marketplace

What policies or tools would strengthen the marketplace and/or impact the success of the public option?

Defining Success

- Strengthening the Marketplace might mean something different across stakeholders.
  - More carriers in the market?
  - More plans offered?
  - Lower premiums?

Ensuring a Level Playing Field

- Need to balance creating a unique public option product with tailored cost-sharing designs, networks, etc. with also ensuring a level playing field so as to not reduce competition in the Marketplace.
- When possible, State agencies will coordinate oversight to reduce administrative burden.

Policies to strengthen the Marketplace could include:

- Reinsurance pool
- Cost-sharing design for public option plans through Medicaid procurement mechanism

Which policies should the State pursue that could strengthen the Marketplace?

Reinsurance to Lower Premiums and Mitigate Against Unknown Risk Pool

15 States have implemented a reinsurance pool through a 1332 Waiver. A prior actuarial study concluded external funding was necessary for reinsurance in NV to be successful. Pass-through funds may provide most, but likely not all of the external funding.

Reinsurance Pool Overview

- Reinsurance pools provide subsidies to carriers for high-cost enrollees. In competitive markets, the reinsurance subsidy reduces enrollee premiums.
- Reinsurance may reduce the risk for carriers to join the Marketplace, especially for a previously-uninsured population with an unknown risk profile.
- Reinsurance requires dollars. Most states use a combination of pass-through funds plus insurer contributions or state appropriations.

Reinsurance in the Nevada Context

- A 2019 actuarial analysis estimated that a reinsurance program in conjunction with a 1332 waiver could a reduce average market premiums by **13 percent**, resulting in an estimated annual savings per targeted enrollee of **$780**. [1]
- This study also concluded external funding was necessary for reinsurance in NV to be successful. Pass-through funds may provide most, but likely not all of the external funding.

Scan of Reinsurance Impacts[1]

Percent Impact on Premiums

- **Alaska** - 30% annually since 2018
- **Colorado** - 22% in 2020
- **Maine** - ~10% annually since 2019
- **Maryland** - ~35 annually since 2019
- **Minnesota** - 20% annually since 2018
- **Oregon** - <10% annually since 2018

**Note, BBB includes grant funding for State to pursue reinsurance waivers*

A public option, complemented by a reinsurance pool, could strengthen the individual market, reduce carrier risk in covering a population of unknown health risk, and promote affordability.

Source. 1. Nevada Division of Insurance (Prepared by Wakely Consulting Group): Market Options Study: Final Report. March 31, 2019.

Next Steps

Next Steps

- Visit the Public Option webpage for regular updates: https://dhhs.nv.gov/PublicOption/
  - To submit questions or comments, write to NVpublicoption@dhhs.nv.gov
- Attend Design Session #6 on **January 28th 1-2 pm PT.** This session will focus on:
  - Licensure and oversight
  - Offering the public option in the small group market
  - Actuarial analysis
  - Highlighting subsequent opportunities for stakeholder feedback

Public Comments

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