# North Dakota Legislative Health Care Task Force Meeting #3

*April 4, 2024*

bailit health

# Agenda

- Welcome and Meeting Overview
- Health Care Expenditures in the Commercial Market and Medicaid
  - BCBS of North Dakota
  - Sanford Health Plan
  - Medicaid
- Stakeholder Engagement
  - Meetings to date
  - Key Takeaways
- Measuring Quality of Care in North Dakota
  - Review of Quality Findings
  - Approaches to developing standard measure sets
- Areas of Focus Going Forward

# Meeting Goal

- Consider where the Task Force should focus next based on data presented in previous meetings and today.
- We will circle back to these two questions:
  - What criteria do we want to use in determining potential areas of focus?
  - What do you recommend as proposed areas of focus?

# HEALTH CARE EXPENDITURES IN THE COMMERCIAL MARKET AND MEDICAID

# BLUE CROSS BLUE SHIELD OF NORTH DAKOTA


# Health Insurance Financial Basics

April 4, 2024 | Health Care Task Force

Jordan Thielen, Director, Actuarial Services

# Health Insurance Financing

- Health Insurance is a financing mechanism that allows employers and individuals to share risk to fund future health care needs that could not be supported otherwise
- The potential catastrophic nature of health care requires this type of risk "pooling", as a small number of individuals make up the majority of spend
  - 10% of members generate 80% of total medical/drug expenditures
  - 1% of members generate 35% of expenditures
- The cost of health care represents a substantial portion of economic output
  - ND per capita income was $61,091 in 2020
  - ND per capita health expenditures were $11,301 vs $10,191 nationally in 2020

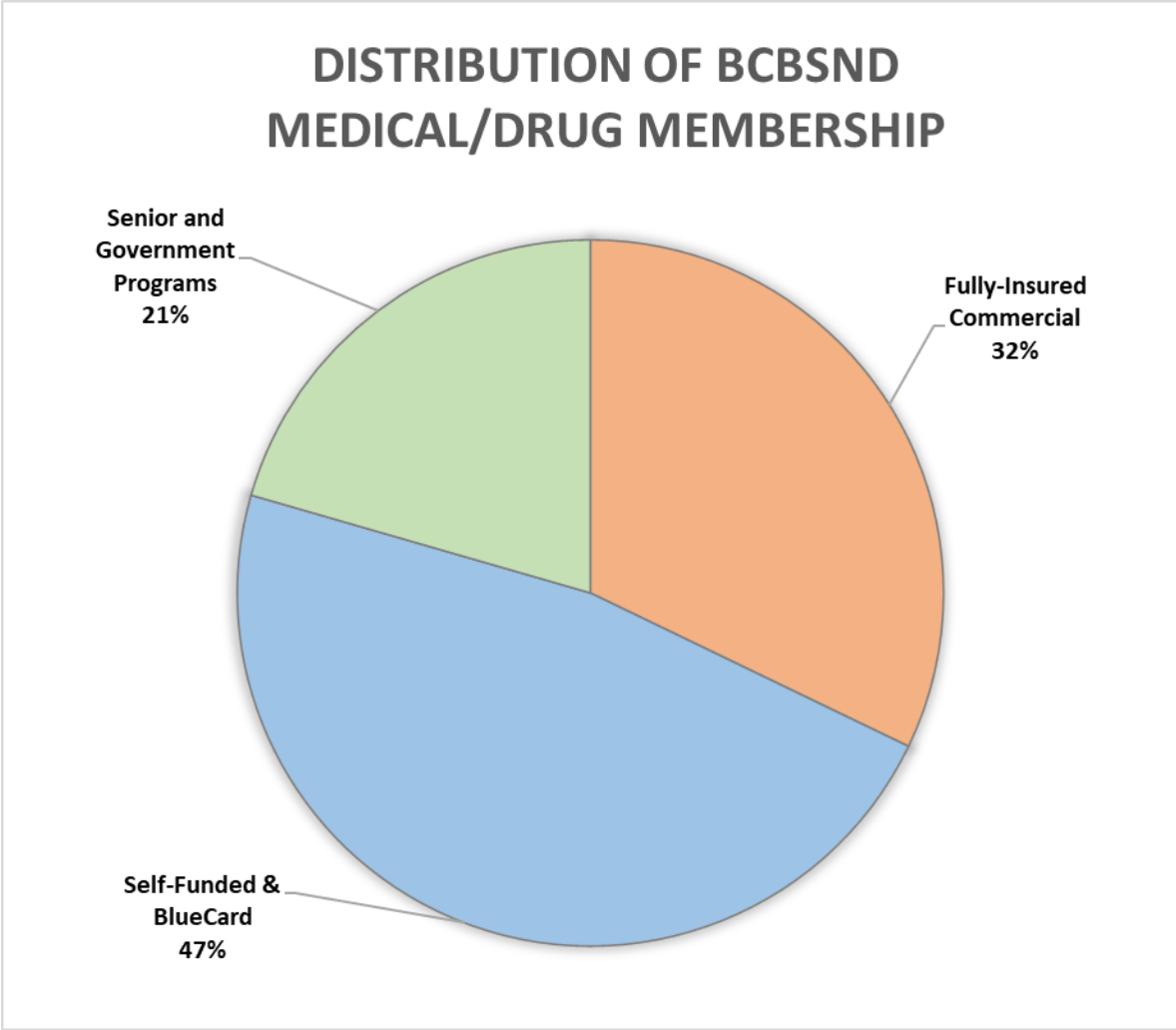
Sources: BCBSND internal commercial claims data, CMS national health expenditure data, Kaiser Family Foundation state health spending data, St. Louis Federal Reserve Bank per capita income data

# Self-Funded vs Fully-Insured

| Self-Funded | | Fully-Insured |
|---|---|---|
| Employer assumes risk<br>Employer provides health benefits directly to employees | Assumption of Risk | Insurance carrier assumes risk<br>Employer purchases insurance from insurance company |
| Employers have the freedom to choose what they cover | Who Picks Benefits? | Carriers file plans with the DOI and offer to FI clients |
| Employer pays claims<br>Carriers are third party administrator and receive admin fees in exchange for networks, claims processing, etc | Who Pays? | Employers and individuals pay premium to insurance company and carrier pays claims |
| Governed by federal law (ERISA) | Who Regulates? | Governed by state law and subject to state mandates |

# Distribution of Health Insurance Business

- 30% of BCBSND's total health membership is Fully-Insured Commercial
- Majority of members are Self-Funded or in Government/Senior products
  - Self-Funded employers have significant leeway in choosing what to cover, as state mandates do not apply
  - Growing costs and increased regulatory requirements have all increased the appeal of Self-Funding over the years
- Approximately 80% of BCBSND total membership is in North Dakota, the rest are out of state employees of groups




Source: BCBSND 2023 membership data

# How Premiums are Spent - 2023


## 2023 BCBSND Premium Dollar Breakdown

What happens to the health insurance premiums our customers pay? As a nonprofit member owned company, whatever remains after paying member claims, operating expenses and taxes is kept in reserves – not distributed as profits to external parties such as shareholders. These reserves are used to weather times of unforeseen financial risk and make future investments in technology & improvements in member care outcomes and experiences

**88%**
Medical and Pharmacy Claim payments to provide care for members

**10.8%**
Processing claims, collecting premiums, care management, member contact center, value-added services and overhead

**1.4%**
Premium Tax, ACA taxes/fees

**-0.2%**
Contribution to surplus



Source: BCBSND 2023 Statutory Financials

# Underwriting Lifecycle

## Plan Year 2025

**Historical Data**
Performance analysis and trends used to support filing assumptions

**Baseline Period**
Period on which filing experience is based

**Pricing Period**
Current year, when work is performed to determine pricing for upcoming plan year

**Benefit Period**
When Members are utilizing the services

**Runout Period**
Final 2025 claims processed and other material items like RAND and Risk Adjustment will be final mid-year

**2022 & Prior** | **2023** | **2024** | **2025** | **2026**

For any given plan year, BCBSND and other carriers set premiums far in advance (over a year or longer) of when services are incurred, or members enroll. Changes after prices are set can cause substantial financial risk to carriers, such as from the following sources.

**New Drugs/Treatments**
New covered services such as weight loss drugs or gene therapies can add substantial unplanned costs

**Changing Populations**
Higher risk level members enroll in plans vs expectations, driven by market changes or federal regulations

**Unit Cost Increases**
Inflationary pressures drive provider reimbursement rates higher than expected

**State/Federal Programs**
Various reinsurance/risk sharing programs such as ND RAND or ACA Risk Adjustment can take sudden drastic turns

# Health Insurance Pricing / Filing Requirements

- Insurance carriers set future premiums for Fully-Insured business as follows:
  - Start with actual historical claims payments from a recent time-period (Ex. calendar year 2023)
  - Adjust for expected changes in utilization, unit cost, population risk, drug rebates, cost-shares etc.
  - Add in administrative expenses, taxes/fees and any explicit margin
- Multiple insurers compete on price in a highly competitive market; the ACA exchange and agent/broker relationships create a transparent process for consumers to shop for the best rates/coverage each year, forcing carriers to minimize margins to compete
- North Dakota is a "prior approval" state, meaning carriers must submit filings demonstrating how rates are calculated before issuing/renewing policies. The Insurance Commissioner usually cuts rates before approving them.
  - North Dakota Insurance department has the authority to cut filed rates, and frequently limits/removes explicit margin in pricing, and pressure tests filed assumptions for trend/admin expense/other adjustments
- Filings must be developed in accordance with accepted actuarial practices and signed by credentialed Actuaries who are members of the American Academy of Actuaries
- ACA/Medicaid Managed Care Organization (MCO)/Medicare Advantage/Part D rates all receive additional review by CMS and have extensive filing requirements/templates

# Medical Loss Ratio Requirements

- In addition to natural marketplace pressures that control rates and insurance department oversight, insurance carriers must comply with federal regulations that explicitly limit margins earned on health insurance
- Medical Loss Ratio (MLR) requirements:
  - MLR is the ratio of claims / premiums, meaning the amount we are required by law to spend on patient care
  - ACA Individual and Small Group business must have MLR > 80%
  - Large Group and Medicaid MCO business must have MLR > 85%
  - If a company does not meet minimum MLR's over 3-year period, rebates must be issued to consumers
- Medicare Supplement has lifetime MLR requirements
- Medicare Part D has risk sharing provisions to return margin back to the CMS if costs are notably better than expected

# Capital Requirements

- Due to the public interest in maintaining the solvency of insurance companies, state laws require BCBSND and other insurers to meet specific capital requirements via Health Risk Based Capital (HRBC)
- HRBC is a measure of a company's financial risk exposure relative to its capital/assets
- Various levels are specified in state law outlining the following possible enforcement actions if HRBC drops below certain thresholds:
  - Mandatory reporting on financial conditions and corrective action plans to insurance commissioner
  - Commissioner authority to require specific corrective actions
  - Optional or even mandatory placement of insurance company operations under regulatory control
- Capital/asset requirements naturally grow over time for the same volume of business due to growth in medical/drug claims
- This requires insurers to earn some level of net income long-term or eventually face regulatory action

# Financial Reporting Requirements

- BCBSND and other insurers are held to strict regulation on financial reporting and capital requirements
- Statutory financial statements must be filed quarterly/annually disclosing revenues/administrative expenses, assets/liabilities, and much more additional financial detail
  - Reporting makes public the financial condition of insurance companies, and the level of margin earned by insurance operations
  - Annually an Appointed Actuary must opine that reserves and other liabilities being held are sufficient for moderately adverse conditions
- Additionally, statutory laws allow the NDID to request a wide array of financial, membership and other various insurance data from carriers on an as needed basis

# ND Fully-Insured Historical Financial Trends

- Below charts show growth in premium, claims and administrative expenses over the last 4 years
- Increases in premiums have been largely driven by claims, as administrative expenses have held relatively flat in recent years
  - Administrative expenses include processing claims, collecting premiums, care management, member contact center, agent commissions, any innovation and value-added services and other overhead costs
- Underlying cost trends '21/'22 are likely higher than shown, as significant growth in ACA Individual enrollment due to enhanced premium tax credits drove more higher-income/low-cost members to the market
- 2023 Statutory financials will be published shortly and will likely reflect elevated claim trends

| North Dakota Statutory Trends - Main Fully-Insured Carriers | | | | | |
|---|---|---|---|---|---|
| Financial Category | 2019 | 2020 | 2021 | 2022 | All Years |
| Premium PMPM | $458.65 | $468.12 | $491.43 | $501.43 | N/A |
| Claims PMPM | $415.81 | $420.42 | $460.50 | $465.76 | N/A |
| Administrative Expense PMPM | $43.47 | $41.44 | $42.70 | $43.23 | N/A |
| Premium Trend | 5.3% | 2.1% | 5.0% | 2.0% | 3.6% |
| Claims Trend | 4.4% | 1.1% | 9.5% | 1.1% | 4.1% |
| Administrative Expense Trend | 2.1% | -4.7% | 3.0% | 1.3% | 0.4% |



Source: 2019-2022 North Dakota Main Fully-Insured Carrier Statutory Financials, Claim amounts include reinsured claims

# ND Fully-Insured Historical Financial Results

- Below charts show historical Underwriting (UW) margins and trends for major carriers in the North Dakota Fully-Insured marketplace, and BCBSND total insurance operation margins
  - UW margin = Premium – Claims – Expenses – Taxes/Fees (basic definition)
  - UW margin represents earnings related to insurance specific operations

| North Dakota Statutory Financial History - Main Fully-Insured Carriers | | | | | |
|---|---|---|---|---|---|
| Financial Category | 2019 | 2020 | 2021 | 2022 | All Years |
| Medical Loss Ratio | 90.2% | 88.2% | 91.7% | 90.2% | 90.1% |
| Administrative Expense Ratio | 9.5% | 8.9% | 8.7% | 8.6% | 8.9% |
| Underwriting Margin Ratio | 0.3% | 3.0% | -0.4% | 1.2% | 1.0% |

*Most underwriting margin was due to unique circumstances related to the COVID-19 pandemic in 2020

| BCBSND 5-year Statutory Financial History (all insurance operations) | | | | | | |
|---|---|---|---|---|---|---|
| Financial Category | 2019 | 2020 | 2021 | 2022 | 2023 | 5-Year History |
| Underwriting Margin % | -3.7% | 1.4% | 0.5% | 0.0% | -0.2% | -0.4% |

Fully-Insured North Dakota financials include ACA Individual/Small Group, Grandfathered Small Group and Large Group business

BCBSND total insurance operation financials include additional lines such as Stop-Loss, ASO administration, Medicare Supplement and Medicaid Expansion

# Summary

- Health insurance enables the financing of health care costs, which are heavily concentrated in a small percentage of members necessitating the sharing of risk
- A significant portion of BCBSND's business (as with the market as a whole) falls outside the purview of state requirements
- Carriers must commit to prices far in advance of when benefits are known, creating significant financial risk for changes in this time-period
- Premiums carriers can offer are heavily regulated and frequently cut by authorities, transparent markets and significant competition force prices to the lowest level, and MLR rule leave minimal room for admin/margin
- Carriers must continue to innovate on managing the cost of care to keep insurance affordable for consumers, while earning enough margin to maintain capital requirements in the long run


# BCBSND Trends and Insights

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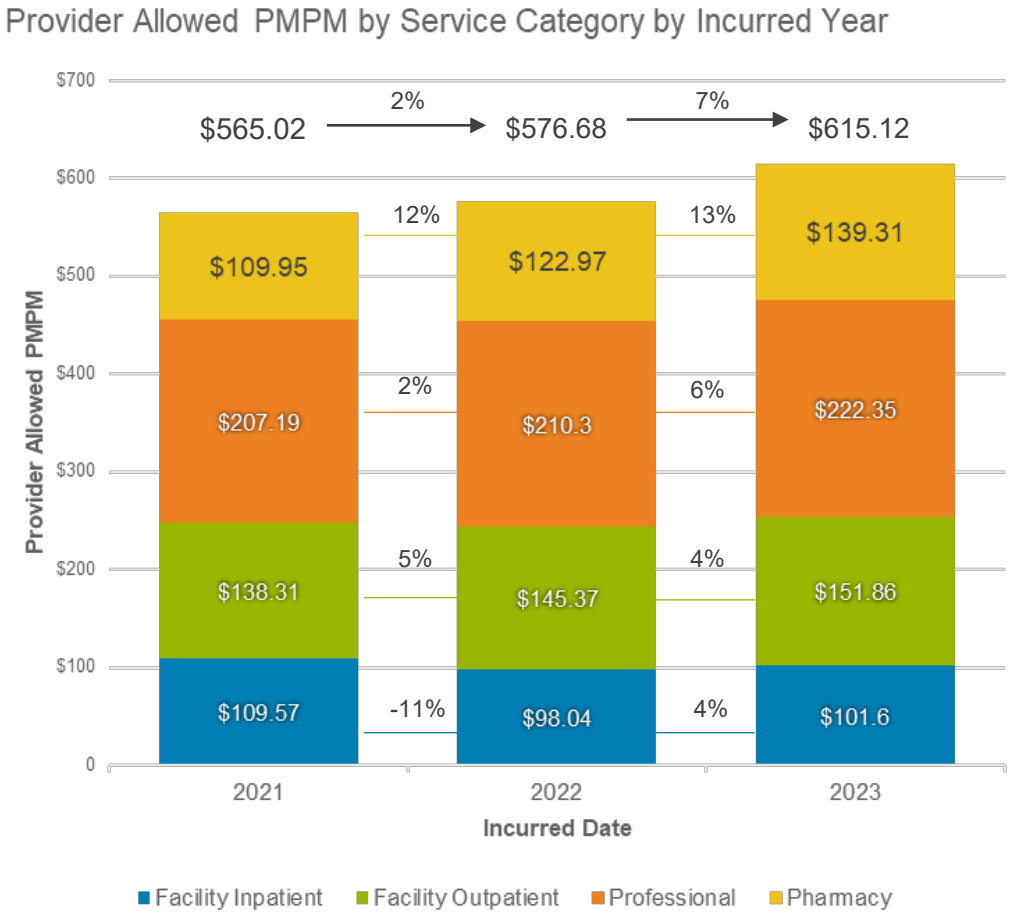
Chelsey Matter, Executive Director, Government Programs

# Total Cost of Care: Commercial

- Total Per Member Per Month (PMPM) spend increased by 9% between 2021 and 2023
- Pharmacy accounts for the largest component of the increase at 13% (2022 to 2023)
- Overall hospital inpatient spend is down from 2021 to 2023.
  - Better management of chronic conditions keeping people out of the hospital and/or
  - More inpatient services are moving to outpatient, likely contributing to the change in inpatient spend
- Overall increase in professional (clinic visits, etc) spend
  - Professional spend increases may be a result of more interaction with a primary care provider




Source: BCBSND claims data | Service dates 2021-2023 | Paid through 2/29/24

# Key Takeaways: Commercial

- Spending on prescription drugs grew most rapidly. This was due to a slight increase in utilization and a significant increase in price.
- Overall hospital inpatient spend is down. This was due to an increased focused on value-based care arrangements and increased care management of chronic conditions.
- Hypertension, Depression and Diabetes all have significant spend. Focused interventions here could be helpful in managing costs long-term.
- Professional spend was driven by psychiatry, with a nearly 14% increase in utilization.
- There are opportunities to increase the rate of primary care visits through expanding access which could lead to more members staying in-state and to more effectively managing total cost of care long-term.

# Total Cost of Care: Medicaid Expansion

- Total Cost of Care (PMPM) tracking lower in 2023 compared to 2022
  - Inpatient spend down 14.3%
  - Outpatient spend down 11.1%
  - Professional spend down 4%
  - Emergency dept spend down 10%
- First year of operations, BCBSND introduced a value-based program (VBP) with providers, focused care management and risk sharing with Arkos Health

| **Total Cost of Care** Service Type | | **2022** PMPM Cost | **2023** PMPM Cost |
|---|---|---|---|
| 1 | Inpatient | $255.99 | $219.39 |
| 2 | Outpatient | $226.47 | $201.33 |
| 3 | Professional | $227.01 | $218.00 |
| 4 | Emergency Department | $65.50 | $58.95 |



Source: BCBSND claims data | Service dates through November 2023 | Paid through 1/31/24

# Key Takeaways: Medicaid Expansion

- Overall spend is lower across all categories despite an increase in risk.
- Hypertension, Depression and Diabetes all have significant spend. Focused interventions here could be helpful in managing costs long-term.
- There are opportunities to increase the rate of primary care visits through expanding access.
- Community based organizations play a key role in connecting members to needed resources.


# Health Insurance Payment Models

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Stacie Heiden, Executive Vice President, Government Markets & Enterprise Analytics

# Payment Models

## Fee for Service

Traditional payment model

Based on contracted rates by diagnoses and procedural codes for each episode of care.

Volume and contracted rates drive payments made on behalf of members and self-funded employer groups.

## Value-based

Supplemental payments

Rewards for quality outcomes, effective care management utilization, and controlling cost of care.

Industry-wide models are continuing to evolve.

May involve shared risk, bonus payments, or increased rates for proven performance.

## Capitation

Replaces fee for service

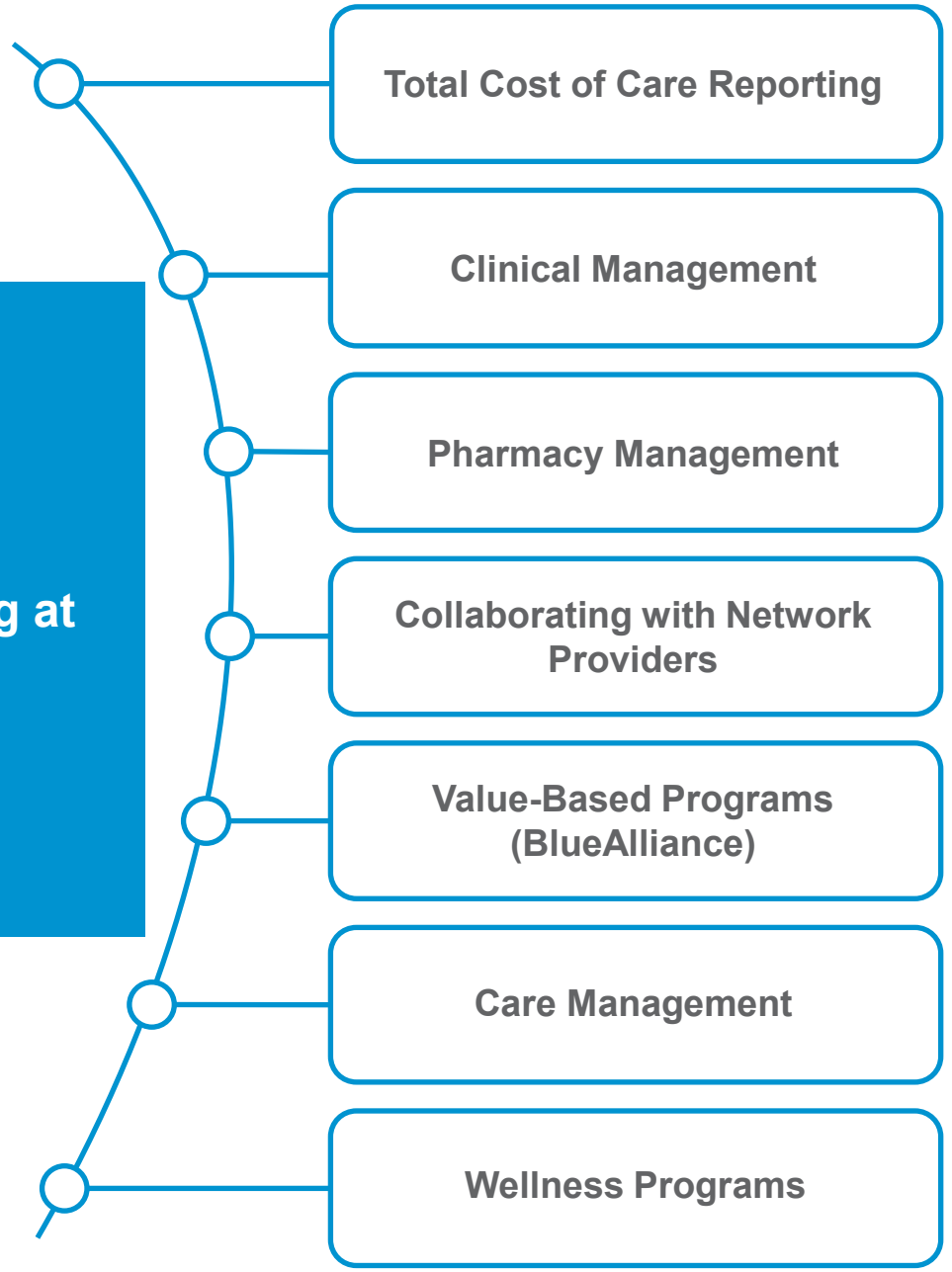
Based on a fixed rate for a defined population, often a per member per month payment.

Generates predictable revenue for providers and predictable costs for payors.

Puts providers at full risk to manage population within capitated payment structure.

# Collaborative Approach to Managing Total Cost of Care

**More member-centric engagement and reporting at every stage of care**



# BCBSND Value-based BlueAlliance Program

- BCBSND has had some form of value-based payment since 2016 in BlueAlliance, which continues to evolve as learnings develop. In 2022, BlueAlliance was extended to Medicaid Expansion with BlueAlliance Care+.
- Based on members attributed to a primary care provider as regular primary care interactions positively impact health care costs and outcomes
- Continually evolving based on feedback from our members, employers and provider partners

## Guiding Principles

Members Come First

Deeper Partnerships with Providers

Pay Providers for Outcomes

Address Key Cost Drivers

# BlueAlliance Redesign Objectives

Address stakeholders' ongoing points of ***feedback***

Develop a forum to ***consistently include key provider stakeholders*** in program development and finalization

Create incentive structure that focuses on ***continuous performance improvement*** year-to-year

Enhance ***social determinants of health*** and health equity measures in program

Ensure financial payments are structured to motivate behavior change and reward investments in ***population health***

Ensure alignment with ***industry standard quality and utilization metrics (HEDIS)***

BlueAlliance redesign efforts centered on incentivizing providers to continually deliver improved outcomes while also addressing known **provider and employer feedback** points.

# Value-Based Programs – 2024 BlueAlliance Program Components (Commercial)

## Social Determinants of Health

Mandatory completion of SDOH questionnaire and Quality Collaboration Call to access incentives

## Quality Measures (HEDIS)

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Well Child Visits First 15 months
- Well Child Visits Age 15-30 Months
- Controlling High Blood Pressure
- Diabetes A1C Poor Control
- Follow-up After Emergency Department Visit for Mental Illness

## Utilization Measures (HEDIS)

- Emergency Department Utilization
- Acute Hospital Utilization
- Plan All Cause Readmissions
- Postpartum Care

## Total Cost of Care

Incentive to beat cost growth target based on network trend, reset each year

# Value-Based Programs – 2024 BlueAlliance Care+ Program Components (Medicaid Expansion)

## Social Determinants of Health

Mandatory completion of SDOH questionnaire and Quality Collaboration Call to access incentives

## Quality Measures (HEDIS)

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Controlling High Blood Pressure
- Diabetes A1C Poor Control
- Follow-up After Emergency Department Visit for Mental Illness

## Utilization Measures (HEDIS)

- Plan All Cause Readmissions
- Adult Access to Preventive/Ambulatory Services
- Potentially Avoidable Emergency Department Visits

## Total Cost of Care

2025 program will add in measure on cost performance

# What We've Learned

Outcomes are improved and costs are reduced with

- Increased primary care interactions
- Intentional care management
- Member care navigation and advocacy
- Incenting value
- More holistic and coordinated care

# What's Next

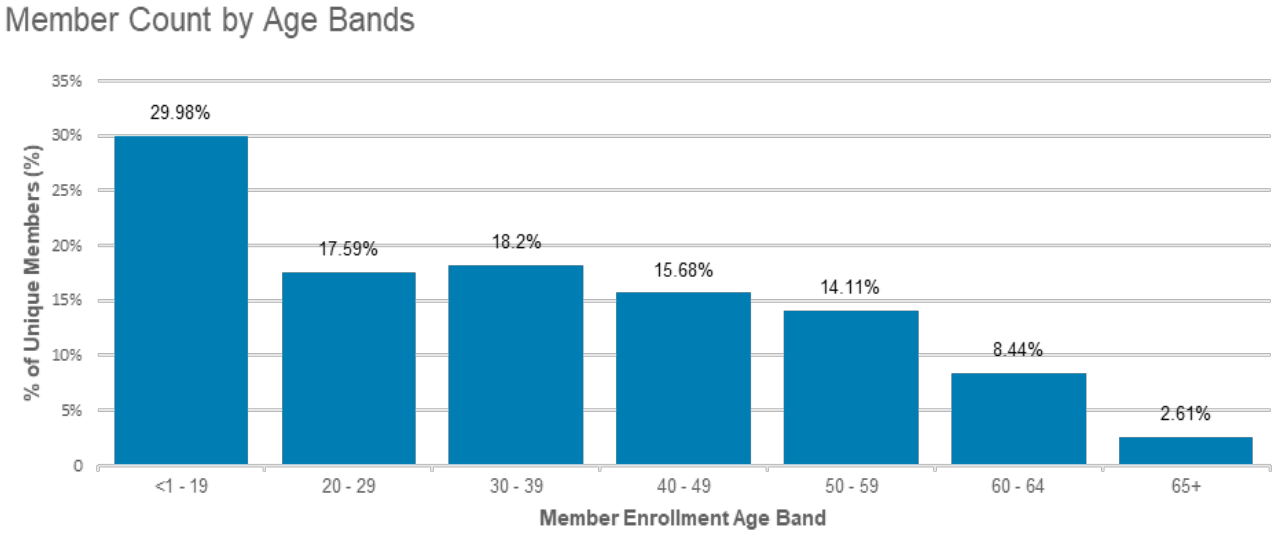
- Support for increased primary care access
- Increased care management support
- Care navigation for members
- Improved tools for
  - Provider and member analytics
  - Quality and utilization metrics
  - Data sharing in support of more effective care management practices
- Continued expansion of value-based payment models


# Appendix

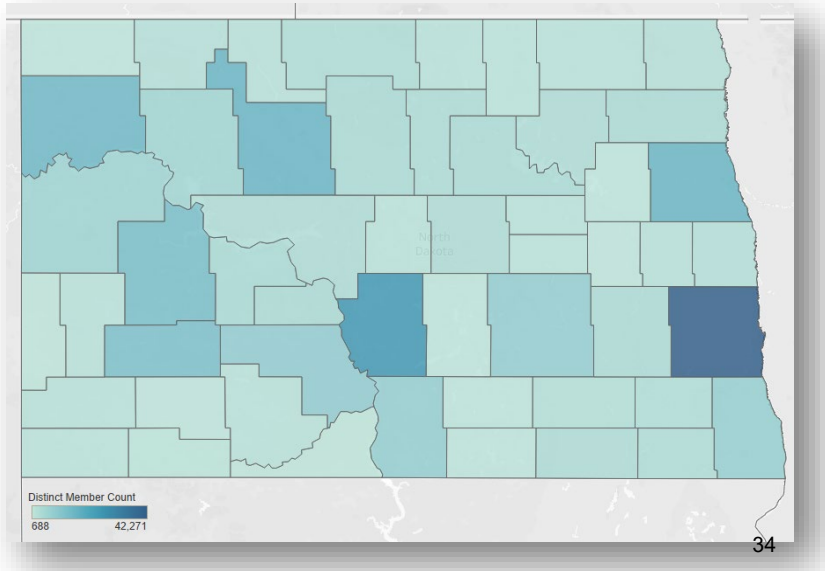
Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

# BCBSND Member Demographics: Commercial

- BCBSND's commercial market makeup:
  - 65% under the age of 40
    - Almost 30% under the age of 19
  - Slightly more males than females
  - Half are subscribers (primary holder of the policy) with 35% of members being dependents
  - Map highlights member distribution by county




| Member County | Unique Members |
|---|---|
| Cass County | 42,271 |
| Burleigh County | 25,477 |
| Grand Forks County | 16,318 |
| Ward County | 16,716 |
| Williams County | 15,431 |
| Dunn County | 13,643 |
| Stark County | 13,093 |

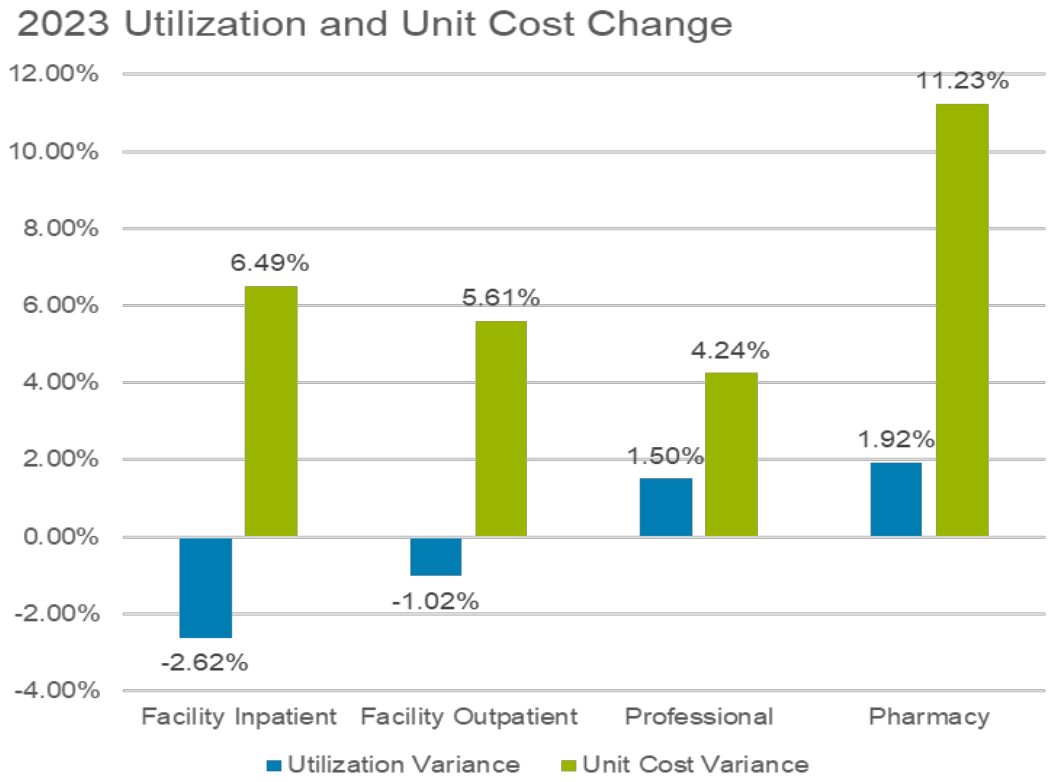





Source: BCBSND membership data through 2/29/24

# Utilization and Unit Cost Growth: Commercial

- Utilization (more services) and unit cost (how much for the service) is driving overall spend increases in professional and pharmacy services
  - Psychiatry – 14% utilization increase
  - Therapeutic Procedures –7% utilization increase
- Utilization is down for hospital inpatient and hospital outpatient; however, unit cost is higher
  - Overall hospital inpatient spend is being offset by decreases in utilization
  - Overall hospital outpatient spend is being driven by unit cost




| Service Category | 2023 Utilization (Per 1,000 Members) | 2023 Unit Cost (Allowed per Service) |
|---|---|---|
| Hospital Inpatient | 29 | $21,557 |
| Hospital Outpatient | 874 | $1,079 |
| Professional | 5,402 | $255 |
| Pharmacy | 3,992 | $216 |

Source: BCBSND claims data | Service dates 2022-2023 | Paid through 2/29/24

# Retail Pharmacy Spend and Utilization: Commercial

- Generic drugs account for ~85% of prescriptions while brand drugs account for ~91% of retail pharmacy spend
- Over the past three years the average scripts per member, per year has remained just above 8 scripts
- Allowed amount per prescription has increased more than 12% per year over the last two years
- 2 of the top 5 drugs by spend are for type 2 diabetes
- 7% of members suffer from diabetes and account for 20% of total spend

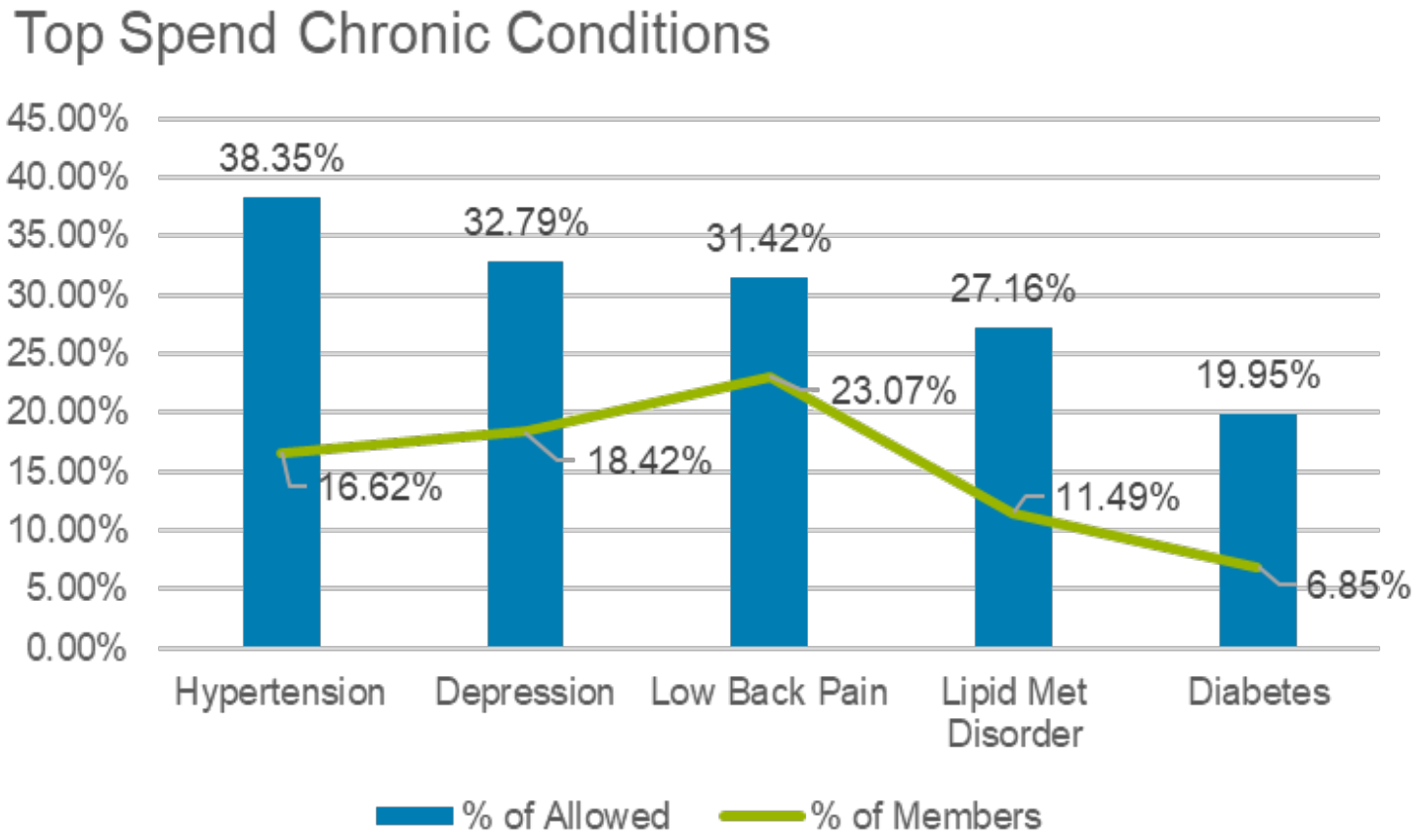
Top Retail Pharmacy Drugs by Spend

| Drug Name | Common Uses | Prescriptions | Allowed PMPM |
|---|---|---|---|
| HUMIRA PEN | Arthritis, skin disorders | 5,779 | $15.35 |
| OZEMPIC | Type 2 diabetes mellitus | 24,676 | $8.47 |
| STELARA | Crohn's disease and ulcerative colitis | 962 | $7.63 |
| SKYRIZI PEN | Plaque psoriasis | 587 | $3.64 |
| JARDIANCE | Type 2 diabetes mellitus | 11,498 | $3.32 |
| ENBREL SURECLICK | Ankylosing spondylitis, plaque psoriasis, rheumatoid arthritis, psoriatic arthritis | 1,253 | $2.81 |
| TREMFYA | Plaque psoriasis, active psoriatic arthritis | 663 | $2.77 |
| COSENTYX SENSOREADY PEN | Plaque psoriasis, active psoriatic arthritis, active ankylosing spondylitis | 1,019 | $2.53 |
| TRIKAFTA | Cystic fibrosis | 275 | $2.33 |
| WEGOVY | Weight management | 4,865 | $2.20 |

Source: BCBSND claims data | Service dates 2021-2023 | Paid through 2/29/24

# High-Cost Claimants: Commercial

- In 2023, 1% of members (~3,000) accounted for ~30% of total spend. This is identical to 2022.
- High spend driven by:
  - Hypertension
  - Depression
  - Low back pain
  - Lipid metabolic disorder (high cholesterol)
  - Diabetes






Source: BCBSND claims data | Service dates 2023 | Paid through 2/29/24

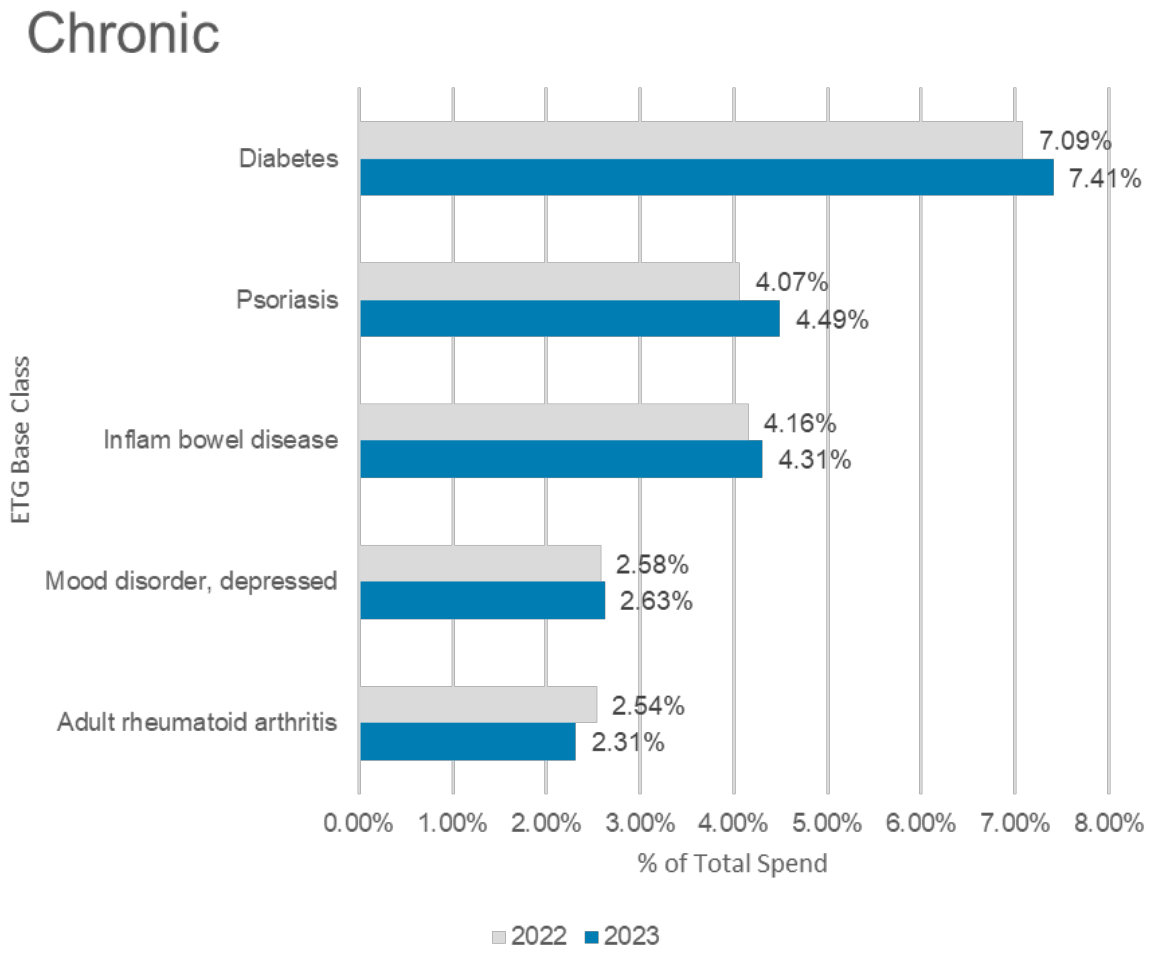
# Out-of-State Services: Commercial

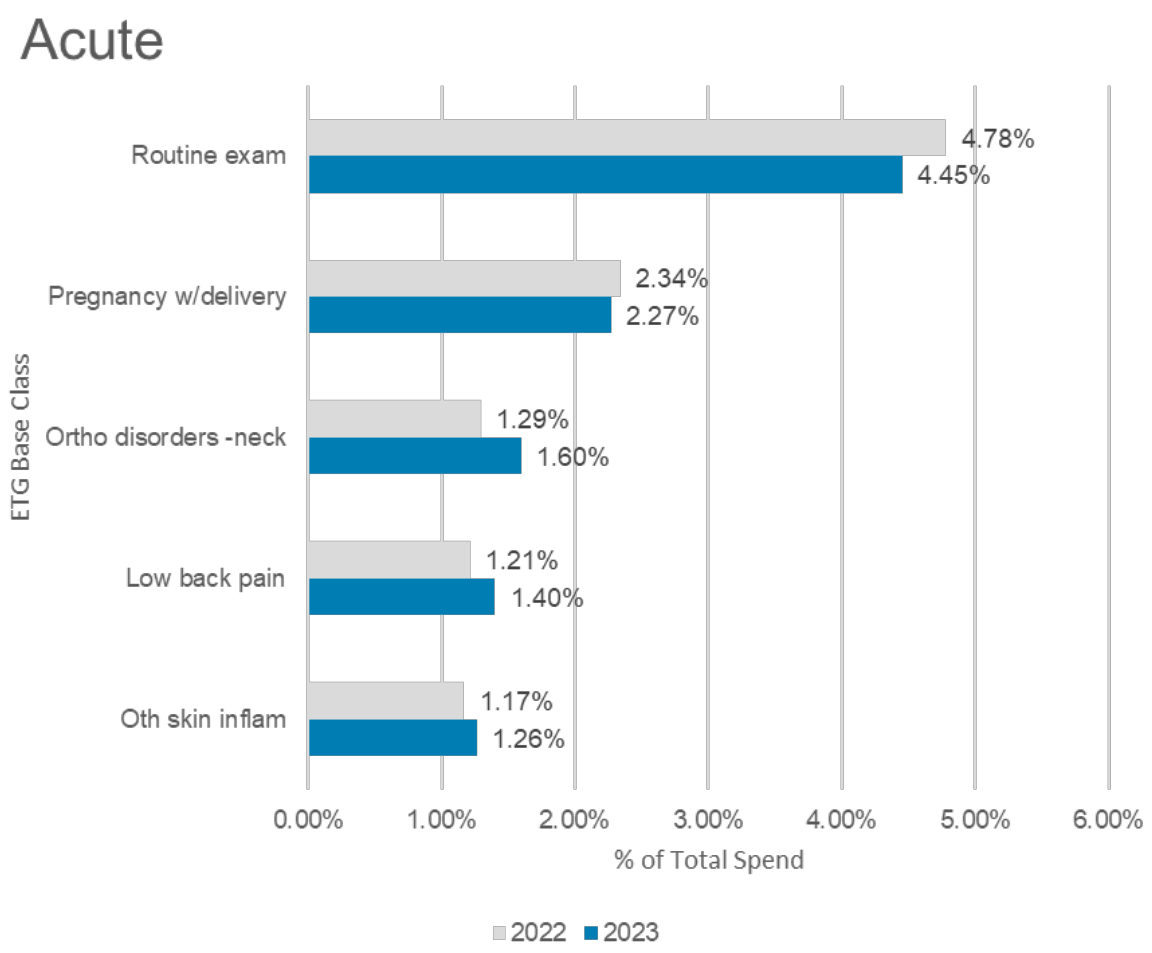
- 20% of total spend for ND-based members goes to out of state providers
  - Increase from 18.5% in 2021
- The top 5 diagnosis categories account for 41.8% of total out-of-state spend
- As a percentage of total spend per category:
  - 67.65% of the spend for congenital malformations go out of state
  - 45.70% of the spend for neoplasms go out of state



Source: BCBSND claims data | Service dates 2023 | Paid through 2/29/24

# Top Episode Treatment Groups: Commercial



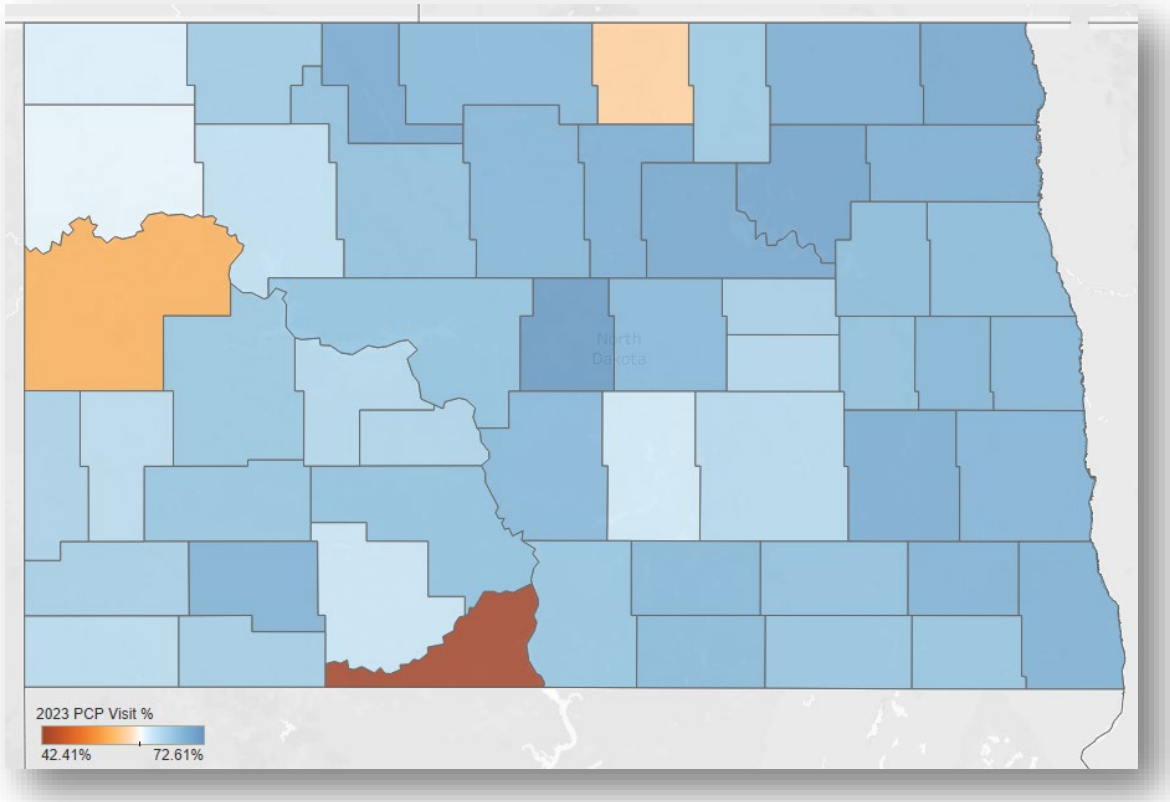




Source: BCBSND claims data | Service dates 2023 | Paid through 2/29/24

# Primary Care: Commercial

- 61% of members had a primary care visit in 2023
  - Across all ages, female members have above average primary care visit rates
  - Males 20-29 years of age make up the lowest primary care visit rate demographic (34%)
  - Females 62-75% primary care visit rate
- Three counties have primary care visit rates below the average of 60.75%
  - Sioux, Rolette and Bottineau counties have the lowest rate of primary care visits
  - Griggs, Steele and Nelson counties have the highest rate of primary care visits

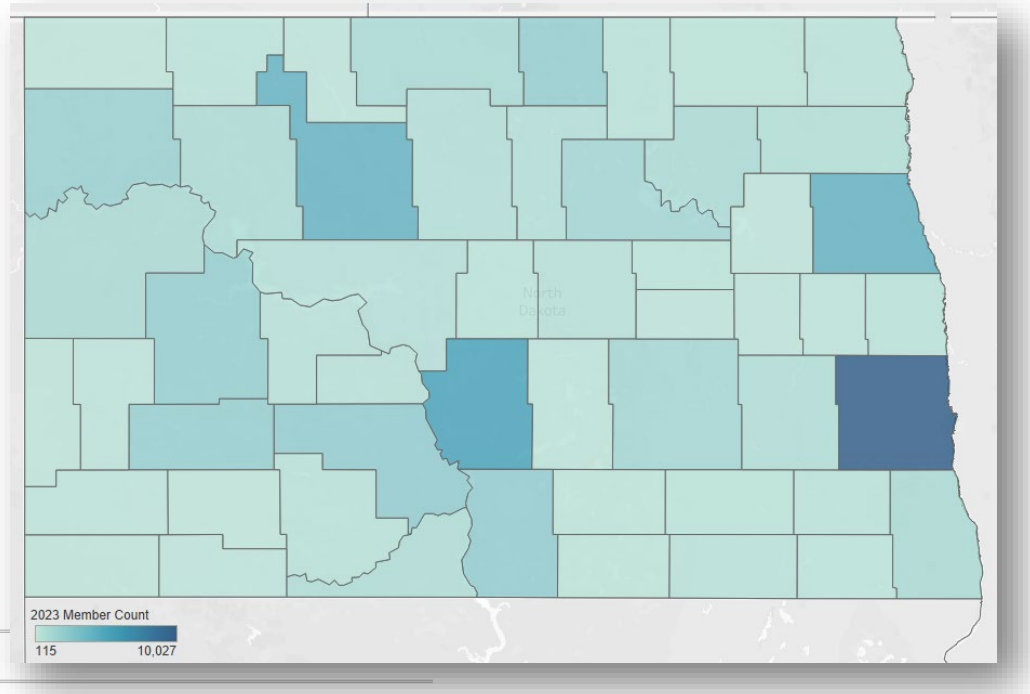
Rate of Primary Care Visits by County

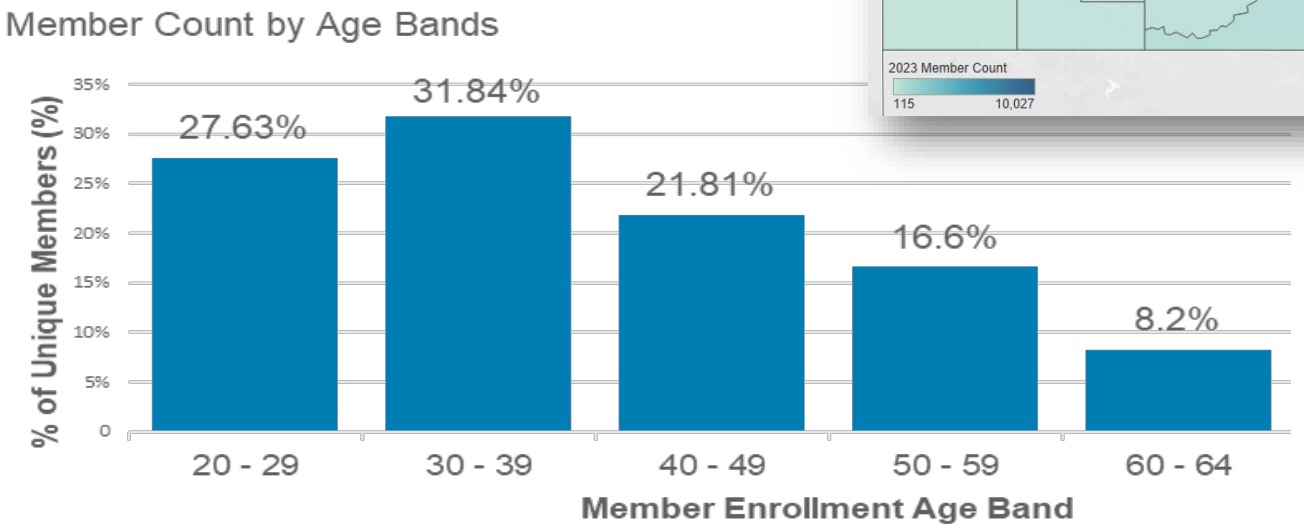



Source: BCBSND claims data | Service dates 2023 | Paid through 2/29/24

# BCBSND Member Demographics: Medicaid Expansion

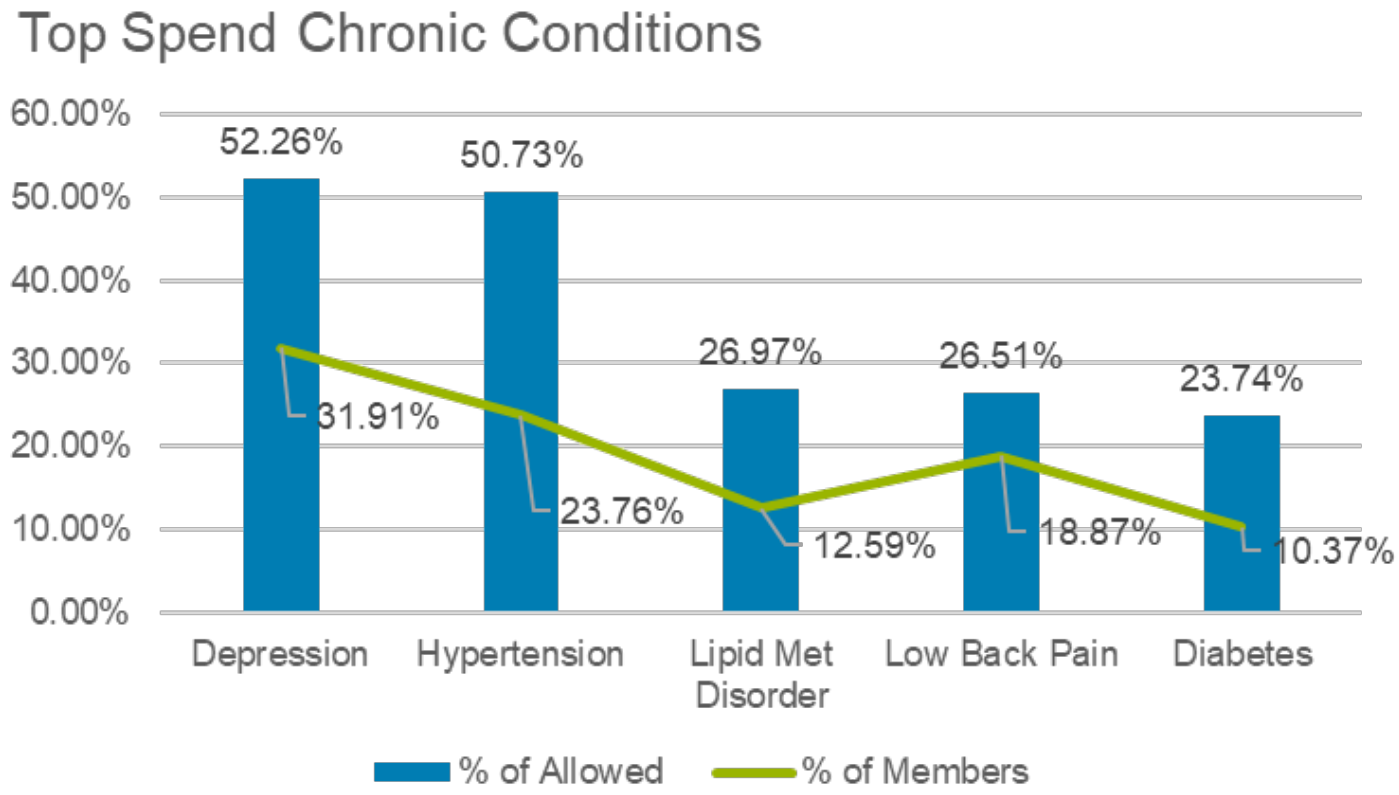
- 59% of Medicaid Expansion members are under the age of 40
- Slightly more females than males
- Map highlights member distribution by county



# High-Cost Claimants: Medicaid Expansion

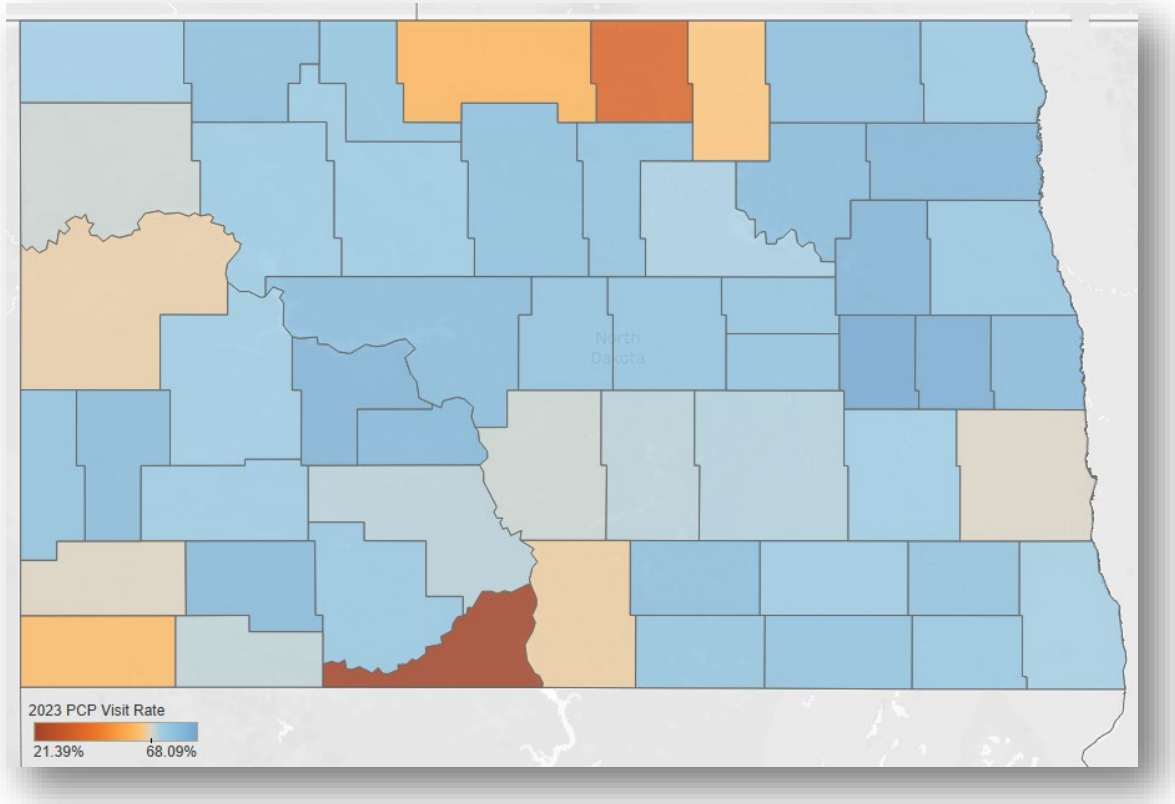
- In 2023, 3.66% of members (~1,630) accounted for ~50% of total spend*.
- High spend driven by:
  - Hypertension
  - Depression
  - Low back pain
  - Lipid metabolic disorder (high cholesterol)
  - Diabetes




Source: BCBSND claims data | Service dates 2023 | Paid through 2/29/24

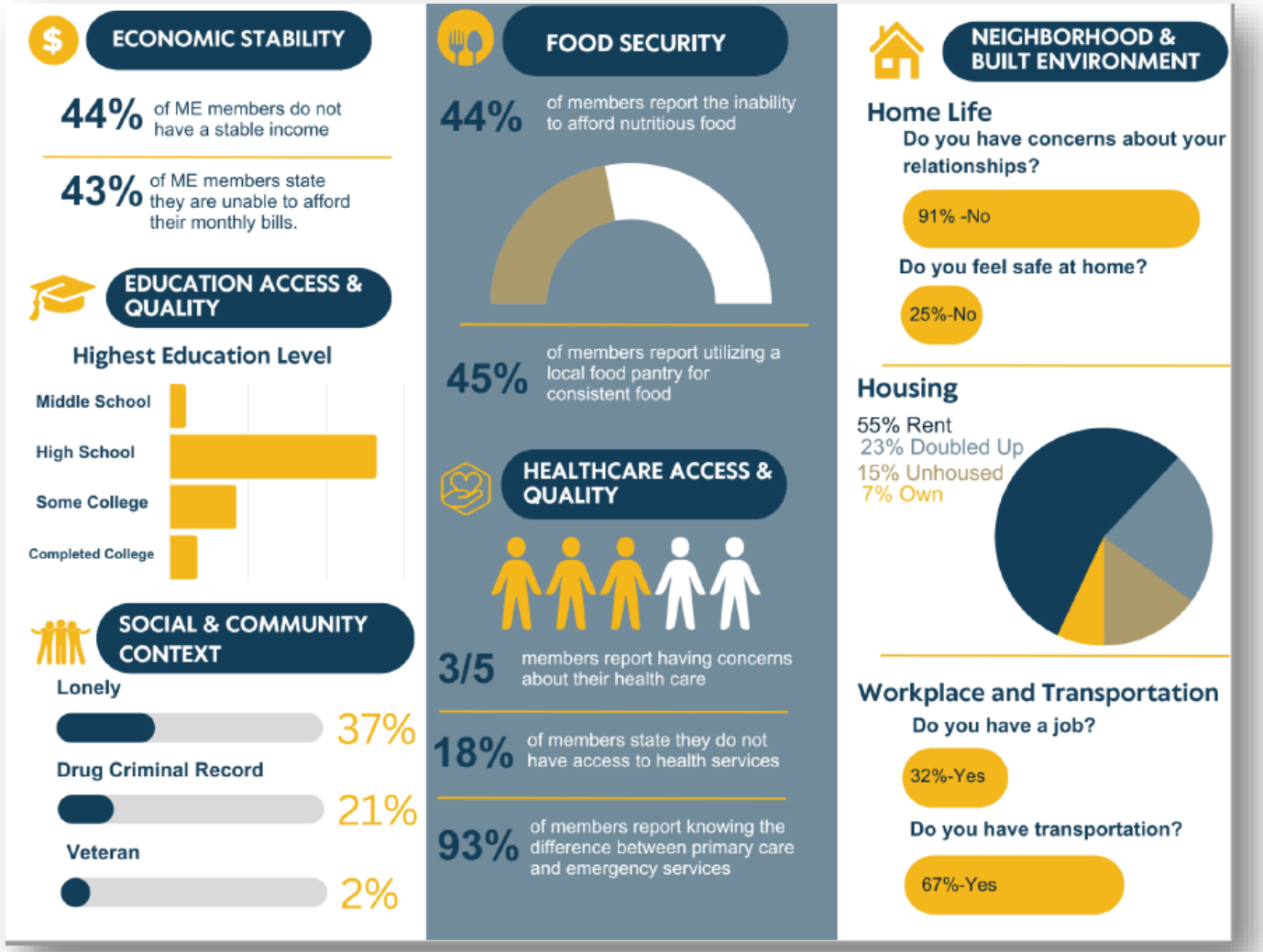
# Primary Care: Medicaid Expansion

- 55% of members had a primary care visit in 2023 (commercial 61%)
  - Across all age bands, female members have above average primary care visit rates
  - Males 21-29 years of age make up the lowest primary care visit rate demographic (36%)
  - Females 56-70% primary care visit rate
- Nine counties have primary care visit rates below the average of 55%
  - Sioux County and Rolette County are significantly below average with 21.39% and 33.65%, respectively
  - Of the largest counties by population, Cass County is the only county below average at 54.77%



# Making An Impact: Medicaid Expansion

- In-home care management services
- Community connections
- Mobile medical van launch
- Food box distribution
- Community health workers




Number of members surveyed: 253


BlueAlliance Collaborative
ND
If you can read this
You are obsessed!

# SANFORD HEALTH PLAN

# SANFORD HEALTH PLAN

## NORTH DAKOTA HEALTH TASK FORCE
## APRIL 2024

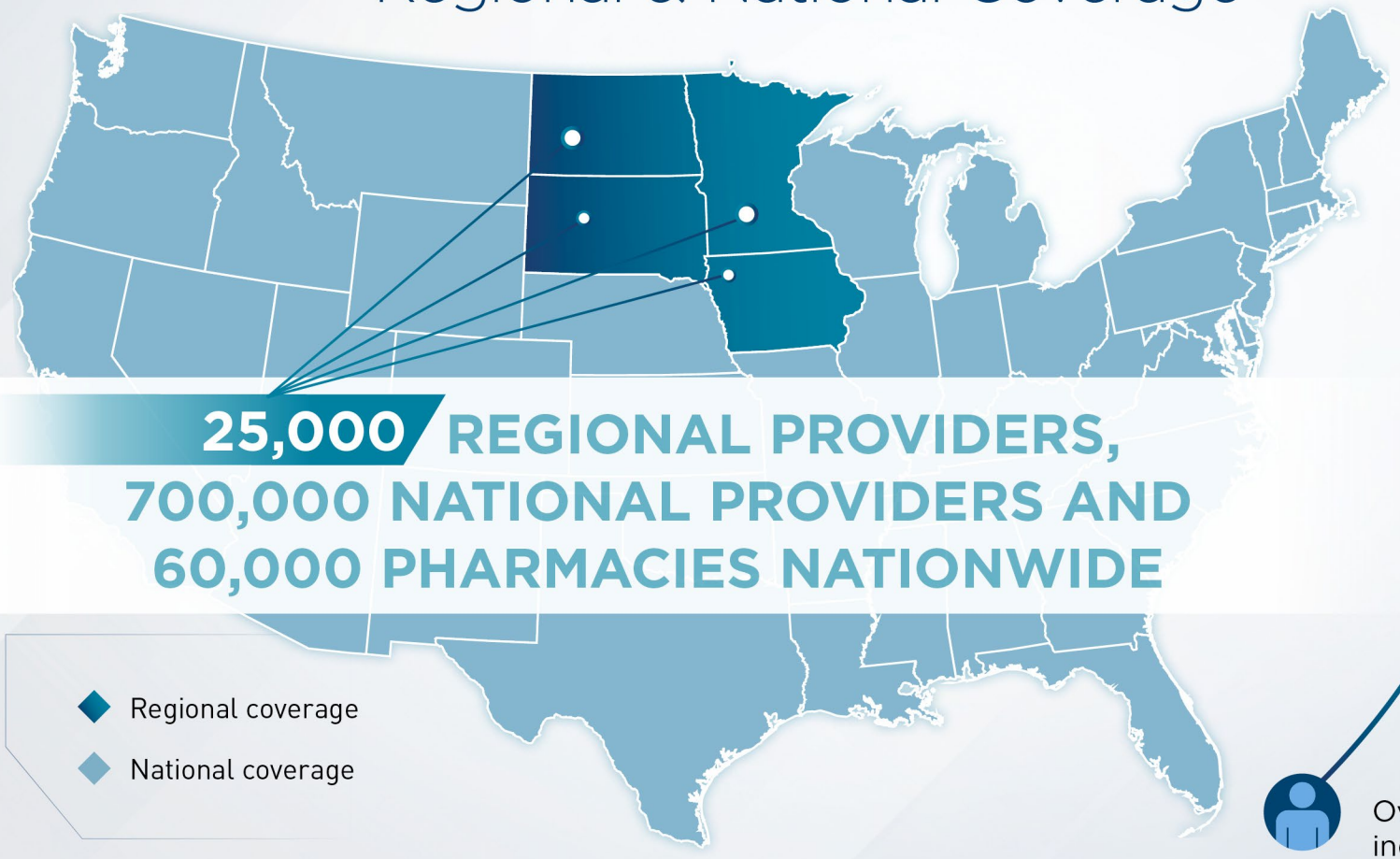
SANFORD HEALTH PLAN

# OUTLINE

- About Sanford Health Plan
- NDPERS Comparisons
- Overview of Cost Drivers and Containment
- Quality Initiatives
- Regulatory Impacts on Cost

# ABOUT SANFORD HEALTH PLAN

## Regional & National Coverage




**25,000 REGIONAL PROVIDERS, 700,000 NATIONAL PROVIDERS AND 60,000 PHARMACIES NATIONWIDE**

**200,000**
lives covered

**NCQA**
Accredited

Projected annual premium revenue of approximately **$950 Million**

Operating on the **Federal Marketplace** in ND and SD

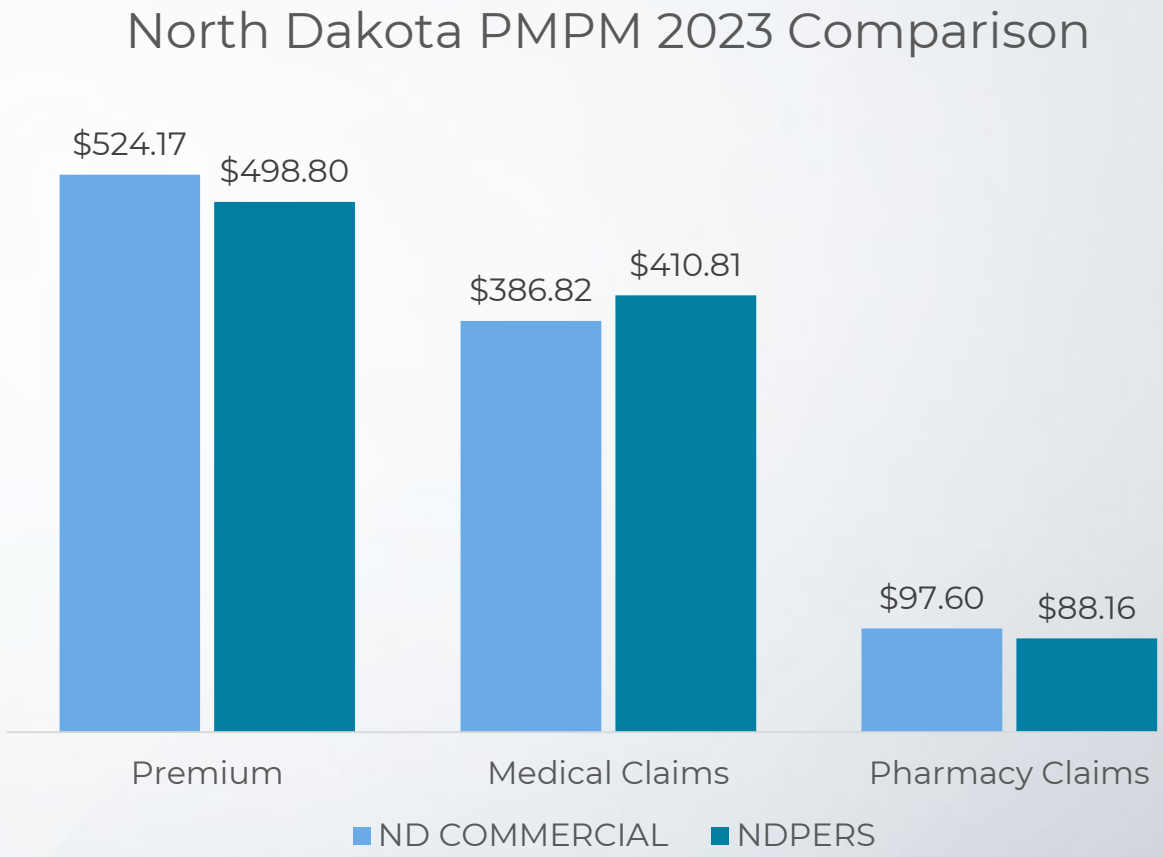
Over **900** appointed, independent insurance agents

# NDPERS COMPARISONS

Two primary differences between SHP's commercial block and NDPERS:

1) Network composition

2) Benefit plan designs



# MEDICAL TRENDS AND COST DRIVERS

**Medical Trend**

- Declining health of the population
- Increased costs and demand for mental health and substance use disorder
- Impact of economic inflation on health care costs:
  - Shortages in supplies
  - Staffing challenges
  - New treatments and technologies
  - Additional regulatory requirements

| Projected Medical Trend 2024 |
| --- |
| **6.8%** |

*Source: Segal 2024 Projected Health Plan Cost Trends*

# PHARMACY TRENDS AND COST DRIVERS

## Pharmacy Trend

- Price inflation is primary driver for inpatient hospital, physician and overall Rx trends
- Specialty drug increases driven by new drugs replacing lower-cost therapies previously used
- Specialty drugs/ biologics now account for over half of all pharmacy spending
- Greatest growth experienced by anti-obesity medications and drugs to treat migraines

**Projected Pharmacy Trend 2024**

**9.9%**

Retail Pharmacy

**14.5%**

Specialty Pharmacy

Had grown 13.5% YOY in 2023

*Source: Segal 2024 Projected Health Plan Cost Trends*

# COST DRIVERS/ INDUSTRY HEADWINDS

## WHAT IS COMING NEXT?

- Permanent shifts in moving some procedures from inpatient to outpatient
- New benefit mandates or coverage requirements
- Widespread utilization and cost increases to GLP-1s and anti-inflammatories
- Rising incidence and cost of specialty care

| Projected Blended Trend 2024 |
| --- |
| **7.3%** overall |

*Source: Segal 2024 Projected Health Plan Cost Trends – Projected Blended based on SHP block of business utilization between medical, outpatient Rx, and specialty Rx*

# COST CONTAINMENT EFFORTS

## Medical Management

- Enhanced Care Management; proven outcomes
- Evolving CM to match membership trends
- Digital Health Solutions to supplement CM
- Health Guides
- Specialized Wellness Solutions
- Prior Authorization Automation

## Provider Partnerships and Contracting

- Expand value-based arrangements
- Optimizing deeper discounts from wrap network vendor
- No Surprises Act Implementation

## Pharmacy Spend Management

- Specialty Drug Management
- Formulary Management
- Prior Authorization
- High Generic Rates

# QUALITY INITIATIVES

**Sanford Health Plan has built a robust infrastructure to guide, support and monitor quality initiatives**

**NCQA**: National Committee for Quality Assurance
- Serving more than 192 million people enrolled in accredited health plans (over 1200 health plans accredited).
- A widely recognized, evidence-based program dedicated to quality improvement and measurement.

**HEDIS®**: Healthcare Effectiveness Data and Information Set,
- Tool used by more than 90% of U.S. health plans to measure performance on important dimensions of care and service.
- 90 measures across six domains of care
- Scores given on 5-Star scale across three main categories:
  - Patient Experience
  - Prevention and Equity
  - Treatment

**CAHPS®**: Consumer Assessment of Healthcare Providers and Systems
- Annual survey to members to provide data an patients' perspectives and experience with health care delivery and health plan administration.


cahps® Surveys and Tools to Advance Patient-Centered Care

# QUALITY INITIATIVES

## QUALITY IMPROVEMENT COMMITTEE

Oversight of SHP Quality Programs:

**Members:**
VPCMO, Senior Medical Officer(s)
Pharmacist
Quality Director/Specialists
UM Director/Manager
Appeals and Grievances Director/Manager
Care Management Director
Customer Service Director/Manager
Marketing Director
Pharmacy Director/Manager
Provider Relations Director/Manager
Credentialing Manager
Population Health Manager
Government Programs

**Sub Committees:**
Member Experience
Network Adequacy & management
Quality Improvement
Utilization Management

## PERFORMANCE IMPROVEMENT

### Member Surveys
- Annual Member Satisfaction/CAHPs
- Annual Behavioral Health Satisfaction (Experience of Care and Health Outcomes (ECHO)- Press Ganey survey)

### Provider Surveys
- Annual Provider Satisfaction and Coordination of Care
- Annual Timeliness of Care Survey (Primary Care, Behavioral Health, and High Volume Specialists appointment wait times).

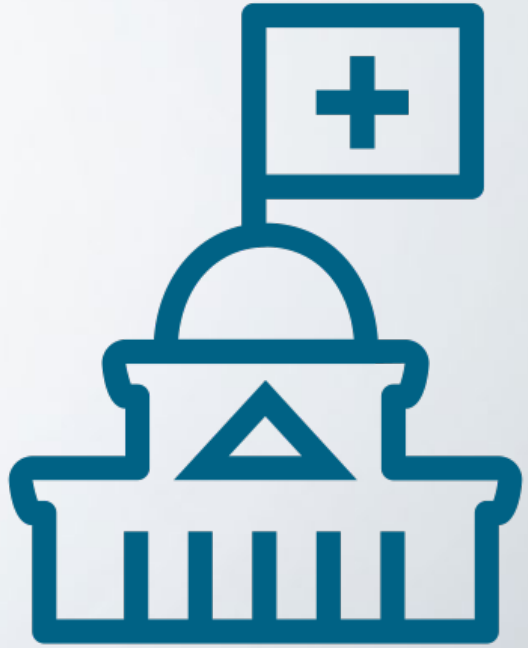
### HEDIS Focus
- Current Data Collection and Quality Improvement Initiatives
- Needs and analysis of:
  - Membership Cultural, Ethnic, Racial and Linguistic
  - Membership Social Determinants of Health
- Network Adequacy (Primary Care, Behavioral Health, and High Volume Specialists distance and availability ratios)
- Provider Directory Accuracy
- Customer Service Accuracy (Pharmacy, UM and CS accuracy in quoting coverage and prior-authorization requirements)
- Complaints and Appeals monitoring
- **Utilization trends**
- **Cancer Screening Rates (Colorectal, Breast, Cervical)**
- **Diabetic Care (A1c control, eye exam)**
- **Prenatal and Post-partum care**
- Readmission Rates
- Immunizations
- **Appropriate diagnosis, treatment and referral of Behavioral Health disorders**
- Appropriate use of psychotropic medications
- Management and treatment access and follow-up for members with co-existing medical and BH disorders
- Special needs of members with serious and persistent mental illness (SPMI)- assessment of SDOH, utilization (over/under).
- Annual Population Health Assessment and Strategy

### Collaborative Efforts
- Quarterly collaborative workgroup with representation from SHP, System Delivery, Psychiatry, and Avera Health is held to review inpatient case details and joint care plan.
- Clinical Practice Guidelines Committee
- ACHP Diabetes Pledge
- SD Immunization Improvement Collaborative
- ND Cancer Coalition

# REGULATORY IMPACT ON COSTS

**Health Insurance is regulated at both the State and Federal level**

- **Federal**
  - Prior-Authorization and Interoperability Final Rule
  - Notice of Benefit and Payment Parameters (Network Adequacy Standards)
- **State**
  - New Benefit Mandates or Coverage Requirements
  - Reinsurance Program
  - Administrative Requirements



- When a new regulation is imposed or legislation is passed affecting health insurance, those costs most often go into additional administrative spending, impacting premiums.

- Health plans want to be responsive to members and patients with cost-effective, evidence-based care that brings value and access.

# SUMMARY

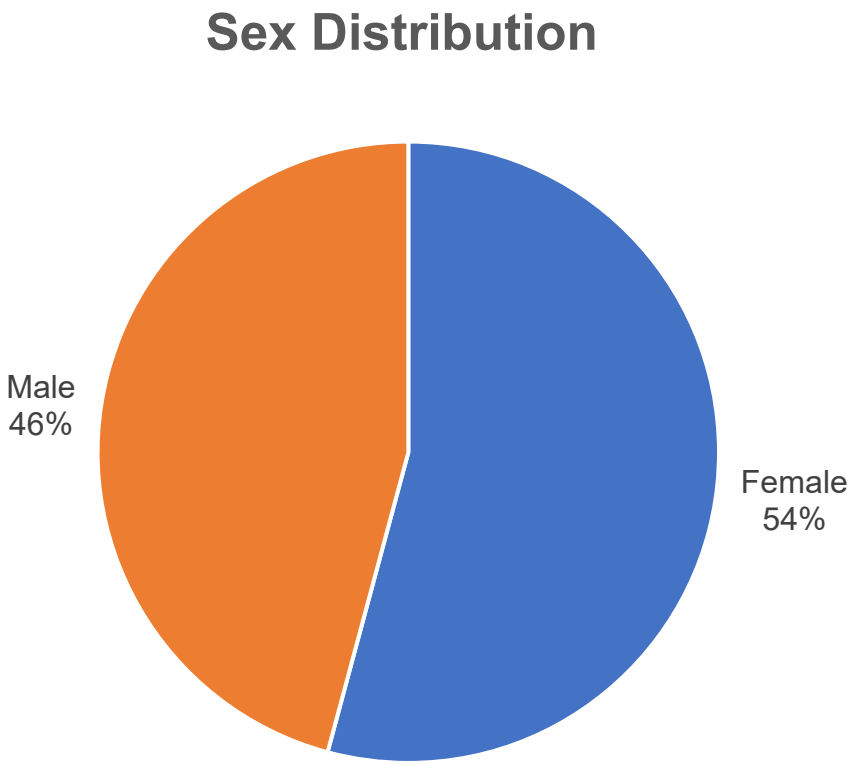
- Economic and inflationary pressures will drive medical and pharmacy cost
- Quality initiatives created to work as a buffer against rising costs by focusing on member outcomes and experience
- Administrative cost and increasing regulatory oversight will continue to add to overall plan costs

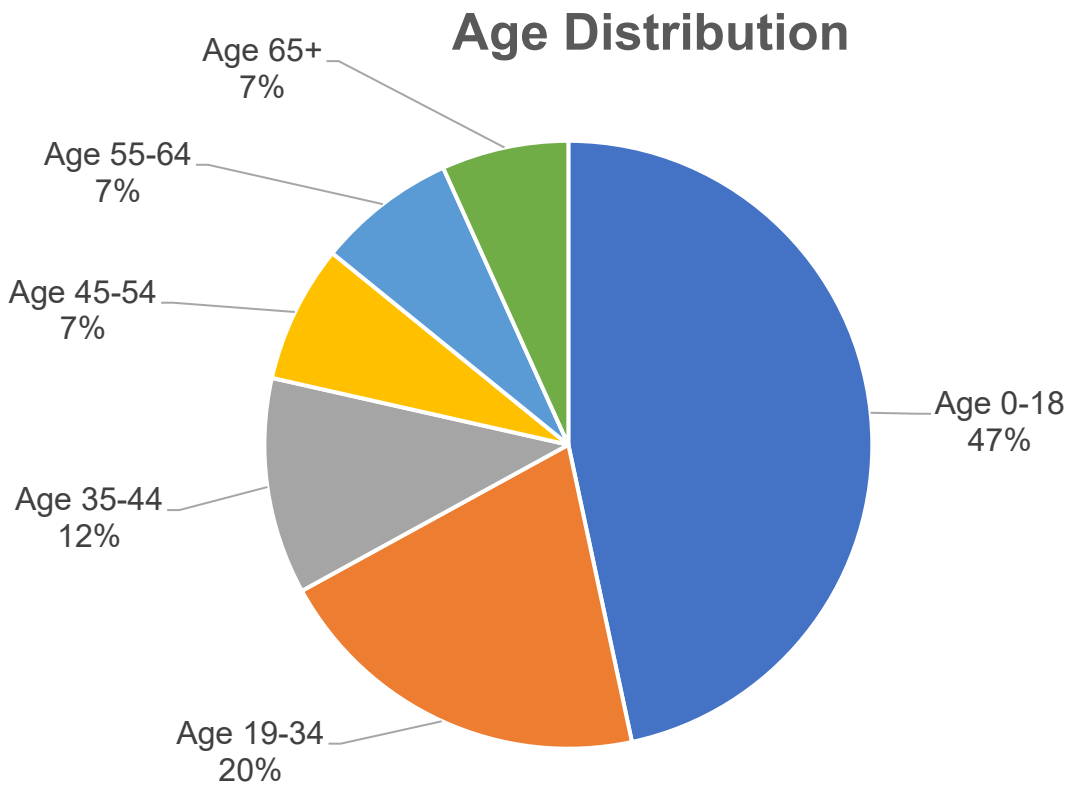
# ND MEDICAID PROGRAM

# About the Medicaid Data

- Data source:
  - North Dakota Medicaid
- Timeframe:
  - Current period: Fiscal Year 2023, July 2022 – June 2023
  - Prior period: Fiscal Year 2022, July 2021 – June 2022
- Important considerations and caveats about the analysis:
  - Medicaid was designed as a government program, which by nature is very different from other health care programs
    - Medicaid covers different services for different people at different rates
  - Reporting for Medicaid is typically structured around financial management and federal claiming purposes which is not well suited for deep dives to inform delivery system initiatives
    - While we tried to follow the analysis and reporting structure used for NDPERS, these analyses are not directly comparable

# Characteristics of the Medicaid Population (Fee-for-Service and Expansion), FY 2023




Average number of Medicaid members in FY 2023:

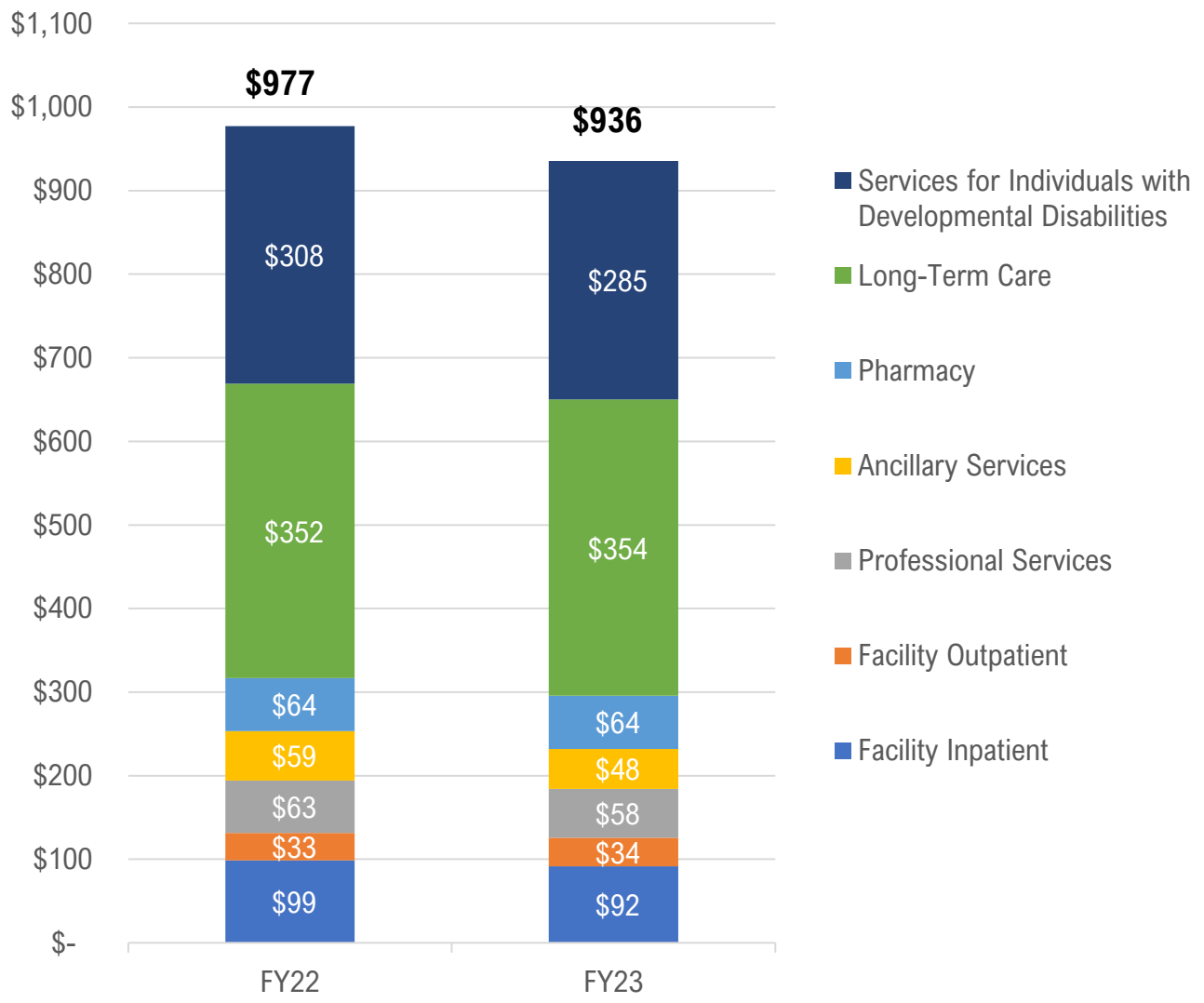
- Fee-for-Service = 96,437
- Expansion = 36,757

# Per Member Per Month Spending and Spending Growth by Service Category for the Fee-for-Service Population

Per member per month (PMPM) spending* decreased 4.4% from FY 2022 to FY 2023.

68% of PMPM spending in FY 2023 was on long-term care and developmental disabilities services.

PMPM spending increased for long-term care and outpatient facility services. It remained the same for pharmacy services, and decreased for all other services.

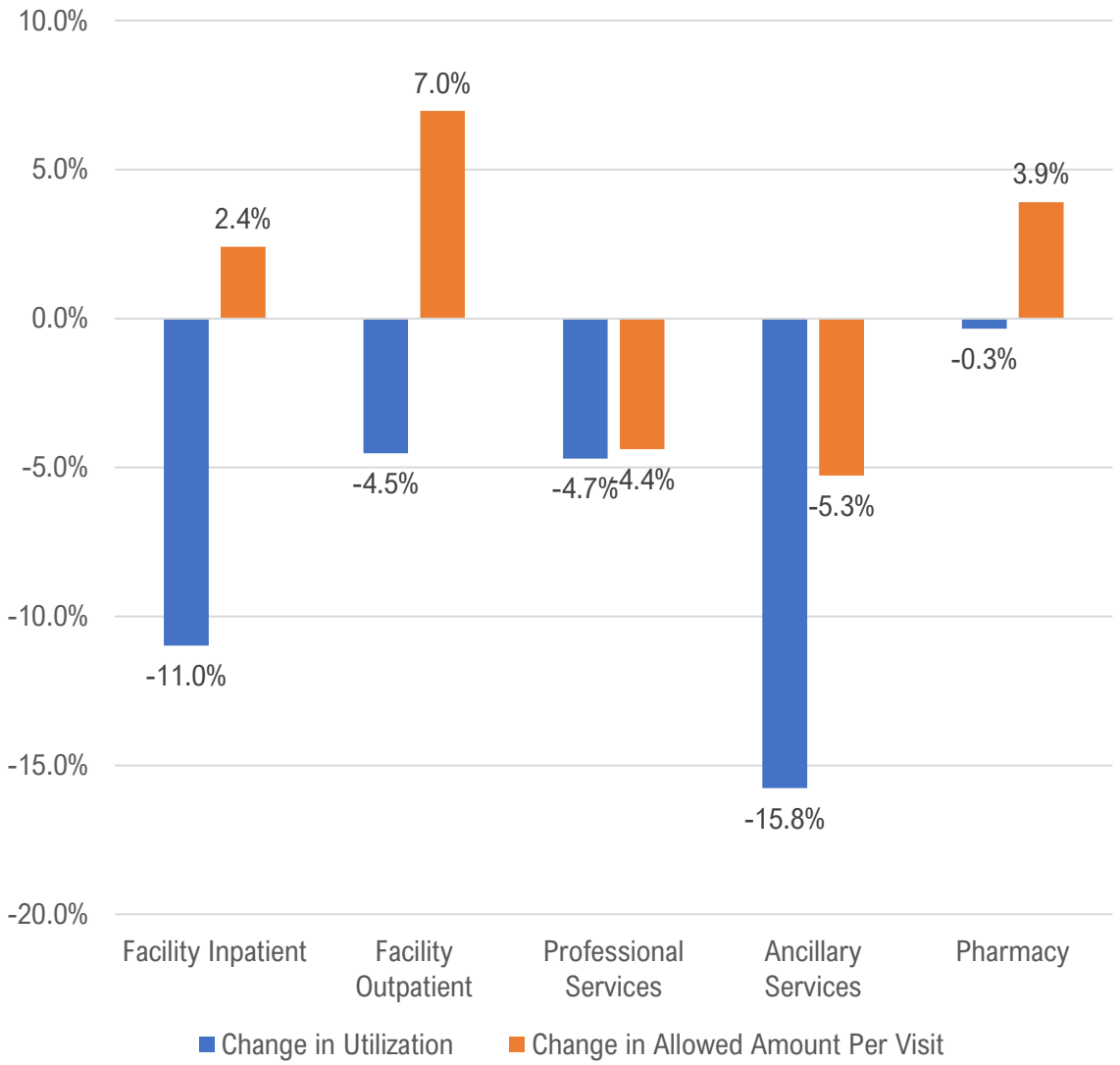



Pharmacy spending is based on paid amounts and do not reflect rebates. Spending on all other services are based on allowed amounts.

# Utilization, Unit Cost and FY 2022-FY 2023 Growth in Utilization and Unit Cost by Service Category for the Fee-for-Service Population

## Increased PMPM spending on outpatient and pharmacy services were driven by increases in price per unit.

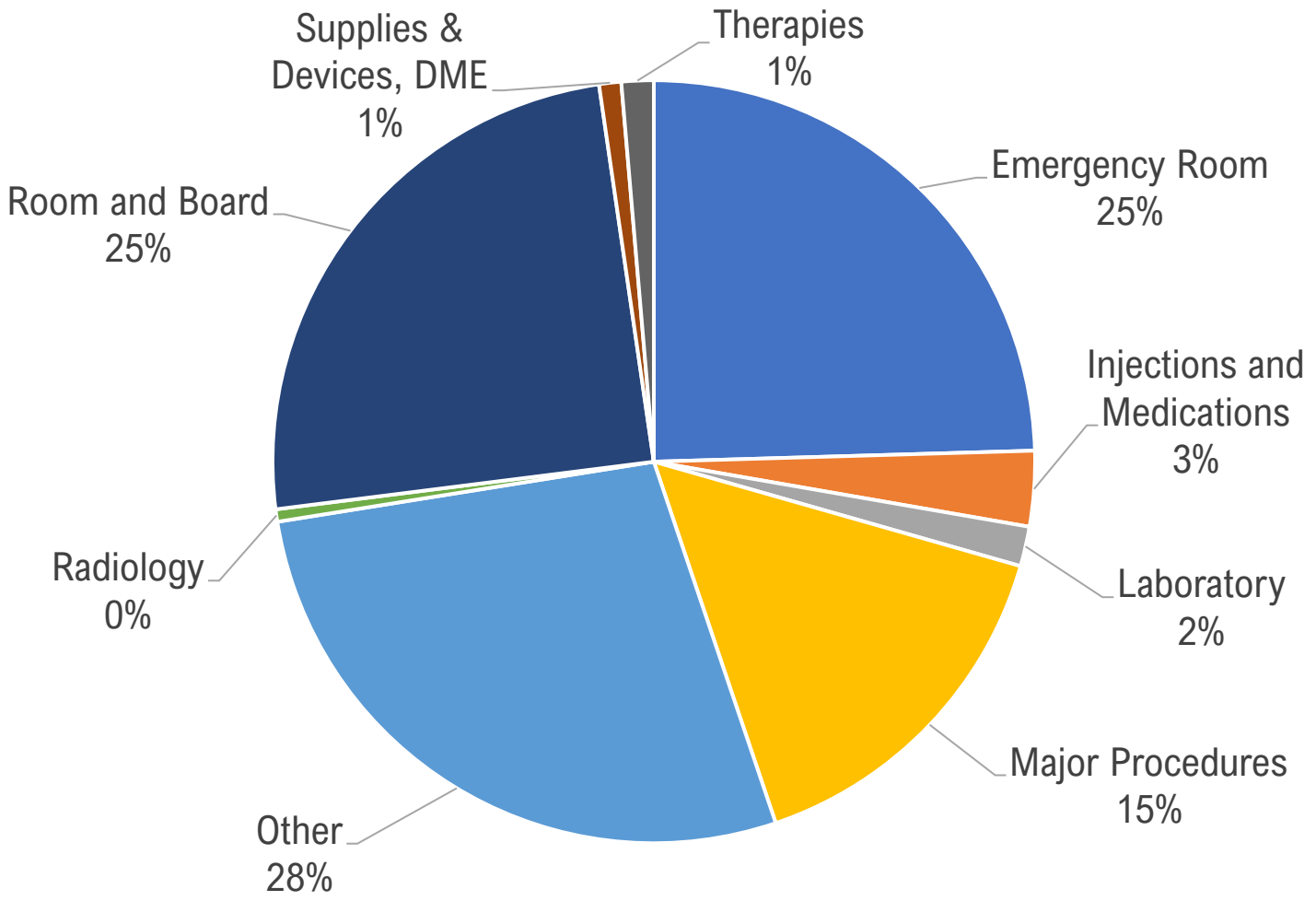
| | 2023 Utilization (Visits per 1000 Members) | 2023 Unit Cost (Allowed Amount Per Visit) |
|---|---|---|
| Facility Inpatient | 72 | $11,151 |
| Facility Outpatient | 798 | $371 |
| Professional Services | 3,726 | $142 |
| Ancillary | 3,695 | $121 |
| Pharmacy* | 2.5 | $109 |




*Pharmacy utilization is on based scripts per patient who received a prescription. Pharmacy unit cost is based on on paid amounts and do not reflect rebates.

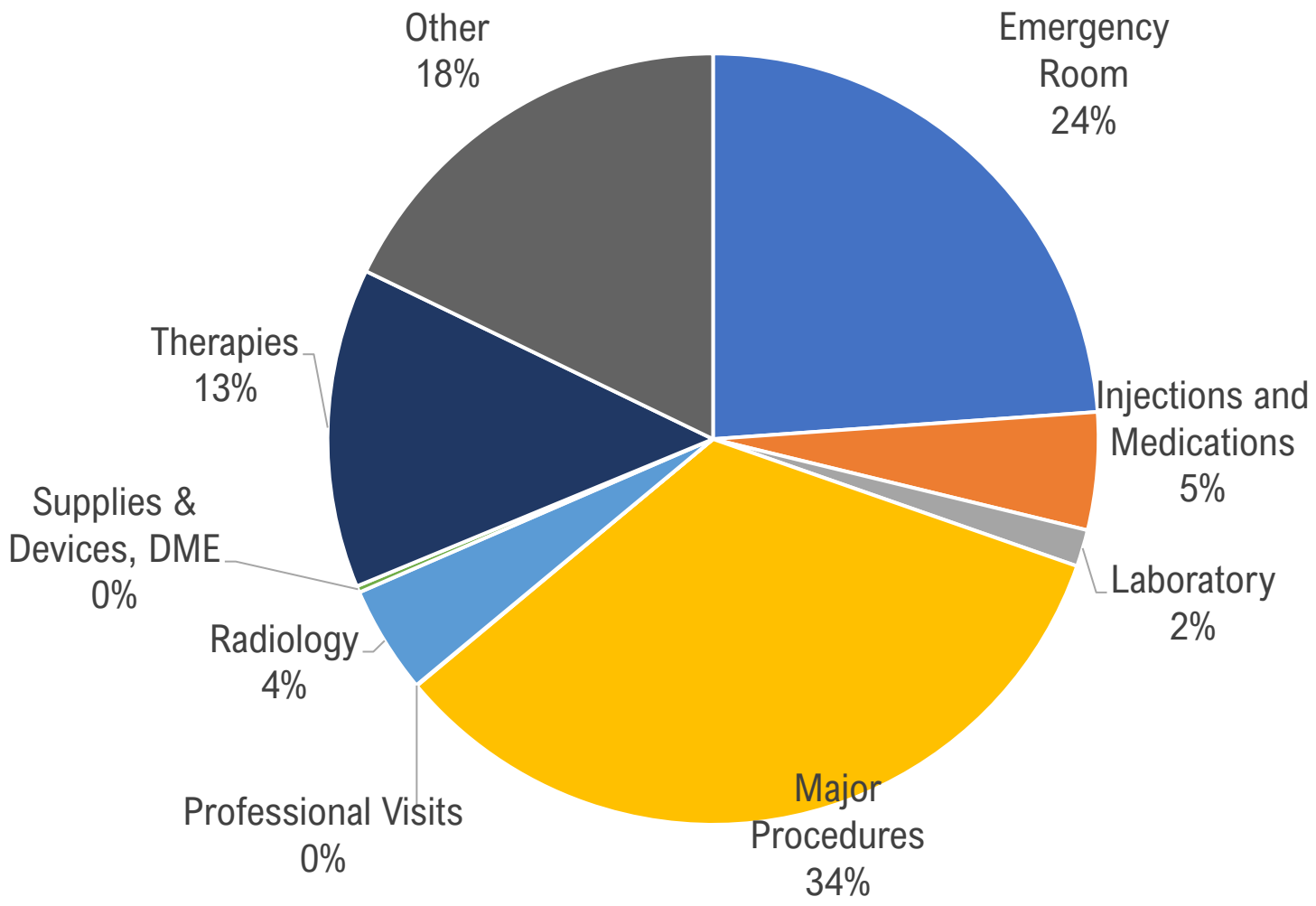
# Spending on and Utilization of Inpatient Facility Services for the Fee-for-Service Population, FY 2023

| Inpatient by Service Classification | Total Allowed Amount |
|---|---|
| Emergency Room | $26,025,327 |
| Injections and Medications | $3,385,825 |
| Laboratory | $1,785,804 |
| Major Procedures | $16,338,381 |
| Other | $29,337,949 |
| Radiology | $556,833 |
| Room and Board | $26,189,882 |
| Supplies & Devices, DME | $993,256 |
| Therapies | $1,446,232 |
| **Total** | **$106,059,491** |



# Spending on and Utilization of Outpatient Facility Services for the Fee-for-Service Population, FY 2023

| Outpatient by Service Classification | Total Allowed Amount |
|---|---|
| Emergency Room | $9,410,006 |
| Injections and Medications | $1,940,849 |
| Laboratory | $608,437 |
| Major Procedures | $13,242,361 |
| Professional Visits | $13,221 |
| Radiology | $1,778,130 |
| Supplies & Devices, DMS | $108,031 |
| Therapies | $5,283,084 |
| Other | $7,026,793 |
| **Total** | **$32,384,118** |



# Spending on and Utilization of Retail Pharmacy Services for the Fee-for-Service Population, FY 2022 and 2023

On average, approximately 19k members receive a prescription per month.

The average amount paid for a prescription is $109. The average amount paid for a generic prescription is $22, and for a brand name prescription is $699.

Most retail prescription drugs prescribed are for generic drugs.

| Measure | FY 2022 | FY 2023 | Change |
|---|---|---|---|
| Monthly Average Number of Members with a Prescription | 18,024 | 19,169 | 6.4% |
| Average Amount Paid per Script | $104.85 | $108.95 | 3.9% |
| Average Amount Paid per Generic Script | $22.15 | $22.08 | -0.0% |
| Average Amount Paid per Brand Name Script | $657.37 | $698.62 | 6.3% |
| % Generic Dispensing | 87.2% | 87.4% | 0.2% |

# Top Drugs by Paid Amount in FY 2023 for the Fee-for-Service Population

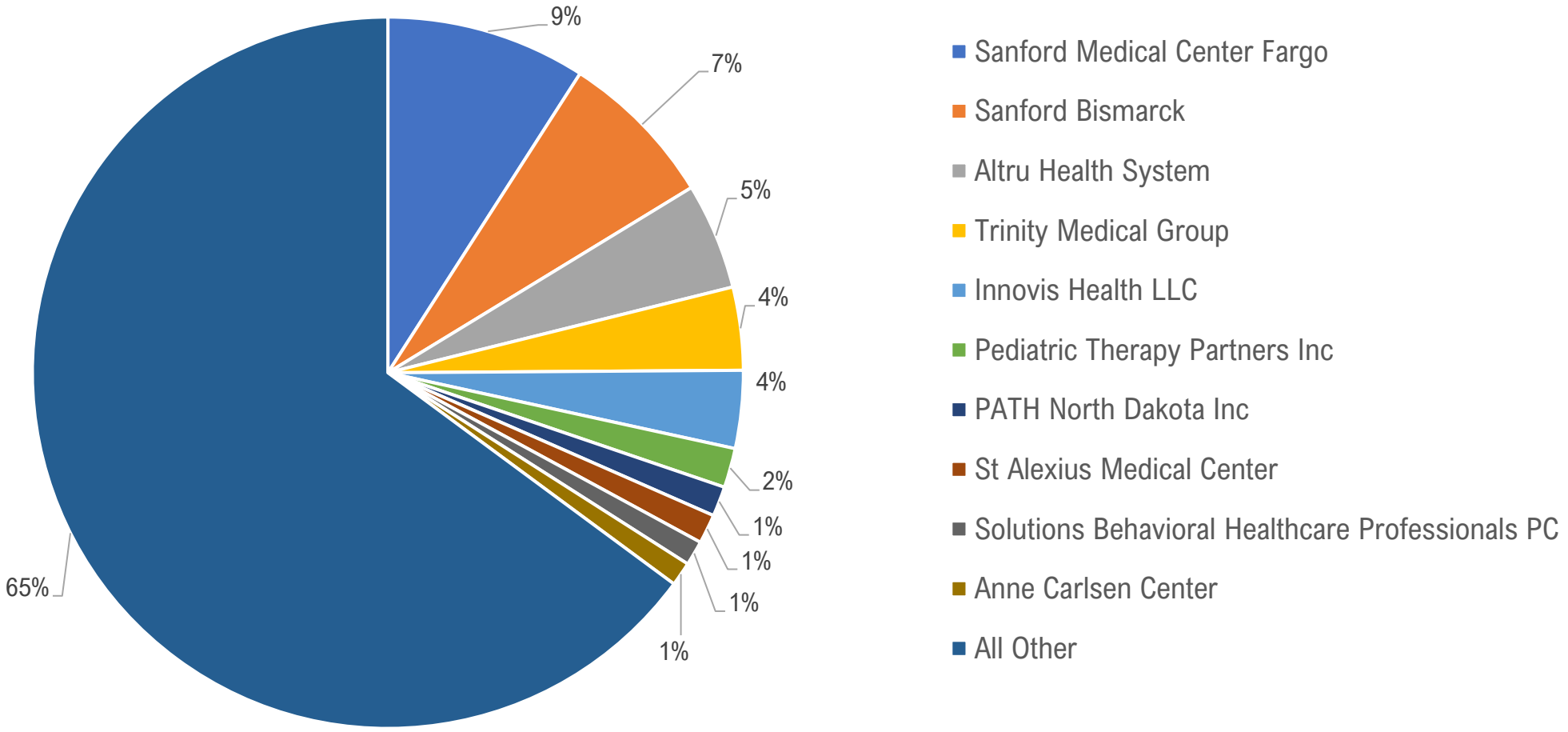
| Therapeutic Class | Total Amount Paid | Avg Number of Members Receiving Rx Per Month | Avg Amount Paid Per Member Receiving Rx |
|---|---|---|---|
| Immunomodulators | $9,037,803 | 82 | $9,184.76 |
| ADHD stimulants | $7,639,060 | 2800 | $227.35 |
| Antipsychotics | $5,572,483 | 1653 | $280.93 |
| NonInsulin Diabetes Med | $3,528,509 | 788 | $373.15 |
| Insulins | $3,561,674 | 370 | $802.18 |
| Antiinfectives | $1,836,062 | 3967 | $38.57 |
| Cystic Fibrosis | $3,322,493 | 13 | $21,298.03 |
| Anticonvulsants | $1,977,789 | 1930 | $85.40 |
| Antidepressants | $1,162,588 | 3979 | $24.35 |
| Oncology | $1,848,511 | 84 | $1,833.84 |

Total retail pharmacy spending for the fee-for-service population in FY 2023 was $73,638,814.

*Pharmacy values are based on paid amounts and do not reflect rebates.

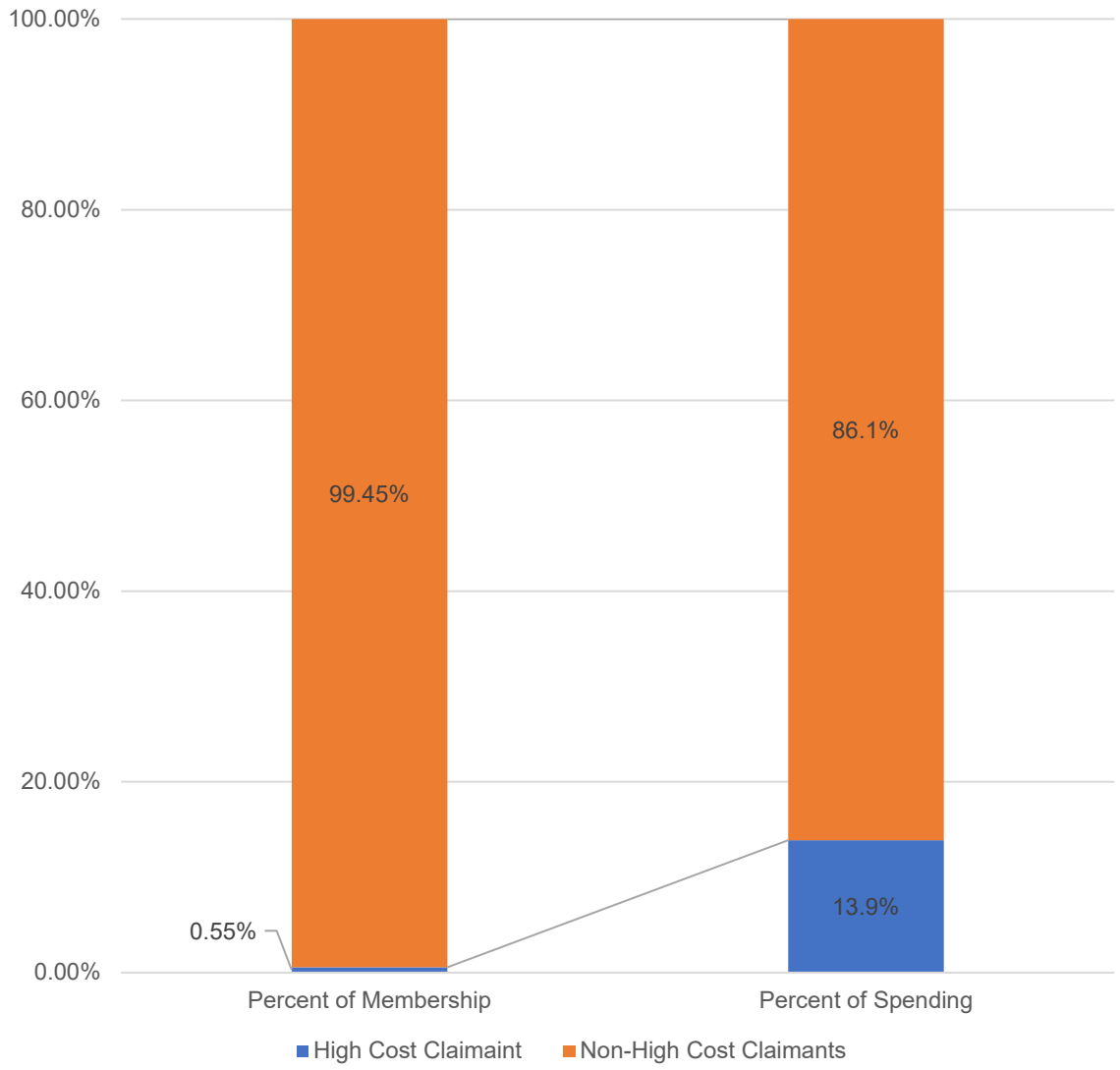
# Medical Spending Attributed to the Top 10 Providers for the Fee-for-Service Population, 2023

## Approximately 35% of spending can be attributed to 10 providers.



# Medical Spending on High-Cost Claimants in the Fee-for-Service Population, FY 2023

- In FY 2023, high cost claimants represented about half a percent of members but accounted for 14% of total spending.
- The top clinical conditions associated with high-cost claimants were:
  - Neurological disorders
  - Cerebral palsy
  - Autism
  - Newborns with and without complications
  - Respiratory disorders




* High cost claimants are members with claims exceeding $200k.

# Top Episode Treatment Group Episodes for the Fee-for-Service Population, FY 2023

## Chronic

- Neurological disorder ($183.7m)
- Mental health conditions – depression, anxiety, substance use, psychoses ($49.0m)
- Autism ($20.1m)
- Diabetes ($12.6m)
- Cerebral Palsy ($9.7m)
- Schizophrenia ($5.9m)
- Chromosomal anomalies ($5.7m)

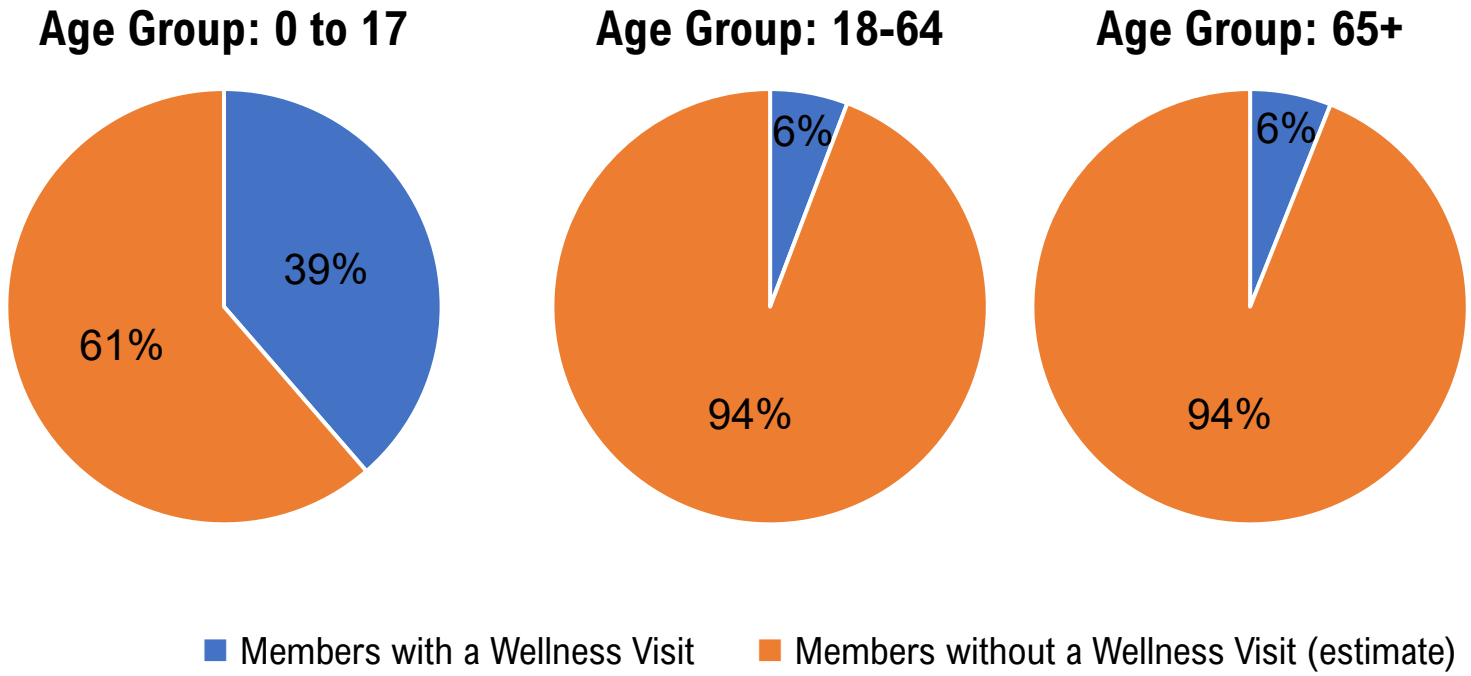
## Non-Chronic

- Preventative/administrative health encounters ($16.3m)
- Ear, nose and throat infections ($4.6m)
- Skin infections ($4.2)
- Vaginal deliveries ($4.0m)
- Respiratory infections (3.6m)

# Wellness Visits for the Fee-for-Service Population, FY 2023

Overall, only 21% of fee-for-service members had a wellness visit, with higher wellness visit rates among younger members.

| Coverage Status | Members | Members with a Wellness Visit |
|---|---|---|
| 0-17 | 55,197 | 21,328 |
| 18-64 | 55,143 | 3,185 |
| 65+ | 7,995 | 482 |
| **Total** | **118,335** | **24,990** |



# Key Takeaways

- The nature of Medicaid eligibility means it covers a different population with different needs than commercial insurers.
  - Medicaid covers more women, children, and elderly.
  - A significant portion of spending is on long-term care and development disabilities services.
- The COVID public health emergency, which required Medicaid to maintain eligibility, meant more people who did not use services were enrolled. This likely contributed to decreases in Medicaid per member per month spending.
- The PMPM increases in outpatient hospital services was largely driven by increases in unit price.
- Individuals with high-cost claims in Medicaid are overwhelmingly those with neurological and developmental disorders – a very different profile than what we typically see in commercially insured populations.

# FINDINGS FROM STAKEHOLDER ENGAGEMENT

# Stakeholder Engagement Meetings

- To round out information gathered from Task Force members and at meetings, Bailit Health reached out to several stakeholder groups to obtain perspectives on the state of health care in ND.
- Groups interviewed include:
  - Critical Access Hospitals
  - North Dakota Medical Association
  - Community HealthCare Association of the Dakotas (CHAD)
  - North Dakota Long Term Care Association
  - Mental Health of North Dakota
  - Local Public Health Association
  - Center for Rural Health
  - State officials focused on pharmacy and EMS

# Key Takeaways from Stakeholder Meetings

- Some frustration with focus on cost-cutting in system.
- Focus on “fixing”, not on “preventing.”
  - Importance of primary care.
  - Limited availability of care coordination services.
- Limited access to services.
  - Limited access to specialty care across state but particularly in rural areas.
  - Unsustainability of rural EMS services being staffed by volunteers.
  - Impacts of workforce shortages (at all levels) on the ability to provide care.
- Crisis in the Mental health system.
- Burdensome prior authorization.
- Limited ability to share data across systems; need for data strategy to support population health efforts.
- Interest in value-based arrangements.
- Impact of high prescription drug costs on patients receiving needed medications.

# Potential Issues To Address

## Population Health and Prevention

- Chronic disease management.
- Quality improvement and population health.
- Investment in health information technology infrastructure.
- Services to keep elders in their homes and prevent nursing home admissions.

## Workforce and Access

- Urgent care availability vs primary care.
- Determination/ certificate of need process for new health care facilities.
- Maternity care in rural areas.
- Critical gaps in oral health access.
- Scope of practice rules.

## Behavioral and Mental Health

- Use of Certified Community Behavioral Health Centers and peer supports.
- Quality relative to antipsychotic medication usage in nursing facilities.

# MEASURING QUALITY OF CARE IN ND

# Discussion on Approach to Measuring Quality

- During the first meeting of Task Force, we reviewed state performance relative to national measures.
- As we think about transparency going forward, it is worth considering potential approaches for consistent measures across payers.
- CMS Core Measure Sets for Medicaid (Adult and Children).
- States with aligned measure sets and their processes.

# Measuring Quality of Care

- Important to measure quality to ensure that health care system is producing the best possible outcomes for North Dakota citizens and to identify where there are opportunities for improvement and/or investment.
- There are many different efforts to measure quality at the provider and plan level.
  - Providers often identify differences in quality measurement as an area of burden.
  - Aligning measures across payers can reduce burden associated with measurement and increase focus on a smaller set of measures, increasing the potential for greater improvement in quality.
- The most common measures used are national, standardized HEDIS measures.

# Commercial Market Performance on Select Quality Measures for the Adult Population, 2021

| Measure | Score | < 25th Pctl | 25th to 50th Pctl | 50th to 75th Pctl | > 75th Pctl |
|---|---|---|---|---|---|
| **Primary Care Access and Preventive Care** | | | | | |
| Cervical Cancer Screening | 71.9 | | | | |
| Colorectal Cancer Screening | 66.0 | | | | |
| Flu Vaccinations for Adults Ages 18 to 64 | 60.7 | | | | |
| Breast Cancer Screening | 71.1 | | | | |
| **Maternal and Perinatal Health** | | | | | |
| Prenatal and Postpartum Care: Postpartum Care | 82.1 | | | | |
| **Care of Acute and Chronic Conditions** | | | | | |
| Controlling High Blood Pressure | 61.9 | | | | |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis | 41.9 | | | | |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* | 65.9 | | | | |
| Plan All-Cause Readmissions* | 0.64 | | | | |
| Asthma Medication Ratio: Ages 19 to 50 | 83.7 | | | | |
| Asthma Medication Ratio: Ages 51 to 64 | 88.5 | | | | |
| **Behavioral Health Care** | | | | | |
| Medical Assistance with Smoking and Tobacco Use Cessation | 9.7 | | | | |
| Antidepressant Medication Management - Effective Acute Phase Treatment (12 weeks) | 78.7 | | | | |
| Antidepressant Medication Management - Effective Continuation Phase Treatment (6 months) | 62.2 | | | | |
| Follow-Up After Hospitalization for Mental Illness: Age 18 + (7 days) | 40.1 | | | | |
| Follow-Up After Hospitalization for Mental Illness: Age 18 + (30 days) | 67.1 | | | | |
| Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 + (7 Days) | 14.5 | | | | |
| Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 + (30 Days) | 20.0 | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 18 + (7 days) | 47.6 | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 18 + (30 days) | 64.0 | | | | |

# Commercial Market Performance on Select Quality Measures for the Child Population, 2021

| Measure | Score | < 25th Pctl | 25th to 50th Pctl | 50th to 75th Pctl | > 75th Pctl |
|---|---|---|---|---|---|
| **Primary Care Access and Preventive Care** | | | | | |
| Childhood Immunization Status (Combo 3) | 77.9 | | | | |
| Childhood Immunization Status (Combo 10) | 55.3 | | | | |
| Well-Child Visits in the First 30 Months of Life (First 15 Months) | 75.0 | | | | |
| Well-Child Visits in the First 30 Months of Life (15 Months-30 Months) | 81.3 | | | | |
| **Care of Acute and Chronic Conditions** | | | | | |
| Asthma Medication Ratio: Ages 5 to 11 | 89.5 | | | | |
| Asthma Medication Ratio: Ages 12 to 18 | 83.2 | | | | |
| **Behavioral Health Care** | | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 6 to 17 (7 days) | 63.4 | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 6 to 17 (30 days) | 80.5 | | | | |

* Lower rate is better for the measure.
Source: Quality Compass (purchased license from NCQA).

# Medicaid Market Performance on Select Quality Measures for the Adult Population, 2021

| Measure | Score | < 25th Pctl | 25th to 50th Pctl | 50th to 75th Pctl | > 75th Pctl |
|---|---|---|---|---|---|
| **Primary Care Access and Preventive Care** | | | | | |
| Cervical Cancer Screening (Ages 21 to 64) | 41.3 | | | | |
| Colorectal Cancer Screening (Ages 21 to 24) | 41.3 | | | | |
| Flu Vaccinations for Adults Ages 18 to 64 | NA | | | | |
| Breast Cancer Screening (Ages 50 to 64) | 36.3 | | | | |
| **Maternal and Perinatal Health** | | | | | |
| Prenatal and Postpartum Care: Postpartum Care | 43.8 | | | | |
| **Care of Acute and Chronic Conditions** | | | | | |
| Controlling High Blood Pressure | 67.8 | | | | |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis | 54.4 | | | | |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* | 35.8 | | | | |
| Plan All-Cause Readmissions* | 0.85 | | | | |
| Asthma Medication Ratio: Ages 19 to 64 | 86.6 | | | | |
| **Behavioral Health Care** | | | | | |
| Medical Assistance with Smoking and Tobacco Use Cessation | NA | | | | |
| Antidepressant Medication Management - Effective Acute Phase Treatment (12 weeks) | 59.3 | | | | |
| Antidepressant Medication Management - Effective Continuation Phase Treatment (6 months) | 40.4 | | | | |
| Follow-Up After Hospitalization for Mental Illness: Age 18 + (7 days) | 29.1 | | | | |
| Follow-Up After Hospitalization for Mental Illness: Age 18 + (30 days) | 53.2 | | | | |
| Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 + (7 Days) | 24.4 | | | | |
| Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 + (30 Days) | 33.9 | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 18 + (7 days) | 44.6 | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 18 + (30 days) | 62.7 | | | | |

# Medicaid Market Performance on Select Quality Measures for the Child Population, 2021

| Measure | Score | < 25th Pctl | 25th to 50th Pctl | 50th to 75th Pctl | > 75th Pctl |
|---|---|---|---|---|---|
| **Primary Care Access and Preventive Care** | | | | | |
| Childhood Immunization Status (Combo 3) | 65.6 | | | | |
| Childhood Immunization Status (Combo 10) | 44.1 | | | | |
| Well-Child Visits in the First 30 Months of Life (First 15 Months) | 36.5 | | | | |
| Well-Child Visits in the First 30 Months of Life (15 Months-30 Months) | 39.3 | | | | |
| **Care of Acute and Chronic Conditions** | | | | | |
| Asthma Medication Ratio: Ages 5 to 18 | 91.6 | | | | |
| **Behavioral Health Care** | | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 6 to 17 (7 days) | 58.0 | | | | |
| Follow-Up After ED Visit for Mental Illness: Age 6 to 17 (30 days) | 76.0 | | | | |

* Lower rate is better for the measure.
Source: Centers for Medicare & Medicaid Services published data based on Mathematica analysis of MACPro and FORM CMS-416 reports.

# DISCUSSION:

# HOW WOULD YOU LIKE TO SEE NORTH DAKOTA MEASURE HEALTH CARE QUALITY?

# The Case for Advancing a Coordinated Quality Strategy

- Quality measurement is fragmented across private and public programs with few similar measures used to assess health care performance across all programs.
- Providers do not receive a unified message on quality measurement, diluting the impact of improvement initiatives and contributing to administrative burden that is both time consuming and costly.
- Most quality measures that are reported on are process measures.  Most outcome measures are burdensome to report for providers and payers alike in the absence of a centralized method for data collection and abstraction.
- A coordinated quality strategy supports a focus on improvement of health care quality and health outcomes, inclusive of health equity, for all state residents and reduces administrative burden on provider and payer organizations.

# CMS Core Quality Measure Sets

- The Core Quality Measures Collaborative (CQMC) is a coalition of health care leaders across country that first came together in 2015.
- Idea of aligned measure set in to :
  - Promote measurement that is evidence based and generates valuable information for quality improvement
  - Supports consumer decision making
  - Supports value-based payment
  - Reduces variability in measure selection across payers
  - Decreases provider burden in collecting data for measures
- CMS leveraged this work to create two core measure sets for Medicaid & CHIP that states must use for measurement beginning in Fall 2024
  - Adult Core Measure Set (2024 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set))
  - Child Core Measure Set (2024 Core Set of Children's Health Care Quality Measure for Medicaid and CHIP (Child Core Set)

# BUYING VALUE

Measure Selection Tool

Helping Purchasers Define Aligned Measure Sets

Buying Value can help states identify and select health plan and provider performance measures for stratification and for use in incentive programs designed to reduce disparities for certain subpopulations.

- Buying Value is a suite of publicly available resources to help purchasers identify and utilize quality measures. It includes:

- **The Buying Value Measure Selection Tool**, assists states in creating and maintaining aligned quality measure sets.
  - Includes over 700 measures, including up-to-date versions of 13 federal and national measure sets, a disparities-sensitive indicator and six state measures.
  - Allows states to score measures for inclusion in a measure set based on criteria identified by the state.

- **The Buying Value Benchmark Repository**, is a database of non-standardized measures in use by state purchasers and associated performance data for benchmarking purposes.
  - Includes nearly 60 measures from seven measure sets focused on preventive care, social determinants of health and more.

  – http://www.buyingvalue.org/

# A Handful of States Have Statewide Aligned Quality Measure Sets

- WA: State legislation mandating use of statewide performance measurement set; administered by non-profit quality organization, Washington Health Alliance
  - Washington State Common Measure Set 2024
- MN: Statewide Quality Reporting and Measurement System
  - Quality Measures: 2024 Report Year - MN Dept. of Health (state.mn.us)
- OR: Aligned Measure Set for State Purchasers
  - Includes 57 measures across 6 domains
- MA: Quality Measure Alignment Taskforce
  - EOHHS Quality Measure Alignment Taskforce | Mass.gov
  - Microsoft Word - 2024 Aligned Measure Set 2023 6-22 (mass.gov)
- RI, CT and ME also have aligned measures sets

# NEXT STEPS

# Discussion of Next Steps for the Task Force

- To date, several presentations to ground the Task Force.
- Based on what you have learned, we now want to circle to “deep dives.”
  - Potential areas for Task Force to identify state-directed or led initiatives.

**Discussion:**

- What criteria do we want to use in determining potential areas of focus?
- What do you recommend as proposed areas of focus?

# Potential Considerations and Topics

## Potential Focus Areas

- Maternal Health
- Mental Health
- Preventive Care
- Tools to Monitor the Health Care System

## Potential Considerations:

- Does the topic sit within the purpose of the Task Force?
  - Transparency, Cost, Quality, Access
- Is the topic one where can have a significant potential for impact?
- Is the topic one that the State may have ability to take on?
  - May want combination of broad strategies and specific interventions

# Revised Task Force Meeting Timeline and Agenda

| Meeting # | Date | Tentative Agenda Topics |
|---|---|---|
| #1 | Held 10/25/23 | • Introduction to the Task Force's charge<br>• Level-setting and discussion of process and meeting ground rules<br>• High-level presentation of national trends in health care costs and cost containment strategies |
| #2 | Held 1/31/24 | • Hospital finances<br>• Health care cost trends in North Dakota<br>• Presentation on APCD |
| #3 | Today 4/4/24 | • Health care cost trends in North Dakota, including feedback from stakeholders on costs and cost drivers in the State (cont.)<br>• Criteria for selecting policy recommendations |
| #4 | 5/29/24 | • High level review of potential policy solutions to consider<br>• Sub-committees held over summer to discuss |
| #5 | Aug/Sept 2024 | • In-depth discussion of policy solutions to recommend to the Legislature, including feedback from stakeholders on potential recommendations |
| #6 | Early Oct 2024 | • Presentation of report to the Legislature and finalization of recommendations |