



MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

October 2, 2019



AGENDA

- **Call to Order**
- Approval of Minutes from June 5, 2019 Meeting
- Prescription Drug Coupon Study: Preliminary Results
- Primary Care Workforce: Nurse Practitioners
- Reducing Administrative Complexity
- Schedule of Next Meeting (**November 20, 2019**)



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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **June 5, 2019** as presented.

REGISTER TODAY! Health Care Cost Trends Hearing VII, Oct 22-23

Agenda

Day One

- **Remarks:** Governor Baker & Speaker DeLeo
- Expert Presentation: Health Care Cost Trends
- **Panel 1:** Confronting Complexity in the Health Care System
- **Panel 2:** Pharmaceutical Market Trends and Cost Drivers
- Public Testimony

Day Two

- **Remarks:** Attorney General Healey and Senate President Spilka
- Expert Presentation: State Policies to Enhance Primary Care
- **Panel 3:** Strengthening Primary and Behavioral Health Care
- **Panel 4:** Provider Market Trends and Cost Drivers



SAVE THE DATE 2019 HEALTH CARE COST TRENDS HEARING

TUESDAY, OCTOBER 22 AND WEDNESDAY, OCTOBER 23
SUFFOLK UNIVERSITY LAW SCHOOL
120 TREMONT STREET, BOSTON, MA 02108



Reserve your seat: tinyurl.com/HCCTH2019



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 - Market Landscape: Trends in Value, Type, and Use of Coupons
 - Impact on Adherence
 - Impact on Spending
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Background: Authorization of Drug Coupons in the Commonwealth

Legislative History

- **Chapter 139 of the Acts of 2012** authorizes drug manufacturers to provide consumers with drug coupons and vouchers.
 - Continues ban on drug coupons for AB rated generic equivalents.
 - Sunsets the authorization of drug coupons (January 2015).
- In 2014 and 2016, the Legislature delayed the sunset on drug coupon authorization.
- **Chapter 363 of the Acts of 2018** delays the sunsets until January 1, 2020, and directs the HPC to conduct a study on the matter.

Statutory Language Directing the HPC to Complete a Study on Use of Prescription Drug Coupons in the Commonwealth

Chapter 363 of the 2018 Session Laws, *An Act Extending the Authorization for the Use of Certain Discount Vouchers for Prescription Drugs*, was signed into law on January 2, 2019. It charges the HPC with conducting an analysis and issuing a report evaluating the effect of drug coupons and product vouchers for prescription drugs on pharmaceutical spending and health care costs in Massachusetts.

- 1 Analyze the **total number and value of coupons** redeemed in the Commonwealth, and the **types of drugs** for which coupons were most frequently redeemed.
- 2 Compare any change in utilization of **generic versus brand name prescription drugs** and any change in utilization among **therapeutically-equivalent brand name drugs**.
- 3 Analyze **effects on patient adherence** and **access to innovative therapies**.
- 4 Study the **availability of coupons** or discounts upon renewals and the **cost impact on consumers** upon expiration of coupons.
- 5 Analyze the **impact of drug coupons on health care cost containment goals** adopted by the Commonwealth and commercial and GIC health insurance premiums and drug costs.

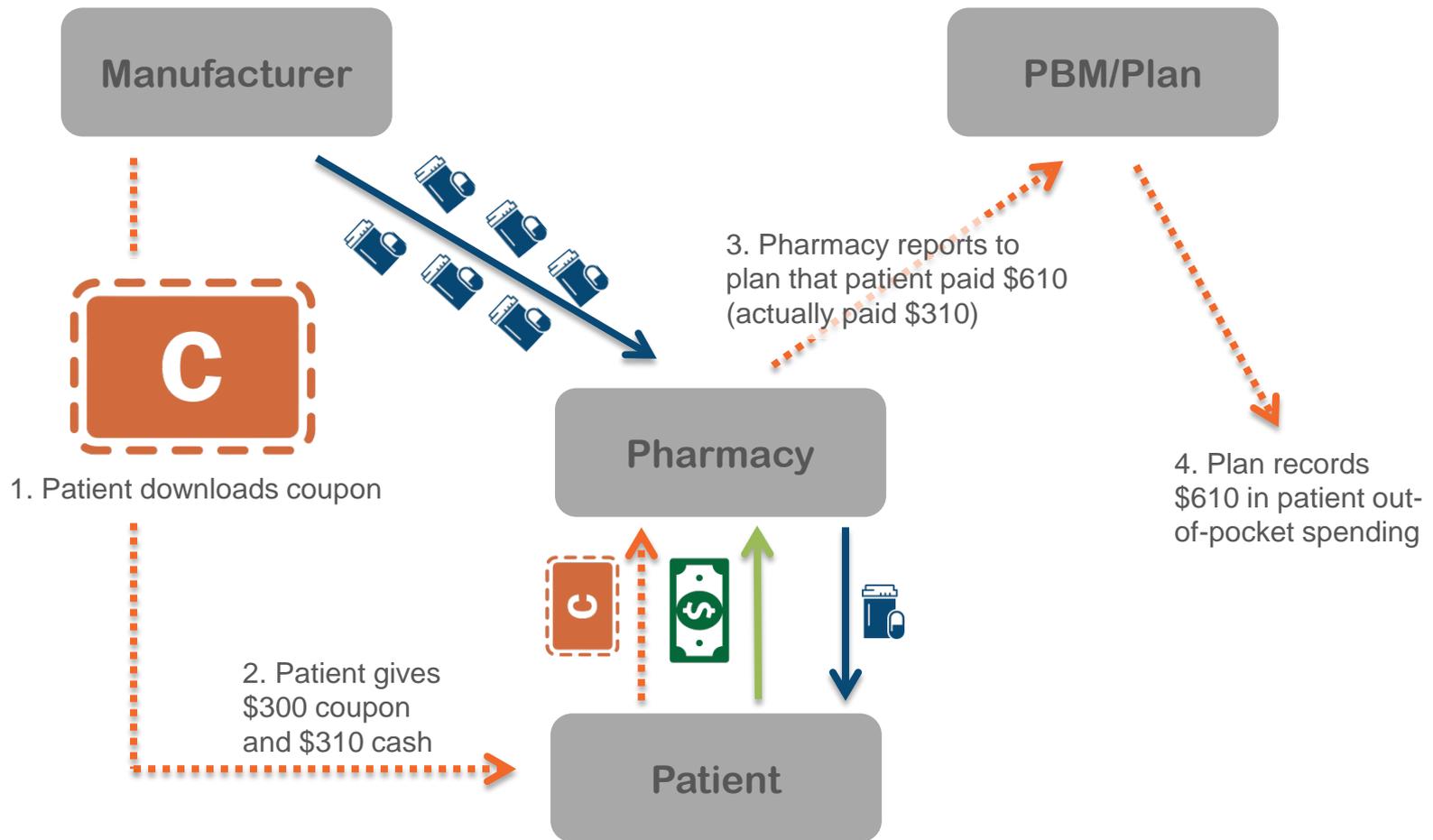
Defining Drug Coupons for HPC Analysis

- Prescription drug coupons offered by manufacturers **reduce the amount of a patient's cost-sharing**, as established by the patient's insurance plan.
 - Common terms: coupon, voucher, copay card
 - Distinct from:
 - Patient assistance programs offered by manufacturers, states, or charities for patients who cannot afford their medication.
 - Cards or offers that reduce prices for patients without insurance.
- Public payers (e.g., Medicare, Medicaid, VA) do not allow the use of coupons.



Flow of Drug Coupons in Patient Out-of-Pocket Spending

Example: Patient is responsible for cost-sharing of \$610, based on insurance plan



Public Listening Session Testimony Frames Key Questions in Drug Coupon Discussion

Testimony

The HPC received testimony, including written testimony submitted following the listening session, from individuals and organizations representing payers, patients, and manufacturers.

Key Takeaways

Stakeholders expressed a range of perspectives on drug coupons:

- Payers said that coupons weaken financial incentives for members to use lower cost treatments when available; while patients have lower cost sharing temporarily, health plans pay substantially more, and these costs translate to higher premiums for patients and employers.
 - Payers also said coupons ultimately hinder their ability to negotiate lower drug prices.
- Patients described facing high cost sharing and using coupons to afford needed medications.
 - A representative for patients with hemophilia noted that many families face high out of pocket requirements for treatments that cost thousands of dollars.
 - Healthcare For All expressed concern about the impact of coupons on raising premiums.
- Manufacturers cited the value of coupons in increasing medication adherence.

Data Sources Used for HPC Drug Coupon Research

- Academic literature
- Public testimony
- All Payer Claims Database
- Vendor data: Symphony Health

Symphony Health is a national data services vendor. Symphony's Integrated Dataverse (IDV)® database contains pharmacy transaction data including:

- All commercially available Symphony pharmacy claims across multiple payers in Massachusetts, 2011-2018.
- Plan payments, patient out of pocket payments, and coupon use.
- Database has pharmacy claims for 1.1 million unique commercial patients in 2018.
- Based on HPC analysis of CHIA data, an estimated 2.9 million unique commercial members had at least one pharmacy claim.



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Drug coupon values vary widely, with an average value of \$229 and a median value of \$55 in 2018.

AMONG COMMERCIAL PATIENTS WHO FILLED A PRESCRIPTION FOR ANY DRUG IN 2018

3%
of commercial patients
used a coupon

AMONG PATIENTS WHO USED AT LEAST ONE DRUG COUPON IN 2018

3.17
claims with coupons
per patient per year

\$229
average coupon value
per claim

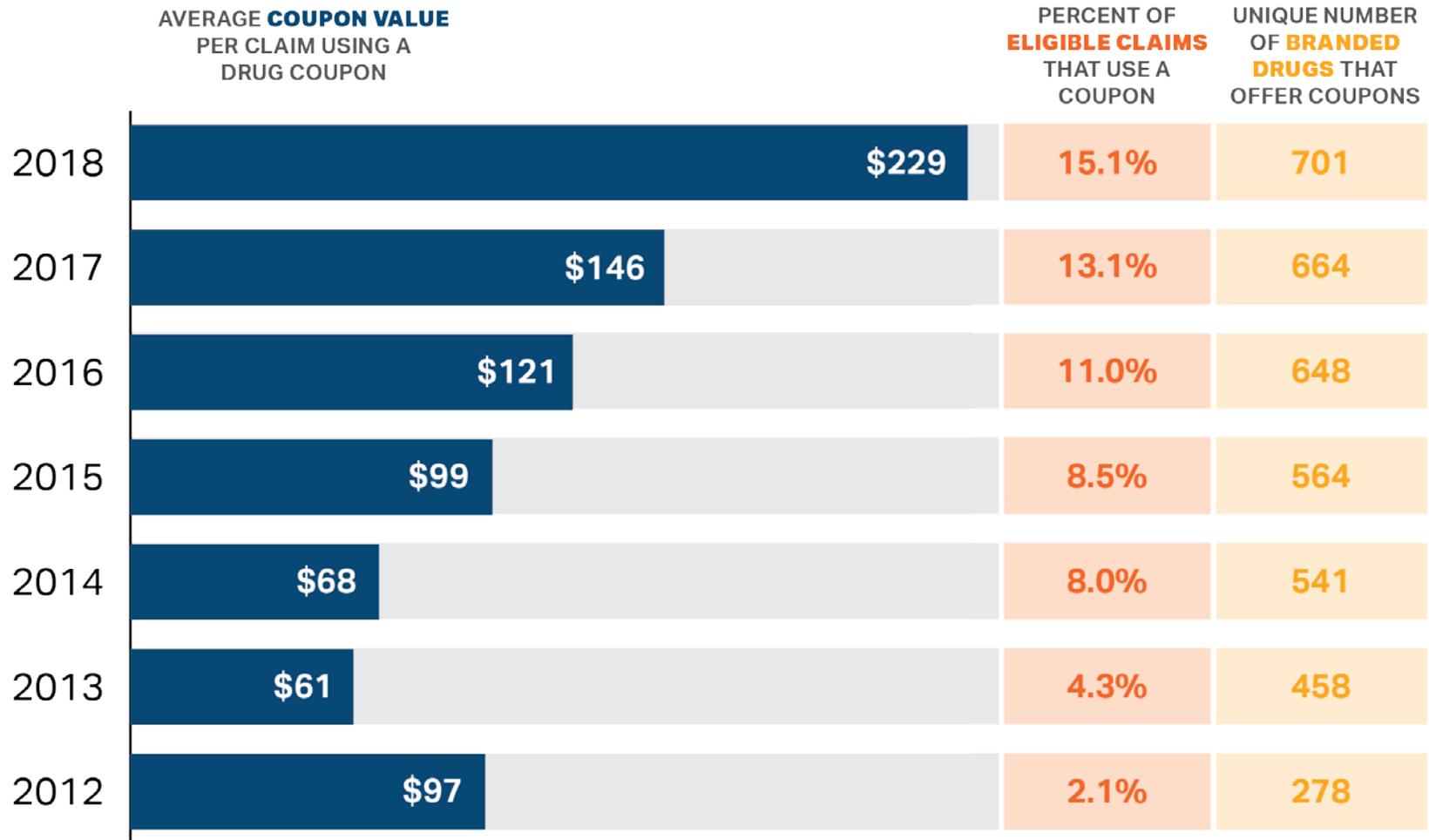
DISTRIBUTION OF COUPON VALUE IN 2018



For drugs where coupons were used, patient out-of-pocket exposure was **21%** of total spending; but using coupons, patients only paid **3%** of total spending out-of-pocket.

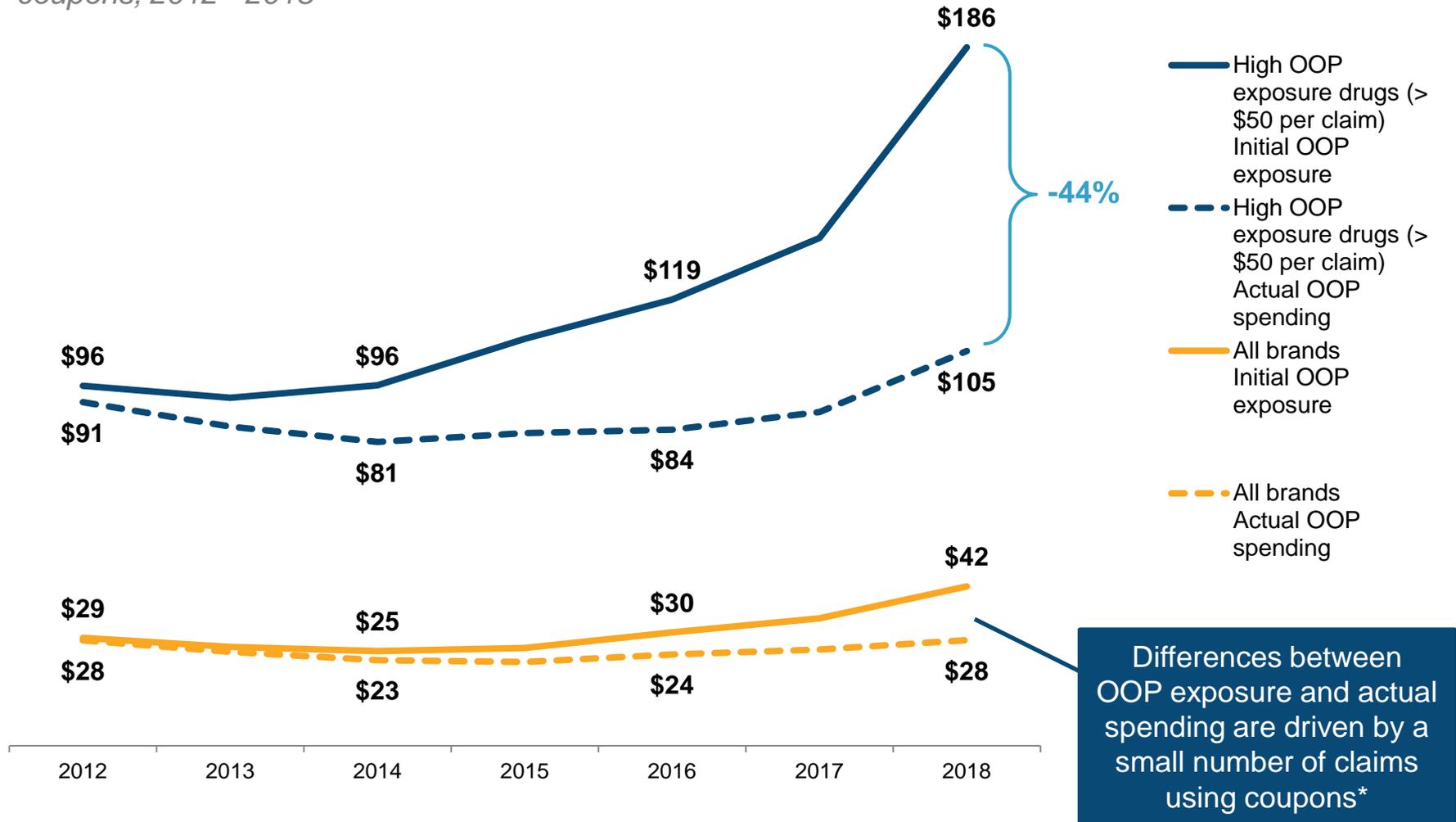
Coupon programs and their uptake have expanded in Massachusetts since 2012, and average coupon values continue to rise.

Average coupon value per claim using a drug coupon, 2012 - 2018



As patient out-of-pocket exposure continues to rise, coupons have the largest benefit for patients with high out-of-pocket exposure.

Average patient out of pocket exposure per branded drug claim and patient spending net of coupons, 2012 - 2018

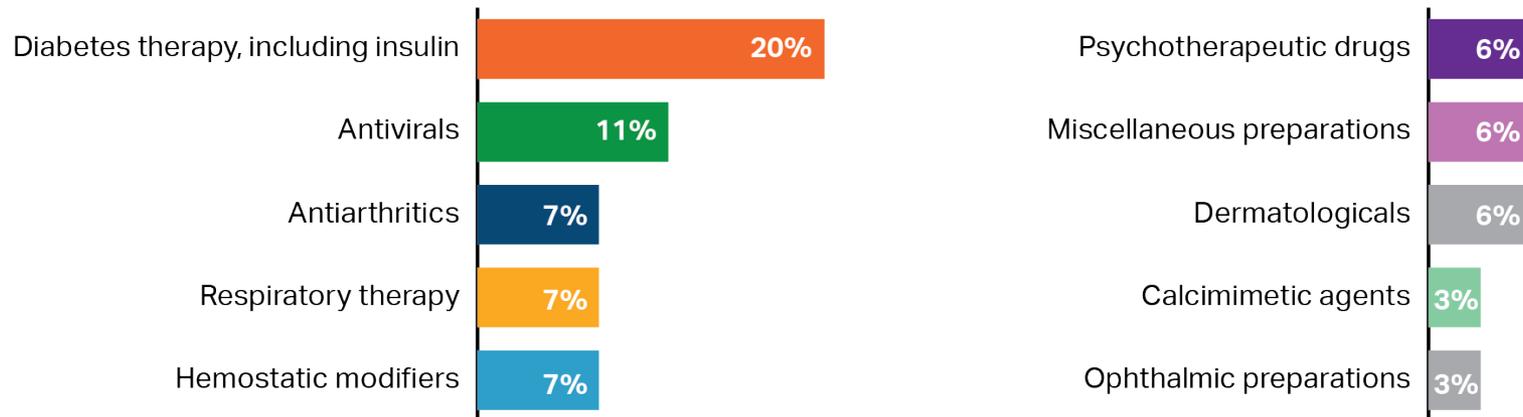


Top Drugs by Total Volume of Coupons Used in Massachusetts, 2018

Drug name	Therapeutic class	Number of claims using a coupon	Percent of claims using a coupon	Average coupon value	Average patient OOP spending after coupon	Average insurer payment
TRUVADA	● Antivirals	6,793	40%	\$117	\$0	\$1,693
TRULICITY	● Diabetes	5,007	26%	\$41	\$32	\$720
SUBOXONE (FILM)	● Miscellaneous preparations	4,546	15%	\$43	\$12	\$275
HUMIRA PEN	● Antiarthritics	4,168	76%	\$159	\$15	\$5,805
ELIQUIS	● Hemostatic modifiers	3,890	18%	\$85	\$12	\$399
SENSIPAR	● Calcimimetic agents	3,845	87%	\$251	\$5	\$1,311
VYVANSE	● Psychotherapeutic drugs	3,018	9%	\$39	\$37	\$211
SYMBICORT	● Respiratory	2,468	12%	\$73	\$4	\$261
XARELTO	● Hemostatic modifiers	2,308	15%	\$74	\$14	\$401
LANTUS SOLOSTAR	● Diabetes	1,971	8%	\$123	\$0	\$411

Top therapeutic categories of coupon use by volume

Percent of total coupon volume



Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs. Table only includes branded drugs with at least 11 claims that used a coupon. Spending values are based on claims for which the insurer is the primary payer. Number of claims include all claims for which a coupon was used. Source: HPC analysis of Symphony Health IDV® database

Top therapeutic categories of coupon use by volume have changed over time, reflecting changing market dynamics.

Top therapeutic categories of coupon use by volume				
Therapeutic class	2013 Rank	2013 % of total	2018 Rank	2018 % of total
Antiarthritics	1	15%	3	7%
Antihyperlipidemic agents	2	14%	18	1%
Miscellaneous preparations	3	13%	7	6%
Gastrointestinal	4	7%	16	1%
Psychotherapeutic drugs	5	5%	6	6%
Respiratory therapy	6	5%	4	7%
Diabetes therapy	7	4%	1	20%
Analgesics	8	3%	28	0%
Ophthalmic preparations	9	3%	10	3%
Cardiac agents	10	3%	27	0%
Contraceptives	11	3%	26	1%
Neurological / neuromuscular disorders	12	3%	11	3%
Anti-obesity	13	3%	15	2%
Vascular agents	14	3%	20	1%
Antivirals	15	2%	2	11%
Hormones	16	2%	13	2%
Dermatologicals	18	2%	8	6%
Hemostatic modifiers	19	2%	5	7%
Immunologic agents	22	1%	12	3%
Calcimimetic agents	24	1%	9	3%
Laxatives	25	0%	14	2%

Factors in rank change may include:

- Entry of new branded products
- Loss of exclusivity (generic entry)
- Policy changes (implementation of ACA)
- Changes in prescribing trends
- Changes in plan benefit design (patient cost sharing)
- Changes in drug prices

Since 2013, coupon availability and use for diabetes therapy has grown significantly; at the same time, spending per person more than doubled.

Therapeutic category of coupon use by volume				
Therapeutic class	2013 Rank	2013 Percent of total	2018 Rank	2018 Percent of total
Diabetes therapy	7	4%	1	20%



Market entry, more brands offering coupons, higher coupon use	Diabetes therapy	2013	2018	
	Number of brands in class	62	91	↑
	Number of brands that offered coupons	28	66	↑
	Percent of brands that offered coupons	45%	73%	↑
	Coupon use (among eligible brands)	3%	14%	↑



Factors driving higher patient coupon use may include:

Increases in spending for diabetes therapy

- Average spending per branded drug claim **increased 93%** from 2013 to 2018 (\$312 to \$601)
- **Spending per person for branded drugs more than doubled**, from \$1,891 in 2013 to \$3,838 in 2018

Increases in patient out-of-pocket exposure

- Average patient OOP exposure per claim for branded products in the **diabetes therapy class grew from \$38 in 2013 to \$57 in 2018**, an increase of 50%



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Literature suggests a modest positive impact of coupons on adherence, with larger effects for high cost drugs with high coupon value.

- **Well-documented relationship between patient drug cost and adherence**
 - Studies find an abandonment threshold of \$125 – \$250 per claim
 - Increasing medication adherence can reduce ED visits, hospitalizations, and total health care costs, particularly for patients managing chronic conditions
- **When the out-of-pocket cost of the drug and the value of the coupon are small, coupons are likely to increase adherence modestly**
 - *Example:* Among statins, studies found an association between coupons and product refill rate, but the improvement was too small to likely impact clinical outcomes
- **Studies suggest larger adherence effects from coupon use for high cost drugs**
 - In a large U.S. study, coupons reduced the proportion of specialty prescriptions for which patient cost-sharing was more than \$250 from 12% to 1%, a point at which patients were far less likely to abandon prescriptions
 - Patients with copay assistance had 88% lower risk of non-initiation and 24% lower risk of discontinuation for ALK inhibitors (for treatment of non-small cell lung cancers)

Sources: Daubresse M, Andersen M, Riggs KR et al. Effect of Prescription Drug Coupons on Statin Utilization and Expenditures: A Retrospective Cohort Study. *Pharmacotherapy*. 2017. 37(1):12-24. Daugherty JB, Maciejewski ML, Farley JF. The Impact Of Manufacturer Coupon Use In The Statin Market. *J Manag Care Pharm*. 2013. 19(9):765-72. Eaddy MT, Cook CL, O'Day K et al. How Patient Cost-Sharing Trends Affect Adherence and Outcomes. *P T*. 2012. 37(1): 45–55. Starner CI, Alexander GC, Bowen K et al. Specialty Drug Coupons Lower Out-Of-Pocket Costs And May Improve Adherence At The Risk Of Increasing Premiums. *Health Affairs*. 2014. 33(10). Seetasith A, Wong W, Tse J et al. The impact of copay assistance on patient out-of-pocket costs and treatment rates with ALK inhibitors. *J Med Econ*. 2019. 22(5):414-420. Devane K, Harris K, Kelly K. Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption. IQVIA. May 18, 2018.



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Coupon availability may impact overall health care spending by increasing drug use or shifting product choice to higher cost branded drugs.



Patient fills prescriptions more often: Could result in higher adherence to medications



Patient fills new prescriptions: Use of new medications that patient did not previously use due to cost

- *Coupon availability may result in use of low value drugs or reduce incentives to try lower cost alternatives first (e.g. over the counter acne treatments versus prescription)*



Shift use to higher cost branded products where there are lower cost therapeutic alternatives

Framework for Analysis of Prescription Drugs that Offer Coupons

	Category 1	Category 2	Category 3	Category 4
<i>Study target: Branded drug that offers coupon</i>	Generic equivalent	Close therapeutic substitute: Generic	Close therapeutic substitute: Branded	No close therapeutic substitute
Example				
Drug with coupon	Lipitor (statin; AB generic available)	Lyrica (nerve pain; no AB generic available)	Repatha (PCSK9; no AB generic available)	Kalydeco (cystic fibrosis; no AB generic available)
Comparator	Atorvastatin (generic Lipitor)	Gabapentin (generic Neurontin)	Praluent	None
Notes	Not eligible in MA		Comparators may also offer coupons	
Estimated distribution of drugs with coupons <i>Based on USC publication that examined the 200 highest U.S. expenditure drugs in 2014 and identified 90 of these drugs that offered coupons</i>	21%	28%	39%	12%

Impact of Coupons on Utilization of Direct Generic Equivalent Drugs

- Previous research has found that coupons were associated with **lower generic utilization, higher price growth, and higher total spending**¹
 - 3.4 percentage point reduction in generic utilization rate (from 95% to 92% on average)
 - Price growth for drugs without coupons of 7-8% per year, versus price growth for drugs with coupons of 12-13% per year
 - Coupons were associated with **\$6-\$24 million higher spending per drug per year**
 - 1.2% to 4.6% higher total drug spending over five years
- **Massachusetts law prohibits use of coupons for branded drugs when a direct generic equivalent is available**

● In circumstances where a direct generic equivalent is introduced at a high price, a select group of patients with high co-pays or deductibles may lose the benefit of the coupon

Example: Generic Gleevec (used in treatment for leukemia) entered the market in 2016

Average price in 2015 for branded Gleevec

Payer paid:	\$9,157
Coupon value:	\$871
Patient OOP:	\$11
Total	\$10,039

Average price in 2016 for generic Gleevec² = \$8,075

Impact of Coupons on Utilization of Alternative Branded Drugs

HPC determined that analyzing the impact of coupons on use of alternative branded drugs was not currently feasible.

- Branded competitors also often offer coupons.
- Rebate data are necessary to understand insurer and pharmacy benefit manager (PBM) tiering practices and perform subsequent analysis of overall cost impact – but this data is unavailable.

EXAMPLE

SGLT2 inhibitors (used to control high blood sugar for people with Type 2 diabetes)

Drug name	Insurer payment	Patient OOP exposure	Coupon value	Patient net OOP
FARXIGA	\$467	\$122	\$87	\$36
INVOKANA	\$485	\$89	\$84	\$5
JARDIANCE	\$526	\$85	\$69	\$16

In this example, patients appear to have the **highest out of pocket exposure** for the **lowest cost drug**. However, the price for insurers/PBMs net of rebates is unknown.

Impact of Coupons on Utilization of Close Generic Alternatives: Background

- HPC analyzed impact of drug coupons on use of branded drugs versus **close generic alternatives** (generic close therapeutic substitutes)
- No literature could be identified on the impact of coupons on use of close generic alternatives

EXAMPLE

<i>Study target:</i> <i>Branded drug that offers coupon</i>	Close therapeutic substitute: Generic
Drug with coupon	Lyrica (nerve pain; no AB generic available)
Comparator	Gabapentin (generic Neurontin)

Impact of Coupons on Utilization of Close Generic Alternatives: HPC Case Study Approach

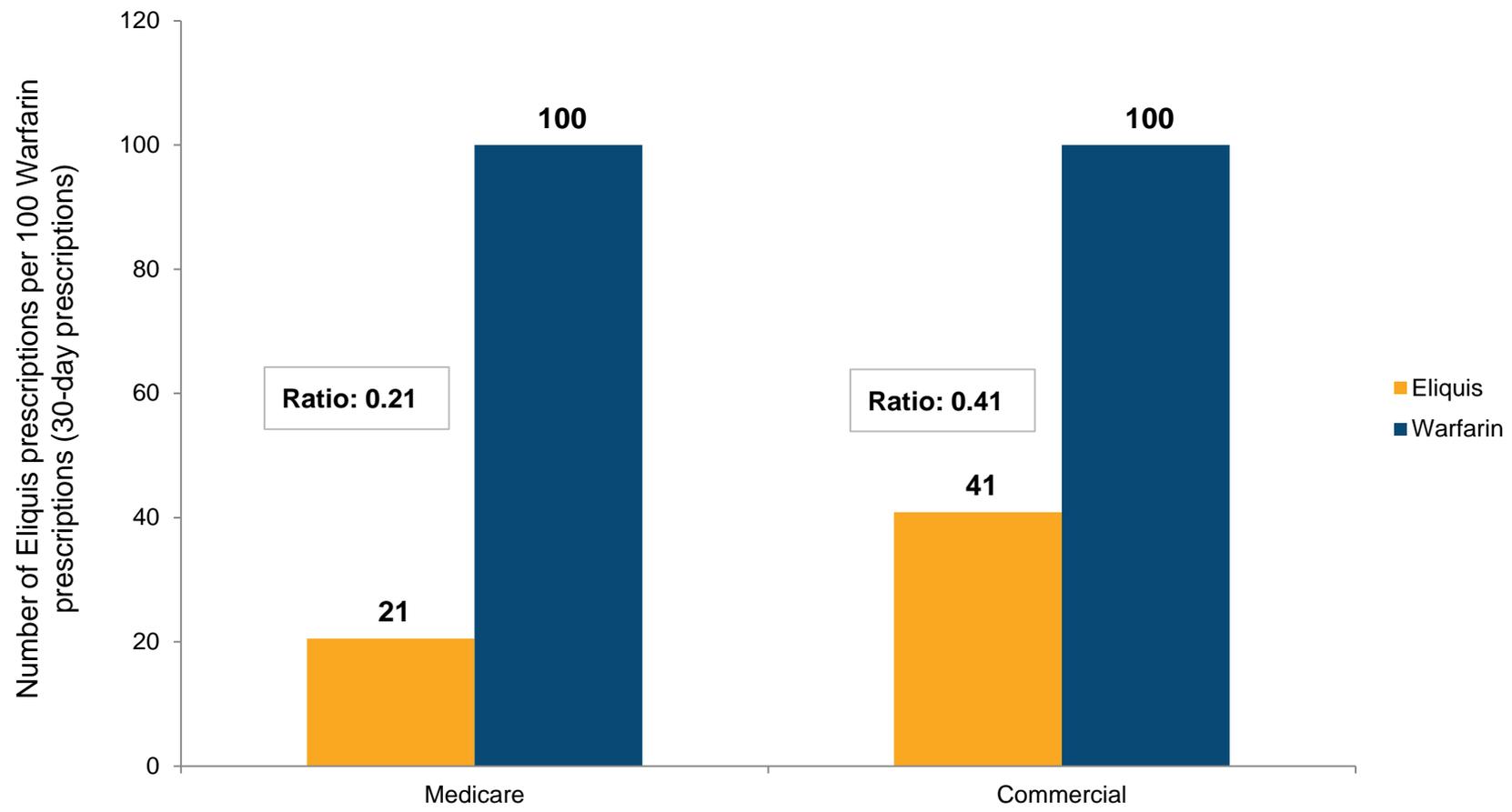
- To examine the potential impact of coupons in this category of drugs, the HPC analyzed the use trends of these drugs for **commercial patients** compared to **Medicare patients** in Massachusetts.
 - *Medicare prohibits coupon use*
- The HPC's approach to selecting drugs for the **case study**:
 - Based on national research and the number of drugs with coupons in Massachusetts, there could be as many as 247 branded drugs which offer coupons that have a close generic alternative¹
 - The HPC focused on those drugs with the highest expenditures, narrowing the analysis to 29 drugs. Based on consultation with a pharmacist advisor, the HPC further excluded drugs where population differences (e.g. age) could affect prescribing choices between the two patient populations
 - Also excluded drugs considered first-line or preferential treatment over close generic alternatives, based on clinical guidelines
 - This conservative criteria resulted in **14 target drugs** for the case study analysis
- For each drug, utilization trends were averaged for the two most recent applicable years of data

1. Van Nuys, Joyce, Ribero and Goldman. University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics. 2018. A Perspective on Prescription Drug Copayment Coupon. Available at: <https://healthpolicy.usc.edu/research/prescription-drug-copayment-coupon-landscape/>

Data sources for analysis: Symphony Health IDV® database (commercial use and prices), CMS Part D Prescriber Use Files (Medicare use), and the Center for Health Information and Analysis, All-Payer Claims Database, 2016

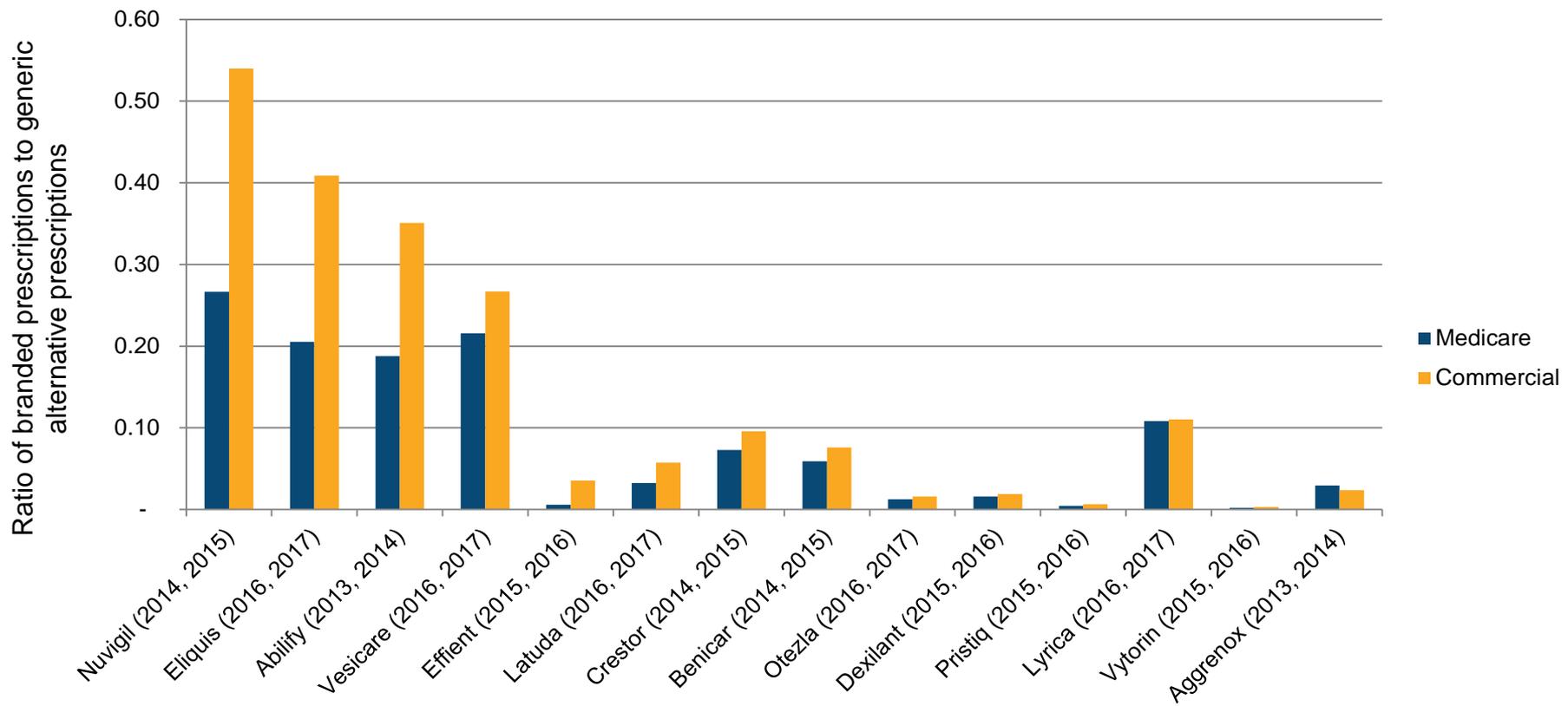
Impact of Coupons on Utilization of Close Generic Alternatives: Example of Utilization Analysis

Relative utilization of Eliquis and Warfarin by population in Massachusetts, 2016 and 2017



Higher use of branded drugs over close generic alternatives in commercial populations suggests coupon availability may increase brand use.

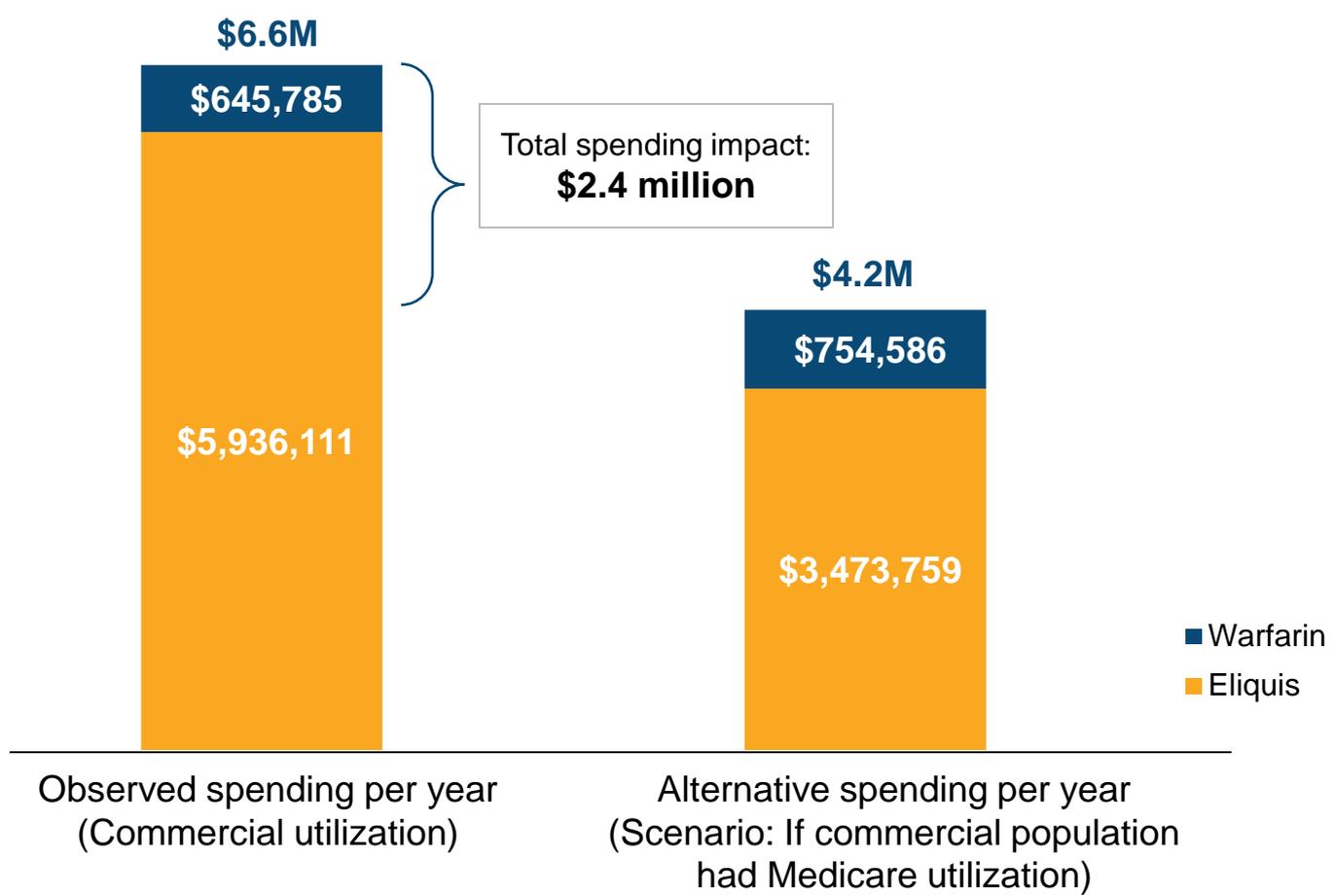
Relative utilization of branded drug versus generic close alternatives in commercial and Medicare populations



Use of branded drugs versus close generic alternatives was **higher in the commercial population for 10 of 14 case study drugs**. For 4 case study drugs, use was similar in commercial and Medicare populations. On average, the percent of patients using coupons was higher for the 10 drugs with higher commercial use.

Impact of Coupons on Utilization of Close Generic Alternatives: Example of Spending Analysis

Annual commercial spending with current commercial utilization ratio of Eliquis and Warfarin versus alternative scenario with Medicare utilization ratio



Notes: Spending analysis includes rebate estimate based on average rebate in the commercial market 2015-2017 from the Center for Health Information and Analysis.
 Source: HPC analysis of Symphony Health IDV® database and CMS Part D Prescriber Public Use Files

Higher brand utilization in the commercial population results in 18% higher spending per case study drug, totaling \$45 million per year.

Key Spending Impact Findings:

- Across 14 case study examples, spending was **18% (\$1.4 million) higher on average per drug** than it would have been if commercial members used the close generic alternative as often as the Medicare population did.
- Extrapolated to the entire commercial market, the dollar amount per drug would be **\$3 million**.
 - For 14 case study examples, spending would be **\$44.8 million** higher per year.

Case Study Considerations:

- While there could be as many as 247 branded drugs that offer coupons in Massachusetts and that have close generic alternatives, **it is unclear if the 14 case studies are representative of all of these.**¹
- While the selection of drugs for the case study was intended to isolate the impact of coupon availability on drug use rates, **other factors may also contribute to higher brand use in the commercial population.**

Final Written Report on Prescription Drug Coupons to be Released this Fall

SUMMARY OF PRELIMINARY RESULTS

- **Coupon values vary widely**: the average coupon value was \$229 in 2018, but for the majority of people who used a coupon, the value was smaller
- Coupon programs and their uptake have **expanded in Massachusetts** since 2012
- For drugs where coupons were used, patient out-of-pocket exposure was 21% of total spending; but using coupons, **patients only paid 3% of total spending out-of-pocket**
- As **drug prices and patient deductibles continue to increase**, coupons have the largest benefit for patients with high out-of-pocket exposure
- Coupons are broadly associated with **increased medication adherence**, but the impact is largest for patients with high out of pocket costs
- For branded drugs with close generic alternatives, coupons availability is associated with moderately **lower generic use** and **higher total spending**
- While coupons for some drugs **may result in potentially unnecessary higher spending**, many patients do not have alternatives and may depend on coupons to improve drug affordability, especially if they have high co-pays or deductibles



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There is an emerging consensus that a more primary care-orientated health care system will improve access, improve outcomes, and reduce costs.

Background

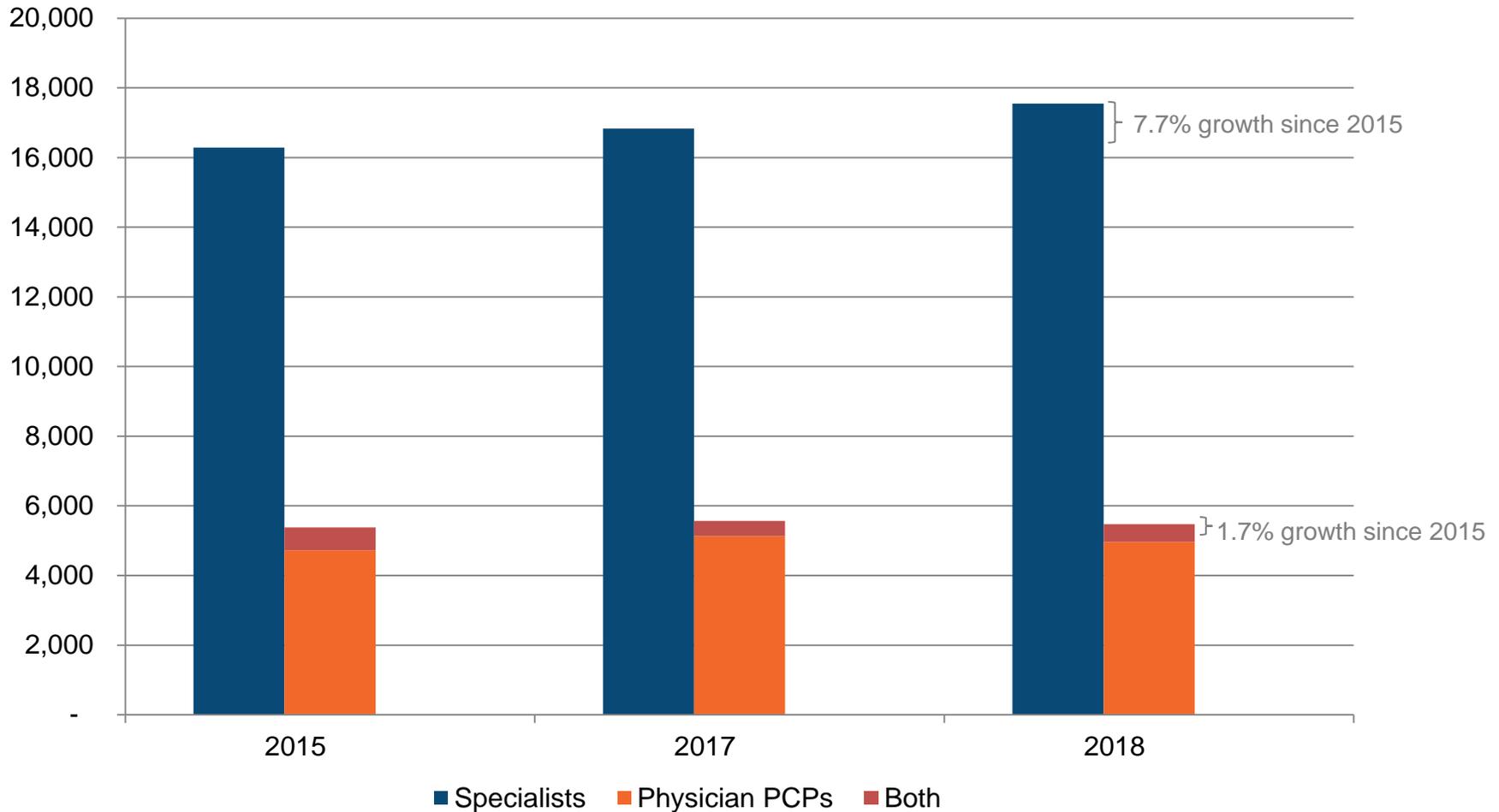
- There is evidence that states and countries with health systems more oriented toward primary care have better outcomes and lower spending.¹⁻³
- Massachusetts has a below-average proportion of commercial spending on primary care compared to other states.⁴
- A number of states have implemented policies directly encouraging an emphasis on primary care.
 - For example, Rhode Island required payers to increase the proportion of spend on primary care by one percentage point per year from 2010 to 2014.
 - Total health spending *declined* over this period, though the decline can not be traced definitively to the primary care initiative.⁵
 - In May 2019, both Colorado and Vermont passed legislation with the goal of significantly increasing investments in primary care.

Sources: 1) Friedberg, Mark W., Peter S. Hussey, and Eric C. Schneider. "Primary care: a critical review of the evidence on quality and costs of health care." *Health Affairs* 29.5 (2010): 766-772.; 2) Robert Graham Center, "Investing in Primary Care: A State-level analysis", June, 2019; 3) Baicker, Katherine, and Amitabh Chandra. "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care: Areas with a high concentration of specialists also show higher spending and less use of high-quality, effective care." *Health Affairs* 23.Suppl1 (2004): W4-184.; 4) Patient-centered primary care collaborative, "Investing in primary care a state-level analysis." June, 2019; 5) Baum, Aaron, et al. "Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers." *Health Affairs* 38.2 (2019): 237-245.

Since 2015, the number of primary care physicians in Massachusetts increased only 1.7% compared to a 7.7% increase in specialist physicians.

Background

Massachusetts primary care and specialist physicians, 2015 -2018



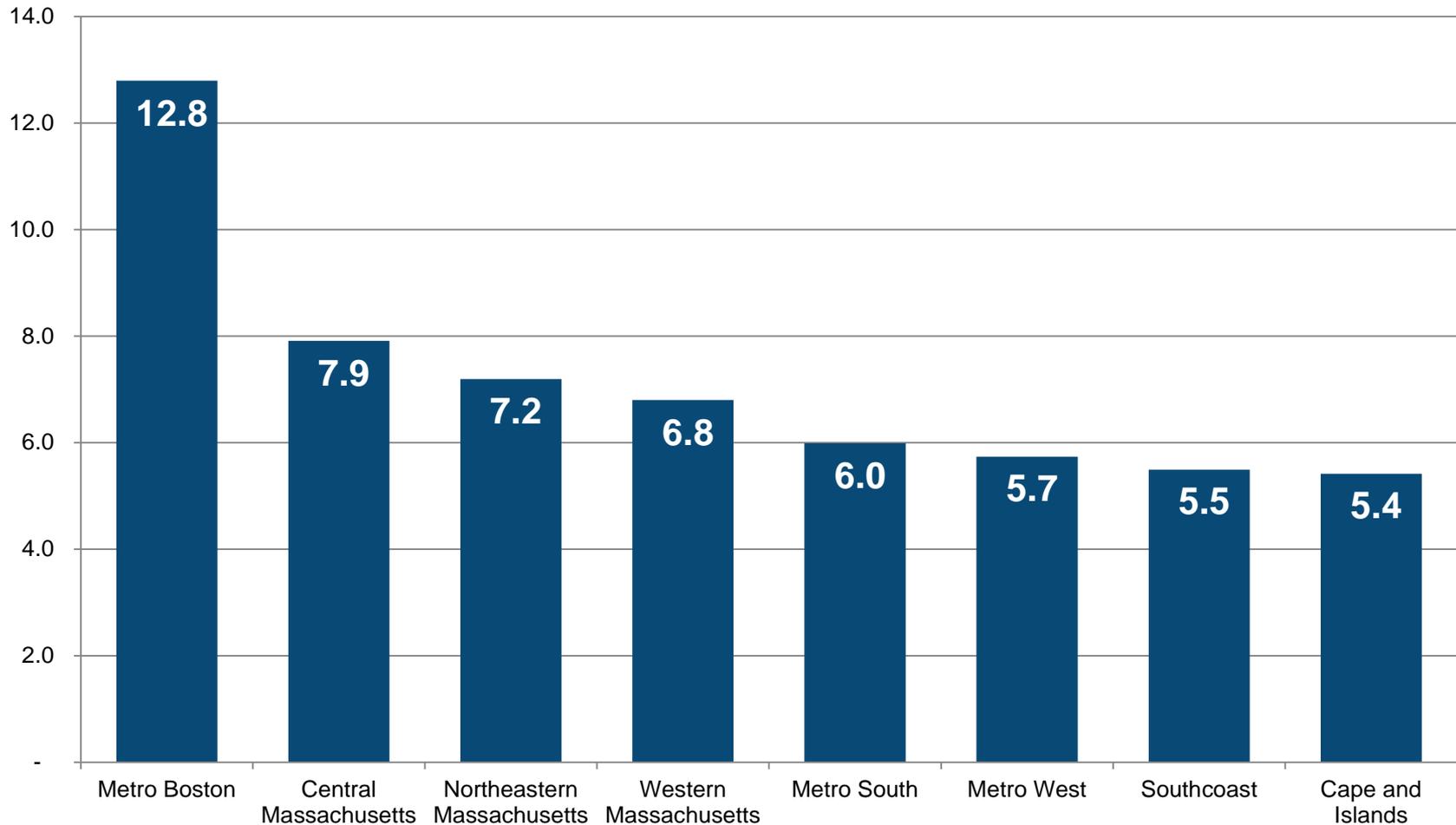
Source: 2015, 2017, and 2018 Registration of Provider Organizations data.

Notes: Data represents roughly 85% of physicians in Massachusetts. Physicians in some smaller organizations are omitted.

The number of primary care physicians per resident also varies considerably across the state, with the highest ratio in Metro Boston.

Background

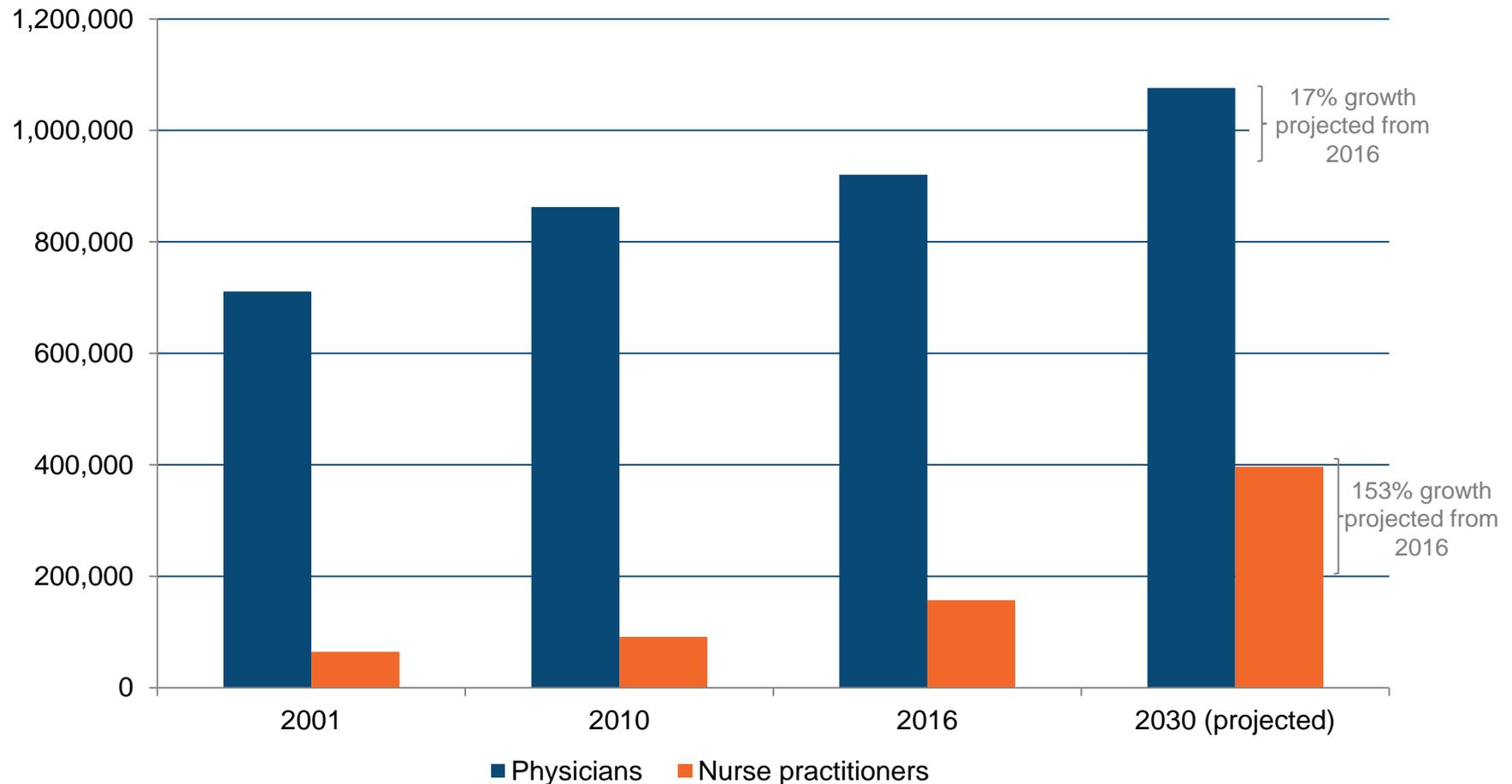
Primary care physicians per 10,000 residents by HPC region, 2018



The national supply of nurse practitioners is growing much more quickly than the supply of physicians.

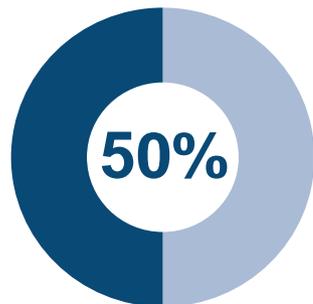
Background

National supply of physicians and nurse practitioners, observed and projected

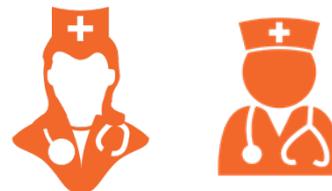


Primary care access would likely be enhanced if nurse practitioner scope of practice restrictions were removed.

Roughly **50%** of NPs work in primary care.¹



The **supply of NPs is larger and grows more rapidly** in states where NPs have full practice authority.²⁻⁴ Also, more NPs have Buprenorphine prescribing waivers.⁵



States that have changed their regulations to allow full practice authority saw **increases in primary care utilization** and **decreases in ED use**.⁶



Researchers generally find **similar quality of care** for primary care patients managed by NPs or physicians; a recent study finds **lower costs** for those managed by NPs.^{7,8}

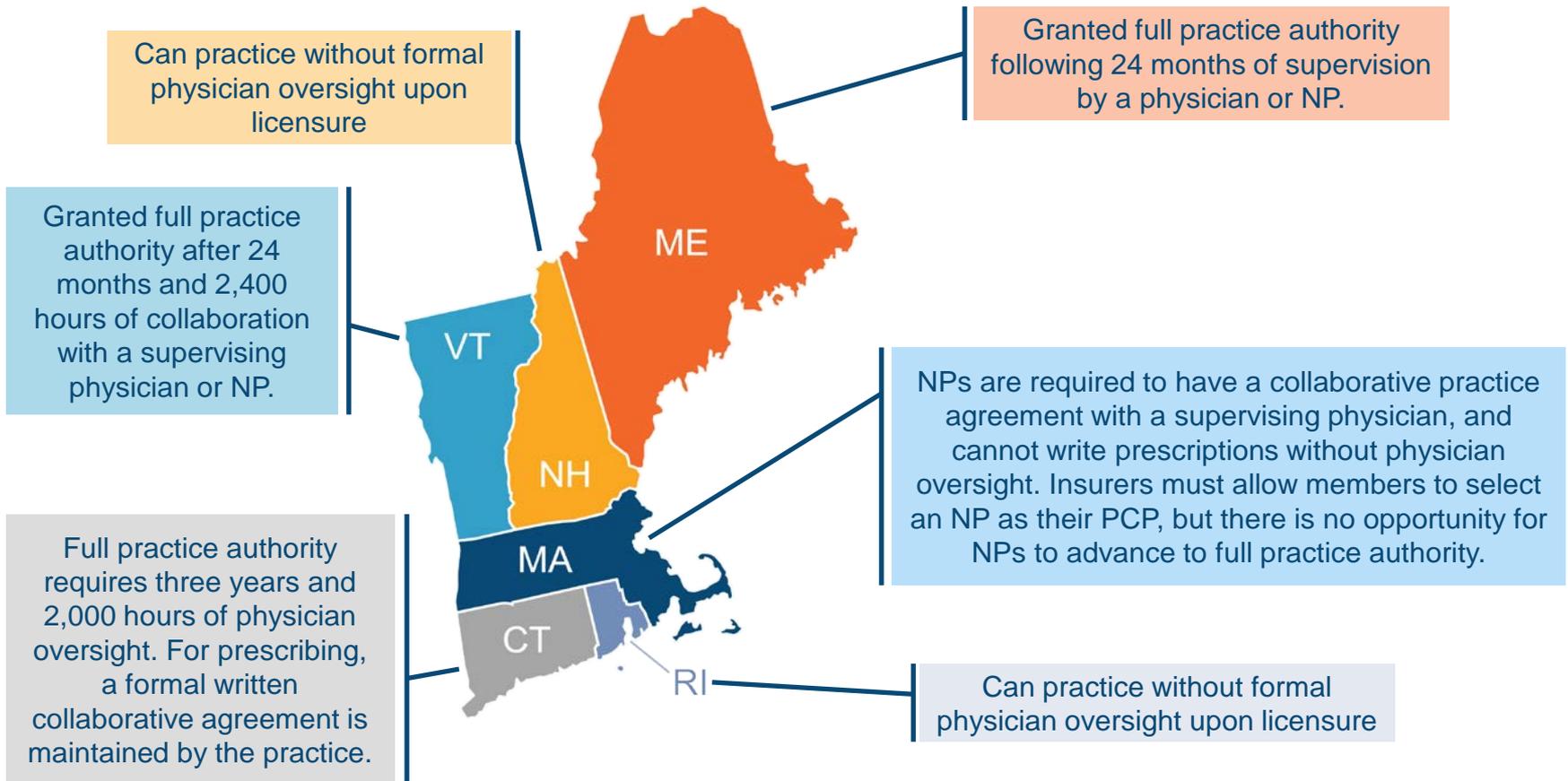


Sources: (1) <https://bhwh.hrsa.gov/sites/default/files/bhwh/nchwa/npsurveyhighlights.pdf> (2) Ying Xue et al., "Full Scope-of-Practice Regulation Is Associated with Higher Supply of Nurse Practitioners in Rural and Primary Care Health Professional Shortage Counties," *Journal of Nursing Regulation* 8, no. 4 (2018): 5–13. (3) P. B. Reagan and P. J. Salsbery, "The Effects of State-Level Scope-of-Practice Regulations on the Number and Growth of Nurse Practitioners," *Nursing Outlook* 6, no. 1 (2013): 392–99. (4) Hilary Barnes et al., "Effects of Regulation and Payment Policies on Nurse Practitioners' Clinical Practices," *Medical Care Research and Review* 74, no. 4 (2016): 431–51, doi:10.1177/1077558716649109. (5) J. Traczynski and V. Udalova, "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," *Journal of Health Economics* 58 (2018): 90–109. (6) Spetz, Joanne, et al. "Nurse Practitioner and Physician Assistant Waivers to Prescribe Buprenorphine and State Scope of Practice Restrictions." *JAMA* 321.14 (2019): 1407-1408. (7) Jennifer Perloff et al., "Association of State-Level Restrictions in Nurse Practitioner Scope of Practice with the Quality of Primary Care Provided to Medicare Beneficiaries," *Medical Care Research & Review* 18 (Sept. 1, 2017); (8) Perloff, Jennifer, Catherine M. DesRoches, and Peter Buerhaus. "Comparing the cost of care provided to Medicare beneficiaries assigned to primary care nurse practitioners and physicians." *Health services research* 51.4 (2016): 1407-1423.

Massachusetts has more restrictive NP scope of practice (SOP) laws than all other New England states.

Background

Summary of state-specific SOP laws for New England states, 2019



Notes: 28 states and the District of Columbia grant NPs full practice authority. Half of these states require that NPs practice in collaboration with physicians or more experienced NPs for a transitional period before they are allowed to practice and prescribe without formal oversight.

Source: Spetz, J. "Expanding the Role of Nurse Practitioners in California: Physician Oversight in Other States," California Health Care Foundation (May 2019), available at <https://www.chcf.org/wp-content/uploads/2019/05/ExpandingNPOversightStates.pdf>. Additional information for MA (1) [Mass. Reg. Code §243-2.10 \(5\)](#) (2) [Mass. Reg. Code §243-2.10 \(5\)](#) (3) [Mass. Gen. Laws Ann. §176R\(4\)](#)

HPC Research Spotlight: Understanding the Role of Primary Care Nurse Practitioners in Massachusetts

Research aims

- 1 Describe the nurse practitioner (NPs) workforce in the Commonwealth
- 2 Understand how many NPs are serving as primary care providers (PCPs), where they practice, and who they provide care for, by:
 - Examining direct billing for office visits
 - Being listed as primary care provider by a payer
- 3 Report on the prevalence of “incident-to billing” in MA by provider organization and implications for health care spending in the Commonwealth

Data sources

- CHIA All-Payer Claims Database (APCD), 2016
- HPC Registry of Provider Organizations, IQVIA (SK&A), and HPC Provider Organization Performance Variation attribution model
- NPPES NPI Registry
- MA Department of Public Health RN Licensure Renewal Survey (2016, 2018)
- Publically available payer documentation on billing guidelines for NPs

Only a small subset of NPs in Massachusetts act as primary care providers by payer assignment.

NPs in Massachusetts

Total NPs in Massachusetts =

~6,300¹

4,926

primary care NPs
(based on specialty; NPPES)²

As observed in the
Massachusetts APCD

141

NPs identified as a
PCP through payer
assignment but not
utilization³

504

NPs identified as a
PCP through both a
payer assignment and
utilization^{3,4}

1,837

NPs identified as a
PCP through
utilization but not
payer assignment⁴

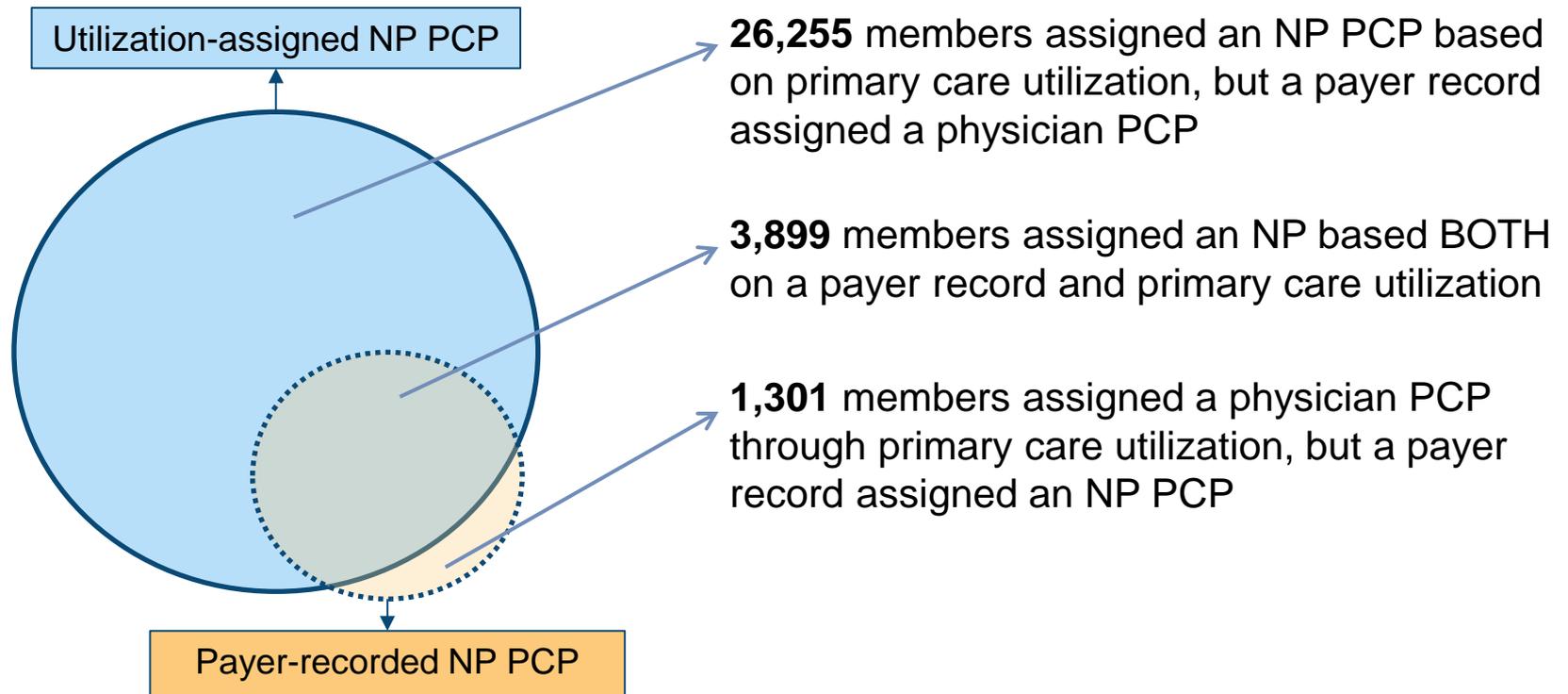
Sources: (1) [BLS OES estimates, May 2017](#); Redi-Data reports 6,264 nurse practitioners in Massachusetts as of March 2019. National estimates from AANP indicate that **73% of all NPs deliver primary care**. (2) NPPES provider list does not reflect the number of actively practicing NPs. (3) Members were attributed to a primary care provider as indicated by their payer's reporting of who their PCP is; 8,725 commercial members were attributed to an NP as their PCP using this method. (4) Members were attributed to a primary care provider as indicated by their utilization of healthcare services that would be expected to be provided by a primary care provider; 50,665 commercial members were attributed to a NP as their PCP.

Notes: The figure is for illustrative purposes only; circle area is not directly proportional to the number of providers in each box.

Many Massachusetts residents see an NP as their primary provider, but their payer-assigned PCP is a physician.

Commercial members

Commercial members in the APCD who are reported by a payer or are assigned through utilization to an NP as their primary care provider, 2016



Source: HPC analysis of All-Payer Claims Database, 2016, RPO, IQVIA (SKA), and NPPES. .

Note: Figure is illustrative and not necessarily proportional. Universe includes only 753,302 members who have an identified PCP both through payer-assignment and utilization-based attribution. Through the utilization method alone, N=993,705 members are attributed to a primary care provider. Through the payer-recorded PCP N=1,154,273 members are attributed to a primary care provider.

Patients attributed to NPs are more likely to be female, younger, and have lower risk scores.

Commercial members

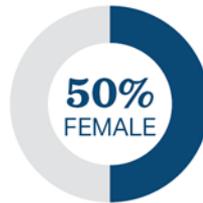
MEMBERS WITH PHYSICIANS AS THEIR PCP VS NPs AS THEIR PCP

661,684

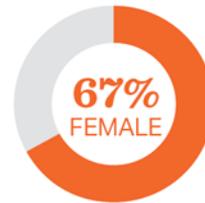


UNIQUE MEMBERS

45,778



PERCENTAGE FEMALE



1.13 vs 1.35



AVERAGE RISK SCORE



AVERAGE AGE



TOTAL SPEND (PMPY)

MEMBERS WITH PHYSICIANS PCP

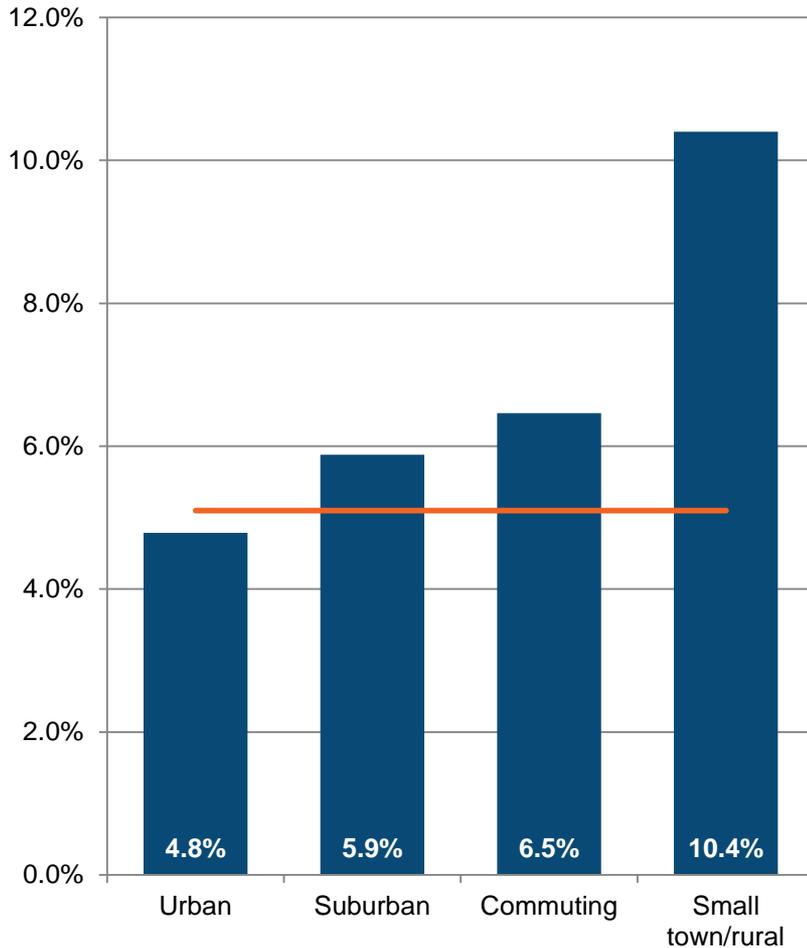
MEMBERS WITH NURSE PRACTITIONER PCP

Source: HPC analysis of All-Payer Claims Database, 2016, RPO, IQVIA (SKA), and NPPES.

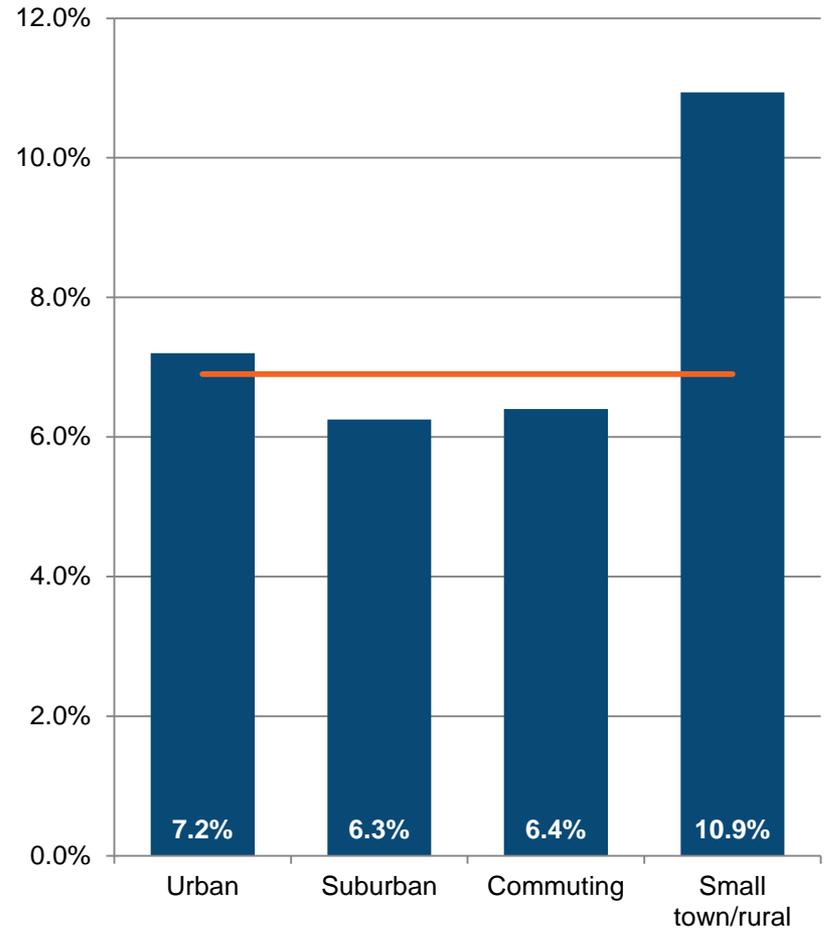
Note: Total spend PMPY has been scaled to reflect instances where members may not have a full year of eligibility in the claims data. Otherwise, this number is raw and has not been adjusted for differences in age, sex, or risk score.

In both commercial and Medicaid managed care (MCO) populations, NPs play a larger role in providing primary care to more rural communities.

Percent of commercial members attributed to an NP by geographic area (N=993,705), 2016



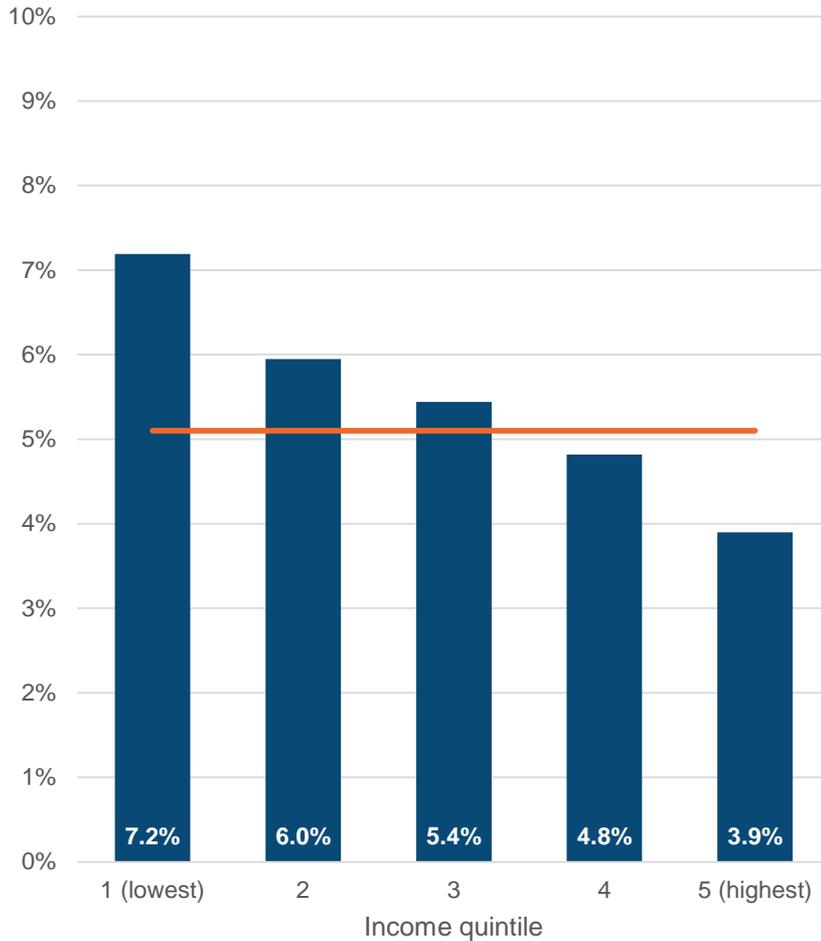
Percent of MCO members attributed to an NP by geographic area (N=458,476), 2016



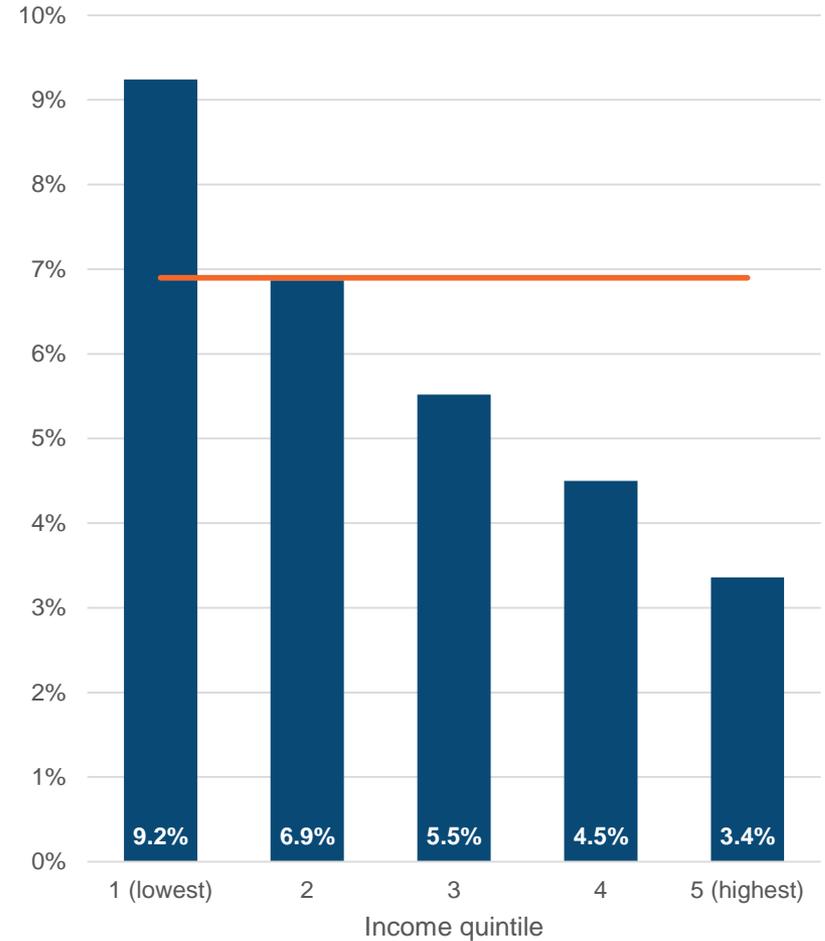
■ % attributed to an NP — Overall % attributed to an NP

In both commercial and MCO populations, NPs play a larger role in providing primary care to lower income communities.

Percent of commercial members attributed to an NP by income quintile (N=933,705), 2016



Percent of MCO members attributed to an NP by income quintile (N=458,476), 2016



■ % attributed to an NP — Overall % attributed to an NP

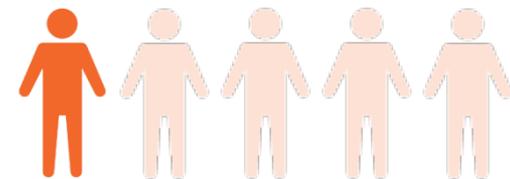
A significant number of NPs report barriers to practice, including employer restrictions and reimbursement restrictions from payers.

Additional credentials

- Responses to the 2018 DPH Licensure Renewal Survey found among NPs:
 - **97%** report having a **national provider identification (NPI) number**
 - **37%** of primary care NPs report being **listed as a PCP in an insurer directory** (up from 31% in 2016)

Practice barriers

- **17%** of respondents reported practice barriers due to **employer restrictions**
 - In a hospital outpatient setting, the number increases to **23%**
- Approximately **one in five** respondents reported practice barriers in the form of reimbursement **restrictions from any payer**
 - In a hospital outpatient setting: **25%**
 - In a physician office: **23%**
 - In a community health center: **24%**

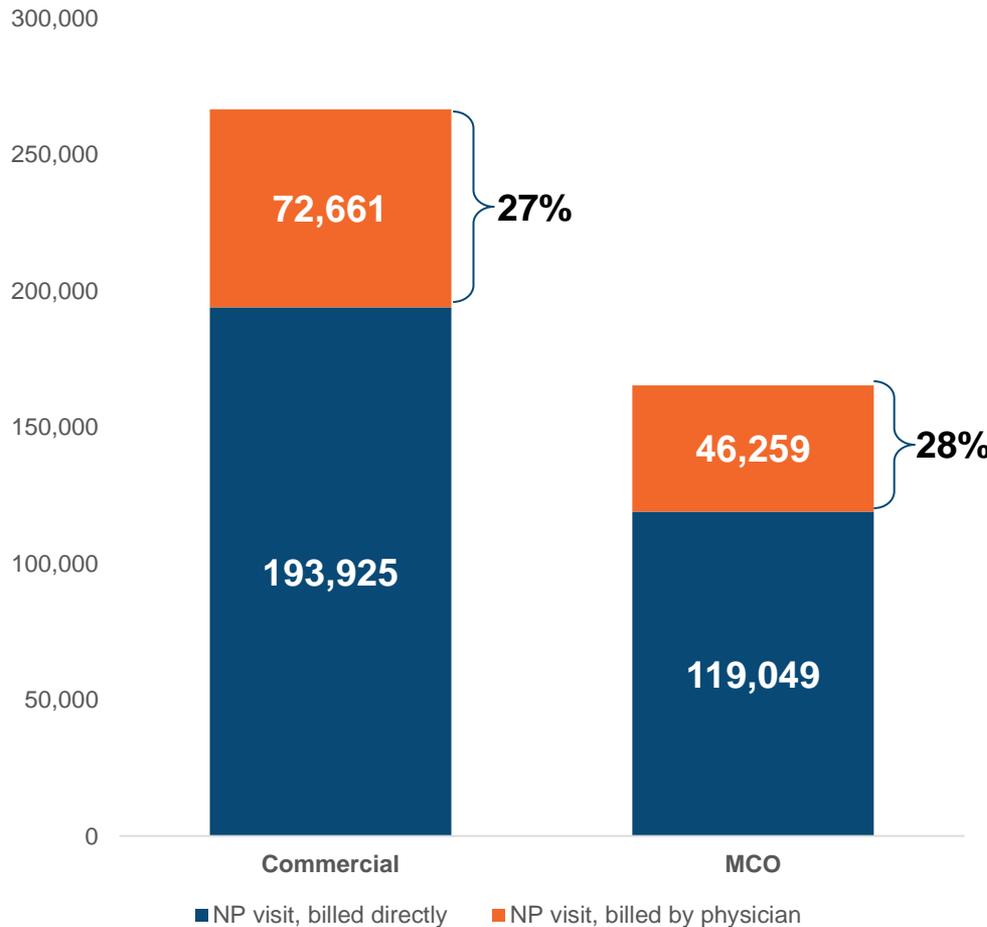


Source: DPH RN Licensure Renewal Survey, 2018

Notes: 5,546 APRNs responded to the survey in 2018. Among these, 1,984 respondents were identified as primary care NPs for the purposes of this analysis. This is a mandatory survey for the purposes of licensure renewal. Primary care NPs were identified through their self-reported practice specialty.

In 2016, at least 27% of primary care visits that were provided by NPs were actually billed by a supervising physician.

Claim counts indicating direct and indirect service provision through use of a procedure modifier (SA procedure modifier), or direct billing in an office setting, 2016



- NPs provided 12% of all primary care E&M visits in 2016.
- Medicare pays 85% of the physician rate when a service is billed under the NP's own NPI, but 100% of the physician rate when the same service provided by an NP is billed "incident to" a supervising physician.¹
- Some other payers mirror these guidelines, and require the use of a specific procedure modifier to indicate "incident to" billing.

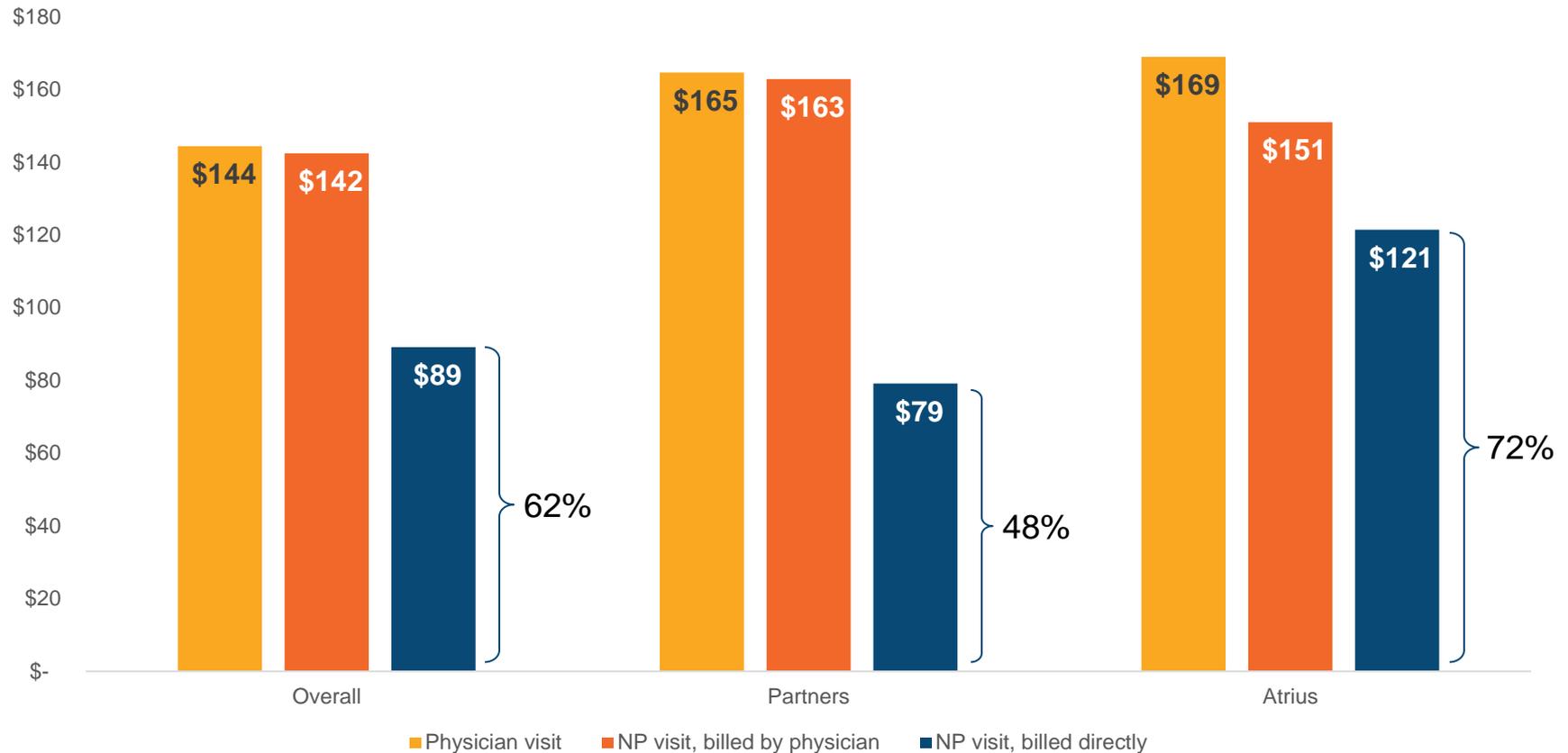
Notes: The proportion of visits that are estimated as NP visits billed incident to a physician is the physician claim counts with an "SA" modifier divided by the sum of the claim counts with a physician NPI and "SA" modifier and the claim counts with an NP NPI. MedPAC estimated that 40% of all NP's E&M office visits for established patients performed in physician offices were likely billed "incident to" in 2016.

Source: HPC analysis of All-Payer Claims Database, 2016. (1) MedPAC Blog: ["Improving Medicare's payment policies for Advanced Practice Registered Nurses and Physician Assistants"](#) (February 2019).

Primary care visits billed by physicians are reimbursed at a much higher rate than visits billed directly by a NP; differentials vary by provider.

Commercial prices

Average price for a medium-level established evaluation and management visit billed directly or indirectly by a physician or nurse practitioner primary care provider, 2016



Notes: Percentages next to the "NP visit, billed directly" bars indicate the percent of the physician visit rate. Bars represent the average price of a 99213 established evaluation and management visit. Claims with zero spending were not included in this analysis. There was no other trimming or imputation done in this analysis.

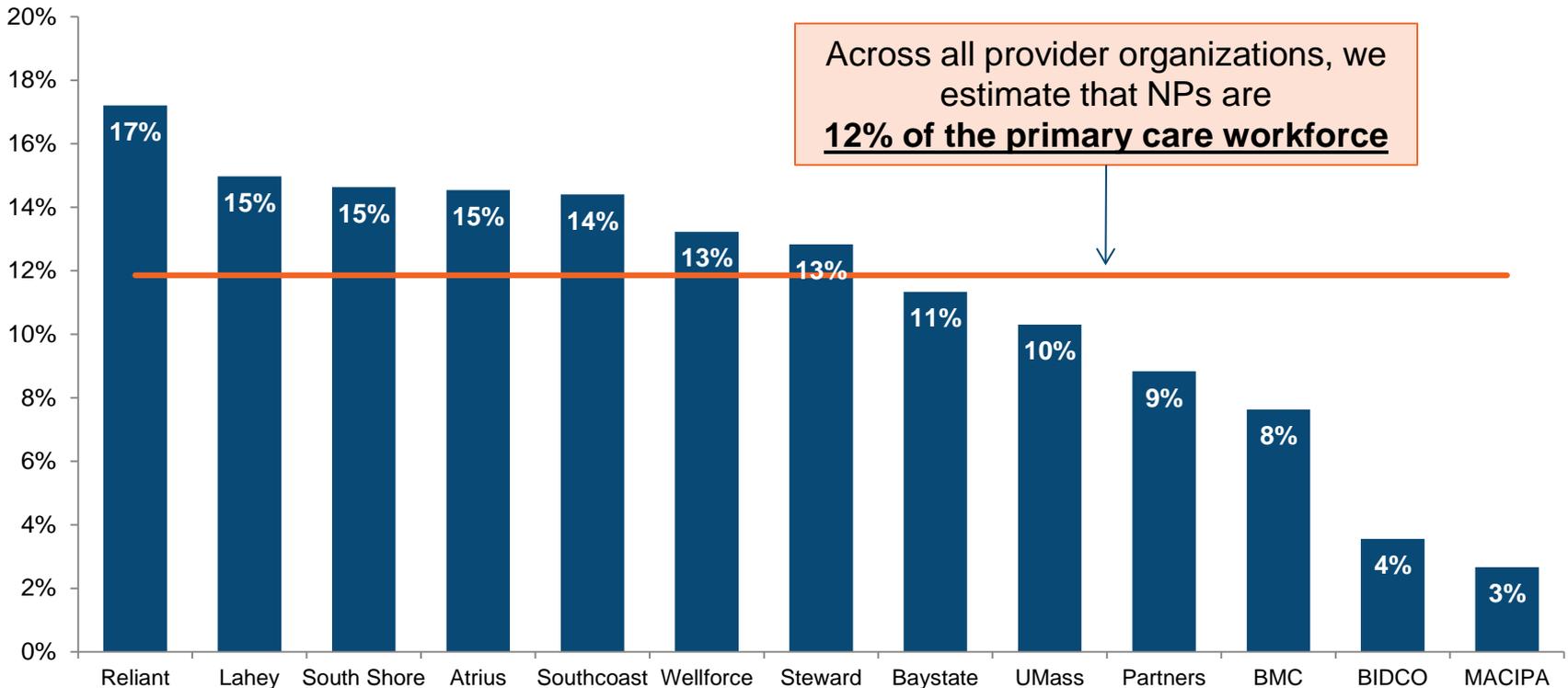
"NP visit, billed by physician claims" were identified through the presence of an "SA" procedure modifier. This modifier is meant to be used to indicate a visit where a NP provided the service. Analysis excluded claims with any other procedure modifier besides SA for all bars except the "NP visit, billed by physician" bar.

Source: HPC analysis of All-Payer Claims Database, 2016.

The percentage of primary care providers that are NPs varies by provider organization.

Providers

Percent of primary care providers who are NPs by provider organization, 2017



Of the 1,262 primary care NPs that are linkable to a provider organization,

420 (17%)

were affiliated with smaller provider organizations, including community health centers.

Notes: Primary care NPs were identified on the basis of the practice specialty reported by IQVIA. NPs that were not found in IQVIA but were used in other areas of this presentation from NPPES have not been reflected in this slide because we cannot currently determine organizational affiliations for these additional NP providers.

Sources: HPC analysis of 2017 Registry of Provider Organizations, SKA (IQVIA) 2017.

Summary of Initial Findings

1

Only a fraction of primary care NPs in Massachusetts were reported by payers as acting as primary care providers for patients in 2016.

- Patients attributed to NPs are more likely to be younger and female; there may be segments of the population who would prefer having an NP as their PCP.

2

Patients living in low income or rural areas, or who are on MassHealth, are more likely to have an NP as their primary care provider.

3

Restrictive scope of practice laws, payer and provider restrictions may be inhibiting Massachusetts' ability to fully utilize its NP workforce to expand access to primary care.

4

“Incident to” billing increases spending and inhibits accurate assessments of provider quality and performance by obscuring who is delivering a primary care service.

Plans for Future Research on Primary Care NPs

Evaluate claims-based quality of care measures and annual health spending for patients attributed to an NP PCP or a physician PCP

- Medication adherence
- Prevention Quality Indicators (PQIs)
- ED and inpatient visit rate

Better understand provider organizations' distinct approaches toward employing NPs in primary care service provision



AGENDA

- Call to Order
- Approval of Minutes from June 5, 2019 Meeting
- Prescription Drug Coupon Study: Preliminary Results
- Primary Care Workforce: Nurse Practitioners
- **Reducing Administrative Complexity**
 - Quantifying Payer and Provider Administrative Spending
 - Identifying Stakeholder Priority Areas
- Schedule of Next Meeting (**November 20, 2019**)



AGENDA

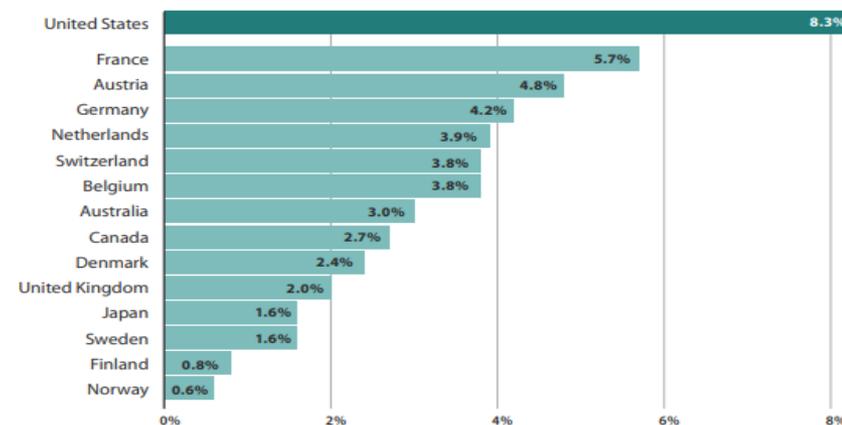
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Administrative costs are a substantial share of national health care spending, contributing to high per capita health care spending in the U.S.

- Nationally, billing and insurance-related activities are estimated to account for **\$496 billion** in 2019. This accounts for approximately **13-14%** of national health care spending.
 - Providers (hospitals, physicians, others): **\$282 billion**
 - Private insurers: **\$158 billion**
 - Public insurers: **\$56 billion**
 - When non-BIR administrative costs are included, administrative costs are estimated to reach **30%** of national health care spending.
- When examining **private and public payer spending on administrative costs**, the U.S. had the highest level of administrative spending of any OECD country.

FIGURE 1
Administrative costs comprise a larger share of health care spending in the United States than in other high-income countries

Administrative spending as a percentage of total health expenditures, 2016*



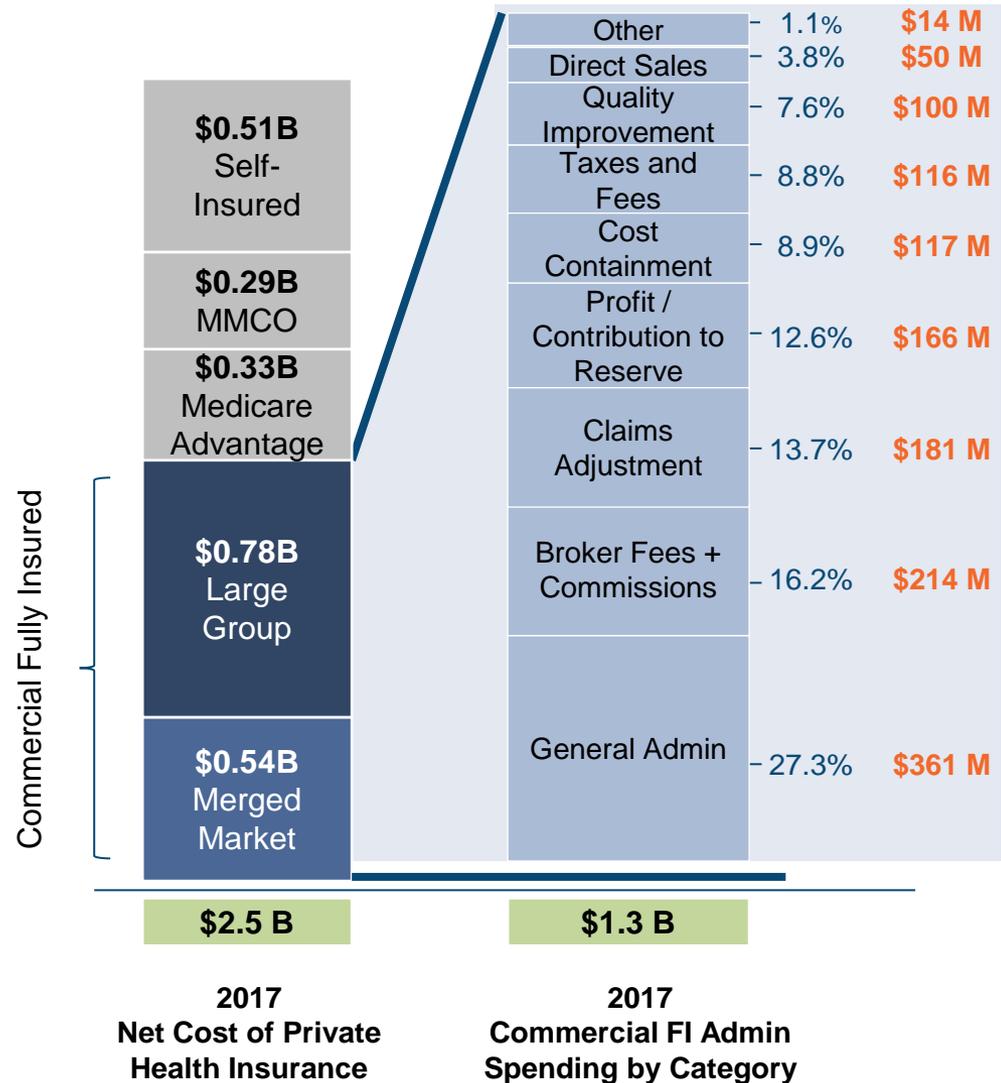
*Note: Data for Australia and Japan are for 2015; data for all other countries are for 2016.

Source: Organisation for Economic Co-operation and Development, "Health expenditure and financing," available at <https://stats.oecd.org/index.aspx?DataSetCode=SHA> (last accessed January 2019).

Note: There are many methods for measuring administrative complexity in healthcare. The figures cited in text above are specific to billing and insurance related expenses for payers and providers. The graph on the right is based on all administrative expenses for payers.

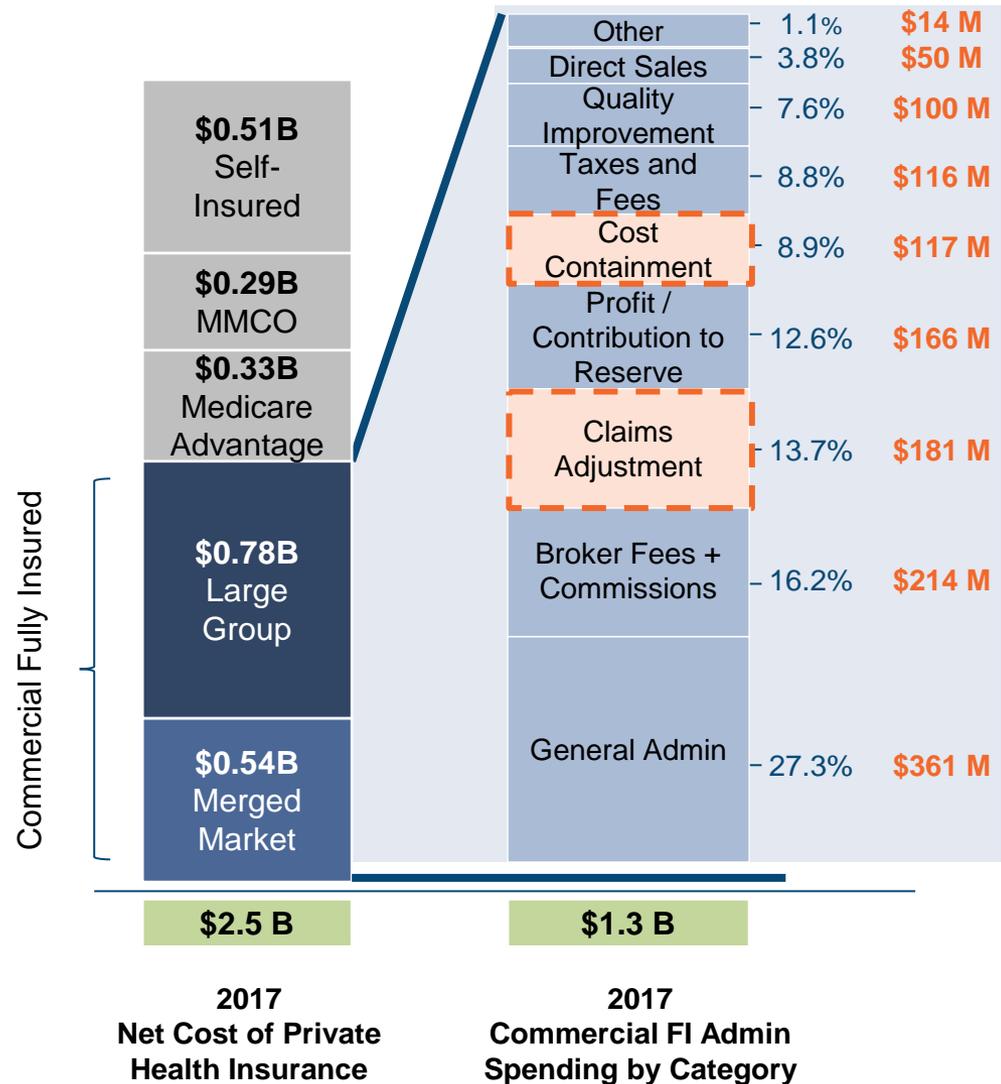
In 2017, \$2.5 billion Massachusetts premium dollars went toward payer administrative expenses and profits/contribution to reserves.

- CHIA estimates that private payers in Massachusetts spent approximately **\$2.5 billion** on non-claims expenses in 2017.
 - Spending on **commercial, fully insured products** accounted for just over half of the total spending, at **\$1.3 billion**.
 - The Division of Insurance reports similar figures, estimating administrative spending on commercial, fully insured products at **\$1.1 billion** for the same year.
- These figures include areas that may constitute complexity without value as well as expenses like underwriting, rent, and salaries.
- These figures do not include carrier **payments to providers**, a portion of which are also spent on administrative tasks.



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Billing and insurance-related activities for commercial payers cost Massachusetts providers at least \$1.3 and \$1.6 billion annually.

Researchers have estimated the costs incurred by physician practices and hospitals in order to interact with commercial insurers.



- Physician practices are estimated to spend **10% to 14% of revenue** on these activities.
- Applying this figure to Massachusetts physician groups, we estimate that they spend approximately **\$600 – \$840 million** per year.



- Hospitals are estimated to spend **8% of revenue** on these activities.
- Applying this figure to Massachusetts hospitals, we estimate they spend approximately **\$768 million** per year.

**\$1.5
billion**

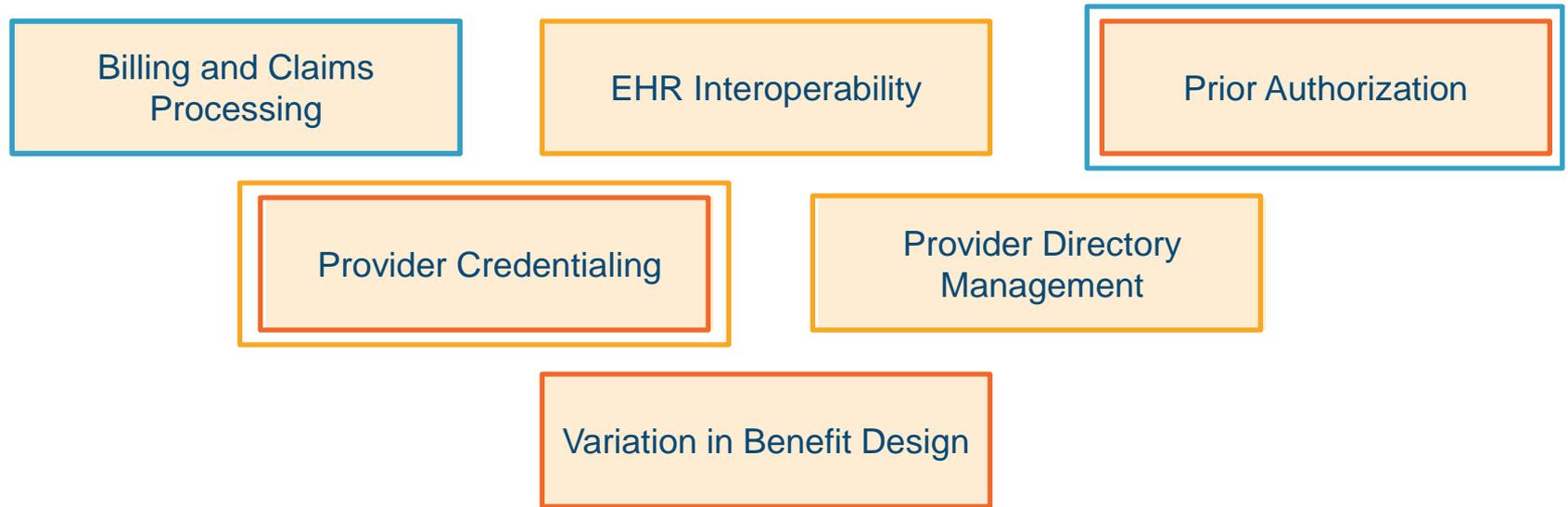
Taken together, we estimate Massachusetts providers' BIR spending at approximately **\$1.5 billion annually**.



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 - Provider Credentialing
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Payers and providers prioritize different areas of administrative complexity for action.



- The HPC's **Advisory Council** identified **Prior Authorization**, **Provider Credentialing**, and **Variation in Benefit Design** as top priority areas.
- Through Pre-Filed Testimony (PFT) collected by the HPC ahead of the 2019 Health Care Cost Trends Hearing, **29 providers** identified **Billing and Claims Processing** and **Prior Authorization** as top priority areas.
- Through PFT, **12 payers** identified **EHR Interoperability**, **Provider Credentialing**, and **Provider Directory Management** as top priority areas.

Levers for Reducing Administrative Complexity



Reduce Variation & Duplication

- Improve processes that require unnecessary repetition
- Standardize requirements and processes across organizations



Leverage Technology

- Reduce the use of faxing, phone, email
- Integrate forms, processes and systems into existing workflows
- Review existing IT systems against new technology



Eliminate Low-Value Tasks

- Identify tasks that are no longer achieving their intended purpose
- Determine whether task is valuable in all circumstances and consider differential application



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Example: Leveraging Technology to Improve Billing and Claims Processing

- Billing and claims processing is estimated to take **30-50 hours of staff time per physician per week**. This is significantly more than other countries spend on these services and significantly more than other industries in the US spend on administrative services.
 - In Ontario, Canada, physician practice staff spend approximately **18 hours on billing and claims**.
 - In many non-health care sectors in the US, **businesses employ ≤100 FTEs** per \$1 billion in revenue collected for payment administration; **physician practices employ closer to 770 FTEs**.
- Following in the footsteps of other industries, the health care industry has adopted standards for certain electronic transactions, thereby allowing for fast, accurate transfer of information and funds. **The CAQH Index** measures industry progress in transitioning from manual to electronic transactions.

Savings Opportunity				
Transaction	% Manual (US)	% Manual (MA)	Per Transaction Savings	MA Savings Opportunity (in Millions)
Eligibility and Benefit Verification	2%	3%	\$6.52	47
Claim Submission	4%	4%	\$1.32	\$6
Claim Status Inquiry	6%	35%	\$9.22	\$59
Claim Payment	37%	18%	\$0.65	\$2
Remittance Advice	9%	10%	\$2.32	\$3
Total				\$117

- While adopting electronic transactions reduces administrative spending for payers and providers, it does not address several other issues with Billing and Claims Processing, including **payer audits, clawbacks, variation in billing rules, and mid-year changes in payment policies**.



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Prior Authorization: Background



➔ **Prior Authorization (PA)** is a tool that payers use to manage the use of drugs and services in their networks.

- By focusing on expensive services and those that may be used outside of clinical appropriateness criteria, payers can target low-value care and act as responsible stewards of their purchasers' premium dollars.



➔ Researchers have found evidence that prior authorization is associated with **reduced utilization and spending** on the services for which PA is required:

- A meta-analysis of studies on prior authorization and step therapy for pharmaceutical products found that PA was associated with lower pharmacy utilization and costs.
- Another study found that after a PA program was implemented, high annual growth in rates of CT, MRI, and PET scans slowed.



Prior Authorization: Impact

- Variation in PA requirements can be challenging for patients and providers (who must determine which procedures require PA) to navigate.
 - In an example shared with the HPC, PA requirements for 26 orthopedic procedures across 8 plans varied considerably.
 - Not a single procedure consistently required or was exempted from PA, leading to questions about clinical criteria or ordering patterns that inform PA programs.
- A study out of Dana Farber identified **17 possible process steps** and **10 decision points** in their PA workflow.

Procedure	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Across All Plans
A				*			PA		*
B				PA			PA		PA
C		PA	PA	PA			PA		PA
D		PA	PA				PA		PA
E	*	PA	PA	PA			PA		PA
F	*	PA	PA	PA			PA		PA
G		PA	PA				PA		PA
H		PA	PA	PA			PA		PA
I		PA	PA	PA			PA		PA
J							PA		PA
K	*	PA	PA	PA			PA		PA
L	*	PA	PA	PA			PA		PA
M							PA		PA
N		PA	PA				PA		PA
O		PA	PA	PA			PA		PA
P	PA			PA	PA	*	PA		PA
Q				PA			PA		PA
R				PA			PA		PA
S				PA			PA		PA
T				PA			PA		PA
U		PA	PA	PA			PA		PA
V		PA	PA	PA			PA		PA
W				PA		PA	PA		PA
X		PA	PA	PA			PA		PA
Y		PA	PA	PA			PA		PA
Z		PA	PA	PA			PA		PA

* PA required for a subset of procedures

Prior Authorization: Physician Perceptions and Evidence

Front line physicians perceive negative impacts associated with PA, and their perceptions are largely supported by research.

Increasing Burden

- 88% of physicians reported that the burden associated with PA has increased over the last 5 years
- 86% describe the burden as high or extremely high

- The 2018 CAQH Index estimated a 14% increase in the national volume of prior authorization transactions from 2017 and a 27% increase from 2016

Time and Resources

- Physicians reported that their offices completed an average of 31 PAs per physician per week
- PAs required almost 15 hours of physician and staff time per physician per week

- Per FTE physician estimates from the academic literature are even higher:
 - Physicians: 1 hour per week
 - Nurses: 13 hours per week
 - Non-clinical staff: 6 hours per week

Impact on Patients

- 91% of physicians reported that PA had a negative impact on patient clinical outcomes
- 47% reported that PA always or often led to delays in treatment

- A 2017 meta-analysis of PA and step therapy found unfavorable results on patient clinical outcomes and medication adherence
- A 2018 study found that PA requirements for medications can lead to delays in discharges

Prior Authorization: State Regulation to Minimize Administrative Complexity

- **Standard Form**

- 18 states have standards around PA forms

- **MA:** Plans must use the standard forms developed by DOI and the Mass Collaborative
- Forms have been issued for imaging, pharmacy, and behavioral health services

- **Response time**

- 28 states regulate response time
- Most divide between urgent (1-3 days) and standard (2-15 days)

- **MA:** 2 business days

MA Payers must also meet NCQA utilization management standards, including for PA.

- **Electronic Prior Authorization**

- 21 states have standards around ePA
- Many require that prior authorizations use the NCPDP SCRIPT standard which allows for uniform information transfer of pharmaceutical data

- **MA:** Requires that the standard PA forms be made available electronically and be capable of being electronically accepted by the payer after being completed
- DOI can consider national ePA standards in developing the standard forms

- **PA Length and Retrospective Denials**

- 12 states have standards in this area
- Most prohibit plans from modifying or rescinding a previous authorization
- Some states mandate a minimum time period during which the PA is valid, ranging from 45 days to 12 months

Prior Authorization: Consensus Statement

Consensus Statement on Improving the Prior Authorization Process	
Signed By	American Medical Association, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, the Blue Cross Blue Shield Association, and the Medical Group Management Association
Date	January 2018
Opportunities for Improvement	1 Selective Application of Prior Authorization
	2 Prior Authorization Program Review and Volume Adjustment
	3 Transparency and Communication Regarding Prior Authorization
	4 Continuity of Patient Care
	5 Automation to Improve Transparency and Efficiency

Levers for Reducing Administrative Complexity: Example Solutions for Prior Authorization



Reduce Variation & Duplication *Example Solutions*

- More consistency across plans and products regarding which services
- Limits on mid-year changes to PA
- Upstream education opportunities for providers on clinical appropriateness criteria where available



Leverage Technology *Example Solutions*

- Transition from manual PA transactions to electronic: estimated \$6M in savings in Massachusetts
- Continued work on adoption of a national standard for electronic PA Attachments.
- Incorporation of forms, requirements, and decision support into EHRs and other practice management software
- Artificial intelligence: real time adjudication of requests based on clinical data



Eliminate Low-Value Tasks *Example Solutions*

- Eliminating PA requirements for drugs and services that have low variation in utilization across providers or low PA denial rates
- Exemptions for providers (individuals, groups, or facilities) that have historically low denial rates.
- Delegation of PA function to ACOs



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 - Prior Authorization
 - **Provider Credentialing**
- Schedule of Next Meeting (**November 20, 2019**)

Credentialing: Overview

- Stakeholders often use the term “credentialing” to refer collectively to **state licensure, controlled substances registration, credentialing, and health plan enrollment**, distinct processes that are all required for initial onboarding and at regular renewal intervals.



- Many of the elements that complicate the credentialing process are intended to protect patients and promote safety, including payer adherence to NCQA credentialing standards, primary source verification requirements, and the re-credentialing of physicians at regular intervals.
- As with Prior Authorization, the processes of seeking credentials, privileges, and enrollment is not uniform across providers or plans and the entire process can take up to 12 months.
- At a minimum, credentialing typically includes a review of:

- Proof of Identity
- Education and Training
- Military Service
- Professional Licensure
- DEA/MCS Registration
- Board Certification

- Affiliation and Work History
- Criminal Background
- Sanctions
- Health Status
- Malpractice Insurance
- Professional References

Credentialing: Impact

Since credentialing must be completed before a provider can begin billing for services, the weekly time and expense associated with this task is not high.

- **Physicians:** 4 minutes per week (per FTE physician)
- **Nurses:** 1 minute per week (per FTE physician)
- **Non-clinical staff:** 2 hours per week (per FTE physician)

However, the upfront time and resources can lead to significant delays in provider onboarding.

- This can create access issues when there are vacancies that need to be filled immediately, especially for per diem and locum tenens positions.
 - The Blue Cross Blue Shield of Massachusetts Foundation's 2019 report *Ready For Reform: Behavioral Health Care in Massachusetts* found that the **complex credentialing process may lead behavioral health providers to decline participation in insurance networks**, thereby exacerbating workforce shortages.
- These processes also pose **financial challenges** for providers. While providers may choose to begin seeing patients before the final health plan enrollment phase is complete, they cannot bill for services provided during this window.
- Several providers reported having had out-of-state physicians **decline employment in Massachusetts** in order to work in another state with a shorter credentialing period.

Credentialing: Attempts to Reduce Complexity



Telemedicine: CMS allows hospitals when granting telemedicine privileges, to rely upon the privileging decisions of a distant-site hospital or telemedicine entity with which they have a written agreement that meets Medicare requirements



Centralized Medicaid Credentialing: Texas and North Carolina have both implemented centralized credentialing processes for their Medicaid programs, which will utilize a third-party Credentialing Verification Organization (CVO). MMCOs will be required to use the CVO for their credentialing programs.



Voluntary Credentialing Platform: In conjunction with CAQH, MA payers have formed Health Care Administrative Solutions (HCAS), which offers providers the ability to submit a centralized credentialing application.

- 95% of completed applications are processed within 30 days.
- Data are used for other processes as well, including provider directory management
- However, only seven plans use HCAS (a few others use CAQH directly)
- Completing enrollment with health plans still requires the submission of additional documents directly to the payer, such as participation agreements, W-9s, and letters of interest.



Levers for Reducing Administrative Complexity: Example Solutions for Credentialing



Reduce Variation & Duplication *Example Solutions*

- Centralized credentialing process
- Massachusetts participation in the Interstate Medical Licensure Compact



Leverage Technology *Example Solutions*

- Applications that streamline data collection process and centralize information and primary source verification records
- Greater plan participation in HCAS



Eliminate Low-Value Tasks *Example Solutions*

- Payer delegation of credentialing to providers
- Assess value of re-credentialing when otherwise credentialed providers change network affiliation

Next Steps

Public Presentations

1

Cost Trends Hearing

Witness panel on *Confronting Complexity in the Health Care System*

2

Board Meeting

Presentation to full Commission and discussion of project goals

Defining HPC Approach

1

Priority Areas

Consensus on initial focus areas

2

Solutions of Interest

Identification of levers and strategies worth pursuing

3

Engagement

Strategy for engaging stakeholders
Expert outreach

4

Project Scope

Timeline, outcomes, defining success



AGENDA

- Call to Order
- Approval of Minutes from June 5, 2019 Meeting
- Prescription Drug Coupon Study: Preliminary Results
- Primary Care Workforce: Nurse Practitioners
- Reducing Administrative Complexity
- **Schedule of Next Meeting (November 20, 2019)**

Upcoming 2019 Meetings and Contact Information



Board Meetings

Monday, December 16



Committee Meetings

Wednesday, November 20



Contact Us

Mass.Gov/HPC

 **@Mass_HPC**

HPC-Info@mass.gov



Special Events

2019 Cost Trends Hearing

Day 1 – Tuesday, October 22

Day 2 – Wednesday, October 23



MASSACHUSETTS
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APPENDIX

Top Drugs by Coupon Penetration Represented by Dermatology and Antiarthritic Therapies, Among Other Therapeutic Categories

Rank	Drug name	Percent of eligible claims that used a coupon	Therapeutic category
1	UTOPIC	99%	Dermatologicals
2	TALTZ AUTOINJECTOR	95%	Immunologic Agents
3	AVAR LS	93%	Dermatologicals
4	BROMSITE	90%	Ophthalmic Preparations
5	ADIPEX-P	87%	Miscellaneous Unassigned Products
6	SENSIPAR	87%	Calcimimetic Agents
7	KERALAC	86%	Dermatologicals
8	TALTZ AUTOINJECTOR (2 PACK)	85%	Immunologic Agents
9	TARGADOX	85%	Anti-infectives, Systemic
10	PLEXION	84%	Dermatologicals
11	VSL#3	83%	Natural Medicine
12	HUMIRA(CF)	83%	Antiarthritics
13	VIMOVO	82%	Antiarthritics
14	OTOVEL	82%	Otic Preparations
15	DUEXIS	82%	Antiarthritics
16	PENNSAID	81%	Antiarthritics
17	AUBAGIO	81%	Immunologic Agents
18	HUMATROPE	79%	Hormones
19	AVAR	79%	Dermatologicals
20	RAYOS	78%	Hormones

Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs. Table includes drugs with at least 50 claims.
Source: Symphony Health IDV® database, 2018

Top Drugs by Total Coupon Spending Represented by Range of Therapeutic Categories

Rank	Drug Name	Total Coupon Amount	Therapeutic Category
1	SENSIPAR	\$5,627,635	Calcimimetic Agents
2	TALTZ AUTOINJECTOR	\$1,921,849	Immunologic Agents
3	TRUVADA	\$1,081,284	Antivirals
4	HUMIRA PEN	\$791,816	Antiarthritics
5	ELIQUIS	\$759,028	Hemostatic Modifiers
6	TALTZ AUTOINJECTOR (2 PACK)	\$451,659	Immunologic Agents
7	EPIDUO FORTE	\$412,889	Dermatologicals
8	GENVOYA	\$330,951	Antivirals
9	ORACEA	\$322,098	Anti-infectives, Systemic
10	XARELTO	\$307,985	Hemostatic Modifiers
11	LANTUS SOLOSTAR	\$296,085	Diabetes Therapy
12	ENSTILAR	\$272,201	Hormones
13	TALTZ AUTOINJECTOR (3 PACK)	\$268,380	Immunologic Agents
14	SOOLANTRA	\$238,301	Dermatologicals
15	SYMBICORT	\$230,667	Respiratory Therapy
16	TRULICITY	\$216,001	Diabetes Therapy
17	BRILINTA	\$200,918	Hemostatic Modifiers
18	DUEXIS	\$196,973	Antiarthritics
19	PENNSAID	\$194,317	Antiarthritics
20	BROMSITE	\$187,850	Ophthalmic Preparations

Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs. Table only includes branded drugs with at least 11 claims that used a coupon.

Source: Symphony Health IDV® database, 2018

State Regulations in Massachusetts

- **Nurse Practitioners as Primary Care Providers:**
 - NPs are recognized in state policy as primary care providers. If a health care carrier requires the designation of a primary care provider, the carrier must provide its insured with an opportunity to select a participating provider nurse practitioner as a primary care provider or to change its primary care provider to a participating provider nurse practitioner at any time during their coverage period. [Mass. Gen. Laws Ann. §176R\(4\)](#)
- **Prescriptive Authority:**
 - A written collaboration agreement must include prescriptive guidelines developed by the physician. Eleven items must be outlined in the agreement including the scope of the NP's prescribing practice and the types of medication that may be prescribed. [Mass. Reg. Code §243-2.10 \(5\)](#)