MEETING MINUTES:

MARKET OVERSIGHT AND TRANSPARENCY COMMITTEE

Meeting of October 2, 2019

MASSACHUSETTS HEALTH POLICY COMMISSION

Market Oversight and Transparency Committee
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, October 2, 9:30 AM

PROCEEDINGS
The Massachusetts Health Policy Commission's (HPC) Market Oversight and Transparency (MOAT) Committee held a meeting on Wednesday, June 5, 9:30 AM, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. David Cutler (Chair); Mr. Ron Mastrogiovanni; and Ms. Cassandra Roeder, designee for Secretary of Administration and Finance Michael Heffernan.

Ms. Barbara Blakeney, Dr. Donald Berwick, Dr. Chris Kryder, and Undersecretary Lauren Peters, designee for Secretary of Health and Human Services Marylou Sudders, were also in attendance.

The meeting notice and agenda can be found here.
The presentation from the meeting can be found here.
A video of the meeting can be seen here.

Dr. Cutler called the meeting to order at 9:32 AM. He welcomed members of the public to the meeting.

ITEM 1: APPROVAL OF MINUTES FROM THE JUNE 7, 2019 MEETING
Dr. Cutler called for a motion to approve the minutes from the June 5, 2019, meeting. Mr. Mastrogiovanni motioned to approve the minutes. Ms. Roeder seconded the motion. The minutes were approved with three votes in the affirmative.

Dr. Cutler provided a brief outline of the day's agenda. Mr. Seltz noted that many of the discussions slated for the day's meeting would be continued at the cost trends hearing (CTH). He provided an overview of the CTH agenda. For more information, see slide 5.

ITEM 2: PERSCRIPTION DRUG COUPON STUDY
Mr. turned the meeting over to Ms. Sara Sadownik, Deputy Director, and Ms. Yue Huang, Research Associate, Research and Cost Trends who presented on the results of the prescription drug coupon study. For more information, see slides 14-33.

Mr. Mastrogiovanni asked why such a small proportion of eligible claimants used coupons. Ms. Sadownik said that this was likely due to a range of factors including a lack of awareness regarding coupons on the part of some patients and the existence of cost-sharing arrangements that nullify the benefits of coupons for certain consumers. Mr. Seltz added that there was variation among different types of drugs in terms of uptake. He said there were cases in which a significant portion of patients were using coupons. Ms. Sadownik agreed that this was the case and noted that Truvada, an anti-viral used for HIV prevention, had an uptake of 40 percent of all claims.

Undersecretary Peters asked how manufacturers generally made consumers aware of the existence of coupons. Ms. Sadownik said that manufacturers provided coupons directly to physicians and also in

some cases make them available online. Ms. Huang added that there are cases in which there are paper coupons that consumers can get through physicians' offices or other sources. She said that staff had seen a number of coupon programs that required people to go through a registration process to make sure they are on commercial insurance.

Regarding the chart on slide 30, Undersecretary Peters asked why different years were listed for each drug on the x-axis. Ms. Huang said that staff had used the two most recent years for each drug prior to a direct generic equivalent coming onto the market.

Regarding the reasons for coupon use listed on slide 23, Dr. Cutler said that the legislature could potentially require that rebates be offered to insurers with any coupons issued to mitigate the shifting of use to higher-cost branded products at the expense of lower-cost alternatives. Ms. Sadownik said that this was an interesting idea and could be a potential avenue to address the spending impact. She said it would be important to take a closer look to evaluate all potential consequences of shifting incentives in that manner.

Dr. Kryder noted that regarding the examples of Nuvigil and Eliquis, for patients over 60 the side effect profile could vary dramatically. He said that because Nuvigil was a stimulant and could cause irregular heart rates, physicians may be less likely to prescribe it to older patients. He said that the same held for Eliquis which causes less bleeding than Warafin. For these reasons, he said, the indications for these drugs may be different for Medicare versus a commercial population. Ms. Sadownik said that this was an excellent point and noted that staff members had been conservative in their analysis and were careful to look at drugs that would not have different use rates in commercial versus Medicare. She added that the drugs analyzed were ranked by the absolute difference and that a ranking based on percentage difference painted a different picture. Dr. Cutler noted that both of these drugs were used more in the commercial than in the Medicare population which was interesting considering that Dr. Kryder's comments would suggest the opposite should be the case. Dr. Kryder said that it may be helpful to have a cardiologist consultant in addition to the pharmaceutical consultants when analyzing these specific drugs.

Undersecretary Peters asked how a close generic alternative was defined for this analysis versus a direct generic alternative. Ms. Sadownik said a direct generic is identical to the drug in question while a close generic may be in the same class. She said that there may be a number of options that fall into the close generic category for a given condition. Undersecretary Peters asked if staff had found any background information on the role of the physician in making a patient aware of alternatives. Ms. Sadownik said this was an excellent line of inquiry and that it spoke to the need of providers to be more aware of the cost sharing that patients face.

Mr. Mastrogiovanni asked if people tend to adopt drugs long-term when using coupons or over time do they stop taking the drug or move to an alternative. Ms. Sadownik said that staff had not examined this issue specifically. She said that if the coupons brought the cost down to a point that was in line with alternatives for a consumer, then there would not be a financial incentive to stop taking the drug.

Ms. Blakeney asked if there had been any outreach to prescribing clinicians as a part of this analysis to get a sense of the role that coexisting diagnoses could account for some percentage of the differences found. She noted that often patients might have a secondary condition that could be exacerbated by a medication that would otherwise be prescribed. She that there may be a number of variables that might be helpful to capture for the study. Ms. Sadownik noted that there are always a number of factors that

cannot be accounted for but said that staff tried to address this by being conservative in the drugs chosen for inclusion in the case studies. Ms. Blakeney asked if staff felt they had adjusted for these variables through this conservative selection of drugs. Ms. Sadownik said yes and noted that if clinical guidelines favored one particular alternative over another, that drug was excluded from a case study. Ms. Huang gave several further examples of exclusion criteria. Mr. Seltz added that these results would all be included in a written report and in crafting that there would be opportunity for additional stakeholder feedback.

Dr. Kryder asked if it was possible that federal regulations were a defining variable with regard to these findings. He asked if Medicare allowed coupons, would there be massive shifts in these numbers. Dr. Cutler said that the consensus among economists was that if coupons were allowed in Medicare, then use of those drugs would increase. He said that he was confident that the conclusions in this analysis were correct. He said that the exact percentages may be subject to shifts based on different variables but that directionally, actionable conclusions could be drawn from these findings. Dr. Berwick said that the proportion of generic use in Medicare was very high and that this was generally considered to be a great success of the program.

Undersecretary Peters asked how long coupons were generally available once a consumer starts using them. Dr. Cutler agreed that adding some context about the longevity of coupon use to the final report would be useful.

Dr. Cutler thanked the presenters.

ITEM 3: PRIMARY CARE WORKFORCE: NURSE PRACTITIONERS

Dr. Cutler introduced the presentation on HPC's primary care workforce study. He turned the meeting over to Dr. Laura Nasuti, Associate Director, and Ms. Hannah James, Research Associate, Research and Cost Trends. For more information, see slides 35-52.

Dr. Berwick asked if the cost values on slide 44 were adjusted in any way. Ms. James said that they were not.

Regarding the chart on slide 49, Mr. Seltz noted that in cases in which a nurse practitioner (NP) had delivered the service but it was being billed at a physician rate, the reimbursement was almost exactly the same as had the physician provided the service his or herself. Given that NP salaries are lower, he said, in these cases the provider organization is essentially using this as a revenue generation mechanism.

Dr. Berwick asked if an NP delivers care and that is billed at a regular rate, has something different actually occurred with regard to the care delivered or is this simply a result of a coding strategy that a provider might use. Ms. James said that it was difficult to speculate what the strategy might be here but there are specific procedure modifiers that are supposed to be used when an NP is providing a service that is being overseen by a physician in some capacity. She said that the criteria to use these procedure modifiers was somewhat of a gray area and could represent a wide range of physician involvement. Dr. Nasuti said that it was also unclear how team-based care might impact this coding.

Regarding the graph on slide 49, Dr. Cutler noted that in Medicare a visit to a NP is supposed to be 85 percent of the physician rate. He noted that that would mean that both the orange and blue bars on this graph would be equal at 85 percent of the yellow bar. Dr. Nasuti said that staff were a little unclear as to

why it was so dramatically divergent from Medicare. She noted that staff had combined many different sites of practice in the commercial prices and that they hoped to touch base with providers to try and better understand this dynamic. Dr. David Auerbach, Director, Research and Cost Trends, clarified that in Medicare the yellow and orange bars would actually be equal. Ms. James said that this was the case as in Medicare the rate was 100 percent when billed under the physician's national provider identifier (NPI). Dr. Cutler asked when the service could be billed under the physician's NPI in Medicare. Dr. Auerbach said that it occurred in the same scenarios seen in this analysis. He said that there was a push to completely remove the category of physician-supervised NP care. Dr. Nasuti said that staff had seen some publicly available payer information that was pushing in that direction as well. She noted that these numbers came from 2016 claims data and that subsequent years' data would hopefully provide additional context.

Mr. Mastrogiovanni asked how physician assistants (PAs) played into this analysis. Ms. James said that around 2,000 commercial members in the all-payer claims database (APCD) analyzed were linked to a PA. She said that there was a lot more that staff would like to learn about the role of PAs and that this could be an area for future study. She said that what made NPs unique and worth looking at in this study was the specific scope of practice restrictions in Massachusetts.

Regarding slide 49, Dr. Berwick asked whether an analysis of patients who had seen an NP by provider would show differences among the providers in terms of the percentage that were billed to the blue and orange categories. Ms. James said that this analysis had not been conducted but that it was definitely possible to do. She said that she would suspect there would be some variation. Dr. Nasuti said that an avenue for future research would be trying to understand why there is variation even in the number of NPs employed in primary care by different providers.

Mr. Mastrogiovanni said that NPs had increased access to medical care. He asked whether staff had found that the physicians' panel had decreased in size due to the use of NPs or had the panel remained the same size and the number of patients treated had been increased by adding NPs. Dr. Nasuti said staff had not tried to estimate average panel sizes but that it might be worth looking at as, in theory, the panels should shrink.

Undersecretary Peters asked if there was less incident-to billing in states that had less stringent scope of practice rules. Ms. James said that there was some indication from Rhode Island's data that there is much less use of that procedure modifier.

Dr. Cutler noted that the HPC had recommended expanding scope of practice to the legislature in the past. Mr. Seltz confirmed that this was the case. Dr. Cutler asked if there was anything further the HPC could do to heighten awareness around this issue. Mr. Seltz said that this presentation and research continues to add objective data to support the case for expanding scope of practice for NPs. He said there had been a hearing on this issue recently and that there was growing momentum in the legislature to address it. Dr. Berwick said that the data here suggested that scope of practice changes would have to be wedded to an in-depth look at incident-to billing.

Dr. Kryder said that this was great research. He said that since the APCD include ICD-10 data, it might be useful to overlay select diagnoses on top of these numbers to get a clearer picture of what kind of care was being administered by PCPs versus NPs. Mr. Seltz said that this was a great idea.

Dr. Cutler thanked the staff for the presentation.

ITEM 4: REDUCING ADMINISTRATIVE COMPLEXITY
In the interest of time, Ms. Amy Katzen, Project Manager, and Ms. Kara Vidal, Associate Director, Market Oversight and Transparency, presented the first portion of the presentation on the HPC's administrative complexity research. For the full presentation materials, see slides 55-76.

Mr. Seltz noted that both payers and providers had identified opportunities for reducing unnecessary administrative spending and said that the problem statement laid out here was a good set-up for the first panel at the CTH in a few weeks. Dr. Cutler asked who would be on the panel. Mr. Seltz said that the panel composition had not yet been announced but that it would be a cross-section of stakeholders with interest on this topic. Dr. Berwick said that a key question for this panel was what the barriers were to making progress here. Dr. Cutler said that this would be a very important panel for the HPC's work. Dr. Kryder added the burden of data entry for providers should also be addressed when discussing this topic.

ITEM 5: ADJOURNMENT
Dr. Cutler thanked the Committee and the staff. The meeting adjourned at 11:03 AM.