Thank you for joining the HPC's Virtual Meeting of the Market Oversight and Transparency (MOAT) Committee.

The meeting will begin shortly and will be immediately followed by the Care Delivery Transformation (CDT) Committee at 11:00 AM.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Committee Meetings

May 6, 2020

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order – Chair Stuart Altman**
- Executive Director's Report
- Market Oversight and Transparency Committee
- Care Delivery Transformation Committee
- Schedule of Next Board Meeting **(June 10, 2020)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Update on HPC Operations

The HPC **temporarily closed** its 50 Milk Street office on Friday, March 13, and has been **fully operating as a remote workplace** for the last seven weeks.

Virtual HPC: Open for Business

- The HPC maintains its **regular business hours** of Monday to Friday from 9:00 AM to 5:00 PM. All public inquiries should be sent via email to HPC-Info@mass.gov, or phone to (617) 979-1400.
- The agency is closely following guidance from the **Baker-Polito Administration and public health officials** regarding re-opening the Boston office, with plans to reassess the situation on a regular basis.
- The **work of the HPC continues** as we strive to understand the **implications of COVID-19** on the overall health care system, while supporting the **critical efforts of our stakeholders on the frontline**.

Office of Patient Protection (OPP) is Open to Assist Patients

Open Enrollment Waivers

- The non-group health insurance open enrollment period is currently extended through May 25, 2020
- OPP is referring all patients who need non-group health insurance to the Health Connector or directly to health plans

External Reviews

- OPP continues to process external review for consumers with fully insured health plans and patients of risk-bearing provider organizations and accountable care organizations
- OPP has no delays in processing, including expedited requests

Consumer Assistance and Information

- OPP's hotline is open and working remotely
- Consumers may also contact OPP through email, mail or fax

HPC

How to Contact OPP

Office of Patient Protection

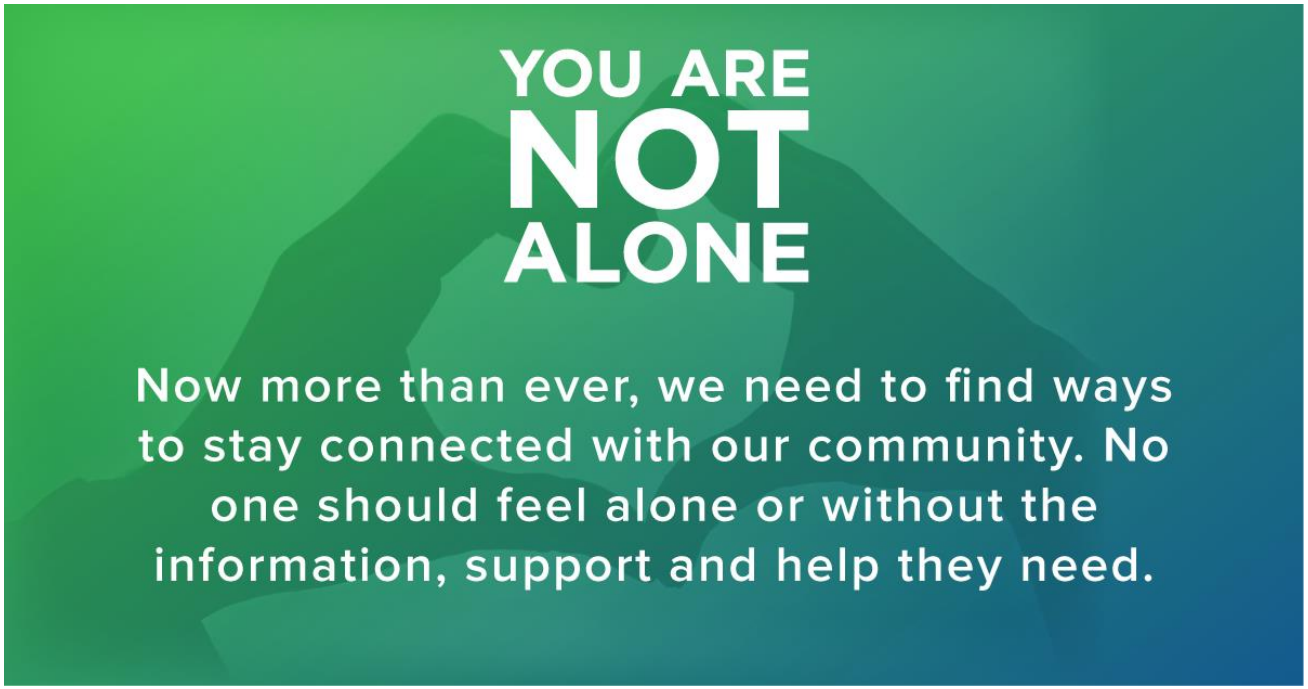
mass.gov/HPC/OPP

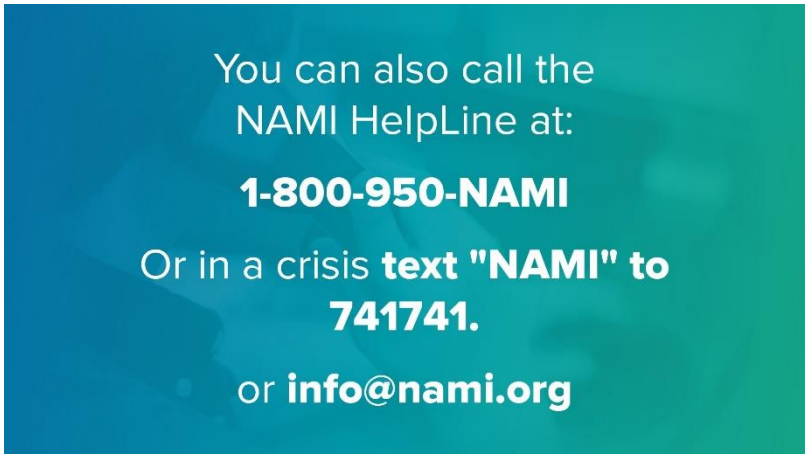
OPP Hotline: (800) 436-7757

Fax: (617) 624-5046

HPC-OPP@mass.gov

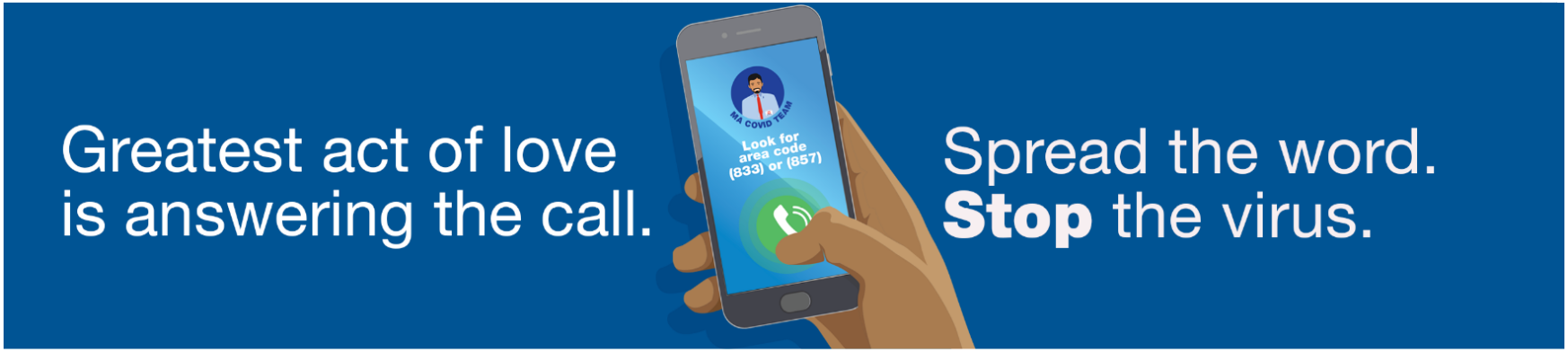
May is *Mental Health Awareness Month*





HPC

Community Tracing Collaborative Overview: Be a Part of the Solution



The Commonwealth of Massachusetts, along with Partners In Health, has created the COVID-19 Community Tracing Collaborative. The program focuses on reaching out to the contacts of confirmed positive COVID-19 patients to help others who have been potentially exposed to the virus. **When the MA COVID Team calls, you can do your part by answering the phone and providing helpful information that will help flatten and reduce the curve in Massachusetts.**

Phone calls will use the prefix (833) and (857), and your phone will say the call is from “MA COVID Team.” Calls will be made daily from 8 a.m. to 8 p.m.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order – Chair Stuart Altman
- Executive Director's Report
- **Market Oversight and Transparency Committee**
  - Approval of Minutes **(VOTE)**
  - New CHIA Reporting Timetable and Implications for the HPC's Calendar in 2020-2021
  - National Data on Impact of COVID-19 Pandemic on Health System Utilization and Spending
  - Out-of-Network Billing Chartpack (2017 Data)
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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Market Oversight and Transparency Committee meeting held on **January 14, 2020,** as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

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Updated Timelines for Reporting Data to CHIA

- In response to the COVID-19 pandemic, and consistent with ongoing consultation with HPC to accelerate the benchmark accountability timeline, **CHIA has elected to change many of its key reporting requirements**:
  - Total Medical Expenses (TME) data is now due in **September** (vs. May), but **will include final data for both 2017-2018 and 2018-2019** (vs. final data for 2017-2018 and preliminary data for 2018-2019);
  - Alternative Payment Methods, Premium, and Prescription Drug Rebate data is also now due in **September** (vs. May/June);
  - Relative Price data is due in **October** (vs. June/July); and
  - Primary and Behavioral Health Care Expenditures data is due in **December**.
- The new reporting requirements will have **implications for the HPC's timelines**:
  - CHIA will likely issue its annual report on health care spending from 2018 to 2019 in **January 2021**, suggesting the HPC follow with its Cost Trends Hearing in **March** in concert with the Benchmark Hearing; and
  - CHIA's referral of payers and providers to the HPC for a potential PIP will also likely occur in **February 2021** for both 2017 to 2018 and 2018 to 2019 spending trends (~8 months earlier accountability for 2018-19 performance).

Updated Cost Trends and PIPs Timelines for 2020 and 2021

	Current Timeline	Revised Timeline
Total Medical Expense Data Collection	May 2020 (final 2017-2018 and preliminary 2018-2019 data)	September 2020 (final 2017-2018 and final 2018-2019 data)
CHIA Annual Report (2018-19 spending)	September 2020	January 2021
Cost Trends Hearing	October 2020	March 2021
PIPs Referral from CHIA to HPC	November 2020 (2017-18 performance only)	February 2021 (2017-18 and 2018-19 performance)
Conclusion of HPC PIP Review and Potential Vote to Require a PIP	July 2021 (2017-18 performance only)	November 2021 (2017-18 and 2018-19 performance)
HPC issues Cost Trends Report	February 2021	May 2021

COVID-19 and the Health Care Cost Growth Benchmark

The law requires the HPC to set an annual health care cost growth benchmark. The HPC Board is expected to set the 2021 benchmark at its next meeting on June 10, 2020.

A detailed analysis of spending relative to the benchmark will be a key strategy to understand the impact of COVID-19.

The COVID-19 pandemic poses a tremendous challenge to the entire health care system. Setting a benchmark and robustly analyzing spending relative to it will be a key strategy to understanding both the short-term spending impacts and the long-term implications of COVID-19 on the health care system.

The benchmark and HPC's accountability framework can account for unique factors impacting spending.

The benchmark is a **long-term measurement strategy**, rather than an annual spending cap, which allows the HPC to identify factors that may lead to increased spending in a given year. Accountability **under the benchmark is also designed to not penalize entities for spending growth outside of their control**. The HPC expects that the current crisis will be weighed heavily as the HPC conducts reviews of 2020 spending performance (which will likely be analyzed in 2022, with more time to understand the impact of COVID-19).

HPC

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Potential Impacts of the COVID-19 Pandemic on the Health Care System

As the COVID-19 pandemic produces unique challenges to the Massachusetts health care system, the HPC can leverage its **data assets, research expertise, investment experience, and market knowledge** to support policy efforts during and after the crisis.

As the first of many discussions on the impact of the COVID-19 pandemic, today will include some initial thoughts on:

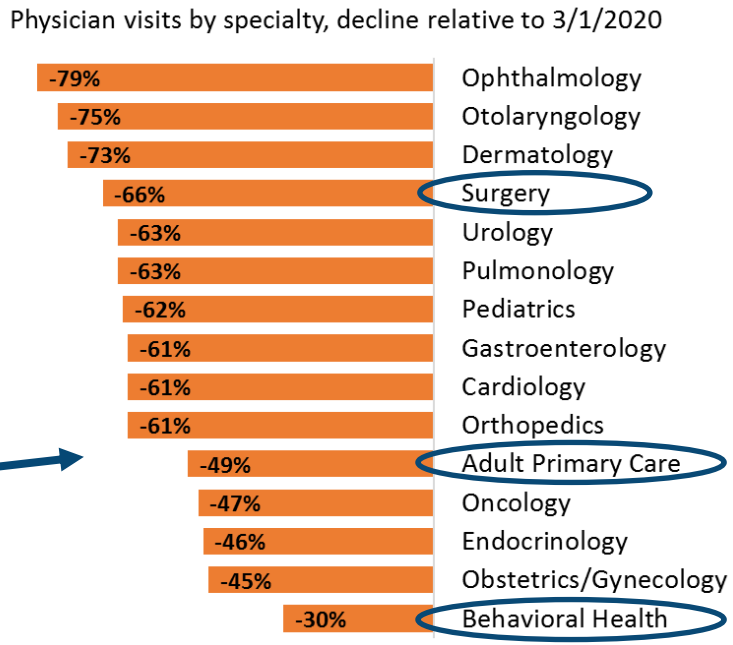
- Key dynamics and effects on **spending** and **utilization**
- Potential impacts on **market participants**
- **Implications** and **opportunities** for HPC work

To inform the discussion, the HPC examined sources including early industry reports on utilization trends,[1] estimates of COVID-related direct spending,[2] and expert opinion pieces and news articles.[3]

Sources:
1. Mehrotra et al, Commonwealth Fund based on Phreesia--database on 50,000 providers from 3/1/2020-4/05/2020; IQVIA COVID-19 Market Impact--Baseline to week ending 4/10/2020; Kaufman Hall National Hospital Flash Report--database on 800 hospitals from 3/1/20-3/31/2020; Kaiser Health News; Health Insurers Prosper As COVID-19 Deflates Demand For Elective Treatments, 4/28/20
2. Fair Health (2020). "The Projected Economic Impact of the COVID-19 Pandemic on the US Healthcare System." March 25, 2020.
3. Cutler, David. "How Will COVID-19 Affect the Health Care Economy?." *JAMA Health Forum*. Vol. 1. No. 4. American Medical Association, 2020; Chernew, Micheal. "How To Read National Health Expenditure Projections In Light Of COVID-19: Uncertain Long-Run Effects, But Challenges For All" Health Affairs Blog, 4/20/20; Huckman, Robert. What Will U.S. Health Care Look Like After the Pandemic? Harvard Business Review, 4/7/20; Ezekiel Emanuel and Amol Navathe, "Will 2020 Be the Year That Medicine Was Saved?" NY Times Opinion, 4/14/20; Shin P, et al "Keeping Community Health Centers Strong During the Coronavirus Pandemic is Essential to Public Health". Health Affairs Blog, 4/10/2020; Grabowski, David C., and Karen E. Joynt Maddox. "Postacute care preparedness for COVID-19: Thinking ahead." *JAMA* (2020). Emily Benfer and Lindsay Wiley, "Health Justice Strategies To Combat COVID-19: Protecting Vulnerable Communities During A Pandemic," Health Affairs Blog, March 19, 2020. Barnett ML, Mehrotra A, Landon BE. Covid-19 and the Upcoming Financial Crisis in Health Care. NEJM Catalyst. April 29, 2020. Kang NS. "Once the Coronavirus Pandemic Subsides, the Opioid Epidemic Will Rage". Health Affairs blog. April 15, 2020.Kirzinger A, et al. "KFF Health Tracking Poll – Early April 2020: The Impact of Coronavirus on Life in Amercia". Kaiser Family Foundation. April 2, 2020.

National industry reports find dramatic reduction in non-COVID-19 care in March and April 2020.

- **Hospitals** (March 2020 versus March 2019)
  - Drop in discharges (-16%), patient days (-15%), OR minutes (-26%) and ED visits (-14%)
  - Reduction in revenue: inpatient (-14%); outpatient (-19%)
  - Median occupancy rate fell from 65% to 53%
- **Physician Office Visits** (through April 12)
  - Overall net reduction: -64%
    - Would be closer to -80% but **telehealth** has backfilled 1 in 5 lost visits; 30% of visits are now remote
    - Drop varies by specialty
- **Prescription Drugs** (through April 3)
  - New prescriptions: -27% overall
  - Office-based drug administration: -65%
- **Laboratory/Diagnostic Tests** (through April 3)
  - Reductions across all settings, with -70% in office-based testing



Source: Commonwealth Fund/ Phreesia database of 50,000 providers comprising 1 million visits weekly

Sources: Mehrotra et al, Commonwealth Fund based on Phreesia--database on 50,000 providers from 3/1/2020-4/05/2020; IQVIA COVID-19 Market Impact--Baseline (weekly average of the 8 weeks ending 3/6/2020) to week ending 3/27/2020; Kaufman Hall National Hospital Flash Report--database on 800 hospitals from 3/1/20-3/31/2020.

Potential Revenue Impacts on Market Participants

Key Factors Affecting Provider Revenue for Hospitals and Physicians

Reduction    Increase

Reduced revenue from displaced or avoided care	Increased revenue from COVID-related care	Federal and state support (CARES Act, Paycheck Protection Program, payment rate enhancements, advanced payment)	Shift away from commercial coverage
			

Effects will vary based on diversity of revenue streams, baseline financial profile, payer mix, and other factors.

Commercial payers
Reductions in non-COVID utilization (and associated savings) could be offset by shifts away from commercial coverage, increased COVID testing and treatment spending, reduced investment earnings, shared savings, and MLR payouts.

HPC

Key Dynamics and Effects on Spending and Utilization

Immediate Impacts

- Major **reduction** in use of **non-COVID** health care
- Substantial **increase** in use of **telehealth**
- **Increase** in COVID-19-related **testing** and **treatment**
- Significant **disruptions** to **post-acute/long-term care** settings and provider workforce

Potential Medium- to Long-term Impacts

- Some **displaced care may not resume** (e.g., pre-op visits, telehealth substitution)
- Some **displaced care should resume normally** (e.g., knee replacement)
- Some **displaced care could return in costlier form**
- New costs related to **COVID-19 treatments and vaccines**
- Potential **increased demand** for **mental health** and **substance abuse services**
- Adverse health impacts related to **social determinants** and **impaired access** may increase

HPC

Discussion: Implications and Opportunities for HPC Work

The HPC can support the Commonwealth with insights about the impact of the COVID-19 pandemic and inform policy efforts during and after the crisis.

Potential HPC work:

- Model **differential impacts** on different types of provider organizations, for example:
  - Community hospitals and Academic Medical Centers (AMCs)
  - Physician practices
  - Community Health Centers
- Explore **market changes**, including consolidation pressures resulting from COVID-19
- Work with payers to **support primary and behavioral health care**, adapt and strengthen alternative payment models, and prioritize consumer affordability
- Evaluate the impact of **temporary** changes in practice and policy (e.g., expansion of telehealth, expanded scope of practice, setting of out-of-network benchmarks, reduction in unnecessary or low-value care, reduction in administrative complexity) and make policy recommendations to **sustain positive changes**
- Evaluate **health system and workforce capacity** to support health planning for potential future infection waves or pandemics
- Target **innovative investments** to foster resiliency within the health care system and communities most impacted by the COVID-19 pandemic and resulting health, social and economic disruptions (e.g., MassUP) – ***HOLD FOR DISCUSSION AT CDT MEETING***

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Out-of-Network Billing Related to COVID-19 Pandemic

April 9, 2020

The Baker-Polito Administration issued an Executive Order requiring insurers to cover all medically necessary emergency department and inpatient services (including all professional, diagnostic, and laboratory services) related to COVID-19 at both in-network and out-of-network (OON) providers, with no cost-sharing by the insured.

The Order prohibits balance billing and establishes the payment amount for OON providers at: (1) the in-network rate for providers that otherwise contract with the insurer; and (2) 135% of the Medicare rate for providers that are completely OON.

Out-of-Network Billing in Massachusetts: A chartpack featuring expanded data, analyses, and insights

The HPC's new analysis focuses on scenarios where patients could not choose an in-network provider for the services they received.

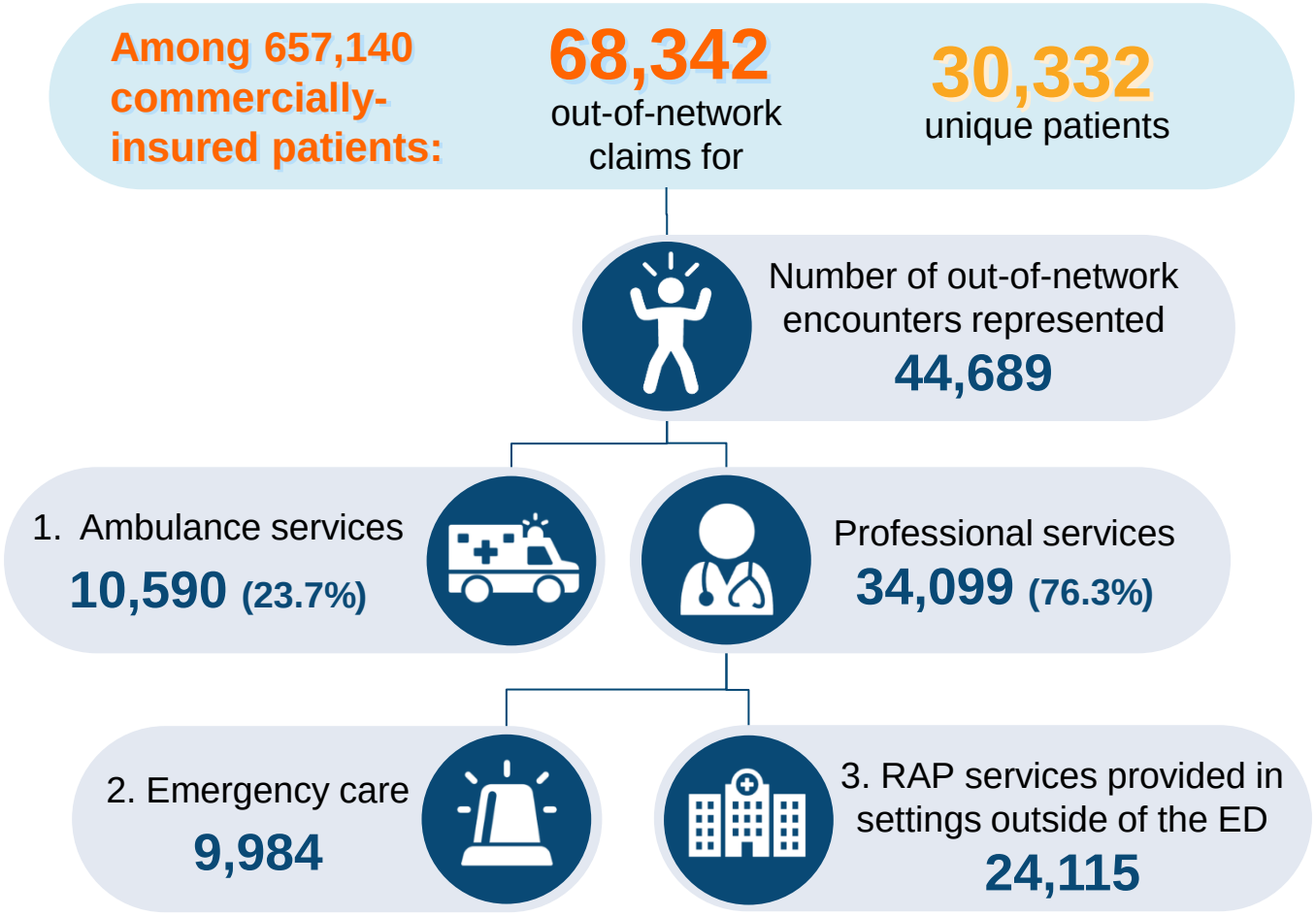
1. Ambulance company that serves the patients' geographic region

2. Emergency care (any providers who treat the patient in an ED)

3. Radiology, anesthesiology, and pathology services provided in settings outside of the ED

Compared to the HPC's 2017 analysis of 2014 data, **many indicators of out-of-network billing in Massachusetts have gotten worse over time**, including the number of claims with a potential balance bill and amounts charged by out-of-network providers.

Out-of-Network Claims in Massachusetts, 2017



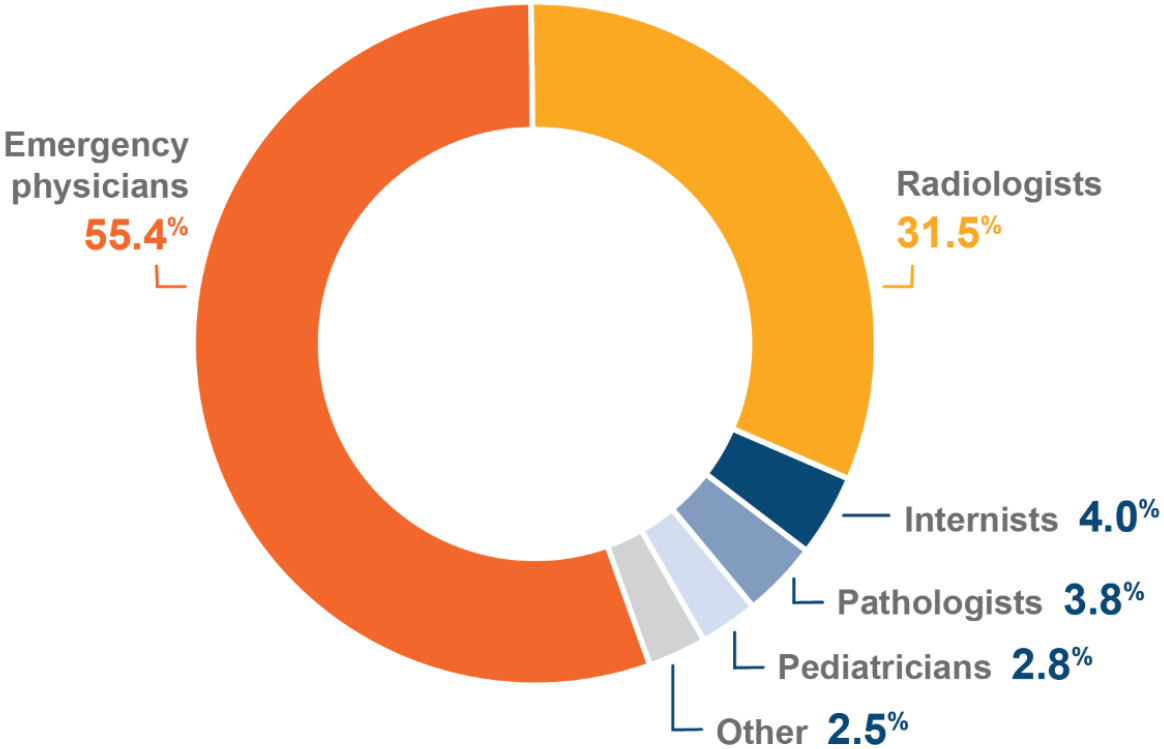
Notes: Only professional claims from an ambulance or from an emergency department or based on services performed by a radiologist, anesthesiologist, or pathologist (RAP) were included in this analysis. An encounter is created by grouping all services received by the same patient on the same day and same site of service. An out-of-network encounter refers to an encounter that results in at least one out-of-network claim line..

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017.

Emergency Department Out-of-Network Claims by Provider Specialty, 2017

Emergency care

- The HPC identified **9,984 out-of-network (OON) encounters at the emergency department (ED)**, accounting for 29.3% of professional services OON encounters.
- The most common provider specialties involved in ED OON encounters were **emergency medicine** (55.4% of claims) and **radiology** (31.5%).
- Other specialties include **internal medicine** (4%), **pathology** (3.8%), and **pediatrics** (2.8%).



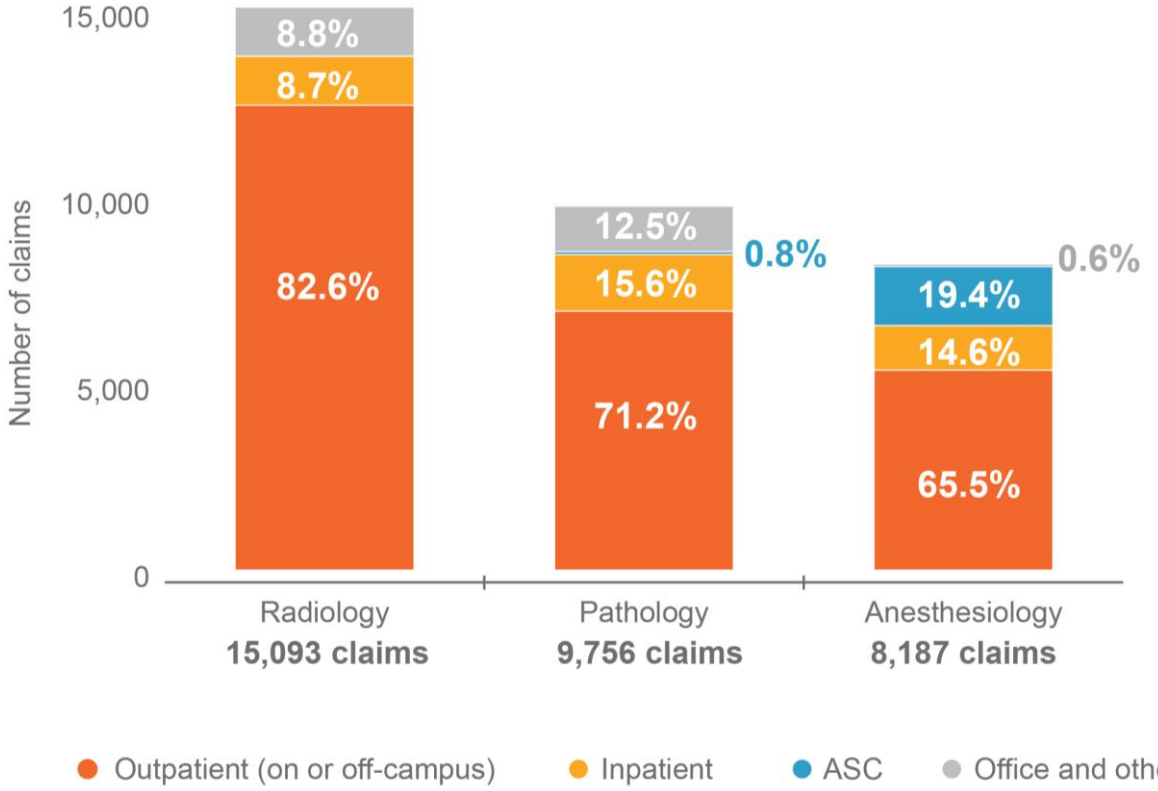
Notes: An out-of-network encounter refers to an encounter that results in at least one out-of-network claim line. Setting was analyzed at the encounter level, and provider specialty was analyzed at the claim line level.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017.

Out-of-Network Claims by Non-ED Sites of Service and Provider Specialty, 2017

RAP providers

- Among provider specialties prone to out-of-network billing, **radiology had the most out-of-network claims in 2017** (15,093), followed by pathology (9,756), and anesthesiology (8,187).
- The **hospital outpatient setting was where most out-of-network encounters occurred**, accounting for 82.6% of non-ED out-of-network radiology claims, 71.2% for pathology, and 65.5% for anesthesiology.



Notes: Other refers to lab settings for pathology and radiology. Percentages are of non-ED out-of-network claim lines performed by specialty physicians that are more prone to out-of-network billing (radiology, pathology, anesthesiology).

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

Potential Balance Bills for Out-of-Network Professional Service Claims, 2017

Professional services

- **Balance billing** occurs when a patient is billed for the difference between the insurer's payment and the provider's charges.
- The HPC found the potential for balance billing in **more than 90% of OON claims for professional services**.
- Insurers paid the full charge in 7.4% of cases; however, even among those insurers there was wide variation with one insurer paying 20.5% of OON professional claims while another paid less than 1%.

Potential Balance Bill: An out-of-network claim where the combined amount paid by the insurer and the patient (through deductible, copay, and coinsurance) is less than the charge amount on the claim.

Payment	Percent of OON claims
Insurer paid out-of-network charge in full	7.4%
Patient paid out-of-network charge in full	0.8%
Out-of-network bill paid in full by insurer and patient	0.6%
Potential balance bill	91.2%
Total	**100%**

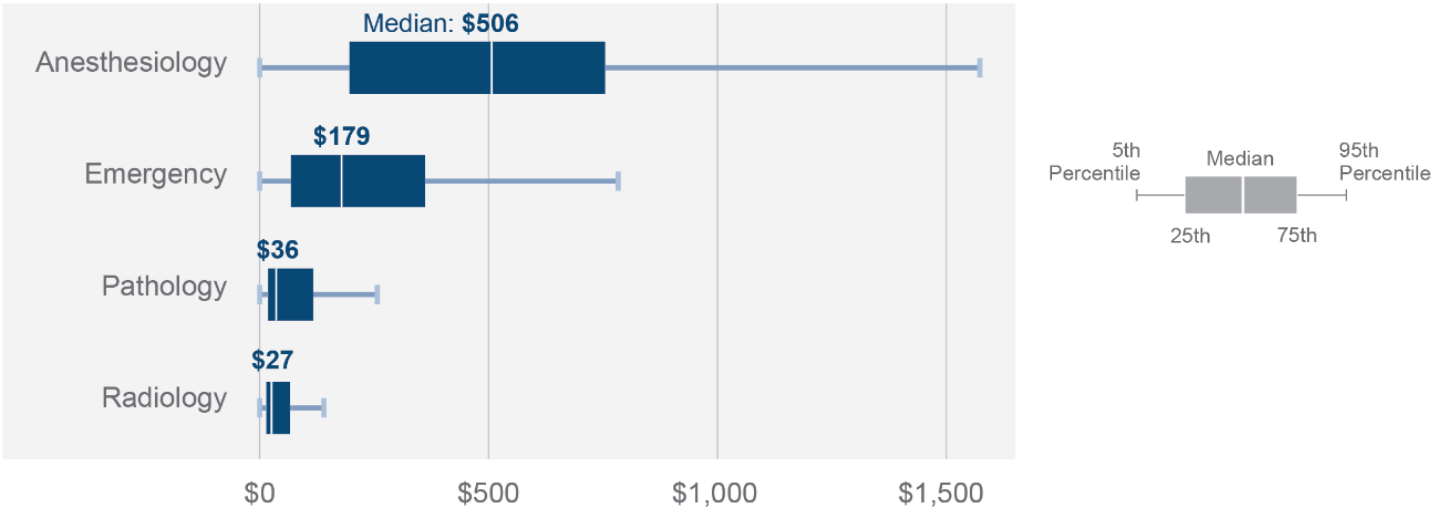
Notes: Only professional claims in the emergency department setting or performed by a radiologist, anesthesiologist, or pathologist were included in this analysis. Ambulance-based services were excluded. Claims with reliable fee-for-service paid amounts (e.g., not paid under a global budget, capitated encounter, or secondary payment) were included in the analysis of out-of-network payment.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

Amount of Potential Balance on Out-of-Network Professional Claims that were Not Paid in Full, 2017

Professional services

- Within the 91.2% of OON professional claims with potential for balance billing, the average balance potentially billable to patients was **$167 per claim**.
  - Amounts varied widely, ranging from **$5 at the 5th percentile to $749 at the 95th percentile**.
- The amount also varied significantly by specialty, with **anesthesiology claims having the highest** average potential balance ($588) and **radiology claims having the lowest** ($58).
  - The average potential balance was **$249 for emergency claims** and **$85 for pathology claims.**



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Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

Out-of-Network Billing Implications for Payers, Consumers, and Overall Market Functioning

In an OON billing scenario, the provider typically submits a bill to the insurer for the "list price" or charge for services rendered, and the insurer then determines the amount of payment, which may be the full charge or some lesser amount.

- When insurers pay higher rates to OON providers (as is often the case):
  - Those costs are passed along through **higher premiums[1].**
  - Providers can use those higher rates as leverage to negotiate **higher in-network rates**, and;
  - The costs of out-of-network payments may **diminish or even surpass any savings** the payer may be able to achieve through **limited network products**.
- If a payer does not pay the full amount charged by an out-of-network provider, the patient can be **balance billed** and expected to pay the difference, sometimes totaling thousands of dollars.
  - This can occur even where the patient did not knowingly choose to see an out-of-network provider (referred to as a "surprise bill").

Because of the cost of OON billing, some payers seek to bring as many providers in-network as possible, even at higher negotiated rates.

Therefore, looking at the *frequency* of OON billing for the largest/broadest payer networks understates its impact on total health care spending.

HPC

1. Cooper Z, Nguyen H, Shekita N, Morton FS. Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians. Health Affairs; 2020 Jan;39(1):24-32.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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  - Moving Massachusetts Upstream (MassUP) Investment Program
  - Top-Line Evaluation Results from the HPC's Telemedicine Pilot Program
  - HPC Policy Brief: *The Nurse Practitioner Workforce and Its Role in the Massachusetts Health Care Delivery System*
- Schedule of Next Board Meeting **(June 10, 2020)**

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HEALTH POLICY COMMISSION

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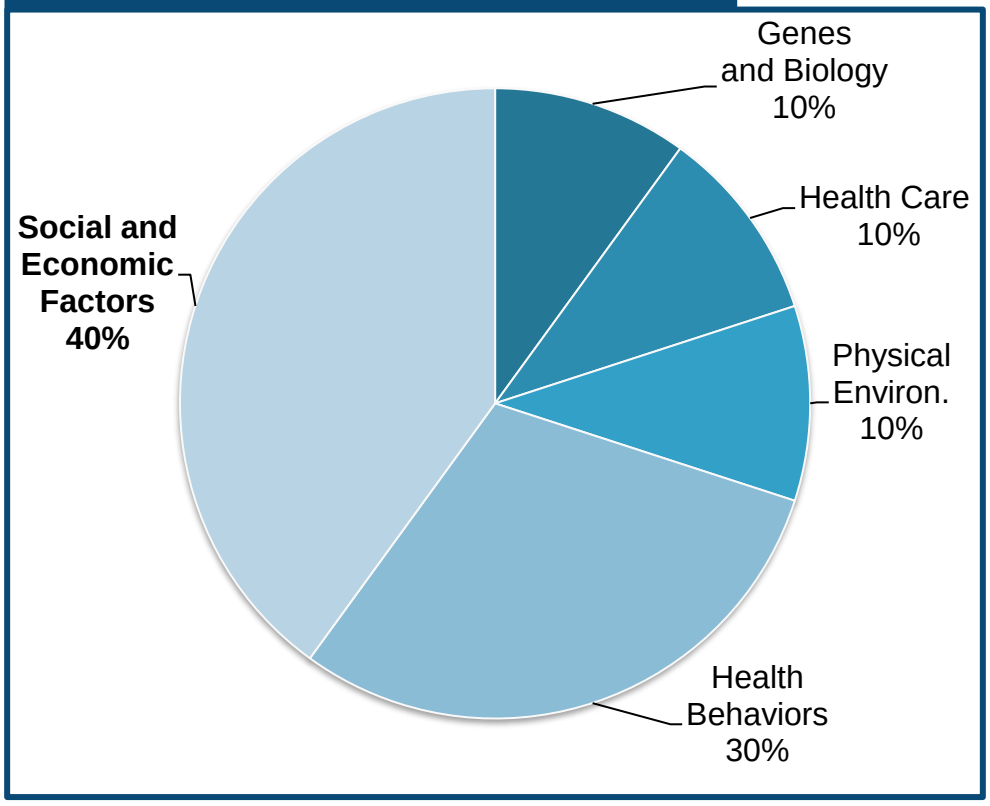
Addressing social determinants of health is essential to improving population health, reducing health inequities, and controlling health care costs.

Factors that Impact Health



MASSACHUSETTS HEALTH POLICY COMMISSION

2019 ANNUAL HEALTH CARE COST TRENDS REPORT

POLICY RECOMMENDATIONS

11 HEALTH DISPARITIES

b. Social determinants of health (SDOH): The Commonwealth should promote upstream collaborations among government agencies, health care providers, payers, and community-based organizations to understand the root causes of health inequity in communities – the social determinants of health (SDOH) – and leverage their combined expertise, resources, and influence to address those inequities through strategic investments, policy advocacy and alignment, and authentic engagement with community members.

SOURCE: Tarlov, A. Public Policy Frameworks for improving population health. Annals of the New York Academy of Sciences. 1999. 896. 281-93

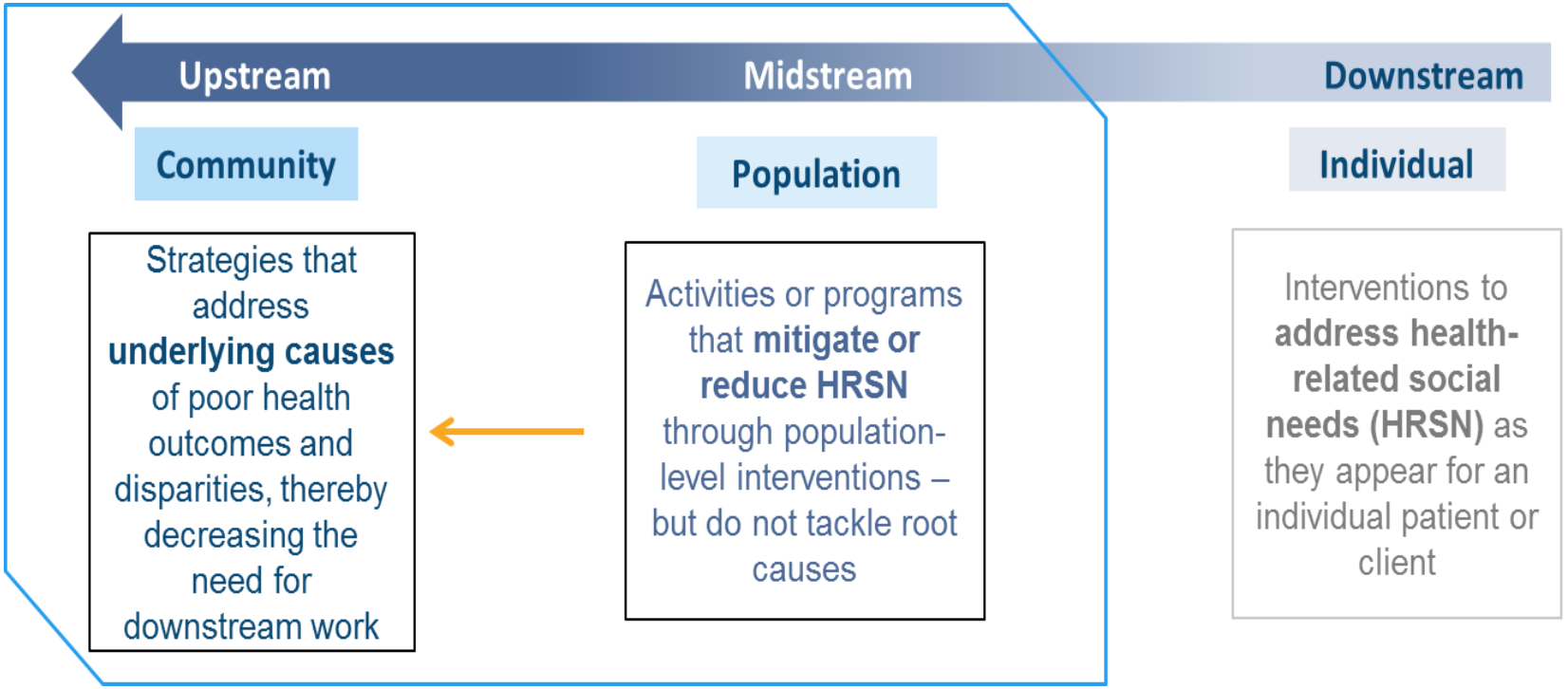
Moving Massachusetts Upstream (MassUP)

MassUP Vision:
Better health, lower costs, and reduced health inequities — across communities and populations in Massachusetts — through effective partnerships between government, health care systems, and communities to address the social determinants of health (SDoH).

- **A partnership across state agencies: DPH, MassHealth, AGO, EOEA, and HPC**
- Goal: To engage in **policy alignment activities** and make **investments to support health care system–community collaborations** to more effectively address the "upstream" causes of poor health outcomes and health inequity

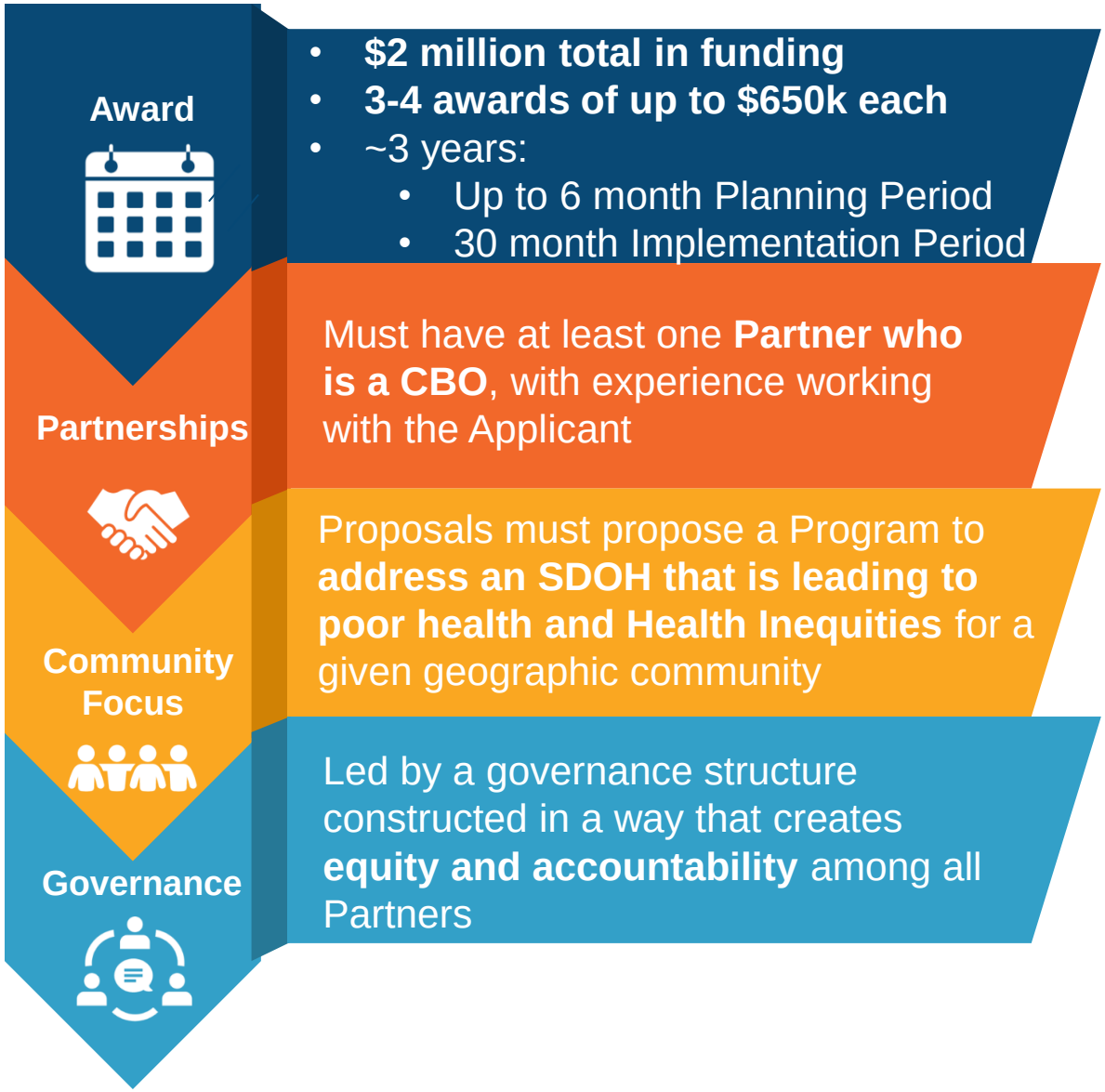
MassUP Investment Program Purpose

The purpose of the MassUP investment program is to build and/or expand upon existing efforts—particularly Partnerships between Provider Organizations and Community-based Organizations (CBO)—to implement Programs that move farther upstream in addressing the SDOH and the root causes of Health Inequities.



MassUP Investment Program Overview

Solicited Proposals from Applicants (provider orgs) on behalf of themselves and Partners seeking support to form a **Partnership** that will work to address upstream challenges to and enable sustainable improvements in **community health and health equity**



The HPC received 22 applications for funding from across the Commonwealth.

13 Hospitals

5 Community Health Centers

4 ACOs/Other Provider Organizations

Many MassUP applicants are previous HPC investment programs awardees

9 SHIFT-Care Awardees

6 HCII Awardees

6 CHART Hospitals

~$14 million

Requested by 22 applicants

$2 million

Available from the HPC/DPH

HPC

Areas of Focus for Proposed Partnerships

Transportation

Housing

Social Inequity

Economic Stability

Immigration Status

Early Childhood Needs

Food Security

HPC

Selection Criteria Domains

Applicant and Partners

- History of prior working relationship
- Status of Applicant and/or Partners as MassHealth provider
- Status of Applicant as HPC-certified ACO or ACO Participant
- Past performance in HPC investment programs

Proposed Program

- Alignment of Program with MassUP opportunity
- Demonstrated understanding of SDOH need in community
- Focus on upstream work, and use of Racial Equity Principles
- Feasibility and capacity of Partnership to achieve goals

Partnership Governance/Oversight

- Clarity of proposed governance structure to support effective leadership
- Governance creates equity and enables accountability
- Incorporation of community in decision-making

Partnership Operations and Budget

- Inclusion of 1.0 FTE role, additional dedicated staff
- Appropriate resource allocation, efficiency of budget
- In-kind funding, staff support, other resources

Sustainability

- Feasibility, strength of approach to sustaining Partnership
- Alignment with ACO Population Health Management programs; Community Benefits, DoN, and/or anchor institution strategy

HPC

MassUP Investment Program Next Steps

Procurement

June 10
- Staff present recommended awardees for Board review and approval

Contracting

June-August
- Kick-off webinar(s)
- Contracts executed with awardees

Program Launch and Planning Period

September 1 (or earlier)
- Planning Period begins
  - *Engage community members*
  - *Formally establish governance structure*
  - *Develop Implementation Plan and Measurement Plan*

Implementation Period

March 1, 2021
- Implementation Period begins

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order – Chair Stuart Altman
- Executive Director's Report
- Market Oversight and Transparency Committee
- Care Delivery Transformation Committee
  - Approval of Minutes **(VOTE)**
  - Moving Massachusetts Upstream (MassUP) Investment Program
  - **Top-Line Evaluation Results from the HPC's Telemedicine Pilot Program**
  - HPC Policy Brief: *The Nurse Practitioner Workforce and Its Role in the Massachusetts Health Care Delivery System*
- Schedule of Next Board Meeting **(June 10, 2020)**

Expanding Telehealth During the COVID-19 Pandemic

March 20, 2020

The Baker-Polito Administration issued an Executive Order requiring all commercial insurers and the Group Insurance Commission (GIC) to cover medically necessary telehealth services in the same manner they cover in-person services.

The Order prohibits carriers and the GIC from limiting the technologies used for delivering telehealth (including telephone or live video) and requires that payment for services delivered by telehealth be no less than the rates paid for in-person services.

MassHealth also acted to provide coverage for telehealth services for members and issued specific guidance to providers.

Since COVID-19, telehealth visits in MA have increased dramatically based on one major commercial health plans' experience.

3,600% increase between February and March of this year.

Source: Blue Cross Blue Shield of Massachusetts Telehealth Claims Skyrocket During Coronavirus Pandemic. Accessed 4/24/2020. https://www.prnewswire.com/news-releases/blue-cross-blue-shield-of-massachusetts-telehealth-claims-skyrocket-during-coronavirus-pandemic-301039447.html

Telemedicine Pilot Initiatives: Overview

A one-year regional pilot program designed to **increase access to behavioral health care** using telemedicine for **children and adolescents**, **older adults aging in place**, and **individuals with substance use disorders (SUD)** residing in the Commonwealth.

4 initiatives
Funded by the HPC

$1.7 million
HPC funding

Launched summer 2017

Heywood Hospital

School-based telemedicine for adolescents

Pediatric Physicians Organization at Children's

Pediatrician-based telemedicine for youth

Riverside Community Care

Home-based telemedicine for homebound older adults

UMass Memorial Medical Center

Hospital-based telemedicine for patients with SUD

HPC

Telemedicine Pilot Initiatives: Key Lessons

- The Pilots **demonstrated telemedicine has broad applicability** and can be used in a range of community settings, including schools, primary care offices, and homes
- **Patients expressed high satisfaction and comfort** with the telemedicine platform
- Telemedicine models must be accompanied by **appropriate staffing models, workflow adaptations, and wrap around services**
- Participating behavioral health clinicians and referring providers **felt that telemedicine expanded access to high-quality care**; however, several programs noted limited availability of behavioral health providers, particularly those comfortable with telemedicine, as a barrier to scalability

Telemedicine Pilot Initiatives: Data Highlights

Over 780 patients were served across the three target populations: children and adolescents, older adults aging in place, and individuals with substance use disorders (SUD).

Over 85% of patients and families expressed satisfaction with the programs

Over 1,600 telemedicine sessions conducted

Wait time decreased 37% for a psychiatric consult at PPOC

UMass **initiated or maintained medication assisted treatment** during 188 hospitalizations

Avoided 6.3 missed days of school per student at Heywood

89% of Riverside patients with depression experienced a **decrease in depression symptoms** as measured by PHQ-9

Source: Telemedicine program Final KPI data.

MASSACHUSETTS
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Expansion of Advanced Practice Registered Nurse Scope of Practice During the COVID-19 Pandemic

March 26, 2020

The Baker-Polito Administration issued an Order allowing advanced practice registered nurses (APRN) with two years of supervised practice or equivalent practice in another jurisdiction to prescribe without supervision during the COVID-19 state of emergency and relaxing written collaboration agreement requirements for APRNs with less than two years of supervised practice.

HPC

While the nurse practitioner workforce is growing rapidly, restrictive scope of practice laws in Massachusetts and other states reduce access to quality care.

Background

- The nurse practitioner (NP) workforce has been growing rapidly across the U.S. and in Massachusetts.

- Despite this growth, **22 states** (including Massachusetts, the only New England state) maintain scope of practice (SOP) laws that **require NPs to have a clinical supervisor** (either a physician or a more senior NP) and other operational practice restrictions.

- There is no rigorous evidence showing improved quality of care resulting from these restrictions – but there is evidence that they **reduce access to care**.[1]

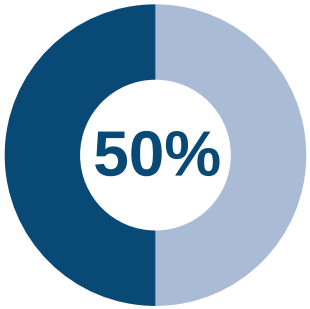
- While Massachusetts allows NPs to be recognized and deliver care as a primary care providers, and carriers must allow patients to select an NP as their PCP, scope of practice laws require[2]:
  - A **collaborative practice agreement** with a supervising physician
  - **Physician oversight of prescriptions** written for patients

HPC

Sources: (1) Spetz, J. "California's Nurse Practitioners: How Scope of Practice Laws Impact Care." (2019). (2) Section 28 of Chapter 305 of the Acts of 2008

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]

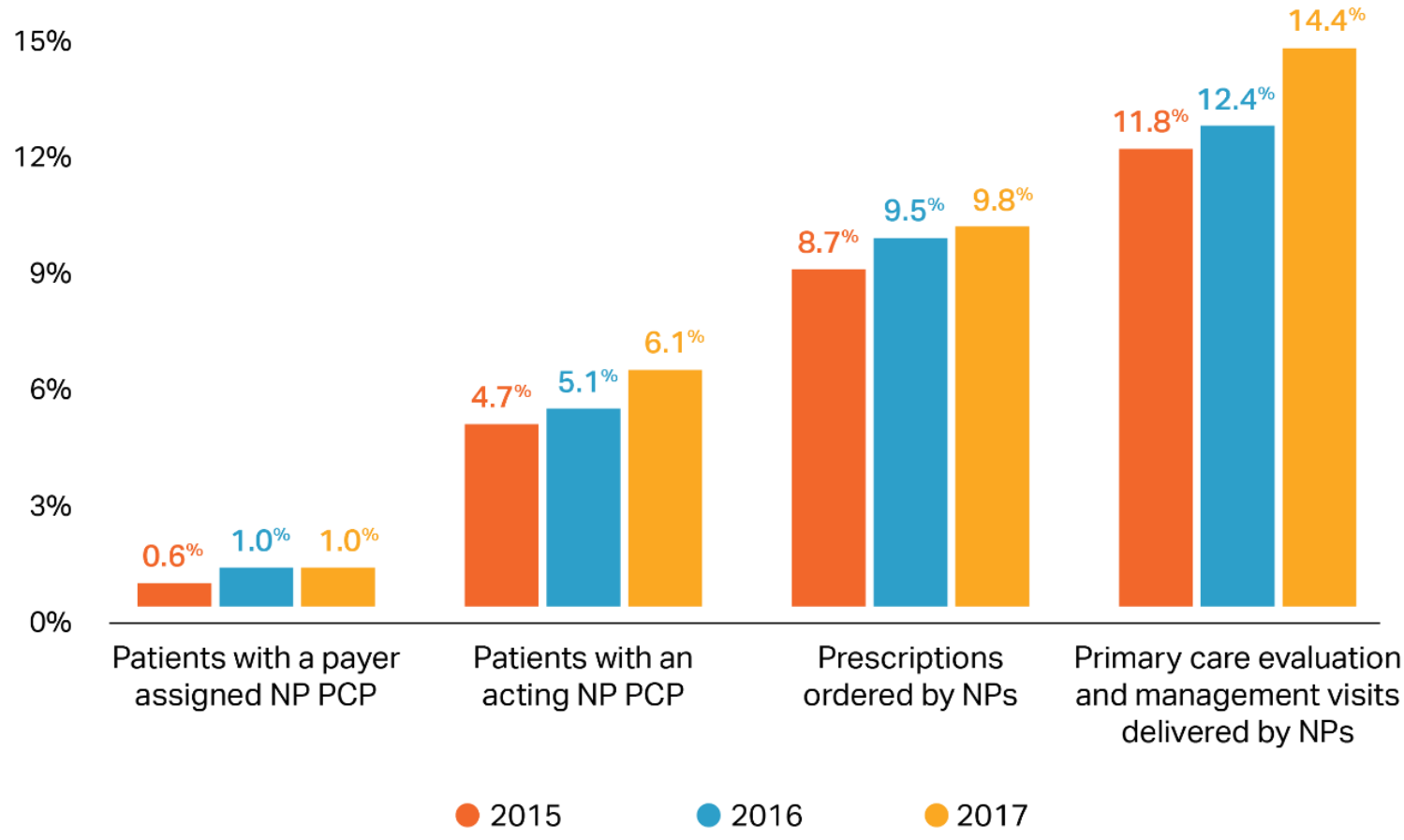
States that have changed their regulations to allow full practice authority saw **increases in primary care utilization** and **decreases in ED use**.[6]

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://bhw.hrsa.gov/sites/default/files/bhw/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. Salsberry, "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.

The number of NPs acting as PCPs in Massachusetts grew across all measures of involvement of NPs in patient care.

Commercial



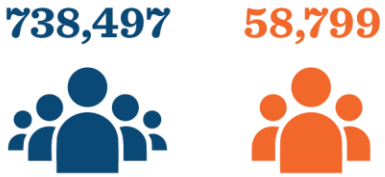
Notes: Analyses comparing proportion of patients assigned by their payer to an NP and patients attributed to an NP through observed claims utilization exclude commercial patients with insurance from Anthem which does not report PCP assignments in claims data.

Sources: HPC analysis of All-Payer Claims Database, 2015-2017 including Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Plan, Anthem and Neighborhood Health Plan; Massachusetts Registry of Provider Organizations (RPO), IQVIA (SK&A), and National Plan and Provider Enumeration System (NPPES).

Patients with an NP acting as their PCP are more likely to be women, younger, have lower risk scores, and have lower medical spending.

Commercial

■ PATIENTS WITH A PHYSICIAN AS A PCP ■ PATIENTS WITH A NURSE PRACTITIONER AS A PCP

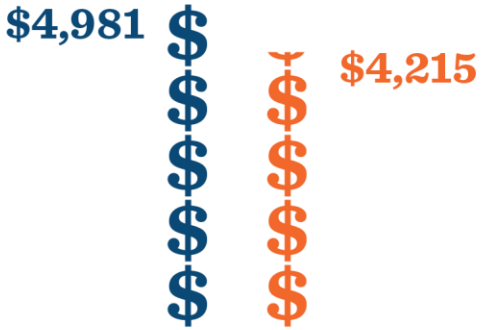


ADULTS

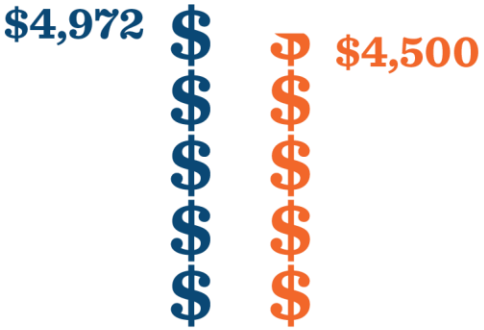
PERCENTAGE FEMALE

AVERAGE RISK SCORE

AVERAGE AGE



UNADJUSTED PMPY MEDICAL SPENDING



ADJUSTED PMPY MEDICAL SPENDING

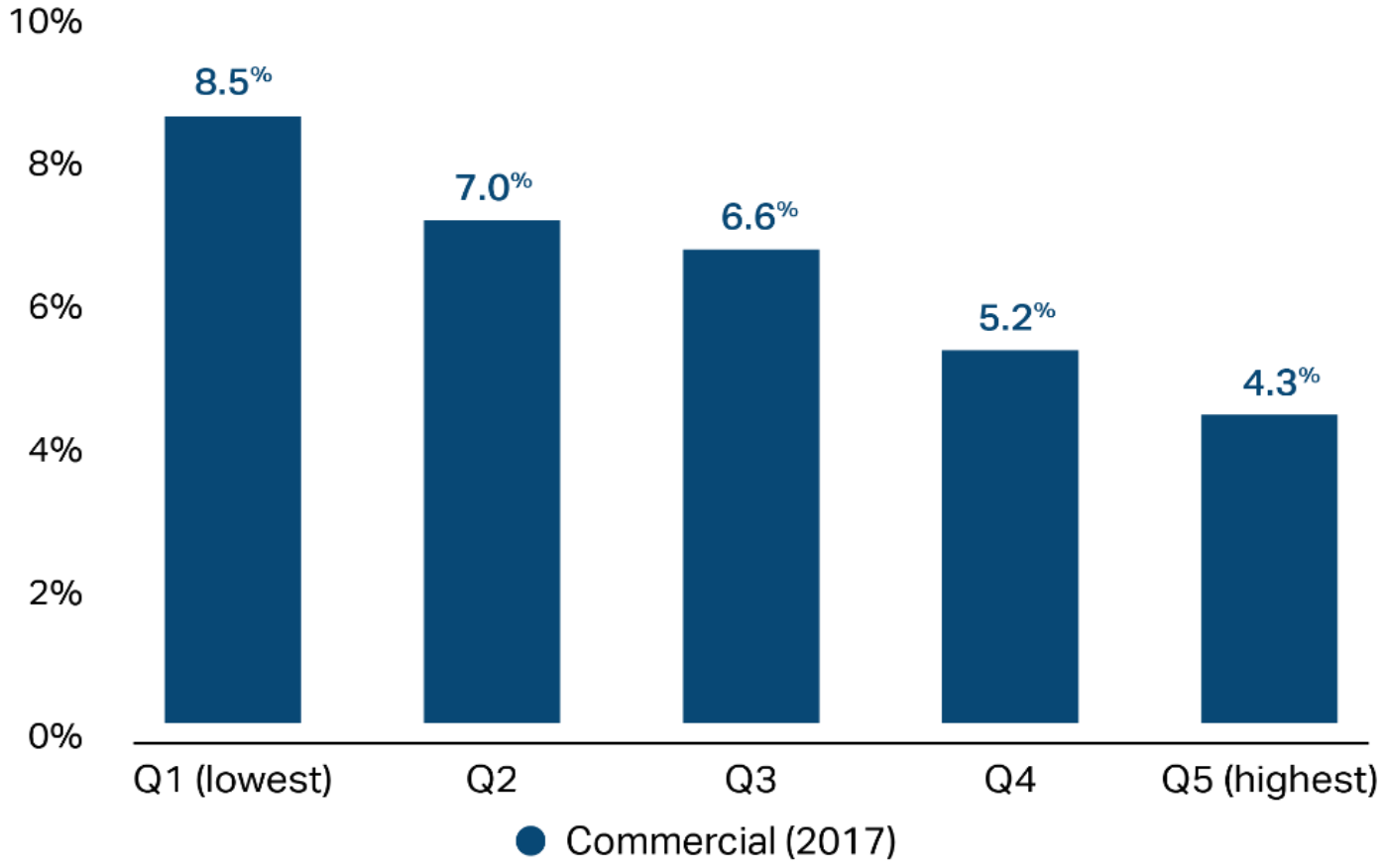
HPC

Source: HPC analysis of All-Payer Claims Database, 2017, RPO, IQVIA (SKA), and NPPES.

NPs play an important role in providing primary care to lower income communities.

Commercial

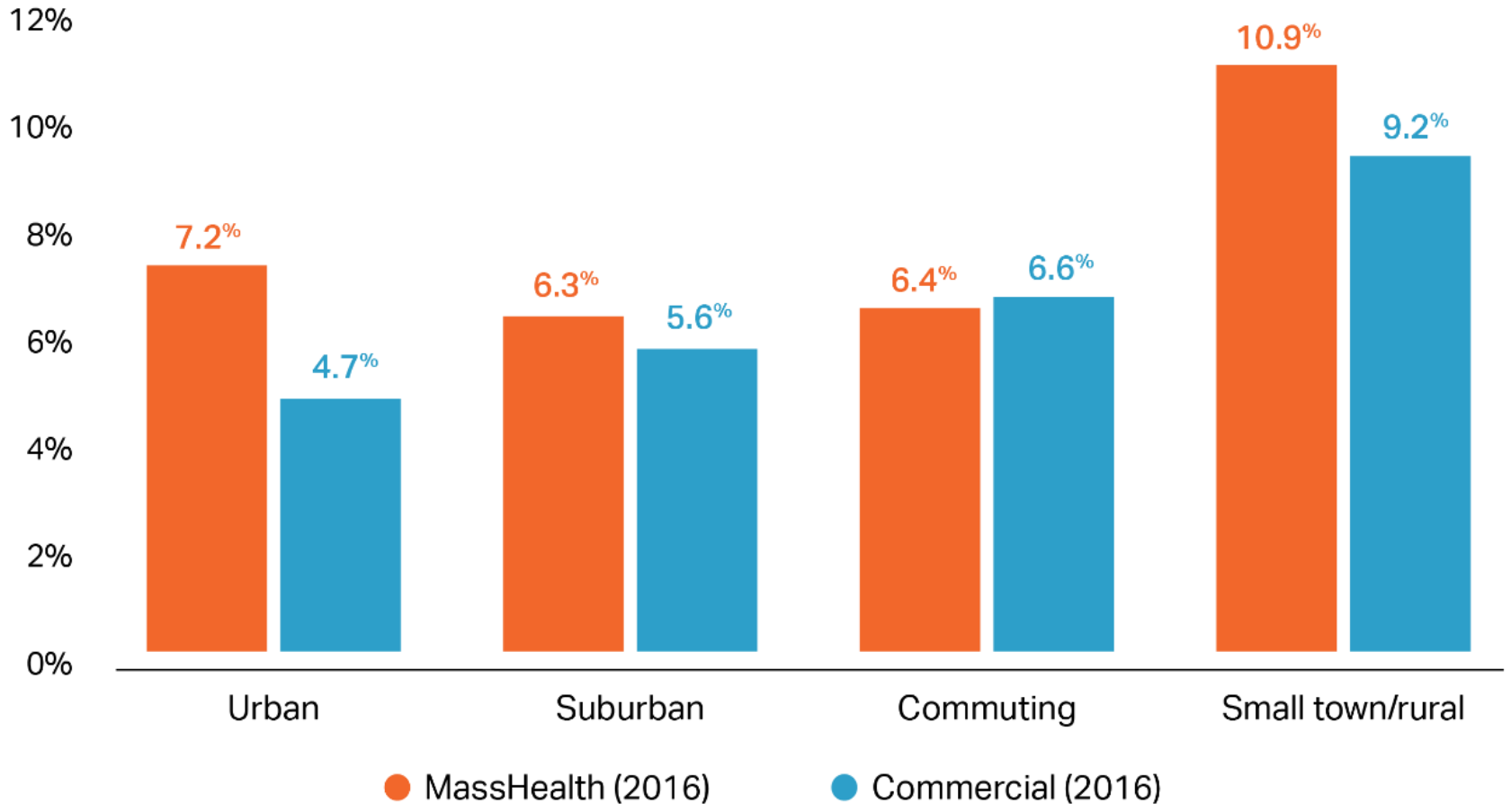
Percentage of commercial residents with an NP as their primary care provider, by income quintile of the patient's zip code, 2017



Notes: Commercial patients attributed based on utilization.
Sources: HPC analysis of All-Payer Claims Database, 2017, RPO, IQVIA (SKA), and NPPES.

In both commercial and MassHealth managed care (MCO) populations, NPs play an important role in providing primary care to more rural communities.

Percentage of patients with an NP as their primary care provider by geographic area and insurance coverage type, 2016

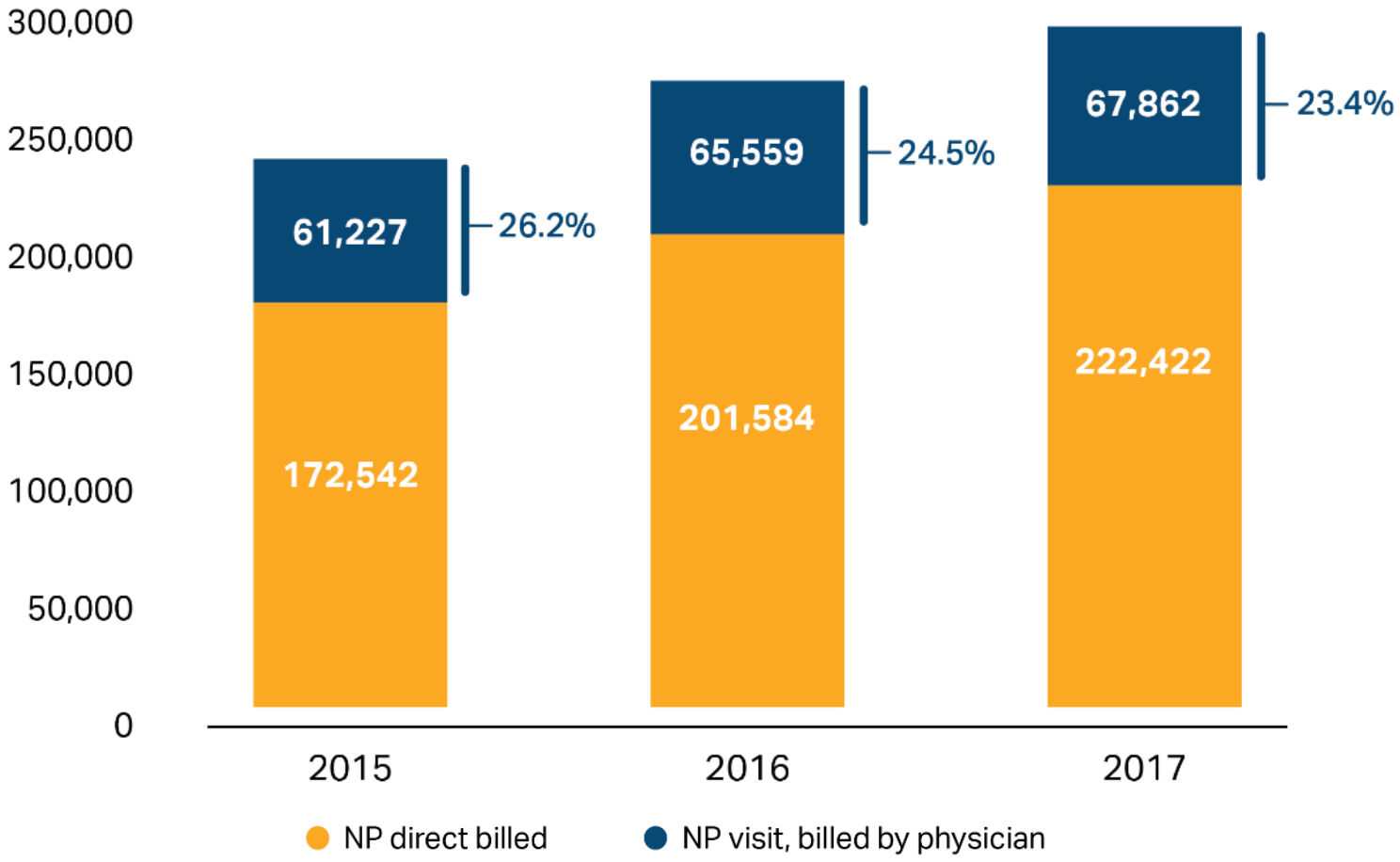


Notes: Members attributed to primary care providers based on utilization patterns and not insurer-assignment.
Sources: HPC analysis of All-Payer Claims Database, RPO, IQVIA (SKA), and NPPES.

At least 23% of all commercial primary care evaluation and management visits delivered by NPs were billed by physicians in 2017.

Commercial

Extent of "incident to" billing among commercial evaluation and management visit claims, 2015-2017



Notes: Claims analyzed include professional claims for E&M visits (CPT 99201-99205, 99211-99215) occurring in an office setting. "Incident to" billing indicated by a modifier code placed in the claim record by the insurer.

Source: HPC analysis of All-Payer Claims Database, 2015-2017.

Conclusions and Policy Recommendations

- Timely access to high quality care is essential to a well-functioning health system that delivers positive health outcomes equitably across the Commonwealth.
- Nurse practitioners have the potential to **fill gaps in access to care** and better serve **underserved areas and lower income populations.**
- **Care provided by NPs is lower-cost** compared to care provided by physicians.
- The HPC has recommended **eliminating SOP restrictions** in its annual policy recommendations and reinforces that recommendation with this policy brief.
- The HPC also recommends **ending the practice of "incident to" billing**, as it increases health care costs and there is no evidence that it increases quality of care.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

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- Care Delivery Transformation Committee
- **Schedule of Next Board Meeting (June 10, 2020)**

Upcoming 2020 Meetings and Contact Information

Board Meetings

Wednesday, June 10
Wednesday, July 22
Tuesday, September 15
Wednesday, December 16

Advisory Council

Wednesday, February 26
Wednesday, June 24
Wednesday, September 2

Committee Meetings

Wednesday, September 30
Wednesday, November 18

Contact Us

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HPC